Appendix A

Application Cover Sheet
and
Proposal Submission Checklist

Request for Proposals
(RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services:

HealthTec

Quick Connect

Housing Stability Services

Mobile GO Teams

ATTACHMENT 1.1

COVER SHEET AND
PROPOSAL SUBMISSION CHECKLIST

(Complete one Cover Sheet for the Entire Application Proposal Package.)

Certification of eligibility to apply to Miami-Dade County for funding the following:

ENDING THE HIV EPIDEMIC (EHE) INITIATIVE SERVICES:
HEALTHTEC, QUICK CONNECT, HOUSING STABILITY, AND MOBILE GO TEAMS

(RFP No. EHE-2223)

Full Legal Name of Proposing Organization:	
Federal Tax ID Number:	
Street Address: *(Street, City, State, Zip)*	
Mailing Address (if different): *(Street, City, State, Zip)*	
Agency Phone:	
Agency Fax:	
Official Applicant Contact Person:	
Email address:	

Service Category	**Amount Requested** *(enter $0 below, if not applying for a listed component)*
HealthTec	
Quick Connect	
Housing Stability Services	
Mobile GO Teams	

ENDING THE HIV EPIDEMIC (EHE) INITIATIVE SERVICES

HEALTHTEC, QUICK CONNECT, HOUSING STABILITY, AND MOBILE GO TEAMS

(RFP No. EHE-2223)

Proposal Submission Checklist

Please **circle** the appropriate response for each of the following questions; then complete the certification at the end of this page.

1) Is the proposing organization located (headquartered) in Miami-Dade County?

   YES *(skip to #3)* NO

2) If no to #1, does the proposing organization provide services within Miami-Dade County?

   YES NO NOT APPLICABLE

3) Is the proposing organization a for-profit or non-profit organization?

   FOR-PROFIT NON-PROFIT

4) If the proposing organization is a non-profit, is a copy of the organization's IRS letter of determination documenting its current status as a 501(c)3, along with a copy of the most current IRS Form 990, included with the application?

   YES NO NOT APPLICABLE

5) Is a copy of the proposing organization's most current tax returns included with the application?

   YES NO

6) Is a copy of the last certified audit, if available, or audited/unaudited financial statements; and documentation of the proposing organization's annual agency-wide operating budget included with the application?

   YES NO

7) Does the proposing organization comply with the requirement to not discriminate on the basis of race, color, religion, ancestry, national origin, sex, pregnancy, age, disability, marital status, familial status, gender identity, gender expression, sexual orientation, veteran status, source of income, or real or perceived status as a victim of domestic violence, dating violence or stalking, in regards to its contractual obligations, work, and services performed?

   YES NO

I certify that all information contained in this application is true and accurate. I understand that material omission or false information contained in this application constitutes grounds for disqualification of the Proposing Organization and this application. I further understand that by submitting an application I, as an authorized representative of the organization, am accepting the terms and conditions as they appear in the RFP Solicitation document and attachments.

______________________	______________________
Signature	Title
______________________	______________________
Print Name	Date
______________________	
Agency Name	

(Affix Corporate Seal or Notary Stamp and Signature)

Appendix B

BUDGET FORMS,
BUDGET FORM INSTRUCTIONS,
NARRATIVE BUDGET JUSTIFICATION INSTRUCTIONS

Request for Proposals
(RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services:

HealthTec

Quick Connect

Housing Stability Services

Mobile GO Teams

APPENDIX B.1 - RFP No. EHE-2223
ATTACHMENT 11a

LINE ITEM BUDGET FORM

Organization	Service Category	Budget Period
		12 Months *(12-month budget)*

Object Class Categories		Ryan White		Other Funding						
COSTS:		**EHE Direct Service Costs**	**EHE Indirect / Admin. Costs***	**Other EHE / Part A / MAI Funds**	**All Other Federal Funds**	**City and/or State**	**General Oper./ Private**	**Total Agency Cost For Budget Period**	**Adjusted Salary Cap ****	**Percent to be Charged to EHE on this budget (of "Adjusted Salary Cap", where applicable)**
Personnel										
1. Position								$0		
Fringes								$0		
2. Position								$0		
Fringes								$0		
3. Position								$0		
Fringes								$0		
4. Position								$0		
Fringes								$0		
5. Position								$0		
Fringes								$0		
Travel: Mileage (local)								$0		
Travel: Parking & Tolls (local)								$0		
Supplies								$0		
Equipment								$0		
Contractual								$0		
Other Direct Costs:								$0		
Other Direct Costs:								$0		
Other Direct Costs:								$0		
Other Direct Costs:								$0		
Other Indirect/Admin. Costs:								$0		
Other Indirect/Admin. Costs:										
SUBTOTAL		$0	$0	$0	$0	$0	$0	$0		
TOTAL AMOUNT REQUESTED			**$0**							

* **Total not to exceed 10% of Total Amount Requested for this service category.**

** **In accordance with the Consolidated Appropriations Act, 2023 (P.L. 117-328), the limitation on charging salaries to DHHS/HRSA grant funds is $212,100 (Executive Level II salary cap effective January 1, 2023); and the allowable percent to be charged is proportionate to the time and effort dedicated to services provided under this budget. This reference and salary cap are subject to change with the new Consolidated Appropriations Act of 2024.**

Instructions for Completing
Line Item Budget Form

NOTE: Proposers MUST use the Line Item Budget Form provided; a separate form for each Ending the HIV Epidemic (EHE)-funded service category (HealthTec, Quick Connect, Housing Stability Services, and Mobile GO Teams). Projected costs must be allowable, reasonable, and allocable as per Subpart E, Cost Principles, of the federal Uniform Guidance. See 45 CFR Part 75 for Health and Human Services programs (https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75).

1. In the box titled **"Organization,"** please indicate the full legal name of the proposing organization.

2. In the box titled **"Service Category,"** please indicate the name of the service category that the organization will provide with funding under the EHE Program.

3. In the box titled **"Budget Period,"** please indicate the time period as **12-Months.** Please note that, if awarded funding, the organization will later be instructed to complete a budget form allocating funds to provide the service identified in Item #2 above for the initial project period (i.e., 12/1/2023-2/29/2024).

4. In the spaces provided under the column labeled **"Object Class Categories," first,** list all direct service personnel and fringe benefits for each proposed position. **Next,** list all indirect/administrative personnel and their fringe benefits. For all staff listed, indicate their position title, first initial (at a minimum), last name, and the percent at which the fringe benefits are calculated. **NOTE: Each staff person must be listed separately. Do not combine salary and fringe benefits costs for staff under similar positions. Then,** in the following order, list travel for direct service personnel, direct service supplies, direct service equipment, contractual direct services, and any other direct costs (please see below for more information regarding allowable direct costs).

5. In the column labeled **"EHE Direct Service Costs,"** please indicate the projected amount for each line item to be requested under EHE as a direct cost for this service category only.

6. In the column labeled **"EHE Indirect/Admin. Costs,"** **<u>please indicate the projected amount of indirect/overhead/administrative costs to be requested under EHE for each applicable line item (i.e., personnel, travel, supplies, equipment, or other indirect line item, etc.), for this service category only</u>**. The total amount of the combined costs under the column labeled "EHE Indirect/Admin. Costs" cannot exceed 10% of the total amount requested per service category. For example, if the total amount of funds being requested is $10,000, then the combined total for the "EHE Indirect/Admin. Costs" column may not exceed $1,000 (i.e., 10% of the $10,000 award). **Due to Federal requirements, a detailed breakdown of individual indirect/administrative expenses is required; except for agencies with a Federally-approved indirect cost rate, in which case a copy of the most current "Federal Indirect Cost Rate Agreement" (FICRA) must be included as part of the organization's submission. The 10% indirect/administrative cap also applies to those organizations that have a Federally-approved indirect cost rate. Subrecipients with a FICRA <u>cannot</u> separate out (i.e., list separately) any line item that is already included in the approved indirect cost rate agreement.**

7. In the columns to the right labeled **"Other Funding"**, indicate all other funding sources [i.e., Other EHE, Ryan White Part A or Minority AIDS Initiative (MAI), Ryan White Part B, HOPWA, local County funding, State funding, other Federal funding, fees, contributions, general operating/private funds, etc.] which are expected to support the proposed budgeted line items, where appropriate. Where the time periods overlap, if any line item under any other EHE, Part A, or MAI-funded service category (i.e., same line item on other EHE, Part A, or MAI budgets) is also listed under this budget, the proposing organization must include this contribution as "Other EHE/Part A/MAI" funds. For all other funding, be sure to calculate (prorate) the proposed contribution from other sources based on the time period indicated on this budget in Item #3 above.

8. In the last three columns, for each service category, the proposing organization must indicate the projected total cost, adjusted salary cap if applicable, and projected percentage to be charged to EHE, Part A, or MAI per budget. Note the following:

   a. **First,** indicate the **"Total Agency Cost for Budget Period"** (i.e., this is the total projected cost to the proposing organization for each line item for the budget period indicated). This should not be a guesstimate, but should be based on real, historical costs, and factor in any potential adjustments or increases for the proposed grant fiscal year. If the same line item appears on multiple budget forms in this RFP application be sure that the "Total Agency Cost for Budget Period" is consistent across all budgets and is reflective of the budget period indicated in Item #3 above.

   b. **Second**, where applicable, indicate the **"Adjusted Salary Cap"**; otherwise leave the cell shaded. [NOTE: In accordance with the Consolidated Appropriations Act, 2023 (P.L. 117-328), the limitation on charging salaries (i.e., the salary cap) to DHHS/HRSA grant funds is $212,100, effective January 1, 2023. This amount is subject to change annually with each new Consolidated Appropriations Act. The allowable percent to be charged to the Ryan White Program is proportionate to the time and effort dedicated to services provided under this budget, and is based on the Total Agency Cost for Budget Period unless an Adjusted Salary Cap is indicated.]

   c. **Third,** calculate and insert the **"Percent Charged to EHE (this budget)"** (of the Total Agency Cost for Budget Period or the Adjusted Salary Cap, if applicable). This must be done for each line item that would be charged to EHE funding.

      i. For each direct service line item, the percent charged to EHE, for each service category, equals the amount listed as a **"EHE Direct Service Cost"** divided by the amount identified as the **"Total Agency Cost for Budget Period"** or the **"Adjusted Salary Cap"**, if applicable.

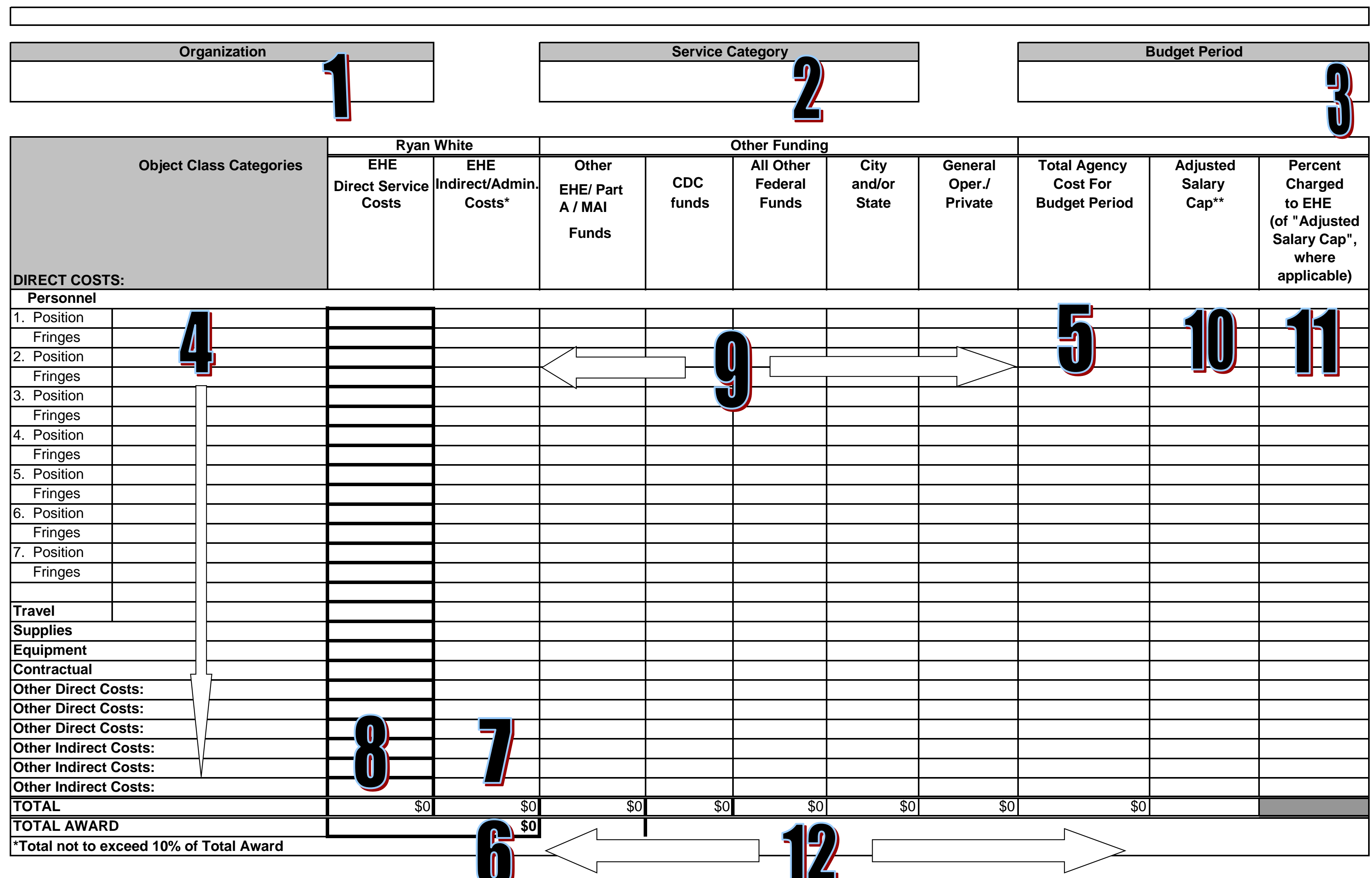
      ii. Similarly, for each indirect/administrative line item, the percent charged to EHE, for each service category, equals the amount listed as a **"EHE Indirect/Administrative Costs"** divided by the amount identified as the **"Total Agency Cost for Budget Period"** or the **"Adjusted Salary Cap"**, if applicable.

      iii. If a line item has an EHE direct and indirect/administrative allocation (that is not already included in a FICRA), add these amounts together then divide them by the total proposed cost to your organization, or the adjusted salary cap, if applicable, to get the total percent proposed to be charged to EHE for each line item budget.

9. Indicate the Subtotal for each column in the appropriate space(s) provided.

10. Indicate the Total Amount Requested from EHE under this service category only in the space provided (i.e., the sum of "EHE Direct Service Costs" and "EHE Indirect/Administrative Costs" columns). This amount MUST match the amount per service category indicated on the Application Cover Sheet in Appendix A.

SAMPLE - See referenced steps in Appendix B.4



Appendix B.3
12-Months
EHE

LINE ITEM BUDGET FORM

Organization	Service Category	Budget Period

DIRECT COSTS: Object Class Categories	Ryan White: EHE Direct Service Costs	Ryan White: EHE Indirect/Admin. Costs*	Other Funding: Other EHE/ Part A / MAI Funds	Other Funding: CDC funds	Other Funding: All Other Federal Funds	Other Funding: City and/or State	Other Funding: General Oper./ Private	Total Agency Cost For Budget Period	Adjusted Salary Cap**	Percent Charged to EHE (of "Adjusted Salary Cap", where applicable)
Personnel										
1. Position										
Fringes										
2. Position										
Fringes										
3. Position										
Fringes										
4. Position										
Fringes										
5. Position										
Fringes										
6. Position										
Fringes										
7. Position										
Fringes										
Travel										
Supplies										
Equipment										
Contractual										
Other Direct Costs:										
Other Direct Costs:										
Other Direct Costs:										
Other Indirect Costs:										
Other Indirect Costs:										
Other Indirect Costs:										
TOTAL	$0	$0	$0	$0	$0	$0	$0	$0		
TOTAL AWARD		$0								

*Total not to exceed 10% of Total Award

Miami-Dade County

Ryan White Ending the HIV Epidemic (EHE) Initiative

Preparation of a Line-Item Budget

(NOTE: PLEASE REVIEW THESE INSTRUCTIONS THOROUGHLY.)

STEP 1: ORGANIZATION

- Provide the organization's full legal name.

STEP 2: SERVICE CATEGORY

- Include the complete name of the service category.
- Use only one budget form (multiple pages, if necessary) per service category.
    - ✓ For example, one budget form for HealthTec and a separate budget form Quick Connect.

STEP 3: BUDGET PERIOD

- The budget period will be for an entire 12 month-period.
    - ✓ CAUTION: This time period drives the entire budget.
    - ✓ This time period is based on an *annualized* Total Award without expectations of additional funds being available through the reallocations (Sweeps) process.
        - Example, if the budget amount is limited, consider fully budgeting 5 positions for 12 months as opposed to budgeting 10 positions for only 6 months each.

STEP 4: DIRECT AND INDIRECT LINE-ITEM COSTS

A. DIRECT VS. INDIRECT

- **First**, list all direct service personnel and fringe benefits for each budgeted position.
- **Next**, list all indirect/administrative personnel and their fringe benefits, unless they are included in a Federal Negotiated Indirect Cost Rate Agreement (FICRA/NICRA) or covered by the *de minimis* rate if the agency was eligible for and elected to use this option.
- **Then**, in the following order, list travel for direct service personnel, direct service supplies (includes computer devices), direct service equipment, contractual direct services, and any other direct costs (please seebelow for more information regarding allowable direct costs).
- **Finally**, list direct cost line-items which include those expenses that are required for the provision of direct services to EHE clients.
- Indirect cost line-items are those expenses that are administrative in nature (e.g., overhead).
- See "Instructions for Preparing a Budget Justification" **(Attachment D)** for information related to local Ryan White Program EHE allowable Direct and Indirect/Administrative Costs.
- **CAUTION:** Few service categories have allowable travel, supply, telephone, and rent costs as a direct cost. Please work with your EHE Administrator on a case-by-case basis if your organization has concerns about where to place a particular line item on the budget (i.e., direct vs. indirect/administrative).
- **Only include line items that are being charged to the EHE Program.**

B. PERSONNEL

- Identify personnel to be covered by EHE funding per service category.

- Identify each staff person's annual salary and fringe benefits and prorate those amounts based on the established budget period (e.g., March through February), or shorter time period, if applicable.

  - ✓ Include position title on the first line.

  - ✓ Include the staff person's first initial and last name on the second line.

  - ✓ For confidentiality reasons, do not include names of Peers, Peer Educators, or Peer Navigators. Simply type the individual's initials on the line below the position title.

  - ✓ Budget period for an individual staff person may differ from the overall budget period for service category.

- Use a range of dates in parentheses (e.g., 3/1/2023 – 5/31/2023) to identify the time period that the staff person will be covered by EHE if the time period is less than the total grant budget period identified in Step 3 (e.g., 12 months).

- List salary and fringe benefits on separate lines as indicated on the budget form. Indicate the percentage at which each position's fringe benefits package is calculated (e.g., 20%, 33%, 18%, etc.).

- The percentage of salary to be covered by EHE funding may not exceed the level of effort each staff person contributes to the EHE Program.

  - ✓ For example, if a full-time staff member spends 50% of their time providing direct service to EHE clients, 15% of their time to administrative duties, and 35% of their time to another program, your organization may charge up to 50% of that person's salary and fringe benefits to EHE as a direct service cost, and up to 15% of the salary as an indirect/administrative cost. All other costs must be covered by another funding source.

  - ✓ Each staff person's Time and Effort must be documented, tracked and used to support year-end reporting of actual expenditures as per applicable Unform Guidance requirements (see Code of Federal Regulations – 45 CFR 75). Time and Effort reports must be signed by the employee, reviewed and signed by the supervisor, and reconciled timely by an appropriate HR/payroll/fiscal staff.

- Salaries and fringe benefits for personnel not providing direct services to clients must be listed as EHE Indirect/Administrative Costs.

C. TRAVEL

- Include costs associated with mileage expenses (local travel only) as allowable and appropriate to the service category. For example, travel incurred by the organization's medical case management direct service staff to conduct client home visits or to accompany eligible EHE clients to initial medical and social service appointments can be included in this line item.

- Tolls and parking as allowable and appropriate to the service category may be included as a separate line item.

- Travel outside of Miami-Dade County is not covered.

- Gas is not covered as a separate cost.

- Providers will be reimbursed at the current U.S. GSA POV mileage rate. Currently, the U.S. GSA Privately Owned Vehicle (POV) rate is $0.655 per mile as of January 1, 2023, and is subject to change. Annual changes are anticipated. The County will change whenever this federal rate changes and will notify subrecipients of such changes. When changes occur, subrecipients are responsible for updating the rates in their approved line-item budgets, as applicable.

D. SUPPLIES

- Include the cost of supplies. Program supplies such as medical supplies, telehealth supplies, telehealth equipment less than $1,000 per item, Quick Connect supplies, outreach supplies, etc. are direct service costs. General office supplies are indirect/administrative costs. Note: supplies charged 100% to the EHE Program must be stored and tracked separately.

E. EQUIPMENT

- Include costs associated with the purchase or lease of large equipment (e.g., fax machine, copier, other telehealth equipment, etc.).

- Does not include computers or other computing devices. These would be Supplies.

- Equipment purchases (and computing devices under Supplies) that have a cost greater than $1,000 per item become County Inventory (i.e., property of the County and the EHE Program).

  - ✓ Inventory must be tracked annually for purchases of items greater than $1,000 per item.

  - ✓ Prior authorization is required from the County for purchases of $1,000 or more per item.

- All equipment and products purchased with EHE funds under this Agreement or prior year Agreements should be American-made, to the greatest extent practicable.

F. CONTRACTUAL

- Include contracted services (i.e., subcontracts) related to EHE service category program.

- CAUTION: Contractual agreements (i.e., subcontracts) MUST receive prior consent from Office of Management and Budget-Grants Coordination/Ryan White Program management.

  - Subcontract agreements must include reference to payment structure (e.g., # of hours and rate of pay), HIPAA, client confidentiality, adherence to prime contract requirements between the County and direct agency contract, term of the agreement, termination clause, reference to renewal process, etc. Contact the Office of Management and Budget-Grants Coordination/Ryan White Program for guidance on language to be included in a subcontract agreement.

G. OTHER DIRECT COSTS

- Must be related to direct EHE program services provided to or on behalf of EHE clients.

- List each additional direct cost separately [e.g., transportation vouchers (i.e., discounted EASY Tickets), room occupancy costs, etc.)

H. OTHER INDIRECT/ADMINISTRATIVE COSTS

- Include any other expense not related to the provision of direct EHE program services to or on behalf of EHE clients. These expenses generally include administrative staff, rent, utilities, general use office supplies, audit, bookkeeper, general use telephones, etc.

- Total sum of the indirect/administrative costs may not exceed a 10% maximum of the Total Award per service category.

STEP 5: TOTAL AGENCY COST FOR BUDGET PERIOD

- Determine realistic estimates for the Total Agency Cost for the Budget Period for each line item identified in Step 4. This should be based on a review of prior year actual expenses.

- Start with annual, 12-month totals.

- Prorate, as needed, for a line-item budget period that is less than 12 months.

  - Expenditures must be prorated where applicable to agree with the budget period.

  - Prorate = To divide, distribute, or assess (costs) proportionately. For example:

    - adjusting an annual total cost by 12 (i.e., 12 months in the year), then multiplying that number by 5, in order to find what the prorated Total Cost would be for 5 months: $12,000 / 12 = $1,000 X 5 = $5,000;

      or

    - prorating a 12-month salary to 7 months if the budget period for an individual staff or item only covers 7 months: $15,000 annual / 12 months = $1,250 prorated monthly, $1,250 x 7 months = $8,750 prorated total.

- If your organization has a vacancy and does not expect for the position to be filled until a few months after the contract start date, then prorate the total salary properly for the number of months that person is expected to be employed within the 12-month budget period. For example, if the person will start on May 1st and will have an annual salary of $60,000, prorate the salary for 10 months (5/1/2023 through 2/29/2024) as follows: $60,000 / 12 = $5,000 X 10 = $50,000. Please keep in mind that for the purpose of completing this RFP, proposed projects costs should be based on a 12-month budget period. If awarded funding, the organization will be instructed to complete a budget form allocating funds to provide the service identified in Step #2 above for the initial project period (i.e., 12/1/2023-2/29/2024).

    - Prorating is especially important when showing contributions from other budgets, including EHE, Part A or MAI, where there is an overlap in the time periods.

- Each organization should maintain documentation as to how each total cost was determined.

    - ✓ For example, to determine the Total Cost for telephones, look at telephone bills for the lines being charged to EHE from several months of the last contract period or last year's final expenditures, if available. Determine an average monthly cost. Then multiply that cost times the number of months in your new budget period.

- Take into consideration cost of living increases and merit increases, if applicable, for staff salaries and fringe benefits.

- **Arbitrary guesses are not realistic and will become problematic when completing your organization's Final Line-Item Expenditure Report (FLIER) for the year-end closeout.**

STEP 6: TOTAL AMOUNT REQUESTED

- The Total Amount Requested must agree with the total of Direct Service Costs column plus the total of the Indirect / Administrative Costs column for program-allowable line items only.

- The Total Award is the sum of all EHE Service Costs and all EHE Indirect/Administrative Costs for each service category.

- This amount is subject to change through the Reallocations (Sweeps) process.

STEP 7: EHE INDIRECT/ADMINISTRATIVE COSTS TOTAL

- The amounts indicated in this column for allowable costs when added together may not exceed 10% of the Total Award identified in Step 6 above.

STEP 8: EHE DIRECT SERVICE COSTS TOTAL

- The total for the EHE Service Costs column equals the Total Award minus the total for the EHE Indirect/Administrative Costs column; or the total of all direct service line-item costs in the "EHE Direct Service Costs" column.
  - ✓ For example, if the Total Award is $100,000 and the EHE Administrative Costs Total is $10,000, then $90,000 must be allocated to program-allowable EHE direct service expenses.
- Only expenses directly related to the provision of direct services to EHE clients may be included in this column.

STEP 9: OTHER FUNDING

- Identify all other funding sources that contribute to each line item listed on the budget form. These other funding sources can be combined, using logical groupings (federal, state, local), but must be specifically referenced in the budget narrative.
- List all funding contributions for each line item to accurately reflect the total cost for each expense during the budget period.
- Include contributions from other EHE service category budgets that have similar line items with overlapping budget periods. These Other EHE contributions can be combined in one column or listed separately if the column header clearly identifies the source.
- List each other funding source under a separate column heading unless otherwise directed by the Office of Management and Budget-Grants Coordination.

STEP 10: CONSOLIDATED APPROPRIATIONS ACT SALARY CAP

- Indicate the adjusted salary cap, if necessary, for any staff persons whose 12-month salary exceeds the Federal Executive Level II salary cap. In accordance with the Consolidated Appropriations Act of 2023 (P.L. 117-328), the limitation on charging salaries to HHS Grant Funds is $212,100; and the allowable percent to be charged is proportionate to the time dedicated to services under the budget. **Note:** This salary cap reference and amount are subject to change for 2024; and annually thereafter.

- Fringe benefits (FB) are calculated based on the FB rate times the salary cap amount. For example, if a position has a 20% fringe benefits rate, then for the salary cap of $212,100 in Step 10, the corresponding FB amount would be $ 42,420 ($212,100 X 20% = $42,420).

- The Percent Charged to EHE in Step 11 below will be based on this salary cap, as may be amended.

STEP 11: PERCENT CHARGED TO EHE (for the corresponding budget)

- The Percent Charged to EHE is a planned number that should be driven by the agency's cost allocation plan, the planned level of effort of direct service staff's time to be dedicated to clients, or the planned level of effort of administrative staff's time to be spent providing services to the program. For staff expenses, these planned numbers must be properly documented as support or apportioning of salaries and wages (e.g.,time and effort reporting) and reconciled regularly by appropriate HR/payroll/fiscal staff. If funded, actual dollar amounts and percentages charged to the program must be reported in the Final Line-Item Expenditure Report (FLIER), and the supporting documentation is subject to audit.

- **Calculation per line item:**

  ✓ **For annualized salaries that are less than or equal to the Consolidated Appropriations Salary Cap or for non-personnel amounts:**

  [(EHE Direct Service Cost + EHE Indirect/Administrative Cost) / Total Agency Cost for Budget Period]

- ✓ **<u>For annualized salaries that are greater than or equal to the Consolidated Appropriations Salary Cap:</u>**

  [(EHE Direct Service Cost + EHE Indirect/Administrative Cost) / Adjusted Salary Cap (i.e., $212,100)]

  - ➢ For example, for a physician whose total salary for the 12-month period is $200,000 (or $150,000 for 9 months) and expects to dedicate 50% of their time to EHE services, in the "Total Agency Cost for Budget Period" column type $150,000, in the "Adjusted Salary Cap" column type $147,975, and in the "Direct Service Costs" column for this staff position, the maximum amount that can be typed in (charged to the program) is $73,988 (or 50% of the $147,975 adjusted salary cap prorated for 9 months).

- ✓ Round amounts to the nearest whole number.

- ✓ If an adjusted salary cap is indicated, then use the adjusted salary cap and corresponding fringe benefits instead of the Total Agency Cost to calculate the Percent Charged to EHE.

- The Percent Charged to EHE, in most cases, is limited to the percentage of EHE clients as a portion of your organization's total client population, as detailed in the narrative budget justification.

  - ✓ For example, if EHE clients who are receiving medical case management services make up 20% of your organization's total client population, then up to 20% of the expense for the agency's utility costs could be charged to EHE as an indirect/administrative cost under the HealthTec budget, unless otherwise justified.

- However, the Percent Charged to EHE for staff salaries and fringe benefits is limited to the staff person's level of effort provided to EHE clients (for direct services) or to the EHE Program (for indirect/administrative related work).

  - ✓ For example, if a full-time medical case manager is scheduled to dedicate 50% of their time to providing medical case management services to EHE clients, up to 50% of their salary and fringe benefits could be charged to the Ryan White EHE Program as a direct service cost. However, this must be tracked through Support or Apportioning of Salary and Wages (i.e., time and effort reports), signed by the employee, reviewed and signed by the employee's directsupervisor, then

analyzed and reconciled by appropriate HR/payroll/fiscal staff for reporting in the end of year Final Line-Item Expenditure Report.

- The Percent Charged to EHE for some expenses (e.g.,rent, telephones, and supplies) is based on usage.

  ✓ For example, the Percent Charged to EHE for telephones can be based on the number of phone lines dedicated to the EHE Program.

  ✓ The Percent Charged to EHE for rent can be based on the square footage used by the program; and may be considered a direct cost if the cost is justified for the space used specifically by direct service staff for direct client services.

- IMPORTANT: The method used to assign costs MUST be used consistently across all funding sources in order to ensure that costs are distributed in a reasonable proportion to the benefit received.

- When in doubt, consult your organization's assigned contracts administrator, the EHE Administrator.

STEP 12: <u>TOTALS</u>

- Add up the amounts in each column to determine the remaining totals.

STEP 13: <u>HEADER</u>

The corresponding Fiscal Year and the RFP number have been referenced in the top right corner of the form:

IMPORTANT NOTES:

- **CHECK FOR ACCURACY!**
    - ✓ **Verify that the detail provided is complete and accurate BEFORE submitting it to the County's EHE Program for review.**
- **Check your math. Round amounts to the nearest whole number.**
- **When using the electronic version of the Line-Item Budget Form, check that the formulas are correct in each calculated cell, AND THAT THE MATH IS CORRECT. Be careful to check for and correct any calculation or rounding errors.**
- **If you create your own form, or use a form from a previous year, it <u>MUST</u> be updated to look like and include all the column headers, page footers, and information as presented on the County EHE Program's current budget form.**
- **Budgets that do not conform to these instructions may be returned to your organization for correction and will delay the contract development process.**

RYAN WHITE EHE PROGRAM
INSTRUCTIONS FOR PREPARING A
NARRATIVE BUDGET JUSTIFICATION

NOTE: These instructions may also be used as a guide to complete proposed budgets for a corresponding Request for Proposals process. In such cases, "Proposing Organization" and "Subrecipient" are used interchangeably in these instructions for the Ending the HIV Epidemic (EHE) RFP Solicitation.

A budget justification (narrative) must be submitted along with **each** categorical (line item) budget form explaining the association of each planned expenditure to EHE-funded service program in relation to the organization's total planned expenditures. Narrative budget justifications must be specific, concise, and reflective of the budget period. **NOTE: A separate line item budget form is required for each service category.**

The following guidelines must be followed when preparing a narrative budget justification:

- **IMPORTANT: Please be advised, due to Federal requirements all costs (direct and indirect/administrative) must be presented on the line item budget form provided by the Office of Management and Budget-Grants Coordination/Ryan White Program (OMB) using the standard line item categories of personnel, fringe benefits, travel, supplies, equipment, contractual, and other. In addition, the budget narrative must include a justification for each line item. A total dollar amount for indirect/administrative charges without a detailed breakdown of individual expenses will not be accepted unless the subrecipient (service provider) has a Federal Indirect Cost Rate Agreement.** In general, the percentage to be charged to EHE for any individual indirect/administrative cost may not exceed the percentage of clients, in relation to your organization's total HIV/AIDS client population, who are expected to receive the specific service for which the EHE budget is being presented.

- In accordance with HRSA Policy Clarification Notice #16-02, the following costs are **unallowable** under this grant:
    - Cash payments to program recipients (clients)
        - However, "where direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used."
    - Clothing
    - Employment and employment-readiness services (except in limited, specified instances in service categories that are not funded by the local Part A Program)
    - Funeral and burial expenses
    - Property taxes
    - Pre-Exposure Prophylaxis (PrEP)
    - non-occupational Post-Exposure Prophylaxis (nPEP)
    - Materials designed to promote or encourage, directly, intravenous drug use or sexual activity
    - International travel

- o Purchase or improvement of land
- o Purchase, construction, or permanent improvement of any building or other facility

➢ The total amount of all indirect/administrative costs (i.e., total combined amounts in the EHE Indirect/Administrative Cost column) may not exceed 10% of the Total Amount Requested for each service category. **Indirect/administrative expenses that do not conform to this standard policy will be reviewed in relation to their corresponding justification and adjusted, if necessary, during the contract development process.**

➢ For Direct Client Services budgets, in the **opening paragraph of the Budget Justification**, each budget justification should include, as an introductory statement, the proposing organization's planned total client population (or more specifically the organization's HIV client population) and the percentage of clients who would receive a particular EHE-funded service. For example, the opening paragraph may read as follows:

- o ABC Clinic, Inc. (ABC) anticipates serving approximately 2,000 clients during the 12-month budget period. A total of approximately 500 (25%) of these clients are people with HIV who will receive EHE-funded HealthTec services during the 12-month budget period.

OR

- o ABC Clinic, Inc. (ABC) anticipates serving a total of 1,500 people with HIV, regardless of the funding source, during the 12-month budget period. It is anticipated that approximately 500 (33%) of these people with HIV will be clients who are enrolled in the EHE-funded HealthTec services during the 12-month budget period.

- o NOTE: This description may be necessary to help justify the percentage of a line item cost to be charged to the EHE Program in a particular service category. At a minimum, the number of clients proposed to be served in the Ryan White Program-funded service category must be identified in the opening paragraph of the budget justification. This helps to clarify a "fair share" allocation to the Ryan White Program, and identify the proposed number of clients to be served for each service category or service category component (e.g., medical case management and peer education services; level I or II mental health services; etc.).

Budget Period

➢ The **budget period** must be consistent with the requested budget amount(s) indicated in the organization's corresponding line item budget form. For the purposes of this RFP Solicitation, budgets must reflect a 12-month contract period (e.g., March through February). **Agencies should not propose a budget with the expectation that other EHE, Part A or MAI funds will become available through reallocation (sweeps) processes during the year to sustain budgeted costs through the end of the contract period, if funded.** If your organization's expenses are not totally covered by the EHE funding, and there are no other State, Federal, and/or local resources available to support these costs, then your organization may need to eliminate and/or reduce expenses to ensure that the program is operating in accordance with its current funding level and not in a deficit throughout the budget period.

Direct Service Costs

- Direct service costs are those that can be identified specifically with the provision of services directly to or on behalf of EHE program-eligible person with HIV (i.e., client). Direct service personnel are those who actually provide services to eligible clients. Personnel who complete paperwork solely for billing and record keeping purposes (with the exception of health insurance billers, medical case managers, peers, and outreach workers) are not considered direct service costs. Similarly, salaries and fringe benefits for administrative personnel are not considered direct service costs.

- Other allowable direct service costs are those items or services that are utilized by direct service personnel to provide services to clients or those items utilized by the clients directly.

- **Any costs included in an organization's Federal Indirect Cost Rate Agreement (i.e., Negotiated Indirect Cost Rate Agreement) cannot be separated out as a direct service cost.**

- **Direct Service Personnel** expenditures must be explained by including a brief description of the role of the position that would be providing EHE-funded HealthTec, Quick Connect, Housing Stability, or Mobile GO Teams services to or on behalf of EHE program clients and the percentage of their projected salary to be charged to the EHE budget. Proposing organizations must justify the percentage to be charged to the EHE program by indicating the amount of time individual staff members would contribute or dedicate to the EHE Program. Organizations must indicate if the position is planned as full-time or part-time. For full-time staff, the percentage of time they will spend providing direct services to EHE Program clients must be included in the justification. For hourly, part-time, or per diem employees, the rate of pay (e.g., pay rate per hour or per day) must be indicated, as well as the planned number of hours of work per day/week/month. The methodology utilized by the proposing organization to arrive at the amount and percentage to be charged to the EHE Program for each line item must be clearly explained.

- **<u>IMPORTANT</u>: Do <u>not</u> group personnel costs together under one line item, by position or similar assignment. Each staff person on the line item budget form must be listed separately. In few instances, with sufficient justification, County OMB may allow an exception to this rule for outpatient medical care providers; and prior approval is required.**

- A breakdown of **fringe benefits** components (including the overall fringe benefits percentage) must be included as part of the justification for each direct service position listed on the proposed budget. List the fringe benefit components specifically (e.g., FICA, MICA, health insurance, dental insurance, vision insurance, retirement, 401(k), etc.). **Also include the specific percentage for EACH fringe benefit component for personnel listed in either EHE service category budget.**

- **Travel: Mileage (local only)** is only allowable for direct service staff and the reasons for travel must be explained and justified. Organizations will be reimbursed at their internal rate as long as said rate does not exceed the County rate, which is equivalent to the most current U.S. GSA Privately Owned Vehicle (POV) mileage reimbursement rate posted on <u>www.gsa.gov/mileage</u>. For example, the **U.S. GSA POV rate is currently $0.655 per mile as of January 1, 2023**, and is subject to change on January 1, 2024. The County will change whenever this federal rate changes. Gas is not covered as a separate cost.

- **Travel: Parking and Tolls (local only)** is only allowable for direct service staff and the reasons for travel must be explained and justified. Organizations must maintain proper and sufficient documentation to support the cost and its relation to direct client services. Gas is not covered as a separate cost.

- **Supplies** are allowable only for the direct provision of services under the funded program. These costs must be described in detail and the amounts, percentages, and need for each item must be justified. If necessary, these supplies may be listed as separate line items in the rows labeled "Other Direct Costs." If separately listing the supply item, please clearly and briefly list the name or type of supply (e.g., Other Direct Costs: Telephones; Other Direct Costs: Program Supplies; etc.). The methodology your organization utilized to arrive at the amount and percentages to be charged to EHE must be clearly explained. **Any supplies included in an organization's Federal Indirect Cost Rate Agreement (i.e., Negotiated Indirect Cost Rate Agreement) cannot be separated out as a direct cost.**

- **Equipment** is allowable if it is utilized in the direct provision of services under the funded program. The type of equipment must be listed and its proposed use for the EHE Program must be described and justified. The methodology your organization utilized to arrive at the amount and percentages to be charged to the EHE Program must be clearly explained. If the proposing organization is funded, an inventory of equipment purchases that are equal to or greater than $1,000 per individual item must be maintained by the subrecipient and reported annually to the Miami-Dade County OMB in a format to be provided by the County.

- **Contractual** services such as contracted medical providers, therapists/counselors, etc., must include a description of the proposed service they would provide in context of the corresponding service category. Contractual line items must include details of the payment structure: a description of hourly rates and number of hours, per visit charges, procedure costs, monthly fee, etc. **If the proposing organization is funded and prior to contract execution**, all contractual line items require a subcontract agreement including items required by the County which must be submitted to Miami-Dade County OMB for review and consent **prior to implementation**. Failure to adhere to this requirement may cause the County OMB to disallow or require repayment of reimbursed funds.

- **Telephones, Cellular Phones, and Facsimiles** are allowable expenditures. Telephones, cellular phones and faxes must include the number of phone lines and cost per phone line. If included as a direct service cost, indicate what percentage (%) of time the phones and faxes are used towards the provision of EHE direct client services; or what % of phones out of the agency's total phones is dedicated to use by direct service staff under the Ryan White Program budget. Cell phones must include the cost per month for cellular service, the percentage of time the cell phone is utilized for the provision of direct client services, and the number of cell phone(s) being charged to EHE.

- **Generic line items, such as "Miscellaneous", will not be accepted.** Each line item must be clearly identified and adequately justified. If a line item is composed of several related costs, each cost must be itemized separately as part of the justification for that overall line item.

- **Other costs may be considered as direct service costs if they are properly justified. If**

funded, these other costs require prior approval from Miami-Dade County OMB prior to contract execution or implementation. The line item's relation to the provision of EHE-funded direct client services must be described as well as the methodology utilized by your organization to arrive at the amount and percentage to be charged to the EHE Program.

- In accordance with HRSA Policy Clarification Notice # 15-01, as may be amended, for all Part A and MAI service providers (subrecipients), the following programmatic costs are not required to be included in the 10% limit on administrative costs; they may be charged to the relevant service category directly associated with such activities:

  - Biannual RWHAP client re-certification;

  - The portion of malpractice insurance related to RWHAP clinical care (e.g., medical, etc.);

  - The portion of fees and services for electronic medical records maintenance, licensure, and annual updates, and staff time for data entry related to RWHAP clinical care and support services;

  - The portion of the clinic receptionist's time providing direct RWHAP patient services (e.g., scheduling appointments and other intake activities);

  - The portion of medical waste removal and linen services related to the provision of RWHAP services;

  - The portion of medical billing staff related to RWHAP services;

  - The portion of a supervisor's time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities, sufficient to assure the delivery of appropriate and high-quality HIV care, to clinicians, case managers, and other individuals providing services to RWHAP clients (would not include general administrative supervision of these individuals); and

  - RWHAP clinical quality management (CQM). However, expenses which are clearly administrative in nature cannot be included as CQM costs.

  - **NOTE:** "See §§ 2604(h)(5)(B)(ii), 2618(b)(3)(E)(ii)(II), and 2664(g)(3) of the PHS Act, which indicate that although CQM is considered an administrative cost, expenses for this activity do not count towards the administrative cost cap. Similarly, § 2671(h)(3)(B) of the PHS Act defines as "services" those services that contribute to or help improve primary care and referral services, and include CQM."

  * Use of RWHAP funds to pay for professional licensure.

- Also in accordance with HRSA Policy Clarification Notice #15-01:

  - The "portion of direct facilities expenses such as rent, maintenance, and utilities for

areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, substance abuse treatment facilities) are not required to be included in the 10% administrative cost cap. Note: by legislation, all indirect expenses must be considered administrative expenses subject to the 10% cap." For rent, maintenance, and utilities to be considered a direct service cost, the total square footage of the facility and square footage of the space to be considered as a direct service cost must be included in the budget justification. OMB will review the narrative justification for such items to determine if they can be considered a direct service cost in accordance with this policy.

- Insurance for vans used for mobile clinics, transportation services, or meal delivery count toward the 10% administrative limit.

➢ **The following are some examples of allowable direct service costs by service category:**

✓ HealthTec:

1) Infrastructure Network and Technology

-- Computer hardware and software needed to provide telehealth services in a secure, confidential, and HIPAA compliant format. Technology expenses needed to develop, enhance or support a telehealth infrastructure network, acquire smartphone or tablet or other telehealth equipment, internet/phone service and media plan, etc., then educate clients on how to use the technology

2) Direct Service staffing, including salary and fringe benefits or contractual expenses related to time and effort of:

-- physician, physician assistant, advance practice registered nurse, etc. who provide telemedicine;
-- psychiatrist, licensed clinical social worker, licensed mental health counselor who provides tele-mental health or tele-substance abuse counseling
-- medical case manager who provides tele-medical case management services.

3) Case conferencing expenses.

✓ Quick Connect:

1) HIV Education for Non-RWP-Funded Medical Practitioners

-- Costs to develop materials to promote capacity building by educating non-RWP-funded medical practitioners (in clinics, hospitals, and ERs) about HIV clinical guidelines, referral options, and available resources.

-- Direct service staff salary and fringe benefits involved in developing

materials to promoted capacity building and/or to educate non-RWP or EHE-funded medical providers in Miami-Dade County.

2) HIV Treatment Information Dissemination

-- Costs to identify or develop information that promotes the benefits of HIV treatment adherence and provide this information to EHE Quick Connect team(s) for use in hospitals, clinic, or emergency room encounters.

3) Link to HIV Care by EHE Quick Connect Team on TTRA Model

-- Staff salaries and fringe benefits costs to facilitate linkages to HIV care [Ryan White Program (RWP) or non-RWP] by EHE Quick Connect team(s) following the local Test and Treat / Rapid Access (TTRA) model especially for, but not limited to, people with HIV who are not eligible for RWP services; conduct regular follow-up to ensure EHE Quick Connect clients are connected to a medical home and retained in care and to monitor their viral load.

-- Transportation vouchers for public transportation, rideshare service expenses, etc.

✓

Housing Stability Services (HSS):

1) Direct rent and utility payments and payments for associated incidentals necessary to facilitate moving EHE HSS clients

-- Application fees, rental and utility subsidies.

-- Moving expenses including vehicle and equipment rentals, cleaning supplies/kits, packing basics, and other appropriate, pre-approved moving expenses.).

2) Direct Service staffing, including salary and fringe benefits or contractual expenses related to time and effort of:

-- Housing case management to facilitate placement of HSS clients to affordable units; securing permanent tenant based rental assistance, or placement in permanent supportive housing.

-- Development and implementation of a plan to ensure ongoing housing stability by improving opportunities to increase client income through employment or access to SSI/SSDI Outreach, Access and Recovery (SOAR).

Mobile GO Teams):

1) Mobile Unit Acquisition and Furnishing

-- Pre-approved purchase of a new mobile unit including medical supplies and necessary equipment.

2) Direct Service staffing, including salary and fringe benefits or contractual expenses related to time and effort of:

-- Physician or Advanced Practice Registered Nurse (APRN), a Community Health Worker, and a Driver / Attendant to provide Mobile GO Teams services.

Indirect/Administrative Costs

- Expenses included in the **"Indirect/Administrative Cost"** category **must be individually listed in the budget justification**. **Do not lump administrative personnel costs by department, unless your organization has a Federal Indirect Cost Rate Agreement (i.e., Negotiated Indirect Cost Rate Agreement).** If there is no Federal Indirect Cost Rate Agreement, please indicate the amount of indirect/overhead/administrative costs covered by the EHE Program for each applicable line item (i.e., personnel, travel, supplies, rent, equipment, etc.) individually. Organizations with a Federal Indirect Cost Rate Agreement (i.e., Negotiated Indirect Cost Rate Agreement) can simply lump all indirect costs in one line item.

- In accordance with HRSA Policy Notice PCN #15-01, subrecipient "administrative activities" include:

  - usual and recognized overhead activities, **including established indirect rates** for agencies;

  - management oversight of specific programs funded under the RWHAP; and

  - other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP Continuous Quality Management)."

- Some indirect/administrative costs require similar detail as indicated for direct service costs (e.g., mileage, parking, tolls, etc.).

- General liability, crime, Medicaid bond, or related liability coverage are considered indirect/administrative costs. D&O insurance is liability for Directors and Officers, and is definitely not related to direct client services. These costs may be included as Indirect/Administrative Costs if sufficient justification is provided by the organization, but may not be included as Direct Service Costs. In addition, no insurance line item is allowable as a direct service cost for Federally Qualified Health Centers (FQHCs), since free medical malpractice liability coverage is afforded to these Centers under the Federal Tort Claims Act (FTCA).

- Allocations/expenditures for **Administrative Personnel** must be explained by including a brief description of the role of the position that would be providing EHE-funded services to the program and the percentage of their proposed salary to be charged to the EHE budget. Proposing organizations must justify the percentage to be charged to the EHE Program by indicating the amount of time and effort individual staff members would contribute to the EHE Program. Please indicate if the position is planned as full-time or part-time. For full-time staff, the percentage of time they will spend/dedicate providing direct services to the Ryan White Program must be included in the justification. For hourly, part-time, or per diem employees, the rate of pay (e.g., pay rate per hour or per day) must be indicated, as well as the planned

number of hours of work per day/week/month. The methodology the proposing organization utilized to arrive at the amount and percentages to be charged to the EHE Program must be clearly explained.

- **IMPORTANT: Unless the proposing organization has a Federal Indirect Cost Rate Agreement (i.e., Negotiated Indirect Cost Rate Agreement), it may <u>not</u> group personnel costs together under one line item, by position or similar assignment. Each staff person on the budget must be listed separately. For organizations with a Federal Indirect Cost Rate Agreement, see Important Notes #1 below.**

➢ A breakdown of **fringe benefits** components (including the overall fringe benefits percentage) must be included as part of the justification for each direct service position listed on the proposed budget. List the components specifically [e.g., FICA, MICA, health insurance (for the employee only), dental insurance (for the employee only), vision insurance (for the employee only), retirement, 401(k), etc.]. <u>**The percentage for each fringe benefit component must be included in the budget justification narrative.**</u>

➢ Annual certified audits are considered indirect/administrative costs subject to the 10% administrative cap.

➢ <u>**Subrecipients will be allowed to request any amount up to 10% of the Total Amount Requested for each service category to cover administrative and/or indirect costs.**</u> However, if funded, when reconciling actual costs at the end of the grant year, subrecipients may only charge up to 10% of the <u>**total amount reimbursed**</u> by Miami-Dade County's Ryan White Program per service category as indirect/administrative costs.

➢ Indirect/Administrative costs must be specified under the "EHE Indirect/ Administrative Costs" column utilizing the aforementioned object class categories.

<u>**IMPORTANT NOTES**</u>:

1) **Due to Federal requirements, a detailed breakdown of all indirect costs must be included on the line item budget form (except for organizations with a Federally approved indirect cost rate; in which case a copy of the "Federal Indirect Cost Rate Agreement (i.e., Negotiated Indirect Cost Rate Agreement) must be included as part of this complete budget packet submission). However, the 10% indirect/administrative cap imposed by Ryan White Program legislation and EHE guidance also applies to those organizations that have a Federally-approved indirect cost rate, regardless of the approved rate.**

2) **In accordance with the Consolidated Appropriations Act, 2023 (P.L. 117-328), the limitation on charging salaries to DHHS/HRSA grant funds (i.e., the salary cap) to DHHS/HRSA grant funds is $212,100, effective January 1, 2023. This amount is subject to change annually with each new Consolidated Appropriations Act; and the allowable percent to be charged is proportionate to the time and effort dedicated to services provided under each budgeted service category.**

Appendix C

LABEL

Request for Proposals
(RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services:

HealthTec

Quick Connect

Housing Stability Services

Mobile GO Teams

-- LABEL --

RFP No. EHE-2223

ENDING THE HIV EPIDEMIC (EHE) INITIATIVE SERVICES:
HEALTHTEC, QUICK CONNECT, HOUSING STABILITY, AND MOBILE GO TEAMS

PROPOSAL DUE DATE: JUNE 28, 2023

DELIVER COMPLETE PROPOSAL TO (SELECT ONE OF TWO OPTIONS):

Daniel T. Wall, Assistant Director, OMB & RFP Contracting Officer

**OPTION #1: In Person, hand-delivered on June 28, 2023,
no later than 2:00 p.m. (local time) ONLY to:**

OR

**OPTION #2: By Federal Express (FedEx) mail delivery – must be received
in the County Clerk's Office no later than
2:00 p.m. (local time) on June 28, 2023, at:**

**MIAMI-DADE COUNTY
CLERK OF THE BOARD OF COUNTY COMMISSIONERS
STEPHEN P. CLARK CENTER (SPCC)
111 NW 1st STREET, 17th FLOOR, SUITE 17-202
MIAMI, FL 33128**

FULL LEGAL NAME OF PROPOSING ORGANIZATION	
PROPOSING ORGANIZATION'S ADDRESS	
PROPOSING ORGANIZATION'S TELEPHONE NUMBER	

Appendix D

COUNTY VENDOR AFFIDAVITS AND REQUIREMENTS

- Acknowledgment of Addendum/a
- Lobbyist Affidavit
- Subcontractor/Supplier Listing
- Fair Subcontracting Policies Affidavit
- Collusion Affidavit
- Contractor Due Diligence Affidavit
- Public Entity Crime Affidavit

Request for Proposals
(RFP No. EHE-2223)

Ending the HIV Epidemic (EHE)

HealthTec, Quick Connect Housing Stability, and Mobile GO Teams Services

ACKNOWLEDGEMENT OF ADDENDUM / A

Instructions: Complete Part I or Part II, whichever is applicable.

PART I: Listed below are the dates of issue for each Addendum received in connection with this solicitation.

Addendum #1, Dated ____________________________, 20___

Addendum #2, Dated ____________________________, 20___

Addendum #3, Dated ____________________________, 20___

PART II:

____ No Addendum was received in connection with this solicitation.

Authorized Signature:________________________________ Date: ______________

Print Name: ____________________________ Title: __________________________

Full Legal Name of Proposing Organization:

____

APPENDIX D.2
RFP No. EHE-2223

Attachment 13b

AFFIDAVIT OF MIAMI-DADE COUNTY
LOBBYIST REGISTRATION FOR ORAL PRESENTATION

(1) Solicitation Title: ______ Solicitation No.: ______
(2) Department: ______
(3) Proposer's Name: ______
Address: ______ Zip: ______
Business Telephone: ______ E-Mail: ______

(4) List All Members of the Presentation Team Who Will Be Participating in the Oral Presentation:

Name	Title	Employed By	Email Address

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

The individuals named above are Registered and the Registration Fee is not required for the Oral Presentation ONLY.

Any person who appears as a representative for an individual or firm for an oral presentation before a County certification, evaluation, selection, technical review or similar committee must be listed on an affidavit provided by the County. The affidavit shall be filed with the Clerk of the Board at the time the response is submitted. The individual or firm must submit a revised affidavit for additional team members added after submittal of the proposal with the Clerk of the Board prior to the oral presentation. Any person not listed on the affidavit or revised affidavit may not participate in the oral presentation, unless he or she is registered with the Clerk's office and has paid all applicable fees.

Other than for the oral presentation, Proposers who wish to address the county commission, county board or county committee concerning any actions, decisions or recommendations of County personnel regarding this solicitation in accordance with Section 2-11.1(s) of the Code of Miami-Dade County MUST register with the Clerk of the Board and pay all applicable fees.

I do solemnly swear that all the foregoing facts are true and correct and I have read or am familiar with the provisions of Section 2-11.1(s) of the Code of Miami-Dade County as amended.

Signature of Authorized Representative: ______ Title: ______

STATE OF ______

COUNTY OF ______

The foregoing instrument was acknowledged before me this ______,

by ______, a ______, who is personally known
(Individual, Officer, Partner or Agent) (Sole Proprietor, Corporation or Partnership)

to me or who has produced ______ as identification and who did/did not take an oath.

______
(Signature of person taking acknowledgement)

______
(Name of Acknowledger typed, printed or stamped)

______ ______
(Title or Rank) (Serial Number, if any)

Appendix D.3 RFP
No. EHE-2223
Attachment 13c

MIAMI-DADE COUNTY RYAN WHITE PROGRAM
SUBCONTRACTOR/SUPPLIER LISTING - FY 2023

Full Name of Subrecipient Organization ______________________ FEIN # ______________________

Project/Contract Number ______________________

In accordance with 45 CFR 75.330 of the Uniform Guidance, this form is being used to identify and report the gender, race and ethnicity of this Subrecipient's subcontractors and suppliers, where applicable. This form must be submitted by Miami-Dade County Ryan White Program subrecipients that have a Professional Services Agreement which involves expenditures of $100,000 or more; all services combined. This Subrecipient shall not change or substitute first tier subcontractors or direct suppliers or the portions of the contract work to be performed or materials to be supplied from those identified, except upon written approval of the County. Enter the word "NONE" under the appropriate heading of this form if no subcontractors or suppliers will be used on the contract. Then, sign the form below.

(Please duplicate this form if additional space is needed. Submit the completed form(s) only with the final reimbursement request (invoice) for grant fiscal year 2023.)

Business Name and Address of First Tier Subcontractor/ Sub-consultant	Principal Owner	Scope of Work Performed by Subcontractor/ Sub-consultant	Principal Owner (Enter the number of male and female owners by race/ethnicity)								Employee(s) (Enter the number of male and female employees and the number of employees by race/ethnicity)							
			Gender*		Race/Ethnicity						Gender		Race/Ethnicity					
			M	F	White	Black	Hispanic	Asian/Pacific Islander	Native American/Native Alaskan	Other	M	F	White	Black	Hispanic	Asian/Pacific Islander	Native American/Native Alaskan	Other

Business Name and Address of First Tier Direct Supplier	Principal Owner	Supplies/Materials/ Services Provided by Supplier	Principal Owner (Enter the number of male and female owners by race/ethnicity)								Employee(s) (Enter the number of male and female employees and the number of employees by race/ethnicity)							
			Gender*		Race/Ethnicity						Gender		Race/Ethnicity					
			M	F	White	Black	Hispanic	Asian/Pacific Islander	Native American/Native Alaskan	Other	M	F	White	Black	Hispanic	Asian/Pacific Islander	Native American/Native Alaskan	Other

I certify that the representations contained in this Subcontractor/ Supplier listing are to the best of my knowledge true and accurate.

* Note: If "Gender" above is other than M or F, please enter the number with "O" or "E" here: Subcontractor/Sub-consultant - Other: _____. Supplier - Other: ______.
(O = owner; E = employer)

______________________ Signature of Subrecipient's Authorized Representative

______________________ Print Name

______________________ Print Title

______________________ Date

SUBCONTRACTING FORM

Solicitation Number EHE-2223

*Vendor Name ______________________ *FEIN # ______________________

Complete "A" or "B":

A. ☐ No subcontractors or direct suppliers will be utilized pursuant to this solicitation.

B. ☐ The below listed subcontractors and/or suppliers will be utilized pursuant to this solicitation:

Business Name and Address of First Tier Subcontractor/ Subconsultant	Name of Principal Owner	Scope of Work to be Performed by Subcontractor Subconsultant	Subcontractor/ Subconsultant License (if applicable)

Business Name and Address of First Tier Direct Supplier	Name of Principal Owner	Supplies, Materials, and/or Services to be Provided by Supplier

And

Below and/or attached is a detailed statement of the firm's policies and procedures for awarding subcontractors:

(Duplicate this form if additional space is needed to provide the required information)

When Subcontracting is allowed and subcontractors will be utilized, the Contractor shall comply with Section 2-8.8 of the Code – Fair Subcontracting Practices: (1) Prior to contract award, the Bidder shall provide a detailed statement of its policies and procedures for awarding subcontracts and (2) As a condition of final payment under a contract, the Contractor shall identify subcontractors used in the work, the amount of each subcontract, and the amount paid and to be paid to each subcontractor via the BMWS at http://mdcsbd.gob2g.com.

Pursuant to Section 2-8.1(f) of the Code – Listing of subcontractors required on certain contracts, for all contracts which involve the expenditure of one hundred thousand dollars ($100,000) or more, the entity contracting with the County must report to the County the race, gender, and ethnic origin of the owners and employees of its first tier subcontractors and suppliers via the BMWS at http://mdcsbd.gob2g.com. The race, gender, and ethnic information must be submitted via BMWS as soon as reasonably available and, in any event, prior to final payment under the Contract. The Contractor shall not change or substitute first tier subcontractors or direct suppliers or the portions of the Contract work to be performed or materials to be supplied from those identified except upon written approval of the County.

I certify that the information contained in this form is to the best of my knowledge true and accurate.

*Signature of Vendor's Representative	*Print Name	*Print Title	*Date

COLLUSION AFFIDAVIT

(Code of Miami-Dade County Section 2-8.1.1 and 10-33.1) (Ordinance No. 08-113)

BEFORE ME, A NOTARY PUBLIC, personally appeared ___________________________ who being duly sworn states: (insert name of affiant)

I am over 18 years of age, have personal knowledge of the facts stated in this affidavit and I am an owner, officer, director, principal shareholder and/or I am otherwise authorized to bind the bidder of this contract.

I state that the bidder or vendor(s) of this contract:

☐ is not related to any of the other parties bidding in the competitive solicitation, and that the contractor's proposal is genuine and not sham or collusive or made in the interest or on behalf of any person not therein named, and that the contractor has not, directly or indirectly, induced or solicited any other proposer to put in a sham proposal, or any other person, firm, or corporation to refrain from proposing, and that the proposer has not in any manner sought by collusion to secure to the proposer an advantage over any other proposer.

OR

☐ is related to the following parties who bid in the solicitation which are identified and listed below:

_________________________ _________________________
_________________________ _________________________
_________________________ _________________________

Note: Any person or entity that fails to submit this executed affidavit shall be ineligible for contract award. In the event a recommended contractor identifies related parties in the competitive solicitation its bid shall be presumed to be collusive and the recommended contractor shall be ineligible for award unless that presumption is rebutted by presentation of evidence as to the extent of ownership, control and management of such related parties in the preparation and submittal of such bids or proposals. Related parties shall mean bidders, vendors or proposers or the principals, corporate officers, and managers thereof which have a direct or indirect ownership interest in another bidder, vendor or proposer for the same agreement or in which a parent company or the principals thereof of one (1) bidder, vendor or proposer have a direct or indirect ownership interest in another bidder, vendor or proposer for the same agreement. Bids or proposals found to be collusive shall be rejected.

By: ______________________________ ________________, 20___
Signature of Affiant Date

______________________________ ___/___-___/___/___/___/___/___/___/
Printed Name of Affiant and Title Federal Employer Identification Number

______________________________ ______________________________
Printed Name of Firm Address of Firm

NOTARY PUBLIC INFORMATION

STATE OF FLORIDA

COUNTY OF MIAMI-DADE

The foregoing instrument was acknowledged before me by means of ☐ physical presence or

☐ online notarization, this ______ day of ________, 20____, by ________________________________ as
(numeric date) (month) (year) (name of person acknowledging)

_____________________________________ for ____.
(type of authority - e.g., officer, trustee, etc.; or title) (name of party/entity on behalf of whom instrument was executed)

____
Signature of Notary

____
(notary seal or stamp)

____
Name *(typed, printed, or stamped)*
Notary Public, State of Florida

☐ Personally Known or ☐ Produced Identification

Type of Identification Produced: ____

APPENDIX D.6
RFP No. EHE-0521

Attachment 13f

Miami-Dade County

Contractor Due Diligence Affidavit

Per Miami-Dade County Board of County Commissioners (Board) Resolution No. R-63-14, County Vendors and Contractors shall disclose the following as a condition of award for any contract that exceeds one million dollars ($1,000,000) or that otherwise must be presented to the Board for approval:

(1) Provide a list of all lawsuits in the five (5) years prior to bid or proposal submittal that have been filed against the firm, its directors, partners, principals and/or board members based on a breach of contract by the firm; include the case name, number and disposition;

(2) Provide a list of any instances in the five (5) years prior to bid or proposal submittal where the firm has defaulted; include a brief description of the circumstances;

(3) Provide a list of any instances in the five (5) years prior to bid or proposal submittal where the firm has been debarred or received a formal notice of non-compliance or non-performance, such as a notice to cure or a suspension from participating or bidding for contracts, whether related to Miami-Dade County or not.

All of the above information shall be attached to the executed affidavit and submitted to the Procurement Contracting Officer (PCO)/ AE Selection Coordinator overseeing this solicitation. The Vendor/Contractor attests to providing all of the above information, if applicable, to the PCO.

Contract No. : ______ **Federal Employer Identification Number (FEIN):** ______

Contract Title: ______

Printed Name of Affiant | Printed Title of Affiant | Signature of Affiant

Name of Firm | Date

Address of Firm | State | Zip Code

Notary Public Information

Notary Public – State of ______ County of ______

Subscribed and sworn to (or affirmed) before me this ______ day of, ______ 20___

by ______ He or she is personally known to me or has produced identification

Type of identification produced ______

Signature of Notary Public | Serial Number

Print or Stamp of Notary Public | Expiration Date | Notary Public Seal

SWORN STATEMENT PURSUANT TO SECTION 287.133 (3)(a),
FLORIDA STATUTES, ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS

1. This sworn statement is submitted to ________ Miami-Dade County ________

   by ______________________________
   (print name of individual submitting sworn statement)

   for ______________________________
   (print name of entity submitting sworn statement)

   whose business address is ______________________________

   and if applicable its Federal Employer Identification Number (FEIN) is ____________. If the entity has no FEIN, include the Social Security Number of the individual signing this sworn statement:

2. I understand that a "public entity crime" as defined in paragraph 287.133 (1)(g), Florida Statutes, means a violation of any state or federal law by a person with respect to and directly related to the transactions of business with any public entity or with an agency or political subdivision of any other state or with the United States, including, but not limited to, any bid, proposal, reply, or contract for goods or services, any lease for real property, or any contract for the construction or repair of a public building or public work, involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.

3. I understand that "convicted" or conviction" as defined in Paragraph 287.133 (1)(b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, nonjury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that an "affiliate" as defined in paragraph 287.133 (1)(a), Florida Statutes, means: 1. A predecessor or successor of a person convicted of a public entity crime; or 2. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5. I understand that a "person" as defined in Paragraph 287.133 (1)(e), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. (Please indicate which statement applies.)

______ Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity, has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

______ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989. However, there has been a subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and the Final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. (Attach a copy of the final order.)

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND, THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND AND THAT I AM REQUIRED TO INFORM THAT PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, FLORIDA STATUTES, FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

____
(Signature)

NOTARY PUBLIC INFORMATION

STATE OF FLORIDA
COUNTY OF MIAMI-DADE

The foregoing instrument was acknowledged before me by means of ☐ physical presence or

☐ online notarization, this ______ day of ________, 20____, by ______________________________ as
(numeric date) *(month)* *(year)* *(name of person acknowledging)*

___________________________________ for ____.
(type of authority - e.g., officer, trustee, etc.; or title) *(name of party/entity on behalf of whom instrument was executed)*

____
Signature of Notary

____
(notary seal or stamp)

____
Name *(typed, printed, or stamped)*
Notary Public, State of Florida

☐ Personally Known or ☐ Produced Identification
Type of Identification Produced: ____

Appendix E

ON-LINE VENDOR REGISTRATION INSTRUCTIONS

Request for Proposals (RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

Vendor Registration

Share:

Register through the Vendor Portal to receive alerts to procurement opportunities and submit bids/proposals. Vendor registration is free.

In order to enter into contract with Miami-Dade County, a firm must be fully registered.

Note: Vendor registration requires a valid email address.

Review the following list of required documents prior to completing your registration:

- **Miami-Dade County current Local Tax Receipt** (for vendors physically located within Miami-Dade County)
- **Certificate of Incorporation** (if applicable)
- **W-9** (or applicable IRS form)
- **IRS letter 147C**, verifying your business name and FEIN or any other preprinted IRS form issued by the IRS identifying you
- **Final Summary pages must be notarized** and attached to the online vendor application (required to complete the approval of your application)
- **Miami-Dade County strongly recommends using a Federal Employer Identification Number (FEIN)** rather than a social security number for vendor registration purposes. If you do not have an FEIN number, you can obtain one from IRS.gov (http://www.irs.gov/) at no cost
- **If you decide to use a social security number instead of an FEIN number**, it may be used for the purposes of verifying identity, maintaining vendor database, payment processing and/or tax reporting to government agencies. In accomplishing these purposes, the number used to register with Miami-Dade County may be transmitted internally within the various departments and divisions of Miami-Dade County and externally to the Internal Revenue Service.

This statement concerning the purposes for collection of a social security number is provided pursuant to section 119.071(5)(a)2., F.S.

Update Registration Record

The following updates to your profile can be done online:

- Physical address
- Contact information
- Owner information
- Principal information
- Add/Delete category codes

If there are changes to any or all of the following portions of your profile, please email the Strategic Procurement Department at ISD-VSS@miamdidade.gov (mailto:ISD-VSS@miamdidade.gov) or call 305-375-5773:

- Company name change
- FEIN change
- Add or remove DBA
- Merger or acquisition involving the company
- Sale of company's assets

If you desire to change your remittance address, please call the Finance Department at 305-375-5111.

Was this page helpful? Yes No

ONLINE OPTIONS

VENDOR PORTAL (HTTPS://SUPPLIER.MIAMIDADE.GOV)

PHONE NUMBER(S)

Vendor Outreach & Support Section
305-375-5773

EMAIL / MAIL

isd-vss@miamidade.gov (mailto:isd-vss@miamidade.gov)

STRATEGIC PROCUREMENT (/GLOBAL/STRATEGIC-PROCUREMENT/HOME.PAGE)
Namita Uppal, Director (/global/government/biographies/strategic-procurement.page)

Stephen P. Clark Center
111 NW 1st Street,
13th Floor
Miami, FL 33128
305-375-5773 (tel:305-375-5773) | ISD-VSS@miamidade.gov (mailto:ISD-VSS@miamidade.gov)

Appendix F

COUNTY DUE DILIGENCE CHECKLIST

Request for Proposals (RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

MIAMI-DADE COUNTY ENDING THE HIV EPIDEMIC (EHE) INITIATIVE
DUE DILIGENCE CHECKLIST

DATE: ______________

FULL LEGAL NAME OF AGENCY OR SUBRECIPIENT: ____

FISCAL YEAR: ____ CONTRACT TYPE: _____________________________________

#	DUE DILIGENCE ITEM ***(NOTE: Save results as a PDF Document and store them in the appropriate electronic file.)***	IS AGENCY COMPLIANT WITH THIS ITEM? ***(YES, NO, OR N/A)***
1	**MIAMI-DADE COUNTY OFFICE OF INSPECTOR GENERAL** *http://www.miamidadeig.org/ (At "SEARCH", type in agency/subrecipient's full legal name in quotation marks, click "Submit", save confirmation whatever article is found or if nothing is found.)*	
2	**VENDOR REGISTRATION DOCUMENTS (i.e., INFORMS active status), AFFIDAVITS AND/OR APPLICABLE LICENSES**	
3	**INSURANCE AND/OR BONDS**	
4	**ISD SBD COMPLIANCE REPORT** **[Compliance Report of Open and Closed Small Business, Wage and/or Workforce Violations in the last three (3) years]** *https://www.miamidade.gov/Apps/ISD/SBDReports/ [(At the "Firm Name" box, type in the full name of the subrecipient. If the organization appears in the dropdown, click the organization, then click "View Report" button. Then click the "Export" link and export to PDF. File will appear at bottom left corner of open screen. Follow up with organization if any unresolved compliance issues. If the subrecipient you type in does not appear, make a copy of the page (HINT: if you cannot Save as PDF from SBD's data system, use the "Snip & Sketch" function to copy a screen shot, then save that screen shot to a Word document.) If the query for the organization had no results, print a copy of the results page to PDF and make a notation that no records were found.*	
5	**FLORIDA CONVICTED VENDOR LIST** *http://dms.myflorida.com/business_operations/state_purchasing/vendor_information/convicted_suspended_discriminatory_complaints_vendor_lists/convicted_vendor_list (Save this "Convicted Vendor List" page as is, even if no Ryan White Program agencies/subrecipients are listed or there are no vendors listed. Do not use the search engine for this page. IF the subrecipient organization's name appears under "Vendor Name/Address" column, also copy results from the link under the "Convicted Vendor" column).*	

#	DUE DILIGENCE ITEM ***(NOTE: Save results as a PDF Document and store them in the appropriate electronic file.)***	IS AGENCY COMPLIANT WITH THIS ITEM? ***(YES, NO, OR N/A)***
6	**DEBARRED CONTRACTORS (FORMERLY KNOWN AS CONTRACTOR DEBARMENT REPORT)** *https://www.miamidade.gov/smallbusiness/library/reports/contractor-debarment.pdf Search for the subrecipient organization. Print the document to PDF. Make a notation on page 1 if the organization was not found.* ***or*** *https://intra.miamidade.gov/procurement/vendor-compliance.asp and select the "Debarred Contractors" link. Search for the subrecipient organization. Print the document to PDF. Make a notation on page 1 if the organization was not found.*	
7	**DELINQUENT CONTRACTORS – (DISCONTINUED)** *NOTE: Previous web link is still broken. No new link was found on the Miami-Dade County intranet webpages for Internal Services Department (ISD)'s Procurement division.*	N/A
8	**GOAL DEFICIT MAKE-UP REPORT - (DISCONTINUED)** *NOTE: This report was discontinued by Miami-Dade County's Small Business Development (SBD) division, effective 4/1/2020. The information maintained on this report can now be found in SBD's Compliance Report, when applicable. See #4 above.*	N/A
9	**SUSPENDED CONTRACTORS (MIAMI-DADE COUNTY) – (REVISED -- APPEARS TO BE DISCONTINUED – Check link anyway. If same error message appears, note "Discontinued" in column to the right; otherwise follow action steps below)** *http://egvsys.miamidade.gov:1608/wwwserv/ggvt/bnzawbcc.dia (SITE NOT FOUND -- URL NOT FOUND; PROGRAM LOAD FUNCTION FAILED; REASON: PROGRAM NOT FOUND) (Under "Contractor Information Search", **select "Company Name"**, then type in the agency or subrecipient name in the appropriate box, click "Submit". **Then,** do the same for **"Contractor Complaint Search"**.)*	
10	**FLORIDA SUSPENDED CONTRACTORS (REVISED)** *https://www.dms.myflorida.com/business_operations/state_purchasing/state_agency_resources/vendor_registration_and_vendor_lists/suspended_vendor_list (Link opens to the current "Suspended Vendors List". Save a copy of the "Suspended Vendor List" page as is, even if no agencies are listed. Do not use the search engine for this page.)*	
11a	**SYSTEM FOR AWARD MANAGEMENT (formerly Federal Excluded Parties List System) – for the SUBRECIPIENT as a whole**	

#	DUE DILIGENCE ITEM ***(NOTE: Save results as a PDF Document and store them in the appropriate electronic file.)***	IS AGENCY COMPLIANT WITH THIS ITEM? *(YES, NO, OR N/A)*
	https://www.sam.gov/SAM/ (Under the "The Official U.S. Government System for:" select "Entity Information" in 2nd column. In middle of page, select "Advanced Search". Scroll down and click "Exclusions", then click the plus sign for "Filter By". A drop down list will appear. Under the Keywords Search box, click the down arrow for "Excluded Entity". In the "Entity Name" box, type the full legal name of the organization. From the filter results, click on the agency/subrecipient you want. You should see the name of agency/subrecipient appear in a green box. Scroll down or back up to top of page and you should see the results: "No matches found" if no matches, or the agency/subrecipient name with a problem. Follow up with agency/subrecipient if there is a potential exclusion.)	
11b	**SYSTEM FOR AWARD MANAGEMENT (formerly Federal Excluded Parties List System) – for the SUBRECIPIENT's KEY STAFF** (if listed on budget) – ***(See also Item # 20 below)*** *https://www.sam.gov/SAM/ (Under the "The Official U.S. Government System for:" select "Entity Information" in 2nd column. In middle of page, select "Advanced Search". Scroll down and click "Exclusions", then click the plus sign for "Filter By". A drop down list will appear. Under the Keywords Search box, click the down arrow for "Excluded Individual". Enter the First Name, Middle Name or Initial if available, and full Last Name. Click "Add Individual." You should see the name of the person appear in a green box. Add additional names as needed (there does not appear to be a maximum number you can add). Scroll back up to top of page and you should see the results: "No matches found" if no matches, or the person's name with a problem. If there is a problem, contact the agency/subrecipient to obtain the middle name or social security number (SSN) of the person whose name resulted in the possible exclusion. By entering the middle name and/or SSN you will be able to determine if there is a match. You MUST redact any SSN from the results page.)*	

#	DUE DILIGENCE ITEM ***(NOTE: Save results as a PDF Document and store them in the appropriate electronic file.)***	IS AGENCY COMPLIANT WITH THIS ITEM? ***(YES, NO, OR N/A)***
12	**SCRUTINIZED COMPANIES [FORMERLY KNOWN AS SUDAN-IRAN AFFIDAVIT (SCRUTINIZED LIST OF PROHIBITED COMPANIES – QUARTERLY REPORT)] – (REVISED)** https://www.sbafla.com/fsb/FundsWeManage/FRSPensionPlan/GlobalGovernanceMandates/QuarterlyReports.aspx *[This link should take you directly to the quarterly reports, under "Funds We Manage"; with the most recent one within the last 3 months – titled, "Global Governance Mandates – Florida Statutes," with the date. If not, find "Funds We Manage" then "Quarterly Reports" under the site menu, or type "**2023"** Scrutinized List of Prohibited Companies" in the address bar of your browser; be sure to get the one for Florida; and click the link for the Florida State Board of Administration, Funds We Manage, Quarterly Reports. Select most current quarterly report. Link opens to the report. Search the document to find if subrecipient organization is listed as a scrutinized company. Save page 1 and the pages with the lists of scrutinized companies if agency/subrecipient is found. Note that the main source document will be saved in the Compliance Tracking, Due Diligence folder for the corresponding contract year.]*	
13	**OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) ENFORCEMENT INSPECTIONS** *https://www.osha.gov/pls/imis/establishment.html – Read the special "Note to Users" -- (In the "Establishment" field, type full name of agency/subrecipient.)*	
14	**STATE OF FLORIDA CORPORATIONS (SUNBIZ)** *http://www.sunbiz.org/search.html (Click on the "Search Records" tab in the middle of the page; then search for agency by name or fictitious name, if appropriate; save the page; **AND** include copy of agency's current Certificate of Status which they submit separately.)*	
	CAPITAL IMPROVEMENTS INFORMATION SYSTEM (CONSTRUCTION ONLY)	N/A
	A&E TECHNICAL CERTIFICATION REPORT (DESIGN & PROFESSIONAL SERVICES ONLY - FOR ARCHITECTURAL AND ENGINEERING SERVICES)	N/A
	PRE-QUALIFICATION REPORT (DESIGN & PROFESSIONAL SERVICES ONLY - FOR ARCHITECTURAL AND ENGINEERING SERVICES)	N/A
15	**WEB SEARCH FOR COMPLIANCE AND PERFORMANCE RECORD (BETTER BUSINESS BUREAU) – (REVISED)** *https://www.bbb.org/us/fl/miami or https://www.bbb.org/local-bbb/bbb-serving-southeast-florida-and-the-caribbean (In the "Find local businesses" search box, type full legal name of agency/subrecipient – probably without*	

#	DUE DILIGENCE ITEM ***(NOTE: Save results as a PDF Document and store them in the appropriate electronic file.)***	IS AGENCY COMPLIANT WITH THIS ITEM? ***(YES, NO, OR N/A)***
	*the "Inc." – and City and State in the appropriate fields; then click "Search" and save the page(s). **If there are any "hits" or results from the search**, scan the list for information related to this subrecipient and read the information **in each link** for any relevant concerns.)*	
16	**REFERENCE CHECKS FOR CONTRACTS SIMILAR IN SCOPE** *(Check if agency is funded by County General Funds or other County Departments for social services; if so, check with assigned CBO Contracts Officer or County Department representative if there are any concerns or outstanding issues – get a response in writing, preferably by email. Usually the RW Program Administrator sends an email at the beginning of the fiscal year to County Department contacts for this purpose, and enters results in a spreadsheet in Compliance Tracking, Due Diligence folder.)*	
17	**TAX RETURNS, FINANCIAL STATEMENTS(AUDITED), PROFORMA STATEMENTS AND OTHER FINANCIAL DOCUMENTS**	See Required Document Checklist
18	**LOCAL PUBLIC RECORDS SEARCH (CLERK OF COURTS)** *https://onlineservices.miami-dadeclerk.com/officialrecords/ (Under "Standard Search", Under "Party Name" type in full legal name of agency/subrecipient. For "Date Range", begin with first month of prior grant fiscal year to present date. Under "Document Types", do a search for each of the following: Bankruptcy, Federal Tax Lien, Notice of Tax Lien, and "~Any Lien Judgment"; click box "I am not a robot"; click "Search"; click on plus sign "+" to expand the box for Search Criteria; and save any confirmations or reports. Click "Back to Search," change "Document Type," and repeat.*	
19	**DUNN & BRADSTREET FINANCIAL REPORTS** *(If fiscal stability issues arise, follow-up with Procurement Management Services to gain access to these subscription-based reports; otherwise indicate "N/A" in box to the right)*	N/A
20	**PUBLIC ACCESS TO COURT ELECTRONIC RECORDS (PACER)** *(If fiscal or programmatic stability issues arise, follow-up with Procurement Management Services to gain access to this subscription-based report; otherwise indicate "N/A" in box to the right)*	N/A

#	DUE DILIGENCE ITEM ***(NOTE: Save results as a PDF Document and store them in the appropriate electronic file.)***	IS AGENCY COMPLIANT WITH THIS ITEM? ***(YES, NO, OR N/A)***
21	**OFFICE OF INSPECTOR GENERAL (OIG) EXCLUSIONS REVIEW** *[For all agencies/subrecipients, staff on budgets and those associated with services provided under the contract, as well their identified subcontractors, check for Office of Inspector General Exclusions (for each, save a copy of the results from https://exclusions.oig.hhs.gov/)]* ***NOTE:*** *You can also do an search with the Office of the Inspector General, U.S. Department of Health and Human Services by visiting the following online "LEIE Downloadable Databases" site: https://oig.hhs.gov/exclusions/exclusions_list.asp* ***This site allows you to verify employee's middle name and date of birth.***	

I certify that I have completed the due diligence review required through Miami-Dade County Resolution # R-630-13 and by the federal funding source for the agency/subrecipient stated on page 1 of this checklist, and that the information on the checklist above is correct.

EHE Administrator (signature): ____

(print name): ____

Date: ____

Comments: ____

____

Appendix G

Miami-Dade County Ryan White Program Telehealth Policies and Procedures

-----

Request for Proposals (RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

Policy Area: Service Delivery	Subject: Telehealth
Title of Policy: Provision of Telemedicine, Tele-Mental Health, Tele-Medical Case Management and Tele-Substance Abuse Outpatient Care as forms of Telehealth	Number: SD-T-2
Effective Date: 3/1/2020	Page Number: 1 of 11
Approved Date: 7/13/2020 Revision Date:	Approved by: Daniel T. Wall, Assistant Director

Purpose:

To provide guidelines that promote effective use of Telehealth as it pertains to provider-patient (client) relationship, evaluation and treatment, client consent, and privacy in efforts to maintain or improve client health outcomes towards viral suppression. This document details guidelines for the provision of Telemedicine, Tele-Mental Health, Tele-Medical Case Management services and Tele-Substance Abuse Outpatient Care (hereinafter referred to collectively as "Telehealth" services unless specifically stated otherwise in this document) in the Miami-Dade County Ryan White Part A/Minority AIDS Initiative (MAI) Program. Telehealth services in Miami-Dade County's Ryan White Part A/MAI may be provided at any time to facilitate access to care; including, but not limited to, during normal operations.

The provision of Telehealth services in these circumstances is designed to address the medical, mental health, medical case management and outpatient substance abuse treatment needs of established Ryan White Program clients when a face-to-face encounter with their medical, mental health, medical case management or substance abuse treatment provider is not available, safe, convenient or appropriate. For example, during the COVID-19 "safer at home" order from the Mayor of Miami-Dade County, Telehealth services would be an ideal mechanism when a client cannot come into the clinic or office because they are in isolation, self-quarantine, practicing social (physical) distancing, or do not feel comfortable (safe) leaving their home.

Telemedicine specifically is the practice of healthcare delivery (e.g., assessment, diagnosis, consultation, treatment, transfer of related data, monitoring of client's care, and education) using interactive audio, video, or data communications. Telemedicine that uses interactive audio, video, or data communication involving real time is "synchronous"; and in near real time is "asynchronous."

Subrecipients using Telehealth must have internal policies and procedures related client consents, service delivery methods and procedures, client confidentiality and Health Portability and Accountability Act requirements, at a minimum.

At a minimum, subrecipients of local Ryan White Part A/MAI Program-funded Outpatient/Ambulatory Health Services, Medical Case Management, Mental Health Services and Substance Abuse Outpatient Care **MUST** develop and implement Telehealth services as described herein, and as appropriate to their Part A/MAI funding, to provide continuity of services during various emergencies. Such emergencies include: a public health emergency (e.g., pandemic), an official state of emergency, a "safer at home" order by the County Mayor, a natural disaster, or other County-approved circumstance that affects normal "in-office" service delivery between a medical, mental health, medical case management or substance abuse treatment provider and a program-eligible patient (client).

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Procedures:

Types of allowable Telehealth services:

- **Medical Case Management**
  - For ongoing care to ensure HIV Treatment Adherence, develop and update care plans, and facilitate referrals to services that address identified client needs
  - Including, but not limited to, Peer Education and Support Network services for Treatment Adherence support
  - See local Ryan White Program Service Delivery Guidelines for detailed staff qualifications

- **Mental Health Services**
  - For assessment, diagnosis, consultation, treatment of a mental health disorder or condition
  - Ongoing treatment requires a documented mental health disorder or condition
  - Providers of this service must possess a Doctorate degree (PhD, EdD, PsyD, etc.; Level I) or a Master's degree (MSW, etc.; Level II); both levels must be licensed in the State of Florida as LCSW, etc. – see local Ryan White Program Service Delivery Guidelines for detailed staff qualifications

- **Outpatient/Ambulatory Health Services**
  - For clinical assessment, diagnosis, consultation, treatment, transfer of related data, monitoring of client's care, and education diagnostics
    - Covers all services listed on the most current Miami-Dade County Ryan White Program's Allowable Medical Conditions List
  - Includes psychiatry services
  - Providers of this service must be licensed in the State of Florida

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Procedures: (continued)

Types of allowable Telehealth services: (continued)

- **Substance Abuse Outpatient Care**
  - For assessment, diagnosis, consultation, treatment of substance abuse disorder
  - Level I providers of this service must meet the educational qualifications as detailed in the most current, local Ryan White Program Service Delivery Guidelines (i.e., PhD or Master's degree, and licensed as Certified Addiction Counselor, Licensed Clinical Psychologist, LCSW, LMHC or LMFT. Level II providers must be appropriate trained and supervised counselors (who may possess a Bachelor's degree or have related experience, and may not be licensed).

- **NOTES:**
  - Where appropriate, "allowable services" noted above that are provided via Telehealth may require eventual "in office" care once the organization resumes full operations.
  - The current Service Definitions and Allowable Medical Conditions can be found here: www.miamidade.gov/grants/ryan-white-program; scroll down to the Service Delivery Guidelines box and select the appropriate section.

Location and Provider of the service:

- Visit may be conducted by telephone or video call following Office of Civil Rights guidance on acceptable formats (see HIPAA section below):
  - From the clinic by a medical, mental health or medical case management provider (in cases where a client calls in), or
  - From the medical, mental health or medical case management provider's home or other secure, remote location (in cases where the office passes along the information to the provider and the provider initiates the contact).

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Client Eligibility Limitations:

- The client must be eligible to receive local Ryan White Program services (i.e., must be HIV+, reside in Miami-Dade County, and have gross household income less than 400% of the Federal Poverty Level).

- The local Ryan White Part A Program must always be the payer of last resort.

    - If the client has private insurance, Medicare or Medicaid Managed Medical Assistance, Long-Term Care, or other Medicaid-supported medical coverage with access to Telehealth services, the Part A Program cannot be billed for these services.

Documentation:

- The client's medical, mental health or social service record must clearly indicate the:

    - Date of service (must be within the authorized period);
    - Circumstance that makes Telehealth allowable (e.g., COVID-19 "safer at home" precautions);
    - Service(s) provided (e.g., pain assessment, review of treatment plan, treatment adherence, etc.) during the encounter/call/visit; and
    - Appropriate billing code(s) used; see below under "Reimbursement."
    - Client's written consent for Telehealth.

Reimbursement:

The billing codes noted in this section for reimbursement of Telehealth services are effective retroactive to March 1, 2020. Agencies that previously billed for a Telehealth service using a different code [or without the Place of Service – 02 (telehealth) for Outpatient/Ambulatory Health Services] will not be required to resubmit with the new codes identified in this section. The Telehealth codes in this section will be available in the Provide® Enterprise Miami data system by July 20, 2020; and must be the only Telehealth codes used for the Miami-Dade County Ryan White Part A/MAI Program thereafter.

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Reimbursement: (continued)

Subrecipient organizations that are currently funded to provide local Ryan White Part A/MAI Medical Case Management, Mental Health Services, Substance Abuse Outpatient Care and Outpatient/Ambulatory Health Services can be reimbursed for Telehealth services as follows, only if the Part A Program is the payer of last resort and the clients are otherwise eligible for Part A/MAI services:

- **Medical Case Management**

New Code	Description	Flat rate Reimbursement
THM	Tele-Medical Case Management provided by Medical Case Manager, Medical Case Management Supervisor or Eligibility Specialist (with degree)	$1.15 per minute
THP	Tele-Medical Case Management provided by a Peer, Medical Case Management Assistant or Eligibility Specialist (with no degree)	$0.65 per minute

- **Mental Health Services**

New Code	Description	Flat rate Reimbursement
THMHT1	Tele-Mental Health provided by a Level I provider (individual client only)	$32.50 per 30-minute session
THMHT2	Tele-Mental Health provided by a Level II provider (individual client only)	$32.50 per 30-minute session

- **Substance Abuse Outpatient Care**

New Code	Description	Flat rate Reimbursement
THSAC1	Tele-Substance Abuse Outpatient Care provided by a Level I provider (individual client only)	$30.00 per 30-minute session
THSAC2	Tele-Substance Abuse Outpatient Care provided by a Level II provider (individual client only)	$27.00 per 30-minute session

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- **Outpatient/Ambulatory Health Services**

  When Telehealth is used for Telemedicine only, the codes and services in the tables in this subsection directly below are billable under the local Ryan White Part A/MAI Program. Along with the billing code, the **Place of Service (POS) code 02** must be used, as noted at the beginning of this section. These codes will be reimbursed at the full amount of the local Part A/MAI Reimbursement rate (i.e., Medicare rate times the local multiplier) or the flat fee reimbursement (with no multiplier) including Psychiatry services. If labs or diagnostics are ordered, those would be entered as regular codes with no Telehealth codes. CPT codes 99205 and 99215 remain disallowed for the local Ryan White Part A/MAI Program.

  The following codes will be paid using the existing Medicare Physician Fee Schedule payment structure for Miami-Dade County's Ryan White Part A and MAI Program, including the locally-defined 2.5 multiplier when using the **POS – 02** code:

Code	Short Description
90785	Psytx complex interactive
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/ E/M 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/ E/M 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/ E/M 60 min
90847	Family psytx w/patient
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99354	Prolonged service office (1 hour beyond usual service)
99355	Prolonged service office (each 30 minutes after 99354)

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- **Outpatient/Ambulatory Health Services (continued)**

  Any authorized medical practitioner or facility, where applicable, who uses the codes in the following table will be paid as indicated in the Supplemental Reimbursement Rate column; and the POS – 02 must be used for the following codes as noted above:

Code	Short Descriptor	Supplemental Reimbursement Rate *(flat fee – no multiplier)*
98966*	Telehealth/Telephone eval independent of E/M (non-face-to-face **Non-Physician** telephone service); 5-10 min.	$18.00
98967*	Telehealth/Telephone eval independent of E/M (non-face-to-face **Non-Physician** telephone service); 11-20 min.	$35.00
98968*	Telehealth/Telephone eval independent of E/M (non-face-to-face **Non-Physician** telephone service); 21-30 min.	$50.00
99244*	Office or Other Outpatient Consultation Services, new or est, 60 minutes	$185.00
99441*	Telehealth/Telephone eval independent of E/M (non-face-to-face **Physician** telephone service); 5-10 min.	$55.00
99442*	Telehealth/Telephone eval independent of E/M (non-face-to-face **Physician** telephone service); 11-20 min.	$90.00
99443*	Telehealth/Telephone eval independent of E/M (non-face-to-face **Physician** telephone service); 21-30 min.	$130.00

** Codes to be added to local Ryan White Program billable services. Codes 99441, 99442, and 99443 are usually used for communications between client and medical provider through an online patient portal.*

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Client Informed Consent to Benefits and Risks of Telehealth:

- Telehealth under this policy and procedures document refers to providing medical care, psychiatry, mental health, and medical case management services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Telehealth is that the client and service provider can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client and the service provider are unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both the client and service provider's parts to be beneficial.

  Although there are benefits of Telehealth, there are some differences between in-person care and Telehealth, as well as some risks. For example:

  - <u>Risks to confidentiality</u>: With Telehealth sessions that take place outside of the medical, mental health or medical case management provider's private office, there is potential for other people to overhear sessions if both parties are not in a private place during the session. The medical, mental health and medical case management provider must take reasonable steps to ensure the client's privacy. It is important for both parties to make sure they find a private place for the Telehealth session where they will not be interrupted. Also, it is important for both parties to protect the privacy of the session on their computers, cell phones or other devices. Both parties should participate in a Telehealth session only while in a room or area where other people are not present and cannot overhear the conversation.

  - <u>Issues related to technology</u>: There are many ways that technology issues might impact Telehealth. For example, technology may stop working during a session, other people might be able to get access to the private conversation, or stored data could be accessed by unauthorized people or companies.

- The provider requesting the Telehealth services at the originating site must advise the client about the proposed use of Telehealth, any potential risks, consequences, and benefits and obtain the client's or the client's legal representative's consent.

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Client Informed Consent to Benefits and Risks of Telehealth: (continued)

- The client must sign a written statement, prior to the delivery of Telehealth services, indicating that he/she/they understand(s) the information provided and that this information has been discussed with him/her/them by the provider of the service and/or his/her/their designee. An emailed acknowledgement from the client would suffice if no other means to obtain a written statement are available.

- The client has the right to withhold/withdraw consent for Telehealth at any time, without affecting his/her/their right to present/future care/treatment or the loss/withdrawal of any program benefits to which he/she/they or his/her/their legal representative would otherwise be entitled.

- Dissemination of any client identifiable images or information from Telehealth interactions with other entities will not occur without the client's consent.

Client Confidentiality:

- The client must always be:

  - Asked if they are in a place where they can speak freely about their case (i.e., medical, mental health, case management, social services concerns),
  - Informed that this is a Telehealth "visit",
  - Informed of the limitations of an audio/video call,
  - Informed that data charges may apply from their cellular or internet service provider; and
  - Asked to give consent to receive the service. Written consent from the client is needed for all Telehealth services. A copy of a related email, text, or other form/image from the client would suffice as documentation of the client's explicit consent for Telehealth services. This documentation of client consent for Telehealth should be uploaded in the client's profile in the Provide® Enterprise Miami data system.

- The service provider must always provide the service from a secure/private location within the clinic, their home or other remote location where the confidentiality of the client's identity and medical, mental health, social service, or case management history can be protected from disclosure.

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Health Insurance Portability and Accountability Act (HIPAA)

- The Office of Civil Rights (OCR) in the U.S. Department of Health and Human Services (HHS) may partially relax the Health Insurance Portability and Accountability Act (HIPAA) regulations during a public health emergency (such as the COVID-19 pandemic):

- For example, in FY 2020 due to the COVID-19 pandemic, HHS allowed for relaxed certain regulations as indicated in the following: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

- The OCR indicates that "covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."

    - The OCR also indicates that, "Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers."

Additional Resources:

- **Department of Health and Human Services (DHHS) and Health Resources and Services Administration (HRSA)**

    - HRSA Telehealth Resources – For Patients (Clients) and Providers (Subrecipients): https://telehealth.hhs.gov/

    - DHHS Office of the Assistant Secretary for Planning and Evaluation: Virtual Case Management Considerations and Resources for Human Services Programs (4/1/2020)
      https://aspe.hhs.gov/pdf-report/virtual-case-management (includes a list of various Telehealth resources: Online Telehealth Resource Compendiums, Telemedicine Guidelines and Practices, Case Management by Telephone, and Web-Based Approaches From Human Services)

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Additional Resources: (continued)

- **MEDICARE**
  - Medicare Telehealth Services (Fact Sheet, March 2020): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
  - Article regarding Medicare temporarily expanding telehealth services for Medicare beneficiaries to reduce the impact of the pandemic. Indicates doctors can use their personal phones for telehealth. https://www.modernhealthcare.com/medicare/cms-expands-medicare-telehealth-services-fight-covid-19?utm_source=modern-healthcare-covid-19-coverage&utm_medium=email&utm_campaign=20200317&utm_content=article2-headline
  - Medicare Telemedicine Health Care Provider Fact Sheet (March 17, 2020) – https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Appendix I

MIAMI-DADE COUNTY RYAN WHITE PROGRAM GRIEVANCE POLICY AND PROCEDURES

Request for Proposals (RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

Miami-Dade County Ryan White Program Part A [and EHE] Recipient Grievance Procedures and Process

ARTICLE I

PREAMBLE

Miami-Dade County (hereinafter "County") adopts the following Grievance Procedures to provide an orderly process for resolving disputes concerning deviations from established, written procurement (e.g., Request for Proposals), contracting, and site visit monitoring procedures, and those attendant rules and regulations that may effect such deviations from established processes, priorities, or allocations. These Grievance Procedures are hereby adopted by the County in accordance with the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). This legislation was first enacted in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act; and has been amended and reauthorized four times (in 1996, 2000, 2006, and 2009).

It is the policy of the County that an equitable solution of any grievance should be secured at the most immediate administrative level. These procedures should not be construed as limiting the right of any organization to discuss any concern with any County staff (especially staff of the Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program. Nothing in this procedure shall be interpreted to limit the County's exclusive final authority over the management of the County's contracting and award process and selection of contractors and their awards.

ARTICLE II

DEFINITIONS

1. **Arbitration:** The submission of a dispute to an impartial or independent individual or panel for a binding determination. Arbitration is usually carried out in conformity with a set of rules. The decision of an arbitrator generally has the force of law, although it generally does not set a precedent.
2. **Arbitrator:** An individual or panel of individuals (usually three) selected to decide a dispute or grievance. Arbitrators may be selected by the parties or by an individual or entity.
3. **Binding:** A process in which parties agree to be bound by the decision of an arbitrator or other third party.
4. **Costs:** Charges for administering a dispute settlement process.

Miami-Dade County Ryan White Program Part A [and EHE] Recipient
Grievance Procedures and Process

5. **County:** Miami-Dade County.
6. **Day:** Refers to a calendar day or a business day, but excludes weekends and the County's recognized holidays. Either reference point can be used, as long as the Grievant and the person or group against which the grievance is brought understand the applicable time frame.
7. **Dispute Prevention:** Techniques or approaches that are used by an organization to resolve disagreements at as early and informal a stage as possible to avoid or minimize the number of disputes that reach the grievance process.
8. **Elements of Due Process:** An activity in which the following procedural safeguards are required: (a) Adequate notice to the affected individual or organization; (b) Right of the individual or organization to be represented by counsel; (c) Opportunity for the individual to refute the evidence presented by the County or the basis of the action taken by the County including the right to confront and cross-examine witnesses and to present any affirmative legal or equitable defense which the individual or organization may have; (d) A decision on the merits.
9. **Facilitation:** A voluntary process involving the use of techniques to improve the flow of information and develop trust between the parties to a dispute. Involves a third party (facilitator) who, as in mediation, uses a process to assist the parties in reaching an agreement that is acceptable to the parties.
10. **Facilitator:** A third party who works with the parties to a dispute, providing direction to a process. A facilitator may be independent or may be drawn from one of the parties, but must maintain impartiality on the topics under discussion.
11. **Grievance:** A complaint or dispute that has reached the stage where the affected party seeks a structured approach to its resolution.
12. **Grievant:** A person or entity seeking a structured resolution of a grievance; or any person or entity whose grievance is presented to the County in accordance with this procedure.
13. **Hearing Officer:** A person selected in accordance with this policy to hear grievances and render a decision with respect thereto.
14. **Individual:** An adult person (or persons), organization, agency, or governmental entity that is the direct object of the County's action, ruling or policy.
15. **Mediation:** A voluntary process in which an impartial and usually independent third party assists parties to a dispute in reaching an acceptable resolution to the issues in the dispute. Mediation may involve meetings held by the mediator with

the parties together and separately. The results of mediation can become binding on the parties if the parties agree to make it binding.

16. **Mediation/arbitration (med/arb):** A mixed approach in which parties agree to mediate their differences and submit those issues that cannot be resolved through mediation to arbitration. This technique helps to narrow the issues submitted to arbitration. The parties may agree to use separate mediators and arbitrators for different stages of the process, or they may use the same third party.
17. **Mediator:** A trained, impartial and usually independent third party selected by the parties to the dispute or by another entity to help the parties reach an agreement on a determined set of issues.
18. **Neutral:** An independent third party, including a mediator or arbitrator, selected to resolve a dispute or grievance.
19. **Non-binding:** Techniques in which the parties to a dispute attempt to reach an agreement. The results must be agreed to by both parties; results are not imposed by the third party as they are in binding arbitration or in a judicial proceeding.
20. **Organization:** An organized provider, consumer group, advocacy or service organization under incorporation with an adopted set of by-laws and elected officers.
21. **Party:** One of the participants in the grievance process. This includes the Grievant (or person or group) who brings the grievance action, and the person or group against which the grievance is brought.
22. **Remedy:** Relief or result sought by a Grievant in bringing a grievance. It can include money damages or a process change. For the purpose of these procedures, any remedies that result from this process will be prospective only.
23. **Recipient:** Miami-Dade County.
24. **Standing:** The eligibility of an individual or entity to bring a grievance. In the case of locally drafted grievance procedures under the CARE Act reauthorization, standing refers to a directly affected individual or entity challenging a decision with respect to funding.
25. **Third Party:** An independent or impartial person, including a facilitator, mediator, ombudsman or arbitrator, selected to resolve a dispute or grievance or assist the parties in resolving a dispute or grievance.
26. **With respect to funding:** The County's contracting and award process and allocations or selection of contractors and their awards.

Miami-Dade County Ryan White Program Part A [and EHE] Recipient Grievance Procedures and Process

ARTICLE III

THE GRIEVANCE PROCESS

A. REQUESTS FOR GRIEVANCES AND NOTICE OF HEARING

1. **Requests for Grievance:** A Grievant shall have ten (10) business days from the date of the alleged incident giving rise to the grievance to file a written grievance with the County. The grievance shall set forth with particularity the dispute to be addressed by the County, Mediator, Hearing Officer, or Arbitrator. All grievances which are timely filed are deemed sufficient if made in writing and delivered personally or sent by certified mail, return receipt requested, postage prepaid, to the County at the following address: (or to such other address to be determined by the County):

Miami-Dade County
c/o Office of Management and Budget-Grants Coordination
Ryan White Program
111 N.W. 1st Street, 22nd Floor
Attn: Daniel T. Wall, Program Director

Failure to timely file said grievance shall result in a refusal by the County, Mediator, Hearing Officer, or Arbitrator to consider the merits of the grievance. A Grievant's failure to timely file the grievance shall result in and be deemed a waiver of any and all rights afforded herein.

2. **Determination of Ripeness and Jurisdiction:** All grievances shall be reviewed by the Office of Management and Budget-Grants Coordination/Ryan White Program, in consultation with the County Attorney's Office, to determine the ripeness of the grievance and/or jurisdictional issues. In the event it is determined that the grievance is not ripe or that there is a lack of jurisdiction, the Office of Management and Budget-Grants Coordination/Ryan White Program shall notify the Grievant in writing within ten (10) business days of receipt of the grievance. A copy of said notice shall be sent to the County Attorney.

3. **Notice of Hearing:** At least ten (10) business days prior to any procedure described below, the County shall deliver a notice of hearing to the parties by personal service or certified mail. Such notice shall include the date, time and place at which the hearing is held.

Miami-Dade County Ryan White Program Part A [and EHE] Recipient
Grievance Procedures and Process

4. **Fees:** As a condition of initiating any grievance within the scope of this grievance process, the Grievant shall present to the Miami-Dade County Clerk of the Board (Clerk of the Board) a nonrefundable filing fee payable to the Clerk of the Board in accordance with the schedule provided below.

Contract Award Amount	Filing Fee
$25,000-$250,000	$500
$250,001-$500,000	$1,000
$500,001-$5 million	$3,000
Over $5 million	$5,000

Filing fees, or any other monies received as payment of protest costs, shall be deposited in a special account administered by the Clerk of the Board and shall be used by the Clerk solely for the purpose of defraying the cost of the mediator, hearing examiner and/or arbitrator, and the Clerk's costs of administering the County's grievance program. If, at any given time, there are insufficient funds available in said special account to pay said costs the requesting department shall be responsible for reimbursement of any shortage to the Clerk of the Board.

B. TYPES OF GRIEVANCES COVERED BY THE PROCEDURE AND WHO MAY BRING A GRIEVANCE

1. Types of County Grievances

The following County processes may be grieved:

a. Disputes concerning the County's contracting and award process;
b. Disputes concerning the County's allocations or selection of contractors and their awards; and
c. Disputes concerning the County's site visit monitoring site processes.

2. Who May Grieve

a. Solely providers eligible to receive Ryan White Program Part A and/or Minority AIDS Initiative (MAI) or Ending the HIV Epidemic (EHE) funding within the Miami-Dade County Eligible Metropolitan Area (EMA) and who have submitted a rejected proposal pursuant to the County's Request for Proposal process may file a grievance with the County.

Miami-Dade County Ryan White Program Part A [and EHE] Recipient Grievance Procedures and Process

C. GRIEVANCE INITIATION AND PRELIMINARY DIRECT MEETING

[Maximum amount of time to complete grievance process once initiated: thirty (30) working days]

Throughout the grievance process (including both non-binding and binding resolution), the following is considered to be public information: the specific process being grieved, the identity of the party submitting the grievance, and the resolution agreed upon. However, any other information shared during the grievance process is considered confidential and shall not be shared with parties who are not involved in the process. The procedures for Grievance are as follows:

(1) Step 1 –Submittal of Grievance

Individuals or entities wishing to grieve a County process must: (a) submit their Grievance in writing to Miami-Dade County's Office of Management and Budget-Grants Coordination/Ryan White Program noting how the County failed to follow the process as outlined in the corresponding RFP, contract, or monitoring site visit process; (b) submit the Grievance in accordance with the provisions set forth in Article III ten (10) business days after the completion of the County process that is the subject of the grievance.

(2) Step 2 –Review for Allowance

The County will distribute a copy of the submitted Grievance to members of a Grievance Committee, which must include at least one (1) person with HIV, created under these procedures.

The committee members must be:

(a) Familiar with the work of the County and the local HIV/AIDS service delivery system; and
(b) Independent of the specific process that is the subject of the grievance; and
(c) Free of direct interest in the outcome of the process being grieved.

The Grievance Committee will determine whether the grievance is allowable as defined by section B(1) of these Procedures.

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Within ten (10) business days from its submittal date, the Grievant must be notified in writing whether or not the grievance is allowable.

(3) Step 3 –Direct Meeting

Within ten (10) business days after Step 2 is completed, the Grievant will meet with the County's representative most appropriate to address the concerns of the Grievant. This meeting will take place at a location agreed to by all parties. The purpose of the direct meeting is to address the concerns of the Grievant and, if possible, make mutually satisfactory adjustments to the grieved process for future implementation. The Grievant shall bear his/her/their or its own expenses with respect to Paragraph C, Steps 1, 2 and 3 of the Procedures for Grievances.

D. NON-BINDING MEDIATION

[Maximum amount of time to complete non-binding mediation: twenty (20) business days]

(1) Step 4 –Selection of Mediator

If resolution of the grievance is not achieved through Step 3, a mediator will be chosen. Selection of this mediator must take place **within ten (10) business days** of the end of Step 3.

The mediator must be:

(a) Independent of the specific processes that are the subject of the grievance;
(b) Free of direct interest in the outcome of the process being grieved; and
(c) Approved by both the Grievant and the County before beginning his/her/their work.

In order to expedite the Grievance Process, the County will create and maintain a pool of at least five (5) persons willing to serve as mediators in this process. These persons are not to be employees or agents of the County and may be from outside the geographic area of the EMA.

The Grievant and the County shall agree as to a date, place and time for meeting with the mediator. The Grievant shall bear his/her/their or its own expenses. The County shall bear expenses of any County members. The expenses of the mediator shall be borne one-half by the

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County and one-half by the Grievant. The Grievant's half of the estimated costs of the mediator must be paid directly to the mediator before mediation begins.

The parties shall set the per diem rate of the mediator. No County employee or agent shall receive such per diem service on their service. Each party shall be responsible for producing their or its own witnesses and shall bear expenses for same.

(2) Step 5 –Mediation

Once the mediator is selected, mediation will take place within a period of **ten (10) business days** at a location agreed to by both parties. During this time, the mediator is responsible for:

(a) Investigating the grievance;
(b) Mediating between the County and the Grievant; and
(c) Pursuing a solution that is mutually satisfactory to both parties.

E. INFORMAL HEARING

(1) Step 6 – Hearing

a. When the County notifies the individual of an action, the County shall also include in that notice that any grievance hearing requests shall be in accordance with the expedited grievance procedure.

b. The Grievant shall have five (5) business days from the date of the notice in which to file a written request for an informal expedited non-binding arbitration hearing to the County. The written request shall specify: (a) The reasons for the grievance; and (b) The action or relief sought.

c. The Grievant shall NOT have the grievance informally discussed as outlined in Section C.

d. Within ten (10) business days of receipt by the County of the Grievant's request for a hearing, the Executive Committee or its designee shall notify the individual of the selection of a Hearing Officer. The individual has five (5) business days from the date of the notice to submit comments as to the selection of the Hearing Panel or Hearing Officer.

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e. Upon the Grievant's compliance with subsection 3 of this section, a hearing shall be scheduled by the Hearing Officer promptly for a time and place reasonably convenient to both the Grievant and the County, not in excess of five (5) business days of the selection of the Hearing Officer. A written notification specifying the time, place and the procedures governing the hearing shall be delivered to the Grievant and the appropriate County official.

f. The hearing shall be held before a Hearing Officer.

g. The Grievant shall be afforded a fair hearing, which shall include:

(a) The opportunity to examine before the grievance hearing any County documents, including records and regulations, that are directly relevant to the hearing. The Grievant shall be allowed to copy any such document at the Grievant's expense. If the County does not make the document available for examination upon request by the Grievant, the County may not rely on such document at the grievance hearing;

(b) The right to be represented by counsel or other person chosen as the Grievant's representative, and to have such person make statements on the Grievant's behalf;

(c) The right to a public hearing;

(d) The right to present evidence and arguments in support of the Grievant's complaint, to controvert evidence relied on by the County, and to confront and cross-examine all witnesses upon whose testimony or information the County or project management relies; and

(e) A decision based solely and exclusively upon the facts presented at the hearing.

h. The Hearing Officer may render a decision without proceeding with the hearing if the Hearing Officer determines that the issue has been previously decided in another proceeding.

i. Except in the case of an expedited grievance procedure, if the Grievant or the County fails to appear at a scheduled hearing, the Hearing Officer may make a determination to postpone the hearing for not more than five (5) business days or may make a determination that the party has waived his right to a hearing. The Hearing Officer shall notify both the Grievant and the County of the determination.

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j. At the hearing, the Grievant must first make a showing of an entitlement to the relief sought and thereafter the County must sustain the burden of justifying the County action or failure to act against which the complaint is directed.

k. **Conduct of the Hearing**: The hearing shall be conducted informally by the Hearing Officer and oral or documentary evidence pertinent to the facts and issues raised by the complaint may be received without regard to admissibility under the rules of evidence applicable to judicial proceedings. The Hearing Officer shall require the County, the Grievant, counsel and other participants or spectators to conduct themselves in an orderly fashion. Failure to comply with the directions of the Hearing Officer to obtain order may result in exclusion from the proceedings or in a decision adverse to the interests of the disorderly party and granting or denial of the relief sought, as appropriate.

(1) Any party or Hearing Officer may call, examine and cross-examine witnesses, and introduce documentary and other evidence into the record. Upon offering an exhibit into evidence at a hearing, a party shall provide an original and four copies to the Hearing Officer, and simultaneously furnish copies to all parties.

(2) All relevant and material evidence, oral or written, may be received. Hearsay evidence shall be accorded such weight as the circumstances warrant. In its discretion, the Hearing Officer may exclude irrelevant, immaterial or unduly repetitious evidence. A party is entitled to represent his or her case by oral and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination. Both parties may appear in person or through any duly authorized representative.

(3) The burden of persuasion, or duty of producing evidence to substantiate any allegation raised in the grievance, remains with the Grievant in all hearings before the Hearing Officer.

l. The Hearing Officer shall open the hearing at the time and place specified in the notice of hearing, or soon thereafter as a Hearing Officer can be obtained. After a reasonable time, if it is determined by the Grievance Committee that no Hearing Officer can be obtained, the hearing shall be continued until such time as a Hearing Officer or Hearing Panel can be obtained.

m. Either party may request a continuance. A continuance may be granted solely at the discretion of the Hearing Officer.

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n. The Grievant or the County may arrange, in advance and at the expense of the party making the arrangement, for a transcript of the hearing. Any interested party may purchase a copy of such transcript.

o. The County must provide reasonable accommodation for persons with disabilities to participate in the hearing. Reasonable accommodation may include qualified sign language interpreters, readers, accessible locations, or attendants. If the Grievant is visually impaired, any notice to the Grievant, which is required under this section, must be in an accessible format.

p. The Hearing Officer shall prepare a written decision, together with the reasons therefore, within a reasonable time after the hearing, but not in excess of seven (7) business days for a standard hearing and not excess of three (3) business days in the case of an expedited grievance hearing. A copy of the decision shall be sent to the Grievant and the County. The County shall retain a copy of the decision in the Grievant's folder. A copy of such decision, with all names and identifying references deleted, shall also be maintained on file by the County and made available for inspection by a prospective Grievant, his representative, or the Hearing Panel.

q. The decision of the Hearing Officer shall be binding on the County which shall take all actions, or refrain from any actions, necessary to carry out the decision unless the County determines within a reasonable time, not to exceed thirty (30) calendar days, and promptly notifies the Grievant of its determination, that:

(a) The grievance does not concern County action or failure to act which adversely affect the Grievant's rights, duties, welfare or status; and

(b) The decision of the Hearing Officer is contrary to applicable Federal, State or local law, regulations or requirements of the contract between the HRSA and the Miami-Dade County.

r. A decision by the Hearing Officer, or Board of Commissioners in favor of the County or which denies the relief requested by the Grievant in whole or in part shall not constitute a waiver of, nor affect in any manner whatever, any rights the Grievant may have to a trial de novo or judicial review in any judicial proceedings, which may thereafter be brought in the matter.

s. **Expenses:** The County shall bear the administrative costs of the hearing as described above, including location costs and any costs related to the Hearing Officer. All other expenses, including the expense of counsel for the Grievant, personal transportation, and meals shall be borne by the Grievant.

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Grievance Procedures and Process

F. BINDING ARBITRATION

[Maximum amount of time to complete binding arbitration once initiated: twenty (20) business days]

If a mutually satisfactory resolution of the grievance is not achieved within the period allotted for mediation, the Grievant may seek to resolve the grievance through binding arbitration.

(1) Step 7 – Submittal of Request for Binding Arbitration

The Grievant must submit a completed Request for Binding Arbitration Form to the County **within ten (10) business days** of the conclusion of mediation. **Within five (5) business days** of submittal of the Request for Binding Arbitration For, the County's representative will (a) notify the County that a Request for Binding Arbitration Form has been submitted; (b) notify the County's contractor for arbitration of the request; and (c) notify the Grievant in writing whether or not the grievance is eligible for binding arbitration.

(The request for Binding Arbitration will be considered eligible as long as steps 1 through 5 above have already been completed).

(2) Step 8 – Arbitration

Within five (5) business days from the date the Request for Binding Arbitration Form is submitted, the third-party arbitrator will forward to both the Grievant and the County's representative previously established rules of arbitration, which will be followed through the remainder of the arbitration process. The arbitration process will include steps which the arbitrator deems necessary to reach a decision, according to the arbitrator's previously established rules, provided such rules are satisfactory to both parties. The Grievant and the County shall agree as to a date, place and time for meeting with the arbitrator. The Grievant shall bear their or its own expenses. The County shall bear expenses of any County's employees or agents. The expenses of the arbitrator shall be borne one-half by the County and one-half by the Grievant. The Grievant' half of the estimated costs of the arbitrator must be paid directly to the arbitrator before arbitration begins. The parties shall set the per diem rate of the arbitrator. No County member shall receive such per diem service on their service. Each party shall be responsible for producing his/her or its own witnesses and shall bear expenses for same. The

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arbitrator must complete the arbitration process and provide a binding decision for future implementation **within fifteen (15) business days** of notification.

ARTICLE IV

SUNSHINE LAWS

All meetings concerning any grievance filed under these Procedures must comply with Florida's Government in the Sunshine laws and Article XII of the Bylaws of the County. Public notice of all meetings shall be given in accordance with State and local requirements. Meetings shall be open to the public. Written notice shall be given at least **ten (10) business days** in advance of any regularly scheduled County meeting date.

ARTICLE V

AMENDMENTS

Any amendments that need to be made to these procedures shall only be made after a 30-day public comment period is allowed and then only after the County has considered the comments received.

Acknowledgement of Receipt of Grievance Procedures:

IN WITNESS WHEREOF, the undersigned hereby acknowledges that he/she/they has received a copy of this procedure and has read or has had read to him/her/them the procedures outlined in this Grievance Procedure.

Signature Printed Name Date

Appendix J

FEDERAL POVERTY LEVEL (FPL) GUIDELINES TABLE

Request for Proposals (RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

2023 HHS FEDERAL POVERTY GUIDELINES
Annual Income Ranges (Gross Household Income)

(approximate calculations)

(Effective March 1, 2023 through February 29, 2024 for Ending the HIV Epidemic (EHE) in Miami-Dade County, FL)

Family Size	A 100-135%	B 136-150%	C 151-200%	D 201-250%	E 251-300%	F 301-400%	G ≥401%
1	< or equal to $14,580 - $19,828	$19,829 - $22,015	$22,016 - $29,305	$29,306 - $36,595	$36,596 - $43,885	$43,886 - $58,465	$58,466 +
2	< or equal to $19,720 - $26,818	$26,819 - $29,776	$29,777 - $39,636	$39,637 - $49,496	$49,497 - $59,356	$59,357 - $79,076	$79,077 +
3	< or equal to $24,860 - $33,809	$33,810 - $37,538	$37,539 - $49,968	$49,969 - $62,398	$62,399 - $74,828	$74,829 - $99,688	$99,689 +
4	< or equal to $30,000 - $40,799	$40,800 - $45,299	$45,300 - $60,299	$60,300 - $75,299	$75,300 - $90,299	$90,300 - $120,299	$120,300 +
5	< or equal to $35,140 - $47,789	$47,790 - $53,060	$53,061 - $70,630	$70,631 - $88,200	$88,201 - $105,770	$105,771 - $140,910	$140,911 +
6	< or equal to $40,280 - $54,780	$54,781 - $60,822	$60,823 - $80,962	$80,963 - $101,102	$101,103 - $121,242	$121,243 - $161,522	$161,523 +
7	< or equal to $45,420 - $61,770	$61,771 - $68,583	$68,584 - $91,293	$91,294 - $114,003	$114,004 - $136,713	$136,714 - $182,133	$182,134 +
8	< or equal to $50,560 - $68,761	$68,762 - $76,345	$76,346 - $101,625	$101,626 - $126,905	$126,906 - $152,185	$152,186 - $202,745	$202,746 +
+1	$5,140	$7,710	$10,280	$12,850	$15,420	$20,560	$20,611 +

SOURCE: HHS Poverty Guidelines for 2023. *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (Based on the table titled, "2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia")*

IMPORTANT NOTES:

1) Using the table above as a guide for families/households with more than eight (8) members, add $5,140 for EACH additional family/household member.

2) The Miami-Dade County Ryan White Program Provide® Enterprise Miami data management system will be programmed according to these guidelines, effective March 1, 2023 through February 29, 2024.

3) **INCOME RESTRICTIONS DO NOT APPLY TO SERVICES RENDERED UNDER THE EHE INITIATIVE.** Income eligibility for referals into the following Ryan White Part A and Minority AIDS Initiative (MAI) Program-funded services in Miami-Dade County is limited to program-eligible clients who have a gross household income at or below 400% of the Federal Poverty Level (FPL). The 400% FPL income limit applies to all locally-funded Ryan White Part A and MAI Program service categories.

4) **Please be advised that this document is simply an internal reference tool and the rounding calculations may be slightly off.** Percentage calculations in the table above are rounded to avoid gaps between whole number dollar amounts. The first number for each household size in column A is exact per the 2023 HHS Poverty Guidelines, as are the calculations in the Provide® Enterprise Miami data management system.

Appendix K

FUNDING SOURCE SUMMARY TEMPLATE & INSTRUCTIONS

Request for Proposals (RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

RYAN WHITE PROGRAM
SERVICE PROVIDER FUNDING SOURCE SUMMARY

Proposing Organization	*Proposing Organization's Fiscal Year*

Funding Source	Program Description/ Services to be Provided	Dollar Amount	Contract Period

Reproduce Copies of this Form as Necessary

Instructions for Completing
<u>Service Provider Funding Source Summary Form</u>

1. Under the title "Proposing Organization," please type the full legal name of the proposing organization.

2. Under the title "Proposing Organization's Fiscal Year," please type the fiscal year of the proposing organization.

3. In the column titled "Funding Source," please identify all non-Ryan White Ending the HIV Epidemic (EHE) funding sources from which the proposing organization will draw funds to cover the costs associated with the provision of the services indicated under the column titled "Program Description/Services to be Provided". For example, include other funding sources such as, but not limited to, Ryan White Part A, Minority AIDS Initiative (MAI), Ryan White Part B, Ryan White Part C, Ryan White Part D, State care and treatment, other federal, state, or local funding, foundation grants, as well as approximate amounts billed to Medicaid, Medicaid Project AIDS Care (PAC) Waiver, Medically Needy, Medicare, etc.

4. In the column titled "Program Description/Services to be Provided," please include a brief description of the service(s) that will be covered under the funding source indicated in the previous corresponding column.

5. In the column titled "Dollar Amount," please enter the total dollars awarded to the proposing organization by the previously identified funding source. If an award is pending, please include the amount and make an appropriate notation.

6. In the last column titled "Contract Period," please indicate the effective period (i.e., date range) for each source of funding.

7. Reproduce this form and attach additional pages as necessary.

Appendix L

MIAMI-DADE COUNTY RYAN WHITE PROGRAM TEST AND TREAT / RAPID ACCESS (TTRA) PRESENTATION FOR MEDICAL PROVIDERS

(local TTRA guidelines for reference)

Request for Proposals
(RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services

HealthTec, Quick Connect, Housing Stability, and Mobile GO Teams

TEST & TREAT/RAPID ACCESS Miami-Dade County Overview for Medical Practitioners

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REVISED

November 9, 2022

(revisions highlighted in yellow)

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World Health Organization Recommendations

"WHO [World Health Organization] recommends ART for all people with HIV as soon as possible after diagnosis…Huge reductions have been seen in rates of death and infections [from HIV/AIDS] when use is made of a potent ARV [antiretroviral] regimen, particularly in the early stages of disease" (World Health Organization, 2019, para. 1).

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Test & Treat/Rapid Access Goal for Miami-Dade County

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For all people with HIV who are not in care, facilitate immediate access to HIV medical care and antiretroviral therapy (ART) to improve client health outcomes, reduce viral load in the community, and get the number of new HIV infections to zero.

Why is Test & Treat/Rapid Access Important?

- **Shortens** the lag time between diagnosis and engagement in care for treatment-naïve (newly diagnosed) persons with HIV (Crowley & Bland, 2018)
- **Facilitates** rapid re-engagement of PLWH who had been in care before (Berger et al., 2015)
- **Immediately acts to reduce viral load levels** to suppress further infections, while allowing refinements in treatment strategy if subsequent analyses suggests more appropriate ARVs would be preferable (Crowley & Bland, 2018)

➢ *Note: since 2012, updated federal treatment guidelines recommend offering ART immediately upon diagnosis, and several randomized trials have validated this recommendation (see N Engl J Med., 2015, 795-807)*

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Miami-Dade County
Test & Treat/Rapid Access Data

- The data in these graphics represent 2,821 people with HIV who were linked to Ryan White Program care through the local TTRA process from July 2, 2018 through June 24, 2022.

- All TTRA Ryan White Program (RWP) clients included in this analysis had a recorded baseline viral load measurement and were prescribed HIV ART as part of the TTRA protocol. Clients who were subsequently determined to be ineligible for RWP Part A services or were determined to be HIV-negative were removed from this analysis.

- Some people with HIV who initially enrolled in TTRA declined to participate, or were administratively removed (see next page).

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Miami-Dade County
Test & Treat/Rapid Access Data - Reasons for Decline / Removal

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Forty-four (44) people with HIV were initially enrolled in TTRA, but were administratively removed or declined to continue participation, including:

- 20 who had entered TTRA inappropriately, since they were already in RWP care, had existing prescriptions or medications from previous treatment, or were existing RWP clients who wanted to change primary providers.
- 16 who refused to continue with TTRA, no reason given, or stated that they were not ready to start HIV/AIDS treatment immediately;
- Four were referred to General Revenue for non-TTRA formulary/protocol medications;
- Two had insurance, and used that resource rather than the RWP;
- One was determined to be ineligible for treatment by the RWP; and
- One requested counseling before starting ARVs.

Definitions of the TTRA Clients in this Analysis

- **New to HIV Care:** completely new HIV/AIDS diagnosis, client never in care before.

- **New to RWP Care:** previously diagnosed HIV positive but had never received services from the Miami-Dade County Ryan White Part A/MAI Program (RWP).

- **Returned to RWP Care:** previously in local RWP care, had been lost to RWP care for some period of time, and are now returning to care through TTRA.
  - *Note: the "lost to care" timeframe is not specified. Clients may be considered lost to care if they had missed multiple medical appointments in a row or had been off medications for a few months. This category is not used for clients who are already adherent to RWP care and simply do not wish to wait for a regularly-scheduled appointment.*

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Distribution of People with HIV Entering Miami-Dade Part A TTRA*
(July 2, 2018 through July 24, 2022)

n = 2,421

Category	Percent
New to HIV Care	37.6%
Returned to RWP Care	34.7%
New to RWP Care	27.6%

*Two clients (0.1%) were not categorized

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Viral Load of Clients Enrolled in TTRA

- **New to HIV Care:** 1,062 (37.6%) of the 2,821 clients tested and enrolled in TTRA were newly-diagnosed (treatment-naïve). Of these clients, **728 (69%) are reportedly virally suppressed**.

- **New to RWP Care:** 778 (27.6%) of the 2,821 clients entering through TTRA were previously diagnosed and may have previously been in treatment but had not received services through the RWP (26%). Of these clients, **611 (79%) are virally suppressed**.

- **Returned to RWP Care:** 979 (34.7%) of the 2,821 clients were local RWP clients who had been lost to care. Of these clients, **688 (70%) are virally suppressed**.

Note: Two clients were not categorized.

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Comparison of TTRA Enrollments by Fiscal Year (FY)

Clients by TTRA Enrollment Type, FY 2018 to FY 2021

360
310
260
210
160
110
60
10
-40

FY 2018 FY 2019 FY 2020 FY 2021

New to HIV Care New to RWP Care Returned to RWP Care

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Comparison of Viral Suppression by Fiscal Year (FY)

Percentage of Enrolled TTRA Clients who are Virally Suppressed by Enrollment Type and FY

100
90
80
70
60
50
40
30
20
10
0

New to HIV Care
New to RWP Care
Returned to RWP Care

FY 2018 FY 2019 FY 2020 FY 2021

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TTRA Impact on Client Health

- The following three elements of the TTRA process in Miami-Dade County have a demonstrated immediate impact on client health:

  1. Diagnosis with an immediate path to medical care;
  2. Medical care with an immediate path to ARV medication;
  3. ARV medication with an immediate path to viral load suppression.

- Especially among the newly-diagnosed, the sooner the clients are placed on ART, the sooner viral loads are suppressed and the greater the number of clients who are unable to transmit HIV to others.

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TTRA Impact on Client Health (continued)

"The probability of a transmitted mutation impacting negatively on a first current regimen success is low, and if identified early through genotyping has relatively low probability of affecting a second regimen choice."

-- Michael A. Kolber, Ph.D., M.D.
Professor of Medicine; Vice Chair for Clinical Affairs, Department of Medicine; Director, Comprehensive AIDS Program; Director, Adult HIV Services, Department of Medicine
University of Miami Miller School of Medicine

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- To date, there has been no evidence of harm to a treatment-naïve PLWHA when a client who is started on a **recommended regimen for rapid initiation** is switched to another regimen due to tolerance, simplification or genotypic concerns within 30-60 days.

Appendix:

The Test & Treat/Rapid Access Protocol

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Test & Treat/Rapid Access Protocol

- Conduct abbreviated, first medical visit with focus on treating the client's HIV within 3 days of TTRA enrollment date; preferably same day, but not more than 7 days later; using CPT codes 99201, 99202, 99203, or 99204 (for new patients) **or** 99211, 99212, 99213, or 99214 (for established patients; i.e., those served in same medical group within the past 3 years)
  - *NOTE: Part A/MAI services to TTRA clients with a preliminary positive test result who are ultimately determined to be HIV negative will need to be disallowed from Part A/MAI reimbursement.*
- Write **two** prescriptions (one for the TTRA pharmacy; one for referral to other source of access to medications – **maximum 5 refills**)
- Order **appropriate, initial labs (see pages 22 & 23)**

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Test & Treat/Rapid Access Protocol (continued)

- Prescribe ART within 3 days of TTRA enrollment date, preferably same day, but not more than 7 days later
- **Recommended 30-day ART regimens for local TTRA include:***
  - bictegravir/tenofovir alafenamide/emtricitabine (Biktarvy®) (see page 20);
  - dolutegravir/lamivudine (Dovato®) (if considering this ART, see pages 17 & 18);
  - dolutegravir (Tivicay®) plus tenofovir alafenamide/emtricitabine (Descovy®);
  - darunavir/cobicistat (Prezcobix®) plus Descovy®;
  - darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza®) (if considering this ART, see page 19)

** To prescribe another ARV medication, please use the local General Revenue Short-Term Medication Assistance referral process.*

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Test & Treat/Rapid Access Protocol (cont'd)

- ARV regimen for women of childbearing potential (or for women presenting with pregnancy potential on inadequate contraception):

  - ❖ dolutegravir (Tivicay®) + emtricitabine/tenofovir disoproxil fumarate (Truvada®)
  - ❖ dolutegravir (Tivicay® + emtricitabine/tenofovir alafenamide (Descovy®)
  - ❖ darunavir (Prezista®) + ritonavir (Norvir®)

NOTE: Tivicay® has replaced Isentress® as a regimen appropriate and recommend regimen for women at all stages of pregnancy – conception to birth.

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Test & Treat/Rapid Access Protocol (cont'd)

If considering prescribing **dolutegravir/lamivudine (Dovato®),** please note:

- ✓ Contact ViiV Healthcare for vouchers or Patient Assistance Program; www.viivconnect.com

- ❖ *Indication*: Dovato® is indicated as a complete regimen for the treatment of HIV-1 infection in adults with no antiretroviral treatment history or to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen **with no history of treatment failure and no known substitutions associated with resistance to the individual components**.

  - ✓ *Note*: Dovato® phase III registrational trials enrolled participants with a screening viral load of 1,000 to ≤500,000 copies/mL though 2% of participants did rise above that viral load threshold by baseline measurements and **the FDA labeled indication for initial therapy does not restrict use based on baseline viral load**.

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Test & Treat/Rapid Access Protocol (cont'd)

- If considering prescribing **Dovato®: (continued)**

✓ *Boxed Warning*: All patients with HIV-1 should be tested for the presence of HBV **prior to or when initiating** Dovato®. Emergence of lamivudine-resistant HBV variants associated with lamivudine-containing antiretroviral regimens has been reported. If Dovato® is used in patients co-infected with HIV-1 and HBV, additional treatment should be considered for appropriate treatment of chronic HBV; otherwise, consider an alternative regimen. Severe acute exacerbations of HBV have been reported in patients who are co-infected with HIV-1 and HBV and have discontinued lamivudine, a component of Dovato®. Closely monitor hepatic function in these patients and, if appropriate, initiate anti-HBV treatment.

✓ This regimen added to TTRA requires the practitioner to be responsible in addressing this risk by assessing lab results in a timely fashion.

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Test & Treat/Rapid Access Protocol (cont'd)

If considering prescribing **darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza®)**, please note:

Providers may prescribe this medication, but they must use the voucher provided by Janssen Pharmaceuticals to cover the cost of this medication as the Florida Department of Health cannot be invoiced for this medication.

If you need additional vouchers, please contact Sam Quintero, Senior Community Liaison – Florida, Janssen Infectious Diseases and Vaccines, by email to squinte6@its.jnj.com or phone call to 305-794-7362; or contact Andrew Werner by email to AWerner4@its.jnj.com or phone call to 786-371-9651; or Tyler Johnson by email to BJohns73@its.jnj.com or phone call to 954-336-4877; or call the health department patient care coordinators for additional vouchers.

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MIAMI-DADE COUNTY

Test & Treat/Rapid Access Protocol (cont'd)

If considering prescribing **Bictegravir/tenofovir alafenamide/emtricitabine (Biktarvy®)**, please note:

Samples of Biktarvy® (or any Gilead product) can be requested by contacting the Gilead representative for Miami-Dade, as follows:

Cesar Pizarro by phone at 305-283-9014; or email to Cesar.Pizarro@gilead.com

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MIAMI-DADE COUNTY

Test & Treat/Rapid Access Protocol (cont'd)

- ART picked up at pharmacy by client and treatment starts, within 7 days of TTRA enrollment, preferably same day as initial medical visit or next day

- Client coordinates with medical case management staff to establish eligibility for RWP Part A and ADAP as soon as possible, preferably within 14 days of initial TTRA enrollment
  - Timely ADAP enrollment is critical to ensure on-going access to ART;
  - Timely Part A enrollment is necessary for access to on-going medical care and other core medical and support services.

- Schedule additional follow-up medical visits, labs and diagnostics, as needed, AFTER Part A/MAI program eligibility and on-going payer source is determined

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Allowable Lab Tests Under TTRA

-- **HIV-1 genotype resistance tests** (CPT 87900, 87901, and 87906),

**** IMPORTANT: order a genotype test at initiation of care for all newly diagnosed clients and for all return to care clients ****

-- HIV 1,2 Ag/Ab, preferred (CPT 87389), if HIV diagnosis is not confirmed

-- Complete Blood Count (CPT 85025 or 85027)

-- Comprehensive Metabolic Panel (ALT, AST, creatinine [eGFR] (CPT 80053),

-- CD4 count (CPT 86360 or 86361),

-- HIV-1 RNA PCR (viral load) (CPT 87536),

-- Hepatitis B surface antigen (if indicated; CPT 87340); also recommended:

- HBsAg (87340; 87341); HBsAb (86706 qualitative; and 86317 quantitative); HBcAb total (86704), and HBcAb IgM antibody (86705)
- Note: if HBV vaccine verified, do not need to order HBsAG

-- urinalysis (CPT 81000, 81001, and 81003),

-- pregnancy test (if indicated, CPT 81025)

-- NOTE: CPT code 36415 (collection of venous blood by venipuncture) is also an allowable procedure under TTRA.

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Possible Additional Labs under TTRA

Order the following labs under TTRA, ONLY IF the client is symptomatic or Part A eligibility has been confirmed:

-- RPR (rapid plasma reagin) test for syphilis [CPT 86592 qualitative; or 86593 quantitative and 86780 (qualitative or semiquantitative immunoassay)]

-- Gonorrhea (CPT 87590, 87591, 87592, and 87850)

-- Chlamydia (CPT 87486 or 87491 NAAT; 87485 or 87490 DNA probe)

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References

Berger, M. E., Sullivan, K. A., Parnell, H. E., Keller, J., Pollard, A., Cox, M. E., Clymore, J. M., & Quinlivan, E. B. (2015). Barriers and facilitators to retaining and reengaging HIV clients in care: A case study of North Carolina. *Journal of the International Association of Providers of AIDS Care (JIAPAC), 15*(6), 486-493.

Crowley, J. S., & Bland, S. E. (2018). *Leveraging the Ryan White Program to make rapid start of HIV therapy standard practice.* Washington D.C.: O'Neill Institute for National and Global Health Law.

World Health Organization (WHO). (2019). *HIV/AIDS: Treatment and care*. [web page]. Retrieved February 27, 2019 at https://www.who.int/hiv/topics/treatment/en/.

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TTRA Champions in Miami-Dade County

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Part A OAHS & MCM Subrecipients:

- AIDS Healthcare Foundation
- Borinquen Health Care Center
- CAN Community Health
- Care 4 U Community Health Center
- Care Resource Community Health Centers
- Citrus Health Network
- Community Health of South Florida
- Empower U Community Health Center
- Jessie Trice Community Health System
- Latinos Salud
- Miami Beach Community Health Center
- Public Health Trust/Jackson Health System
- University of Miami

Other Stakeholders:

- Florida Department of Health (in Tallahassee and in Miami-Dade County)
- Miami-Dade County Office of Management & Budget (Part A/MAI Recipient)
- Miami-Dade HIV/AIDS Partnership (local HIV/AIDS planning council)

Questions? Please contact:

- **Clinical:**
  Dr. Andrea Sciberras
  HIV/AIDS Medical Director
  Andrea.Sciberras@flhealth.gov

- **FDOH Process – Access to HIV testing and medications:**
  Kira Villamizar, B.S., M.P.H.
  STD/HIV Prevention Program Director
  Florida Dept. of Health in Miami-Dade
  1350 NW 14th Street, 4th Floor, Rm. 401
  Miami, FL 33125
  (305) 575-5424
  Kira.Villamizar@flhealth.gov

- **Part A Process: Access to Part A, incl. medical visit, labs & mental health services:**
  Carla Valle-Schwenk
  Program Administrator
  Miami-Dade County
  Ryan White Part A Program
  111 NW 1st Street, 22nd Floor
  Miami, FL 33128
  (305) 375-3546
  Carla.ValleSchwenk@miamidade.gov

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Appendix M

Policy Clarification Notice (PCN)
16-02

Request for Proposals
(RFP No. EHE-2223)

Ending the HIV Epidemic (EHE) Initiative Services:

HealthTec

Quick Connect

Housing Stability Services

Mobile GO Teams

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received…will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under…an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

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[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.

[3] General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*

Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services.*

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
  - Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services

Description:

The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:

The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance

Description:

Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals

Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

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[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See [45 CFR § 75.459]

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care
Description:
Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

See also Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.