United Way of Long Island

United for Good.
United for Impact.
United for Community.

Ryan White HIV/AIDS Program Part A & Minority AIDS Initiative Funding for HIV/AIDS Health and Support Services in the Nassau- Suffolk Eligible Metropolitan Area

Request for Proposals (RFP) Fiscal Years 2027 - 2029

- **Emergency Financial Assistance (EFA)**
- **Medical Case Management (MCM)**
- **Medical Nutrition Therapy (MNT)**
- **Medical Transportation (MT)**
- **Mental Health (MH)**
- **Oral Health Care (OHS)**
- **Other Professional Services-Legal (OPS)**
- **Outpatient Ambulatory Health Services (OAHS)**

Bidders Conference:	**December 2, 2026**	**10am-11am (virtual)**
Written Questions Due:	**December 4, 2026**	**by 5:00pm**
Responses Posted:	**December 8, 2026**	**by 5pm**
Letters of Intent Due:	**December 11, 2026**	**by 5:00pm (Required)**
Proposals Due:	**January 15, 2027**	**by 5:00pm EST**

ALL substantive and technical questions must be submitted in writing by electronic mail to ryanwhiterfp@unitedwayli.org by 5:00pm on December 4, 2026. *Responses will be posted on the United Way of Long Island's website by December 8, 2026.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant #H89HA00020, HIV Emergency Relief Project Grants, in the amount of $5,702,722. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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I. GENERAL INFORMATION AND TIMELINES

A. PURPOSE

United Way of Long Island (acting as technical support agency for the administration of Part A funding in the Nassau-Suffolk EMA) is accepting applications for Ryan White Part A/MAI services for the three-year period starting March 1, 2027 and ending on February 28, 2030 (FY2027-2029). This funding opportunity is open to non-profit agencies serving individuals in the Nassau and Suffolk counties.

The purpose of Ryan White Part A/MAI funding is to provide primary health care and supportive services to eligible individuals with HIV/AIDS who reside in Nassau and Suffolk Counties. Through this competitive Request for Proposal process, Part A and Minority AIDS Initiative funding will be distributed to applicants who are regional community-based service providers to improve service coordination, access, and delivery, and to implement or sustain services for persons with HIV (PWH) in Nassau and Suffolk Counties that improve overall quality of care and assist them in achieving desired medical outcomes.

It is the intent of the Nassau-Suffolk EMA to fund single and bi-county proposals in the service categories of: **EMERGENCY FINANCIAL ASSISTANCE, MEDICAL CASE MANAGEMENT, MEDICAL NUTRITION THERAPY, MEDICAL TRANSPORTATION, MENTAL HEALTH, ORAL HEALTH CARE, OTHER PROFESSIONAL SERVICES – LEGAL, AND OUTPATIENT AMBULATORY HEALTH SERVICES**.

B. RFP CONTACT

All correspondence, including proposals and questions, must be submitted by email to:

United Way of Long Island
Planning and Grants Management Department
Attn: Georgette Beal
Email: ryanwhiterfp@unitedwayli.org
Email cc: gbeal@unitedwayli.org

The individual identified above will serve as the sole contact point for any inquiries or information related to this RFP during the proposal and evaluation process. Any violation of this procedure may be ground for disqualification of the proposer.

C. CONTRACT TERM

The contract period for funded programs will be for a maximum of three years, beginning on March 1, 2027 and ending on February 28, 2030. United Way may, but is not obligated to, extend the awarded contract(s) for up to one additional one-year contingent on the availability of funds, approved allocations by the Nassau-Suffolk HIV Health Services Planning Council, and Contractor performance.

Annual funding allocations are subject to modification based on the Planning Council's annual Priority Setting and Resource Allocation (PSRA) process as well as the EMA's annual award notification from Health Resources and Services Administration.

Current contractors must submit proposals in response to this Request for Proposal (RFP) and be selected to continue providing contracted services after February 28, 2027, unless otherwise notified.

D. AVAILABLE FUNDS

This RFP specifies the total amount of funding that may be available by priority based on the Nassau-Suffolk HIV Health Services Planning Council's funding recommendation for FY27. However, it does not specify the amount that applicants may propose for individual programs. Final priority amounts are subject to change based on the EMA's approved notice of award for FY27-28.

For FY 2027, the Nassau-Suffolk HIV Health Services Planning Council has allocated Part A and MAI funding as follows:

PRIORITY AREAS (Nassau, Suffolk, and bi-county)	Estimated amounts available by priority	Estimated # of programs to be funded
Emergency Financial Assistance	**$ 183,815**	**1**
Medical Case Management	**$ 1,973,968**	**5-6**
Medical Nutrition Therapy	**$ 221,411**	**2-3**
Medical Transportation	**$ 597,607**	**2**
Mental Health	**$ 1,002,977**	**4-5**
Oral Health Care	**$ 307,851**	**2**
Other Professional Services-Legal	**$ 642,274**	**1**
Outpatient Ambulatory Health Services	**$ 11,000**	**1-2**

Note: Applicants under the Mental Health, Oral Health Care, Medical Nutrition Therapy and Outpatient Ambulatory Health Services priorities must be certified to deliver these services, bill third party insurances including Medicaid, and report on program income.

E. PROPOSAL TIMELINE

Bidders Conference (Virtual)	December 2, 2026	10am-11am (see pg. 17 for link)
Deadline for submission of questions	December 4, 2026	By 5:00pm
Responses Posted	December 8, 2026	By 5:00pm
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II. DEFINITIONS

The following terms used in this RFP shall have the meanings given to them in the RFP and as defined below:

A. **Acquired Immunodeficiency Syndrome (AIDS)** – A disease of the body's immune system caused by the human immunodeficiency virus (HIV). AIDS is characterized by the death of CD4 cells, which leaves the body vulnerable to life-threatening conditions, such as infections and cancers.

B. **Administrative Agent**- An administrative or fiscal agency (often called an administrative agent, fiscal intermediary, lead agency, or technical support agency) in the Ryan White HIV/AIDS Program (RWHAP) is an organization designated by a grant recipient (such as a state, local government, or planning council) to manage financial, contractual, and administrative duties on its behalf.

C. **CAREWare**- The Data Reporting System currently utilized throughout the Eligible Metropolitan Area (EMA) that selected contractors are required to use.

D. **Continuum of Care** – A comprehensive range of services required by individuals or families with HIV/AIDS to meet their health care and psychosocial service needs throughout the course of their illness. The organization of services responds to the individual's changing needs in a coordinated, timely, and uninterrupted manner, increasing access to and maintenance in care.

E. **Contract** – The Contract between United Way and the Proposer resulting from the award issued pursuant to this RFP to the successful Proposer.

F. **Contractor** – Any organization to whom a contract award is made by United Way.

G. **Cost Effectiveness** – Cost effective programs do not necessarily lead to cost savings, although they do provide good value for the money. Cost effectiveness can be described in several ways:

1. A service or program is considered cost effective when the unit cost is reasonable and acceptable relative to the benefits and outcomes received/produced.
2. A service may be considered cost effective if it provides an additional benefit worth the additional cost.
3. Ryan White Program services cannot be measured precisely due to regional differences, cost variances, specific population needs, and complexities of care associated with HIV disease. The cost to provide services will be only one consideration in evaluating proposals.
4. Quality of service and actual health outcomes are also factors in determining cost effectiveness. Services with better outcomes may be more costly, but nonetheless more cost effective when outcomes are considered.

H. **Nassau County Department of Health** – The County department that helps to prevent epidemics and the spread of disease, protect against environmental hazards, prevent injuries, promote and encourage healthy behaviors, respond to disasters and assist communities in recovery, and assure the quality and accessibility of health services throughout the Nassau County.

I. **Ending the HIV Epidemic (EHE)** – An initiative that aims to reduce new HIV infections in the U.S. by at least 90% by 2030 through targeted strategies and increased funding.

J. **Grant Period** – The Ryan White Part A Program grant period is March to February.

K. **Human Immunodeficiency Virus (HIV)** – The causative agent of AIDS. It includes the entire spectrum of the natural history of HIV, from post infection through the clinical definition of AIDS.

L. **HIV Continuum of Care** – Sometimes referred to as the HIV treatment cascade, this is a model that outlines sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression. The five stages are diagnosis, linked to care, engaged/retained in care, prescribed Antiretroviral Therapy, and achieved Viral Suppression.

M. **HIV+ or HIV positive** – Having the presence of human immunodeficiency virus (HIV) present in the body. HIV is a virus that attacks the cells of a person's immune system, specifically CD4 cells.

N. **Health Resources Services Administration (HRSA)** – An arm of Health and Human Services, HRSA is a federal agency with the responsibility/authority for awarding Part A, EHE, and Minority AIDS Initiative grants.

O. **Nassau-Suffolk HIV Health Services Planning Council**– The planning body appointed by Nassau and Suffolk County CEO and mandated by Federal law to set service priorities for funding allocations for the expenditures of Ryan White Part A Program funds.

P. **Minority AIDS Initiative (MAI)** – Funds target programs to specifically improve HIV-related health outcomes for racial/ethnic minority communities disproportionately affected by HIV/AIDS and reduce HIV-related health disparities.

Q. **Memorandum of Understanding (MOU)** – An agreement between specified parties for the purpose of linking services for the enhancement of services to People Living With HIV/AIDS (PLWHA).

R. **Office of Management and Budget (OMB)** – The office within the executive branch of the Federal government, which prepares the annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

S. **Part A** –The Federally funded portion of the Ryan White Program (formerly Title I of the CARE Act) that provides assistance to localities (EMAs/TGAs) disproportionately affected by the HIV/AIDS epidemic

T. **Payer of Last Resort** – Services that can be reimbursed by any private or public payers should be determined and used before Ryan White Program funds are used to pay for care making Ryan White funding the "payer of last resort." Ryan White may pay for services that fill the gaps in coverage of these other private or public health care programs, but funds received cannot be used

to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made by another payment source.

U. **Program Income** – Gross income earned by the subrecipient that is directly generated by a supported activity or earned as a result of the award (see exclusions in 45 C.F.R. part 74.24, subdivisions (e) and (h)). Program income includes, but is not limited to, income from fees for services performed, the use or rental of real or personal property acquired under federally funded projects, and interest on loans made with award funds. The Ryan White Program Manual states that income resulting from fees for services performed (e.g., direct payment or reimbursements received from Medicare and third-party insurance) can be considered program income. [45 C.F.R. part 74.2]

All program income is to be used by the contractor to provide Ryan White-eligible services to Ryan White-eligible clients, and it is to be tracked and reported to the County.

V. **Proposal** – The offer to provide specific goods or services at specified prices and/or other conditions specified in the RFP.

W. **Request for Proposal (RFP)** – The request for an offer from Proposers interested in providing the identified services. The RFP specifies the evaluation factors to used and contains, or incorporates by reference, contractual terms and conditions applicable to the procurement.

X. **Ryan White Program** – The federal law enacted in 1990 as the Ryan White CARE Act to address the health care and service needs of people living with HIV/AIDS and their families. The program was reauthorized in 1996, 2000, 2006 and was extended in 2009. The program is currently known as the Ryan White HIV/AIDS Treatment Extension Act of 2009.

Y. **Ryan White Program Moving Forward**- This framework is an initiative launched by the Health and Human Services Administration's HIV/AIDS Bureau to end the HIV epidemic in the United States. The core goals are to: 1. Maintain Current Care; 2. Reach Underserved Individuals; 3. Leverage Partnership; and 4. Focus Interventions.

Z. **Services** – The requested services described in this RFP.

AA. **Subcontractor** – An individual, company, firm, corporation, partnership or other organization, not in the employment of or owned by Contractor who is performing services on behalf of Contractor under the Contract or under a separate contract with or on behalf of Contractor.

BB. **Subrecipient**- Under the Ryan White HIV/AIDS Program (RWHAP) a subrecipient is a public or private non-profit (or sometimes for-profit) organization that receives a sub-award or contract from a direct federal grant recipient (such as a state, city, or community-based organization) to deliver direct HIV care, treatment, or support services to eligible individuals

III. INTRODUCTION

A. FEDERAL RYAN WHITE HIV/AIDS PROGRAM

The Ryan White HIV/AIDS Program (RWHAP) is a federal program that is administered by the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. RWHAP was established by law in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, then reauthorized under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and the Ryan White Treatment Extension Act of 2009. RWHAP is the nation's largest federal investment in HIV care and support services for low-income people with HIV (https://ryanwhite.hrsa.gov/about/legislation). RWHAP funds states, counties, cities, and community organizations to improve health outcomes, reduce HIV transmission, and expand access to care. More than 500,000 people with HIV across the U.S. receive help each year through one or more programs supported by RWHAP. Additional information about this program is available at https://ryanwhite.hrsa.gov.

The purpose of RWHAP is to improve the quality and availability of care for people with HIV and their families, and to establish services for people with HIV who would otherwise have no access to health care. RWHAP is divided into five Parts. **Part A** provides medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are counties/cities that are the most severely affected by the HIV/AIDS epidemic. Under Part A, the Minority AIDS Initiative (MAI) grants provide core medical and related support services to improve access and reduce disparities for racial and ethnic minority populations disproportionately affected by HIV. EMAs and TGAs receiving funds under Part A and MAI must target at least 75 % of the federal funds towards essential "CORE" medical services and 25% towards support services needed for individuals with HIV/AIDS to achieve their medical outcomes unless otherwise approved by a waiver.

Part A and MAI in Nassau and Suffolk Counties- Nassau and Suffolk Counties are designated as an Eligible Metropolitan Area (EMA) under RWHAP. In the Nassau-Suffolk region, the chief elected official (CEO), the County Executive of Nassau County, is the official recipient of the Part A funds. The CEO has delegated the responsibility for Part A grant administration to the Nassau County Department of Health, (otherwise referred to as the "Recipient"). The Recipient selected United Way of Long Island through a competitive bidding process to serve as the administrative/fiscal agent to assist in conducting Part A administrative activities. The Recipient and United Way work in collaboration with the local Part A Planning Council to assess the unmet needs of people living with HIV/AIDS.

The Nassau-Suffolk HIV Health Services Planning Council serves as the regional planning body for Part A. The Council is responsible for setting service priorities for the allocation of Part A funds and developing a comprehensive plan to guide the HIV service delivery system. Council members are appointed by the County Executives of Nassau and Suffolk Counties and include individuals with HIV, community-based organizations, hospitals, academia, and non-elected community leaders. The Council votes and approves regional priorities and sets directives. Funded applicants will contract with UWLI on behalf of Nassau and Suffolk Counties to deliver services under the approved priorities.

B. RYAN WHITE PROGRAM MOVING FORWARD

In April 2024, HRSA introduced the Ryan White Program Moving Forward Initiative, which builds off the foundation of the Ryan White HIV/AIDS Program and the innovative strategies from the first four

years of the federal Ending the HIV Epidemic in the U.S. initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP while expanding efforts to identify and engage individuals with HIV who are undiagnosed or out of care.

Ryans White Moving Forward calls on the HIV community to establish and strengthen partnerships, prioritize community engagement, and utilize focused interventions to end the HIV epidemic. This requires collaboration across sectors, innovation in care delivery, and a commitment to addressing barriers to care. Under Ryan Moving forward, there is a renewed focus on engaging individuals with lived experience and non-traditional partners to inform program planning and care models that are responsive to the needs of these communities.

C. HIV Care Continuum

The HIV care continuum—also referred to as the HIV treatment cascade—is a model that outlines the stages people living with HIV go through from diagnosis to maintaining viral suppression.

The five main stages of the HIV Care Continuum are:

- **Diagnosed -** Number and percentage of persons aged ≥ 13 years with infection who know their serostatus.
- **Receipt of Care –** CDC measures receipt of care as the percentage of persons with diagnosed HIV who had at least one CD4 or viral load test run by a health care professional in a given year. Once in medical care, people can start HIV medicine to help them stay healthy and protect their partners. Initiating ART is recommended for all people with diagnosed HIV.
- **Retained in Care -** CDC measures retention in care as the percentage of persons with diagnosed HIV who had two or more CD4 or viral load tests, performed at least three months apart. People living with HIV who have ongoing, regularly scheduled medical care have been shown to have better health outcomes and increased safer sexual behaviors.
- **Viral Suppression -** CDC measures viral suppression as a viral load test result of <200 copies/mL at the most recent viral load test during measurement year.
- **Linkage to Care -** CDC defines linkage as having one or more documented CD4 or viral load tests within 30 days (1 month) of HIV diagnosis. The denominator is limited to the number of people receiving an HIV diagnosis *in a given year*, rather than the total number of people living with HIV that is used in the calculations for the other continuum steps. Rapid linkage to care is important because it can shorten the time to viral suppression, which helps people stay healthy and prevents sexual transmission of the virus.

By closely examining the proportion of people with HIV engaged in each stage of the HIV care continuum, policymakers and service providers are able to pinpoint where gaps and disparities may exist in connecting people with HIV to sustained, quality care, and to implement system improvements and service enhancements that better support individuals as they move from one stage in the continuum to the next. By identifying these gaps and disparities improvements can be implemented to increase the proportion of people with HIV who are prescribed ART and are able to stay engaged in HIV medical care and adhere to their treatment so that they can achieve viral load suppression. This will allow them to live healthier, longer lives and reduce the chances that they will transmit HIV to others.

Note: Funded providers will be required to work with the Recipient through United Way and with other community and public health partners to improve outcomes across the Continuum of HIV Care, so that individuals diagnosed with HIV are linked and engaged in care and started on ART as early as possible. The HIV/AIDS Bureau (HAB) within the Department of Health and Human Services (HHS) has developed performance measures to assist in assessing outcomes along the continuum. Funded providers will be required to utilize the CAREWare data reporting system to document and report these measures.

D. OVERVIEW OF THE HIV EPIDEMIC IN THE NASSAU-SUFFOLK REGION

The Nassau-Suffolk Eligible Metropolitan Area (EMA) is a two-county suburban region on Long Island comprised of Nassau and Suffolk Counties. The region has a population of over 2.9 million people.

Demographics of HIV/AIDS population in EMA

Total HIV Population: As of December 31, 2024, there were 5,780 individuals with HIV/AIDS in the EMA. Most individuals living with diagnosed HIV are male at 70.8%. Racial and ethnic minorities (including persons of more than one race) account for close to 64.6% of all PLWH in the EMA. The racial/ethnic composition of all PLWH in the EMA is 35.4% White, 33.7% Black, 26.1% Hispanic, 3.3% Asian, .3% American Indian, .1% Native Hawaiian/Pacific Islander and 1.1% Multiracial. Transmission mode is highest for MSM (46.4%) and Heterosexual (31%) followed by Unknown (9.5%), IDU(7.2%), MSM/IDU (3.5%), Pediatric (2.2%) and Blood Products (.3%). The population of individuals living with HIV/AIDS on Long Island continues to age. 58.9% of PLWDH are over the age of 50 (with 36.3% 60 years and older). The age breakdown for the remaining age bands is as follows: 13-19 (.3%), 20-24 (2.1%), 25-29 (5.4%), 30-39 and 40-49 (16.6% each).

New Diagnoses: There were 218 new diagnoses as of 12/31/24. 81.2% of the new diagnoses were among males. The racial and ethnic breakdown for new HIV is 27.5% White, 32.6% Black, 34.9% Hispanic, and 5% Asian. There were no new diagnoses reported for the American Indian, Native Hawaiian/Pacific Islanders nor Multiracial groups. Transmission of new cases as of 12/31/2024 was highest among MSM (52.3% new HIV) followed by Heterosexuals (21.6% new). By age, new diagnoses were highest in the 30-39 age group at 30.3% followed by 25-29 at 19.7%, and 20-24 and 40-19 at 16.5% each. In 2024, 23.9% of all newly diagnosed HIV cases had already progressed to AIDS, with the highest concurrency rates in the Black, Hispanic, and Asian populations.

Barriers to Care

Like many health problems, there is a disproportionate impact of HIV/AIDS in certain populations in the EMA when compared to their proportions in the general population. Key issues affecting the Nassau-Suffolk EMA, include the lack of affordable or low-income housing, inadequate public transportation systems, and pockets of poverty within areas of substantial affluence. These factors directly influence the HIV/AIDS service delivery systems in Nassau and Suffolk counties. Many clients cannot access or interpret the health care delivery system to their best advantage and require interventions to facilitate personalized care in an otherwise impersonal system of care.

Target Populations for Part A funded priorities include:

- The uninsured/under-insured
- Individuals who are virally unsuppressed

- Newly diagnosed
- Out of Care
- Individuals with co-morbidities (e.g.- substance use disorder, mental health issues, etc.)
- Key populations of focus based on Epi Profile and Unmet Need Estimates (African Americans, Latinos, MSM and Young MSM, Aging)
- Individuals who are unhoused or unstably housed

IV. ALLOWABLE USES OF FUNDS

A. PAYOR OF LAST RESORT

The RWHAP is considered the payor of last resort, and as such, funds may not be used for any item or service "to the extent that payment has been made, or can reasonably be expected to be made under any State compensation program, under an insurance policy, or under any Federal or State health benefits program, or by an entity that provides health services on a pre-paid basis." Determining Client Eligibility & Payor of Last Resort (hrsa.gov).

It is incumbent upon all Part A funded programs to ensure that clients are screened for eligibility to receive services through other programs (e.g. Medicaid, Medicare, VA benefits, ADAP, private insurance). RWHAP funded programs must ensure that reasonable efforts are made to use non RWHAP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payers to extend finite RWHAP funds. Funded programs must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible. Programs can continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued. Periodic checks should be conducted to identify any potential changes to clients' healthcare coverage that may affect whether the RWHAP remains the payor of last resort and require clients to report any such changes.

Part A funds cannot 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, with respect to that item or services under any State compensation program, under an insurance policy, or under any Federal or State health benefits program. ***Applicants must clearly demonstrate how billing is handled and the process used to ensure that services billed under Ryan White are non-billable through other payer sources.***

B. ALLOWABLE USES OF RYAN WHITE HIV/AIDS PROGRAM FUNDS

RWHAP funds may be used to fill coverage gaps for individuals who are either underinsured or uninsured in order to maintain access to care and treatment services as allowable and defined by the RWHAP. RWHAP funds may be used for core medical and support services if those services are not covered or are only partially covered by another payer, even when those services are provided at the same visit.

Activities supported and the use of funds awarded under the Ryan White Program must be in accordance with legislative intent, federal cost principles, and program-specific policies issued by the Health

Resources and Services Administration (HRSA). HRSA policy related to Part A states that no service will be supported with Ryan White funds unless it falls within the legislatively defined range of services. See **Appendix B** for allowable and non-allowable Ryan White service categories.

B. CLIENT ELIGIBILITY

The primary intent of Part A funds is the provision of care and treatment services, and support services needed to achieve positive medical outcomes for people with HIV.

All contracted providers receiving Ryan White Part A/MAI funding must have systems in place that document and ensure client eligibility. Documentation of client eligibility must occur immediately upon client enrollment in a Ryan White program or service. Full recertification including supporting documentation is required every two years.

Documentation consists of:

1. Lab report or medical statement verifying HIV positive status (statement must be signed by a medical professional);
2. Current proof of residency in Nassau or Suffolk County;
3. Proof of insurance status/coverage; and
4. Proof of household income. Per the Nassau-Suffolk HIV Health Services Planning Council directive, clients are eligible for Ryan White services if their income is no more than ***500%*** of the Federal Poverty Level.

Eligibility Confirmation and Recertification

While full recertification is only required every two years, providers must conduct annual eligibility confirmations to assess if the client's income and/or residency status has changed. Annual verification can include a signed client self-attestation documented in the client record.

D. AFFECTED INDIVIDUALS[1]

Affected individuals (people not identified with HIV) **may** be eligible for HRSA RWHAP services in limited situations; however, services for affected individuals must always benefit PLWH. In the Nassau-Suffolk Eligible Metropolitan Area, **only a parent or a legal guardian of an HIV infected child under the age of eighteen (18) is defined as an affected individual** eligible to receive limited Part A services for a limited period of time.

With permission from the Recipient (NCDOH), funds awarded under Part A/MAI of the Ryan White Program ***may*** be used for services to individuals not infected with HIV ***only*** in the circumstances described below and ***only*** for a limited time:

1) The service has as its primary purpose enabling the non-infected individual to participate in the care of someone with HIV/AIDS.
2) The service directly enables an individual with HIV/AIDS to receive needed medical care and treatment and support services by removing an identified barrier to care.

[1] DSS Program Policy Guidance No.1 – Eligible Individuals and Services for Individuals Not Infected with HIV.

3) The service promotes family stability for coping with the unique challenges posed by HIV/AIDS. For example, mental health services which focus on equipping uninfected family members and caregivers to manage the stress and loss associated with HIV.

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

V. PROPOSAL REQUIREMENTS

A. WHO MAY APPLY

1. Organizational Eligibility

Applicant organizations must be qualified not-for-profit 501(c)(3) community-based organizations or not-for-profit public agencies with experience in the provision of either medical care and treatment or supportive services to persons living with HIV/AIDS with offices located in the Nassau or Suffolk counties. Organizations with a focus on key populations of interest are strongly encouraged to apply.

2. Joint Proposals

Proposals submitted on behalf of a consortium of providers must designate one of the agencies as the lead applicant for the consortium and must include in the proposal a Memorandum of Agreement (MOA), which clearly delineates the roles of the lead applicant and each co-applicant(s). The MOA should describe the fiscal, administrative, and programmatic responsibilities of the lead applicant and each co-applicant, including the specific activities of each organization and the process for communication and follow-up among participating agencies.

The lead applicant will be the entity with whom United Way of Long Island will contract. The co-applicant(s) will be considered sub-contractors to the lead applicant and must demonstrate that they meet the organizational eligibility criteria stipulated in this RFP.

An organization that submits a proposal as the lead applicant cannot submit another proposal in that priority area as a single applicant or as a co-applicant.

B. EXPECTATIONS FOR ALL APPLICANTS

All proposers must:

1. Adhere to HRSA/HAB National Monitoring Standards as well as regional Service Standards as adopted by the Nassau-Suffolk HIV Health Services Planning Council. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf
2. Demonstrate the capacity to deliver culturally competent services for PWH.
3. Be Medicaid certified if providing services which are Medicaid eligible and billable.
4. Have an office of operation in Nassau and/or Suffolk County.

All program designs must demonstrate the incorporation of the following Nassau- Suffolk HIV Health Services Planning Council directives:

1. Hours of operation for program services must meet the needs of the targeted population(s) including the provision of evening and weekend services.
2. Services must be ethnically, culturally and linguistically appropriate and delivered at a literacy level suitable for the targeted population(s) being served.
3. Programs should endeavor to employ staff (including peers) that are reflect of or have experience serving the targeted populations.
4. Programs must ensure that persons living with, and affected by HIV/AIDS are included, and will continue to be included, in the planning and program design of the services to be offered using consumer advisory boards and other feedback methods.
5. Programs must ensure, through a solid outreach plan that services are targeted to communities most disproportionately impacted by HIV/AIDS and/or who are underserved including.
6. Programs must ensure that services address childcare needs and serve children and adolescents with HIV when applicable.

Preference will be given to applicants that:

- Demonstrate stability in agency staffing, infrastructure, and fiscal operations.
- Demonstrate cost effective and efficient service delivery models that support the continuum of HIV care.
- Demonstrate parity in the delivery of Part A funded services in both Nassau County and Suffolk County.
- Co-locate services for women and children.
- Employ peers in the service delivery model.

C. TIMEFRAMES

1. **Bidders Conference (Not Mandatory)**
   A Bidders Conference will be held virtually on Wednesday, December 2, 2026, from 10am-11am to review the proposal requirements and answer questions. This meeting is optional. Prospective applicants may join by Zoom by clicking on the link below or joining by phone:
   https://us06web.zoom.us/j/82013131618?pwd=fCSrJkFZjW5dYAsNKrAdgQ8ONkz1o2.1

   Meeting ID: 820 1313 1618
   Passcode: 793675

   One tap mobile
   +16465588656,,82013131618#,,,,*793675# US (New York)
   +16469313860,,82013131618#,,,,*793675# US

2. **Questions and Answers**

All substantive and technical questions must be submitted in writing by electronic mail to ryanwhiterfp@unitedwayli.org by 5pm on December 4, 2028. Responses will be posted to United Way of Long Island's website by 5pm on December 8, 2026.

3. **Letters of Intent (Required)**
Letters of intent for this RFP **(Appendix E)** are required and must be emailed to ryanwhiterfp@unitedwayli.org by **5:00pm on December 11, 2026**.

Organizations that will serve PLWH in only one of the two counties, may submit a proposal to provide services in Nassau County only or in Suffolk County only. These proposals will be considered *Single County Proposals*. To be considered a Bi-County applicant and be able to submit a *Bi-County Proposal*, no less than 25% of the PLWH/A being served must be residents of one of the counties.

D. SUBMISSION REQUIREMENTS AND PROCESS

1. Deadline

Applicants must submit a separate proposal for each priority they are applying for. **Proposals and all required attachments and supporting documents must be emailed to: ryanwhiterfp@unitedwayli.org no later than 5:00pm on January 15, 2027.**

Late proposals due to Network connectivity or other issues will not be considered for funding. It is recommended that proposals be submitted a day or two prior to the due date and a delivery confirmation email printed.

2. Format

Points will be deducted for proposals that do not comply with the following submission requirements.

a. Proposals must contain one-inch margins on all sides; use a 12-pitch font; and **SHOULD NOT** exceed **12 double-spaced pages**. This page limit does not include the following:
   - Program summary;
   - Budget;
   - Linkage agreements;
   - Organizational Chart; and
   - All attachments.

b. Proposals must provide responses to all questions and statements and include a budget that is consistent with the proposed services.

c. Attachments must be clearly labeled following the naming guidelines outlined in **Appendix A.**

3. Proposal Checklist

It is the responsibility of the applicant to make sure that the following information and all documents are submitted. Proposals must include all sections as indicated in Section VI. - *Proposal Content*.

Proposals missing any section of the program narrative and/or program budget will be deemed non-responsive and not considered for Part A/MAI funding for fiscal year 2027-2029.

The following is a checklist of items that must be included with all submitted proposals. Please ensure that items are submitted in the order in which they are listed below.

- ☑ **Attachment 1: Cover Page**
- ☑ **Attachment 2: Agency Information**
- ☑ **Attachment 3: Estimated Clients to be Served from High Need Areas**
- ☑ **Project Narrative: Sections I-V of Proposal Content**
- ☑ **Attachment 4: Table of Service Linkages and MOAs**
- ☑ **Attachment 5: Budget – Excel Spreadsheet (consists of multiple tabs)**
- ☑ **Attachment 6: Letter of Commitment from the Executive Director or CEO**
- ☑ **Attachment 6.a: Letter of Commitment from the Board of Directors**

Additional Required Attachments:

- ➢ **Attachment 7: Agency Organizational Chart**
- ➢ **Attachment 8: Proof of agency's 501(c)(3) status**
- ➢ **Attachment 9: Most recent audited financial statements**
- ➢ **Attachment 10: All bi-directional service linkage agreements and MOAs**
- ➢ **Attachment 11: Job Descriptions for all staff positions identified in the program design and personnel page of the budget.**

VI. PROPOSAL CONTENT

INSTRUCTIONS: The following sections comprise the program narrative of your proposal. Respond to each of the following statements and questions in each section regardless of the priority area identified for this proposal. All responses should be specific and complete. (Please refer to Section V. D3 for page limits for the narrative.)

Section I: Program Summary
Maximum Score: Not Scored (limit 1 pg.)

Provide a brief description of the following:

a. The program being proposed;
b. The targeted areas for the proposed services;
c. The anticipated number of clients to be served, proposed units of service, and proposed outcomes;
d. The strategies to move clients along the cascade of HIV care (or HIV care continuum);
e. Staffing composition including staff that are responsible for the direct delivery of services as well as administrative, programmatic and fiscal oversight of the program; and
f. Annual (12 month) budget amount requested.

Section II: Need for Services
Maximum Score: 10 Points

1) Describe the major factors contributing to the need for the delivery of HIV services to the targeted population as it relates to the priority. Include applicable data that supports your description.
2) Describe other programs in the targeted area(s) that provide similar services and any barriers.
3) Describe the other funding (State, Federal, etc.) sources available that support the proposed program services without duplication (e.g.- Part B, health homes, linkage to care, etc.)
4) Describe how if funded, the proposed program will enhance, without duplicating, existing services provided in the area to the targeted population.
5) Describe the plan to ensure that Part A/MAI funds are the payer of last resort for the proposed program services (consider billing, fee schedules, program income, staff training etc.).

Section III: Applicant Organization
Maximum Score: 20 Points

1) Provide a brief description of the agency's overall mission and scope of services. Include the number of years of experience the agency has in providing each of these services.
2) Describe the agency's management and infrastructure capacity to provide administrative and executive support for program implementation, fiscal, grants, and information systems management. Attach a current organizational chart (**Attachment 7**) of the agency that includes a clear representation of the proposed program and reporting structure.
3) Describe the agency's experience in managing government grants including client level data collection and reporting.
4) Explain the agency's procedures and efforts to enroll clients into insurance/benefit programs, utilize third-part reimbursement, and ensure that Ryan White funds are payer of last resort. State if the agency is a Medicaid certified provider. If so, list all services that are billed to Medicaid.

5) Describe the agency's experience providing services to people living with HIV/AIDS. Include population demographics in the description.
6) Describe the agency's experience with providing services to key populations of interest within the HIV/AIDS community that experience health disparities.
7) Describe how agency leadership and direct staff are reflective of the target population in terms of race/ethnicity, sexual orientation, etc.
8) Describe the ability to provide services to limited or non-English speaking, hearing, visual or physically impaired individuals.
9) Describe the extent to which the target population engaged in the development and delivery of the proposed service.
10) Describe the agency's history of working collaboratively with other regional agencies providing services in the targeted geographic area and to people living with HIV/AIDS.

Section IV: Priority Specific Program Design (*Please refer to Section IX of this guidance for priority specific program information that must be addressed in this section.)*
Maximum Score: **40 Points**

1) Describe the specific services that will be offered by this program. Indicate whether all proposed program services will be provided directly by the applying agency, or if some of the services will be provided via subcontracts with other regional service providers.
2) Describe where and when (days and hours of program operations) program services will be provided. If this is a new program, include a timeline for startup and implementation.
3) Describe the staffing pattern for the program including licensing of staff (if applicable), cultural/linguistic makeup, and timeline for hiring or filling vacancies.
4) Describe how people with HIV in need of the proposed services will be identified and engaged. Complete **Attachment 4**– Table of Service Linkages/MOAs and attach all corresponding agreements documenting bi-directional linkages/MOAs. (***Letters of support will not be accepted***.)
5) Describe the process for the initial and ongoing determination of client eligibility for the proposed services.
6) Describe the process to ensure that Part A/MAI funds are the payer of last resort and will not be utilized to make payments for any service that may be reimbursed under any State compensation program, insurance policy, or any Federal or State health benefits program.
7) Describe the process for ensuring that people with HIV receive appropriate and ongoing medical care and treatment, and other supportive services not provided by this agency and/or program.
8) Describe the process for ensuring and maintaining client confidentiality in accordance with Article 27F of the NYS Public Health Law[2].
9) Describe the process for making and receiving timely and appropriate referrals for people with HIV. (Include the activities for tracking and following up on referrals made and received.)
10) Describe the activities for retaining people with HIV in services; and what will occur to re-engage those that have fallen out-of-care.

[2] Appendix D – New York State Confidentiality Law and HIV Public Health Law, Article 27-F

Section V: Clinical Quality Management Plan and Continuous Quality Improvement	
Maximum Score:	**10 Points**

1) Provide a brief description of the agency's quality management plan and improvement plan to evaluate, monitor and adjust the delivery of the proposed program services to ensure the needs of people with HIV are met. Include specific outcome indicators for the proposed program that will be used to facilitate this.
2) Describe the process of involving people with HIV the quality improvement plan; and the process for obtaining ongoing client and staff feedback regarding the delivery of program services.

Section VI: Budget	
Maximum Score:	**20 Points**

Complete the budget forms, located in **Attachments 5**. Include a brief narrative of each item. Provide a clear methodology used to determine costs. Please refer to the instruction tab for guidance. All costs must be related to the program services in this proposal. ***Personnel services on the budget must be consistent with the staffing described in the program design and summary***. Please refer to Appendix D (HRSA Policy Clarification Notice 15-01 and corresponding FAQ) for information on direct vs indirect administrative costs and 10% admin cap.

Applicants should submit a 12-month budget covering March 1, 2027-February 29, 2028.

This funding may only be used to expand existing services or create new services for people living with HIV/AIDS in Nassau and Suffolk counties. These funds **CANNOT** be used to supplant existing funds for currently existing staff and program services. Applicants must include other funding sources on the last tab of the Excel budget spreadsheet.

VII. REVIEW AND SELECTION PROCESS

A. REVIEW PROCESS

A total of 100 points are available per proposal. Proposals will be reviewed and evaluated by a Proposal Review Committee that is jointly convened by the Nassau and Suffolk County Departments of Health.

The Proposal Review Committee will make funding recommendations within each county in accordance with the Planning Council's established priorities and amount of funding allocated to each priority.

The following process applies to **single county proposals**:

- The Proposal Review Committee will make recommendations for approval or rejection to the Health Commissioners or their designees.
- The Nassau County Commissioner of Health (or designee) will review and approve or reject all recommendations from the review committee for funding or proposals solely within Nassau County.
- The Suffolk County Commissioner of Health (or designee) will review and approve or reject all recommendations from the review committee for funding of proposals solely within Suffolk County.

- Upon final approval by the Health Commissioners, approved projects will be forwarded to United Way of Long Island for contracting.

The following process applies to **bi-county proposals**:

- The Proposal Review Committee will make recommendations for approval or rejection to the Health Commissioners.
- Upon final approval by the Health Commissioners, approved projects will be forwarded to United Way of Long Island to begin the contracting process.
- If one Commissioner rejects a proposal, the reason for rejection will be specified in writing, and the proposal returned to the Review Committee for reconsideration. Upon such reconsideration, if the Committee and a single Commissioner continue to approve, an agreement will be made with the approved service provider.
- If both Health Commissioners reject a proposal, it will be rejected with no further consideration.

B. ADDITIONAL CONSIDERATIONS

At the direction of the Recipient, United Way of Long Island, reserves the right to:

1. Reject any or all applications received in response to this RFP;
2. Withdraw the RFP at any time, at the Recipient's sole discretion;
3. Change any of the scheduled dates;
4. Make an award under the RFP in whole or in part;
5. Award more than one contract per priority area as a result of this RFP;
6. Negotiate with applicants responding to this RFP within the requirements to serve the best interests of the EMA;
7. Award grants based on geographic considerations to serve the best interests of the EMA;
8. Visit an applicant's site in cases where the agency and its facilities are not familiar to the counties; or in which cases where the agency is new to the provision of Part A funded programs or services;
9. Negotiate with successful applicants within the scope of the RFP in the best interests of the Recipient and EMA; and
10. Conduct contract negotiations with the next responsible applicant should United Way (on behalf of the Grantee) be unsuccessful in negotiating with the selected applicant.

IX. GENERAL REQUIREMENTS FOR CONTRACTORS

A. GENERAL SPECIFICATIONS

1. Submission of application indicates the applicant's acceptance of all conditions and terms contained in this RFP, including the terms and conditions of the contract.

2. Contractor will possess, at no cost to the Recipient or United Way, all qualifications, licenses and permits to engage in the required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

4. Provisions Upon Default
   a. The services to be performed by the Applicant shall be at all times subject to the direction and control of the Recipient and United Way as to all matters arising in connection with or relating to the contract resulting from this RFP.
   b. In the event the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFP, the Recipient (through United Way) shall have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.

B. CONTRACTING AND REPORTING

There are several contracting and reporting expectations for agencies awarded contracts through this RFP process including but not limited to:

1. The contractor will submit, to the United Way of Long Island (United Way), all required invoices and reports of expenditures, statistical and narrative reports in the time frames stipulated by the grant.

2. Where deemed applicable, the contractor agrees to participate in the established and required Management and Information Systems (MIS). This includes, but is not limited to, the following:
   a) The right of access by United Way's staff and/or other authorized individuals involved in the development, implementation and maintenance of the MIS to the contractor's premises, equipment, electronic files, client files, service utilization data and medical records;
   b) Completion of data entry and software upgrades as deemed necessary for reporting requirements;
   c) Compliance with all policies and procedures related to the use of the MIS;
   d) Participation in on-going technical support assistance and training.

3. The contractor will participate in program evaluations activities as required by the United Way. These activities include, but are not limited to, the collection and reporting of information, and on-site monitoring visits to ensure contractual compliance.

4. The contractor will obtain client authorization to release medical and program records to the United Way, so that the United Way may effectively and efficiently evaluate and audit services. Such authorization may be part of a general release signed by the client.

5. Providers will be required to use HRSA's software program, CAREWare, to track and report unduplicated client-level demographic, medical and other service data. This requirement applies to all Part A/MAI priorities as RFPs are released. To obtain more information about CAREWare visit CAREWare 6 | Ryan White HIV/AIDS Program (hrsa.gov).

6. The contractor will participate in the Nassau-Suffolk EMA's Part A Clinical Quality Management program.

C. OTHER REQUIREMENTS OF FUNDED SUBRECIPIENTS

- At the time of contracting subrecipients must complete a Risk Assessment Survey.
- Submit any and all requested financial information (including: 990's, audited financial statements, single audits, proof of insurance, etc.) in a timely and accurate manner.
- Maintain a general ledger in accordance with generally accepted accounting principles for non-profit organizations.
- Adhere to the New York State Public Health Law Article 27-F and comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA).
- Coordinate all Part A funded services with other community-based HIV/AIDS providers to ensure that a continuum of care is established and maintained.
- Follow national monitoring and regional services standards.

X. Service Category Definitions and Guidance

A. EMERGENCY FINANCIAL ASSISTANCE (Bi-County)

HRSA Definition of Service

Emergency Financial Assistance provides limited one-time or short-term payments to assist the HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including*:

- Utilities
- Food (including groceries & food vouchers)
- Other HRSA RWHAP-allowable cost needed to improve health outcomes
- Housing
- Transportation
  Medication not covered by ADAP or AIDS Pharmaceutical Assistance

*The N-S EMA allows EFA funds to cover food cards/vouchers, personal hygiene packets, eyeglass assistance, and utilities/rental assistance **only**.

Program Guidance

EFA must occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are prohibited. (HIV/AIDS Bureau Policy 16-02). It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through emergency financial assistance.

N-S EMA Emergency Financial Assistance Directives and Service Model	
CARE AND TREATMENT GOALS	The provision of Emergency Financial Assistance is meant to prevent the regression of health status of PWH by augmenting other available assistance programs offered by public and private community and services resources. The goal of Emergency Financial Assistance is to provide eligible individuals with emergency financial assistance to mitigate any barriers that may impact the treatment of HIV infection.
OBJECTIVES	1. To minimize the human and financial impact of negative critical events in the lives of those living with HIV and their families. 2. To address basic human needs and provide a "safety net" for those who have nowhere else to turn when facing a crisis.
PROGRAM COMPONENTS	**EFA programs are limited use and:** • Provide assistance to help offset the costs of purchasing needed personal hygiene items. • Provide food cards/vouchers to support nutritional needs during times of hardship. • Provide assistance for eyeglasses that are not otherwise covered through insurance. • Provide assistance with utilities and rental assistance that can't be covered through other means.

	Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following: 1. Assessing client needs and referring to local services, resources, and case management for on-going, longer-term needs. 2. Collaborating with nutrition and other social service programs (i.e., food banks, food pantries, and social services for SNAP) to ensure client has access to on-going resources. 3. Case conferencing with referring agencies to: a. review eligibility documents, b. assess statement of need to ensure client meets eligibility for emergency financial assistance services, c. inform them of availability of food cards, personal hygiene items and funds for utilities/rent. **Other activities should include but are not limited to the following:** 1. To avoid duplication of effort, providers must coordinate/collaborate with other Ryan White Part A providers in the Nassau-Suffolk Region. 2. Providers must comply with HRSA's Payer of Last Resort requirement and have documentation in the client file that the person has exhausted or is ineligible for other services.
EFA Specific Client Eligibility Criteria	EFA services are specifically designed to be provided to people with HIV who are: 1. Experiencing a documented urgent need for food, personal hygiene items, utilities/rental assistance; and assistance with eyeglasses. 2. Ineligible for food cards, personal hygiene items utilities assistance and eyeglasses elsewhere.

Tips for EFA Applicants.

Strong applications will clearly address and demonstrate:

- How the program will work with other Part A programs to provide assistance to eligible individuals, couples or families and how clients can get food cards and personal hygiene products immediately and during non-traditional hours.
- Procedures for ensuring that all other resources are exhausted (payer of last resort) prior to providing EFA. Discuss knowledge of alternate resources and how your program collaborates with them and how staff will determine eligibility for EFA.
- Referral and linkage process for individuals with on-going need. Describe relationships that exist between your program, food pantries, food banks, utility companies, case management and other programs to address the long-term needs of clients. Clients must be screened for or assisted with applying for SNAP if eligible.

B. MEDCIAL CASE MANAGEMENT (NASSAU, SUFFOLK, Bi-County)

HRSA Definition of Service

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

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.

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).

In addition to providing medically oriented services, MCM 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) (HIV/AIDS Bureau Policy 16-02).

N-S EMA Medical Case Management Program Directives and Service Model	
CARE AND TREATMENT GOALS	Medical Case Management (MCM) services maximize access, engagement and retention in care by decreasing barriers to medical and support services, increasing awareness of treatment options, increasing proportion of clients who have optimal level of ART adherence, and increasing the proportion of clients who are virally suppressed.
OBJECTIVES	1. Link newly diagnosed and out-of-care individuals to HIV primary care services within 5 working days of intake/(re)assessment. 2. Ensure clients attend recommended HIV primary care visits each year (generally two per year). 3. Confirm clients are prescribed and compliant with antiretroviral therapy 4. Achieve client viral load suppression (less than 200 copies/mL at last HIV viral load test during the year). 5. Connect clients with necessary supportive services (directly through community-based case management referrals)

PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:**
	• Initial assessment of service needs
	• Development of comprehensive, individualized service plans
	• Timely, coordinated access to medically appropriate levels of health and support services and continuity of care
	• Continuous client monitoring to assess the efficacy of the service plan
	• Re-evaluation of service plans 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
	
	Other services should include but are not limited to the following:
	• Linkage to available medical and support services, including referrals
	• Risk/harm reduction counseling
	• Provision of information on:
	  ○ Types of treatment available
	  ○ Health literacy
	  ○ Behavioral health
	  ○ Secondary prevention
	  ○ Sexually transmitted infections (STIs)
	  ○ Pre-Exposure Prophylaxis (PrEP)
	  ○ Post-Exposure Prophylaxis (PEP)
	  ○ Side effects of treatment
	  ○ Psychosocial issues
	  ○ Client belief system
	  ○ Cultural beliefs
	  ○ Confusion and forgetfulness
	  ○ Provider relationship

MCM Specific Client Eligibility Criteria	MCM services should focus on the following types of clients: • Newly diagnosed and/or new to ART • Have fluctuating viral loads and/or not virally suppressed (CD4 <200 and/or VL >200) • Out of Care or experience excessive missed appointments and/ or missed dosages of ART • Have comorbidities such as mental health, substance use issues or other health issues that hinder the ability to access and participate in medical treatment

	• Experiencing emergent food, housing and transportation instability that threaten retention in care • Experiencing medical issues such as opportunistic infections, comorbidity with other STIs and/or Hepatitis, have unmanaged chronic health problems, new issues related to aging, etc. • Have screened positive for intimate partner violence • Referred by another clinician for an HIV intervention.

Tips for MCM Applicants.

Strong applications will clearly address and demonstrate:

- A comprehensive MCM service delivery model with strong linkages and coordination of care within or with HIV medical services. Medical Case Managers participate in or work with multidisciplinary teams and in partnership with other professionals to assist clients in managing their disease. *Explain how the program will ensure and track client participation in HIV primary care. Describe relationships with medical care teams, supportive services, and describe existing MOUs*.
- Staffing patterns that are adequate to support the number of proposed clients. *Detail the expected number of clients per MCM or MCM team*. Additional consideration will be given for programs that utilize peers as part of the MCM team.
- Monitoring and tracking of client engagement in HIV care and treatment (including CD4 counts and ART prescriptions). *Share how your program will gain access to client labs and appointment information.*
- ART adherence. *Address how your program will ensure clients' retention in care and adherence to treatment/service plans – including ART*.
- Efforts to maintain client viral load suppression. *Detail the work your program will do to ensure clients' viral load suppression including the availability of non-traditional hours to serve clients who need evening or weekend appointments or through home visits when clients are temporarily homebound due to a fall or injury, etc. and need medical coordination*.
- Referrals for other core medical and support services. *Describe relationships and any existing MOUs*.

C. MEDICAL NUTRITION THERAPY (Nassau, Suffolk, Bi-County)

HRSA Definition of Service

Medical Nutrition Therapy (MNT) is nutrition-based treatment provided by a registered dietitian and include the following services:

- Nutrition assessment and screening;
- Dietary or nutritional evaluation;
- Food and/or nutritional supplements per a medical provider's recommendation;
- Nutrition education and/or counseling.

These services can be provided in individual or group settings, at community organizations or medical facilities (HIV/AIDS Bureau Policy 16-02).

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 professionals.

N-S EMA Medical Nutrition Therapy Program Directives and Service Model	
CARE AND TREATMENT GOALS	Provide eligible individuals with nutritionals services to address proper weight, weight distribution, nutritional needs, and improve overall nutritional status. Medical Nutrition Therapy services will be provided in a culturally and linguistically appropriate manner to facilitate access to and maintenance in primary HIV medical care, and adherence to HIV treatments.
OBJECTIVES	• Provide nutritional planning, assessments, support and supplements, in coordination with the medical care provider orders, outside HIV primary medical visits. • Improve health outcomes for PWH through access to medical nutrition therapy services.
PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:** • Consultation with a licensed, registered dietitian • Comprehensive Nutritional Assessment – Baseline Screen & Food Security Analysis • Clinical Nutrition Analysis • Referral for Food Sources • Medical Nutrition Therapy Care Plan • Individual and group education sessions resulting in behavioral changes that support medical compliance and overall viral suppression. • Medical Nutrition Therapy Education • Medical Nutrition Therapy Reassessment (every 6 months) to determine continued need for program services **Other services should include but are not limited to the following:** • Referrals to other core medical and support services and food resources. Assistance with SNAP applications.
Client Eligibility Criteria	Clients receiving MNT services must be: • Referred by a medical provider

Tips for MNT Applicants.
Strong applications will clearly address and demonstrate:

- Strategies for providing medial nutrition therapy for Part A clients who demonstrate need. Include information on how often and where individual counseling and group sessions will be held.
- Detail outreach, recruitment and collaborative efforts to engage eligible individuals in medical nutrition therapy, including outside your organization and during non-traditional hours. Discuss relationships and agreements with outside partners to assist with client outcomes.
- Procedures for providing medical nutrition therapy in a culturally sensitive manner that addresses food insecurity, limited food options and lack of access to cooking appliances (stove, microwave, etc.). Describe how registered dieticians will provide medical nutrition therapy to individuals who are representative of the HIV epidemic in the N-S EMA and how they will address challenges faced by clients who don't have access to various kitchen appliances.
- Programs must bill for covered services. Explain your billing procedures and how your program will bill insurance for medical nutrition therapy and how revenue will be tracked and returned to the program as RW income.

D. MEDICAL TRANSPORTATION (Nassau, Suffolk, Bi-County)

HRSA Definition of Service
Medical Transportation (MT) is the provision of ***nonemergency*** transportation services that enables an eligible client to access or be retained in core medical and support services (HIV/AIDS Bureau Policy 16-02).

Program Guidance
Medical transportation may be provided through:

- Contracts with providers of transportation services (taxi companies, UBER, Lyft, etc.)
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services
- MetroCards, bus tickets or gas cards

At no time and under no circumstance are direct payments of cash to recipients of services allowed.

N-S EMA Medical Transportation Program Directives and Service Model	
CARE AND TREATMENT GOALS	Medical Transportation services enable eligible individuals to access HIV-related health and supportive services needed to maintain them in HIV medical care.
OBJECTIVES	1. Remove barriers so that people living with HIV are able to attend and participate in core medical and support services. 2. Increase retention, decrease missed appointments, and improve client experience.

PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:** • The provision of medical transportation to ensure access to core medical and support services. • The provision of transportation by arranging taxis, Lyft, Uber rides or by providing Metro Cards/bus tickets or gas cards. **Other considerations include but are not limited to the following:** • Clients are to be transported within the county where they reside. • Clients may only be transported within Nassau and Suffolk Counties. • Certain exceptions may be made in circumstances where services in Nassau or Suffolk are closer than those within the client's county of residence.
Client Eligibility Criteria	Clients receiving Medical Transportation services: • Are not eligible for other existing transportation services (such as Medicaid Transportation) • Need assistance paying for SCAT/Able-Ride

Tips for Medical Transportation Applicants.

Strong applications will clearly address and demonstrate:

- Methods for ensuring clients are linked with primary HIV medical services. List MOUs or other agreements with HIV medical providers. Describe plans to provide clients with MetroCards, taxi/Uber/Lyft rides or mileage reimbursement and assistance with transportation needs during non-traditional hours.
- Plans to obtain feedback and address any client concerns with medical transportation. Share how your program will elicit feedback from clients and respond to complaints about transportation to ensure client retention in medical care.
- Processes to ensure that PWH are transported in a timely manner. Report on how your program will work with transportation providers to ensure prompt rides to and from appointments and how your program will provide MetroCards/bus tickets and mileage reimbursement quickly to avoid interruptions in care.
- Process for re-evaluating clients' transportation needs (every 6 months) and assisting clients in applying for other transportation services as they become eligible.

E. MENTAL HEALTH (Nassau, Suffolk, Bi-County)

HRSA Definition of Service

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 (HIV/AIDS Bureau Policy 16-02).

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

N-S EMA Mental Health Program Directives and Service Model	
CARE AND TREATMENT GOALS	Metal Health Services provide eligible individuals with mental health counseling and treatment in an individual and/or group setting that permits them to enter, and maintain, HIV medical care. Mental health services will be provided in a culturally and linguistically appropriate manner and tailored to the populations served to facilitate access to and maintenance in primary HIV medical care, and adherence to HIV treatments.
OBJECTIVES	1. Assist PWH with reduction of symptoms related to mental health disorders thereby reducing barriers to medical care. 2. Provide psychiatric evaluation and medication monitoring if indicated. 3. Connect clients with necessary supportive services to maintain retention in care and treatment.
PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:** • Comprehensive Assessment and Reassessments of mental health status. • Intensive mental health therapy and counseling provided solely by Mental Health Practitioners licensed in the State of New York. • Individual and group counseling sessions with qualified staff. • Psychiatric/Psychological consultation (testing and medication) provided by a licensed, mental health practitioner. • Coordination and linkage to medical and other necessary service providers. **Other services should include but are not limited to the following:** • Provisions and mechanisms for urgent care evaluation and triage. • Development and maintenance of collaboration with clients' primary care providers to ensure retention in care.
Client Eligibility Criteria	• Diagnosed with mental illness or in need of mental health services (HIV-infected individual has a DSM diagnosis)
Agency Eligibility Criteria	• Licensed Article 31 mental health providers currently certified to deliver outpatient mental health services, licensed Article 28 health care providers currently certified to deliver and bill for outpatient mental health services or Integrated Outpatient Services (IOS) License. • Community based organizations (CBO) with a Memorandum of Understanding/partnership with a licensed Article 31 mental health provider who has added the CBO site to its licensure in accordance with New York

	State Office of Mental Health regulations and is thus able to conduct Medicaid-billable mental health sessions onsite at the CBO. • Organizations providing services should have multidisciplinary mental health programs including mental health counseling, psychiatric care and/or pharmacological management, and AOD (alcohol and other drugs) services. • Organizations providing services should use multiple, evidence-based therapeutic modalities and/or best practices including harm reduction based psychotherapy/counseling for those individuals with substance use disorders. • Organizations providing services must have experience serving HIV+ individuals and active substance users. • Organizations must also have experience reaching out to and engaging individuals who are out of care or sporadically in care, transitioning from institutional care, or in need of self-management support. • Agencies must either be co-located or have established linkages with programs providing medical care, HIV testing, food and nutrition services, alcohol and substance use services, syringe exchange/harm reduction services, comprehensive risk reduction services, medical case management services, housing services, legal services, Medicaid, Medicare, and NYS Health Insurance Exchange Systems, health homes, and supportive counseling and family stabilization services. • Agencies must ensure that staff members have HIV knowledge, training and cultural sensitivity appropriate to the populations that they serve. • Agencies must have the capacity to provide services in the languages spoken by the populations served.

Tips for MH Applicants.

Strong applications will clearly address and demonstrate:

- Strategies for identifying eligible clients whose health and quality of life may be impacted by mental health issues. Describe MOUs and relationships with other Part A providers and the referral process.
- Plans to serve clients with appropriate mental health intervention(s). Explain who will provide mental health services, what modalities and interventions will be used and the availability of crisis intervention and non-traditional hours.
- Methods to ensure that RW funds are payer of last resort. Address how your program will bill public and private insurances and how revenue will be tracked and returned to the program as RW income.

F. ORAL HEALTH CARE (Nassau, Suffolk, Bi-County)

HRSA Definition of Service

Oral Health Care (OHC) is a range of activities that include: outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants (HIV/AIDS Bureau Policy 16-02).

N-S EMA Oral Health Care Program Directives and Service Model	
CARE AND TREATMENT GOALS	Provide eligible individuals with Oral Health Care services that include diagnostic, preventive, therapeutic and restorative services. OHC services will be provided in a culturally and linguistically appropriate manner to ensure optimal health and maintenance in care and adherence to HIV medication regimens.
OBJECTIVES	A. Provide preventive care, maintenance and elimination or oral pathology thereby reducing barriers to medical care. B. Give treatment priority to pain management, infection, traumatic injury or emergency conditions. C. Alleviate discomfort, keep teeth and gums health, prevent infection to optimize overall health.
PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:** • Dental and medical history • Comprehensive oral evaluation/assessment • Dental treatment planning • Phase 1 treatment planning • Oral health education (including tobacco cessation education) • Periodontal screening **Other services must include but are not limited to the following:** • Timely access for clients with emergent and urgent issues (within 24 and 48 hours respectively). • A treatment plan that includes: ➢ Provision for the relief of pain ➢ Elimination of infection ➢ Preventive plan component ➢ Periodontal treatment plan if necessary ➢ Elimination of caries ➢ Replacement or maintenance of tooth space or function ➢ Consultation or referral for conditions where treatment is beyond the scope of services offered ➢ Determination of adequate recall interval ➢ Dental treatment plan will be signed by the oral health care professional providing the services ➢ Methods for monitoring and tracking engagement in oral care and treatment

Client Eligibility Criteria	• All eligible individuals who need preventive care, maintenance and treatment of oral pathology for which there is no other payer. • General Ryan White eligibility: Household income must be below 500% of FPL. Client must live within the Nassau-Suffolk EMA.

Tips for OHC Applicants.

Strong applications will clearly address/describe:

- Strategies for engaging Part A clients in oral health care services. Describe how your program will outreach, recruit and retain clients in OHC.
- Processes for providing urgent and emergent appointments for clients with immediate needs. Explain your process for scheduling appointments within 24 – 48 hours and the availability of non-traditional hours.
- Methods to ensure that RW funds are payer of last resort. Address how your program will bill public and private insurance and utilize RW funds for those clients and services that are not covered by any other payer. Billing procedures for covered services. Explain how your program will bill insurance for oral health care services and how revenue will be tracked and returned to the program as RW income.

G. OTHER PROFESSIONAL SERVICES – LEGAL (Nassau, Suffolk, Bi-County)

HRSA Definition of Service

Other Professional Services (OPS) is 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. (HIV/AIDS Bureau Policy 16-02).

Such services may include:

1. Legal services provided to and/or on behalf of the individual living with HIV 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 RWHAP
   - Preparation of:
     - ✓ Healthcare power of attorney
     - ✓ Durable powers of attorney
     - ✓ Living wills
2. 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.

3. 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.

N-S EMA Other Professional Services - Legal Program Directives and Service Model	
CARE AND TREATMENT GOALS	Provide eligible individuals with legal services that result in engagement and retention in HIV treatment and care.
OBJECTIVES	1. Ensure access to eligible benefits so that clients have uninterrupted health care. 2. Advocate for clients on benefits, landlord disputes, and discrimination issues so that clients can focus on their health and well-being. 3. Represent clients in legal proceedings and secure beneficial outcomes.
PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:** • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under Ryan White • Landlord/tenant advocacy • Assistance with public benefits including Medicaid, SSI/SSD, SNAP, cash benefits through the Department of Social Services including but not limited to: E-5 rental enhancement, shelter allowance, etc. • Income tax preparation services are to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits or when required as part of a legal allowable intervention. • Immigration issues including legal advocacy to assist clients with obtaining benefits to establish and maintain their care. **Other services should include but are not limited to the following:** • Preparation of advanced directives including health care proxies, living will and powers of attorney;

	• Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS. Permanency planning includes the provision of social service counseling or legal counseling regarding: a) drafting of wills or delegating powers of attorney; and b) preparation of custody options for legal dependents including standby guardianships, joint custody or adoption.
Client Eligibility Criteria	• Services need to be directly necessitated by an individual's HIV status in order to engage and retain PWL in treatment and care. • General Ryan White eligibility: Household income must be below 500% of FPL. Client must live within the Nassau-Suffolk EMA.

Tips for OPS - Legal Applicants.
Strong applications will clearly address/describe:
- Strategies for engaging Part A clients in need of legal services. Describe how your program will outreach, recruit and retain clients in OPS. List MOUs and relationships with Part A providers.
- Processes for providing appointments for clients with immediate needs. Explain your process for scheduling appointments during non-traditional hours.

H. OUTPATIENT AMBULATORY HEALTH SERVICES (Nassau, Suffolk, Bi-County)

HRSA Service Definition:
Outpatient/Ambulatory Health Services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight.

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 and provision of education and tools to support treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

- Assessment of diet/nutritional status, measurement of BMI and provision of education on healthy eating

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

N-S EMA Outpatient Ambulatory Health Services Program Directives and Service Model	
CARE AND TREATMENT GOALS	Ensure individuals have immediate and uninterrupted HIV medical care and receive recommended treatments, tests and procedures.
OBJECTIVES	1. Ensure access to medical care and treatment so that clients have uninterrupted health care. 2. Provide linkages to other medical and support services so that individuals can achieve viral load suppression.
PROGRAM COMPONENTS	**Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following:** • Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current treatment guidelines (https://hab.hrsa.gov/clinical-quality-management/clinical-care-guidelines-and-resources and NYS HIV clinical guidelines HOME - AIDS Institute Clinical Guidelines (hivguidelines.org) • Evaluation of viral load measurements at least twice a year. • Assessment for opportunistic infections at each visit and OI prophylaxis if indicated. • Timely and appropriate offer of immunizations • Screens risk behaviors and provides risk reduction education, including PrEP (pre-exposure prophylaxis), nPEP (non-occupational post exposure prophylaxis) for sexual and injection partners, and Undetectable = Untransmittable (U=U) • Referrals for other medical and support services where indicated. **Other services must include but are not limited to the following:** ○ Appropriate baseline testing, including laboratory and radiology values, will be performed within the first two primary care visits scheduled with the primary care provider.
Client Eligibility Criteria	• Individuals in need of health care for which there is no other payer.

Tips for OAHS Applicants.

Strong applications will clearly address/describe:

- Strategies for ensuring that the provision of medical care, procedures and pharmaceuticals to eligible individuals is not covered by another payer.
- Efforts to engage individuals who do not have access to insurance, are not yet covered under insurance or need care that is not covered under their insurance. Explain how you will work with community-based organizations and other health care providers to ensure access to necessary medical care that achieves linkage to care, receipt of care and viral load suppression. Share MOUs and other relationships that exist between your program and others. Explain your process for scheduling appointments during non-traditional hours.

Attachment 1

FY2027-2029 Ryan White Part A/MAI Request for Proposals
Cover Page

Agency Name:_____

Corporate Name *(if different)*:_____

Part A Priority Area Applying for (separate applications must be submitted for each priority):

❑	**Emergency Financial Assistance (Nassau, Suffolk, Bi-County)**
❑	**Medical Case Management (Nassau, Suffolk, Bi-County)**
❑	**Medical Nutrition Therapy (Nassau, Suffolk, Bi-County)**
❑	**Medical Transportation (Nassau, Suffolk, Bi-County)**
❑	**Mental Health (Nassau, Suffolk, Bi-County)**
❑	**Oral Health Care (Nassau, Suffolk, Bi-County)**
❑	**Other Professional Services – Legal (Nassau, Suffolk, Bi-County)**
❑	**Outpatient Ambulatory Health Services (Nassau, Suffolk, Bi-County)**

Indicate if this is a single or joint Proposal:
_____-**Single Proposal** _____- **Joint Proposal** *(lead applicant is the applying agency)*

Indicate if this is a Bi-County or Single County Proposal:
_____-**Bi-County** _____-**Nassau County** _____-**Suffolk County**

Total Proposed Units of Service _____
Total Projected Number of Unduplicated Clients _____
Projected % of Clients from Nassau County _____%
Projected % of Clients from Suffolk County _____%

12 Month Annualized Budget Amount: $_____

Requested Budget Items *(Must match attached budget forms)*

Total Personnel Services	
Total Fringe	
Total Contractual	
Total Equipment	
Total Supplies	
Total Space Costs & Related	
Total Other	
Total Indirect Costs*	
Total Restricted	
TOTAL REQUESTED FUNDS	**$**

*There is a 10% cap on Ryan White Part A funds used to support direct and indirect costs.

Attachment 2

FY2027-2029 Ryan White Part A/MAI Request For Proposals
Agency Information

Agency Name: _____

1. Authorized Representative of the Agency:

Name: _____

Title: _____

Address: _____

_____

Phone: _____ **Fax:** _____

E-mail: _____

2. Contact Person regarding this Proposal:

Name: _____

Title: _____

Address: _____

_____

Phone: _____ **Fax:** _____

E-mail: _____

3. Racial/Ethnic Composition of the Agency:

Indicate for each whether the individuals who comprise the below bodies are **more than 50%** racial/ethnic minority.

Governing Board	____ YES	____ NO
Executive Staff	____ YES	____ NO
Management Staff	____ YES	____ NO
Line Staff	____ YES	____ NO

4. Faith-Based Organization:

A faith-based organization is one that is owned and operated by a religiously affiliated entity such as a Catholic hospital. Indicate whether your agency is a faith-based organization:

____ YES ____ NO

Attachment 3

FY2027-2029 Ryan White Part A/MAI Request for Proposals
Demographics
Clients from High Need Communities

Agency Name: _____

Complete the below table

Nassau County		
	Zip Code	**Percentage of Clients from Each Zip Code Area in Nassau**
Projected number of unduplicated clients from Nassau County High Need Communities: #_____	11042- New Hyde Park	%
	11575- Roosevelt	%
	11550- Hempstead	%
	11553- Uniondale	%
	11520- Freeport	%
	11096- Inwood	%
	11590- Westbury	%
	11561- Long Beach	%
	11542- Glen Cove	%
	11003- Elmont	%
	11020- Great Neck	%
Suffolk County		
	Zip Code	**Percentage of Clients from Each Zip Code Area in Suffolk**
Projected number of unduplicated clients from Suffolk County High Need Communities: #_____	11798- Wyandanch	%
	11901- Riverhead	%
	11713- Bellport	%
	11701- Amityville	%
	11980- Yaphank	%
	11770- Fire Island	%
	11717- Brentwood	%
	11722- Central Islip	%
	11950- Mastic	%
	11706- Bay Shore	%
	11772- Patchogue	%
	11726- Copaigue	%
	11951- Mastic Beach	%
	11967- Shirley	%
	11968- Mastic	%

Attachment 4

FY2027-2029 Ryan White Part A Request For Proposals
Table of Service Linkages/Memorandum of Agreements (MOA)

Agency Name: _____

Complete the below table (Include names and types of agencies that your organization has active linkage or agreements with.)

AGENCY	TYPE OF AGENCY	YEAR SIGNED
	Emergency Room	
	Substance Use Treatment	
	Detoxification Program	
	Adult Detention Facility	
	Mental Health Program/Facility	
	HIV Disease Counseling & Testing Site	
	Housing Provider	

Attachment 6

LETTER OF COMMITMENT FROM EXECUTIVE DIRECTOR OR CHIEF EXECUTIVE OFFICER

(Letter should be placed on agency letterhead)

This letter certifies that I have reviewed and approved the enclosed proposal to United Way of Long Island (technical support agency for the Nassau-Suffolk EMA for Ryan White Part A and MAI funds) for consideration under the Ryan White Part A- Emergency Relief Funding for the provision of _____.

I am committed to ensuring that the proposed HIV related services will be provided and that staff will be qualified appropriately trained and have sufficient agency resources to effectively implement the program.

Sincerely,

Executive Director or
Chief Executive Officer

Attachment 6.a

LETTER OF COMMITMENT FROM THE BOARD OF DIRECTORS

(letter should be placed on agency letterhead)

This letter certifies that the Board of Directors of (*agency name*) has reviewed and approved the enclosed proposal to United Way of Long Island (technical support agency for the Nassau-Suffolk EMA for Ryan White Part A and MAI funds) for consideration under the Ryan White Part A- Emergency Relief Funding for the provision _____.

We are committed to ensuring that the proposed HIV related services will be provided and that staff will be qualified appropriately trained and have sufficient agency resources to effectively implement the program.

Sincerely,

Chairperson or Designee of the Board of Directors

Appendix A

FY2027-2029 N-S EMA Ryan White RFP

Attachment Naming Guidelines- For all attachments and required documents please use the following naming guideline:

Attachment #, Applicant Agency's Name, Priority Area Acronym, Attachment Name

Attachment #	Attachment Type	Example	Notes
1	**Cover Page**	#1-UWLI MNT Cover Page	PDF
2	**Agency Information**	#2-UWLI MCM Agency Information Sheet	PDF
3	**Estimated Clients to be Served from High Need Areas**	#3- UWLI MT Est. Clients from High Need Areas	PDF
4	**Table of Service Linkages and MOAs**	#4- UWLI MNT Linkage Agreements	PDF
5	**Budget**	#5-UWLI EIS Budget	*Excel Spreadsheet (do not PDF)*
6	**Letter of Commitment from the Executive Director or CEO**	#6- UWLI MCM ED Letter	PDF
6.a	**Letter of Commitment from the Board of Directors**	#6.a- UWLI MH Board Letter	PDF
7	**Agency Organizational Chart (must show agency and RW program lines)**	#7- UWLI OPS-Legal Org Chart	PDF
8	**Proof of 501 (c)(3) Status**	#8- UWLI EFA Proof of 501c3 status	PDF
9	**Most recent Audited Financial Statements**	#9- UWLI EIS Financial Statements	PDF
10	**Bi Directional Agreements**	#10- UWLI MT Linkage Agreements	PDF agreements into one document
11	**Job Descriptions for Proposed RW funded staff**	#11- UWLI OH Job Descriptions	PDF all job descriptions into one document

Please note that if your agency is selected for funded through this competitive bidding process that SAM.gov registration, most recent IRS 990, single audit (if applicable), a work plan and revised budget (if needed) will be required for contracting.

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

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18, Grant Policy Update 9/15/25, Revised 1/28/26)
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, at 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) at 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, and modifications at 2 CFR Part 300. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 2 CFR Part 200 and modifications at 2 CFR Part 300. Recipients are required to monitor the activities of a subrecipient as necessary to ensure that the subrecipient complies with Federal statutes, regulations, and the terms and conditions of the subaward. (see 2 CFR § 200.332(e)).

2 CFR Part 200, 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, the regulations at 2 CFR Part 200, modifications at 2 CFR Part 300, 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

[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
    - Life-saving overdose prevention and response services or supplies such as opioid reversal supplies, substance test kits, and overdose reversal education and training services[1]
    - 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.

[1] https://www.samhsa.gov/sites/default/files/dear-colleague-letter-executive-order-ending-crime-disorder-americas-streets-07302025.pdf

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,[7] 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:

[7] 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 2 CFR § 200.459

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
- 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.

Appendix C

New York State Confidentiality Law and HIV: Public Health Law, Article 27-F



What Is Public Health Law, Article 27-F?

Article 27-F is the section of New York State Public Health Law that protects the confidentiality and privacy of anyone who has:

- Been tested for HIV;
- Been exposed to HIV;
- A diagnosis of living with HIV or HIV/AIDS-related illness; or
- Been treated for HIV/AIDS-related illness.

Public Health Law, Article 27-F:

- Requires that every individual age thirteen and older be offered an HIV test at least once as part of routine health care;
- Requires that, with some exceptions, information about a person's HIV status can only be disclosed (shared with others) if the person signs an HIV release form or if the form is signed by the person's legally appointed guardian or health care proxy;
- Applies to persons and facilities that directly provide health care services or social services and to anyone who receives HIV-related information about a person pursuant to a properly executed HIV release form;
- Requires that any person or facility whose work is covered by Article 27-F and who receives HIV-related information MUST keep that information confidential, as required by law.

What is confidential HIV-related information?

This is any information that shows a person:

- Had an HIV-related test (such as an HIV antibody test, CD4 test, viral load test, PCR [polymerase chain reaction] test, or other test;
- Has a diagnosis of living with HIV, HIV-related illness, or AIDS;
- Has been exposed to HIV;
- Has one of these conditions, including information on the person's sexual contacts or needle-sharing contacts; or
- Is a partner or sexual/ substance use contact of a person diagnosed as living with HIV.

Under what circumstances is a person offered an HIV test?

HIV testing must be offered at least once to all patients age 13 or older as part of routine health care services provided in the following health care settings:

- Primary care services in diagnostic and treatment centers (including school-based clinics and family planning sites)
- Primary care services in outpatient departments of hospitals
- Inpatient departments of hospitals
- Emergency departments

HIV testing must be offered by physicians, physician assistants, nurse practitioners or midwives who provide primary care, or their representatives, regardless of setting.
Primary Care means the medical fields of:

- Family medicine
- General pediatrics
- Primary care
- Internal medicine
- Primary care obstetrics/gynecology

There are three exceptions to the requirement to offer HIV testing:

- If the individual is being treated for a life-threatening emergency;
- If the individual has previously been offered or has previously been tested for HIV (unless otherwise indicated due to more recent risk behavior);
- If the individual has been determined by the attending provider to lack mental capacity to consent.

Is consent required for an HIV test?

New York State law requires that a person be informed prior to an HIV test being conducted, including being informed that they have the right to decline an HIV test. Effective November 28, 2016, updates to public health law remove the requirement for obtaining consent for an HIV test in writing or orally, including elimination of written consent for HIV testing in New York State correctional facilities, and removing references to consent forms. The objective of the update to public health law is to eliminate barriers to HIV testing and make HIV testing comparable to the manner in which other important laboratory tests are conducted. HIV testing remains voluntary and patients have the right to refuse an HIV test, but obtaining written or oral consent for testing is no longer required in any setting. Patients must be advised orally that an HIV test is going to be performed. If the patient objects to the HIV test, this should be noted in the patient's medical record.

Can minors consent to their own HIV test, HIV treatment and HIV prevention services?

Yes. Minors have the ability to consent to an HIV test without parental involvement. They should be provided the required information about HIV and be told they have the right to decline an HIV test. Updates to public health regulation in 2016 also now allow minors to consent to HIV treatment and HIV preventive services, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis. (PEP).

What information must be given to a person before an HIV test is conducted?

Prior to conducting diagnostic HIV testing, information about HIV must be provided orally, in writing, through signage or in any other patient-friendly audio-visual format. Placing the NYS DOH HIV testing clinic poster in a visible location or providing patients with the NYS DOH patient brochure on HIV testing are simple ways of conveying this information to patients. The testing poster and brochure are available in seven different languages and can both be found here:
https://www.health.ny.gov/diseases/aids/consumers/testing/index.htm

When is it necessary to have a signed released form in order to share information?

Generally, HIV-related information can only be disclosed if the person signs an approved HIV release form. For example, a medical provider may not share confidential HIV information from a person's medical record with a case manager or other staff person from a community based organization without a signed release form. To disclose HIV-related information from a medical record to a non-medical provider for any purpose, including linkage to care, a specific signed release is required. The DOH Form 2557 Authorization for Release of Medical Information and Confidential HIV Related Information, is used for this purpose. This form allows for the release of both HIV-related information and non-HIV-related information. DOH Form 5032 titled Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS Related Information is available for use when information to be released includes information about alcohol or substance use that is afforded additional protected under federal regulation 42-CFR Part 2.

In what situations may HIV-related information be disclosed without an approved HIV release form?

For medical treatment:

- Medical professionals working on the treatment team with the person's existing provider may discuss a patient's HIV-related information with each other or with their supervisors, but only to give necessary care;
- With a general release, a hospital or health care provider may share HIV-related information with a patient's insurance company if the information is needed to pay for medical care;
- Medical personnel and certain other supervisory staff may have access to HIV-related information to provide or monitor services if the person is in jail or prison or is on parole.

To monitor health care and disease prevention:

- Health care facility staff and committees, oversight review organizations, or government agencies that are authorized to have access to medical records may be given HIV-related information when it is needed to supervise, monitor, or administer a health service or social service;
- Known partners of a person newly diagnosed with HIV must be notified by a physician or public health officer that they have been exposed to HIV. Information about the source of infection will not be disclosed;
- Public health officials may have access to this information when required by law, such as HIV/AIDS case reporting to monitor disease trends and plan prevention programs;
- Researchers conducting research at an academic medical center with the approval of the medical center's Institutional Review Board, the board that is responsible for protecting human subjects.

To promote linkage and retention in HIV care:

If a person appears to be out of care, information may be shared between the Department of Health and a health care provider or care coordinator with a documented care relationship with the individual. If a person with HIV appears to be out of care, he or she may be contacted by the medical provider, care coordinator or health department staff to address barriers to entry into care and to promote engagement in care.

Other circumstances for releasing HIV-related information without an HIV-specific release form include:

- Authorized agencies that work with prospective adoptive or foster parents may have access to this information;
- A judge can issue a special court order that requires release of HIV-related information. The information cannot be released in response to a subpoena issued by an attorney;
- Article 27-F does not cover HIV testing when it is ordered solely for insurance reasons. This is covered by Insurance Law Section 2611. When an HIV test is given for insurance reasons, it generally includes a brief written consent and a referral to a counselor for further questions;
- Disclosure may occur without consent in certain cases of on-the-job exposure to HIV when all criteria for exposure have been met;

When releasing HIV-specific information to another party, is it necessary to include a statement that the information may not be re-disclosed without the protected individual's consent?

Generally speaking, a statement that information may not be redisclosed should accompany all cases where HIV-related information is shared. However, there are a number of exceptions.

A re-disclosure statement is NOT required in the following situations:

- A health care provider or health facility shares the information when knowledge of the HIV-related information is necessary to provide appropriate care;
- Information is shared with third party reimbursers or their agents to the extent necessary to reimburse health care providers for health services; provided that, where necessary, an otherwise appropriate authorization for such disclosure has been secured by the provider;
- In instances of proper consent, which is defined as using the proper form. The proper form includes: specific authorized disclosure of HIV, name of protected individual, name of recipient, reason/ purpose, dated, time period of consent, signed;
- When clients themselves are disclosing HIV related information;
- Internal communications;
- When information is disclosed to parents/ legal guardians;
- For the purpose of contact notification;
- In the context of a court order;
- An authorized agency in conjunction with foster care/ adoption;
- Criminal justice agencies in order to carry out the department functions with respect to the protected individual;
- When disclosed to public health officials;
- When conducing service delivery review/ monitoring;
- When shared for the purpose of transplantation of organs.

An example of a redisclosure statement is the following:
"This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient for further disclosure."
-Public Health Law § 2782 (5)(a)

Resources:

New York State Department of Health HIV Confidentiality Hotline
800-962-5065
Monday - Friday, 8:30 a.m. - 4:30 p.m.

You can send a complaint report to:
Special Investigation Unit AIDS Institute
New York State Department of Health
Empire State Plaza, Corning Tower #308
Albany, NY 12237
518-473-2300

To report a human rights violation anywhere in New York State:
New York State Division of Human Rights, Office of AIDS Discrimination Issues
888-392-3644

To access the form for alleged violations of Article 27-F, please see DOH form 2865, located here:
https://www.health.ny.gov/forms/doh-2865.pdf

For more information regarding federal privacy protection:
U.S. Department of Health and Human Services,
Office for Civil Rights
800-368-1019

For information and help with partner notification:
Partner Services
800-541-2437

Contact Notification Assistance Program (CNAP):
New York City only
212-693-1419 or call 311

For general information or possible legal assistance:
Legal Action Center
212-243-1313

To access informed consent forms and release forms and to learn more about HIV/AIDS-related programs, policies, and regulations, visit the NYSDOH website at:
www.health.ny.gov/diseases/aids/index.htm

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NEW YORK STATE | Department of Health

10/18

Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D

Policy Clarification Notice (PCN) #15-01 (updated 09/01/2020, Grant Policy Update 09/15/2025) Replaces Policy Notice 11-04 Supersedes July 17, 2012 Dear RWHAP Part A and Part B Colleagues letter regarding rent as an administrative cost

Scope of Coverage Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D.

Purpose of PCN

This PCN revises and clarifies the Health Resources and Services Administration's (HRSA) guidelines for the treatment of costs under the statutory 10% administrative cap for RWHAP Parts A, B, C, and D.

Background

Parts A – D of Title XXVI of the Public Health Service (PHS) Act include a cap that limits the recipient costs of administering the award to 10%.[1] With a rapidly changing healthcare environment, increasing requirements for oversight of subrecipients (including contractors performing programmatic activities), and required coordination across other federal, state, and local funding streams, RWHAP recipients have new and additional administrative costs. These additional activities coupled with current policies have resulted in unreimbursed administrative costs for RWHAP recipients and less flexibility in the use of HRSA funds to administer their grant(s). In an effort to provide increased flexibility for recipients, within the boundaries of the statute, the HRSA's HIV/AIDS Bureau (HAB) has re-examined the classification of costs subject to the 10% administrative cost cap.

It is important to note that the additional flexibility with regard to administrative costs will better enable recipients and subrecipients to provide core medical and support services to eligible clients while ensuring that the RWHAP is the payer of last resort.

[1] See §§ 2604(h)(1), 2604(h)(2), 2618(b)(3)(A), 2618(b)(3)(B), 2664(g)(3), and 2671(f)(1) of the PHS Act.

Instructions

Treatment of "Rent" and Other Facilities Costs Incurred to Provide Core Medical and Support Services to Eligible RWHAP Clients

RWHAP Parts A, B, and C Recipients

The portion of indirect and/or 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. [See 2 CFR §§ 200.412 – 414, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards and 2 CFR §§ 300.414 for information regarding the classification of costs as direct or indirect.]

RWHAP Parts A and B Subrecipients and Part D Recipients

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.[2]

Clarifications

Allocable Costs

For all recipients and subrecipients funded by RWHAP Parts A, B, C, or D, 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, as described in HRSA HAB PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds, directly associated with such activities:

- Biannual RWHAP client re-certification;
- The portion of malpractice insurance related to RWHAP clinical care;
- The portion of fees and services for electronic medical records maintenance, technology 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

[2] See §§ 2604(h)(4)(A), 2618(b)(3)(D)(i), and 2671(h)(1) of the PHS Act.

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).[3] However, expenses which are clearly administrative in nature cannot be included as CQM costs.

For Parts A, B, and C recipients—associated indirect costs may also be charged to the relevant service category.

Non-allocable Costs
For all recipients funded by RWHAP Parts A, B, C, or D, costs subject to the 10% administrative cap include, but are not limited to:
- Routine grant administration and monitoring activities, including the development of applications and the receipt and disbursal of program funds;
- Development and establishment of reimbursement and accounting systems;
- Preparation of routine programmatic and financial reports;
- Compliance with grant conditions and audit requirements;
- All activities associated with the recipient's contract award procedures, including the development of requests for proposals, subrecipient and contract proposal review activities, negotiation and awarding of contracts;
- Subrecipient monitoring activities including telephone consultation, written documentation, and onsite visits;
- Reporting on contracts, and funding reallocation activities; and
- Related payroll, audit and general legal services.

For Part A recipients, the cost of all activities carried out by the HIV health services planning councils and planning bodies would count toward the 10% administrative cap.[4]

For Part C recipients, planning and evaluation costs are subject to the 10% administrative cap.

All indirect costs charged by Part D recipients are considered an administrative expense subject to the 10% limit.[5]

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[3] 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.

[4] See §2604(h)(3)(B) of the PHS Act.

[5] See §2671(h)(1) of the PHS Act.

New Clarifications
Staff training necessary to provide high quality RWHAP services may be charged to the appropriate service category. These costs include training registration, maintenance of licensure and/or credentials, and individual membership dues. Service-specific funds used for this purpose should be carefully monitored by the RWHAP recipient and should not exceed 5% of the dollars allocated to provide the service. Organizational membership dues cannot be attributed to a service category, and are therefore administrative costs subject to the 10% cap.

Applicability to Subrecipients

RWHAP Parts A and B Subrecipients[6]
RWHAP Part A and B recipients must ensure that the aggregate total of subrecipient administrative expenditures does not exceed 10% of the aggregate total of funds awarded to subrecipients. Subrecipient administrative expenses may be individually set and may vary; however, the aggregate total of subrecipients' administrative costs may not exceed the 10% limit. Subrecipient administrative activities include[7]

- 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 CQM).

As a reminder: all indirect costs charged by the subrecipient are considered an administrative cost subject to the 10% aggregate limit.

RWHAP Parts C and D Subrecipients
The 10% limit on administrative costs does not apply to subrecipients under Parts C and D. RWHAP Parts C and D recipients are responsible for ensuring that subrecipient administrative costs are allowable, reasonable, and allocable to the RWHAP. [See 2 CFR §§ 200.403 – 405, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards for information regarding basic cost considerations.]

Recipient Management and Oversight Functions

RWHAP Parts A, B, C, and D recipients are responsible for establishing and maintaining written procedures for allocating and tracking funds applicable to the 10% administrative cost cap in compliance with RWHAP authorizing legislation and the requirements included in 2 CFR part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

If a RWHAP Part A or B recipient has contracted with an entity to provide statewide

[6] See §§ 2604(h)(2) and 2618(b)(3)(B) of the PHS Act.
[7] See §§ 2604(h)(4) and 2618(b)(3)(D) of the PHS Act.

or regional RWHAP management and fiscal oversight (i.e., the entity has entered in to a vendor or procurement relationship with the recipient, and is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient's 10% administrative cap. Providers that have contracted to provide healthcare services for the lead agency are considered to be first-tier entities (subrecipients) of the recipient and are subject to the aggregate 10% administrative cap for subrecipients.

Effective Date

All of the revisions and clarifications provided in this PCN are effective for RWHAP Parts A, B, C, and D awards issued on or after January 1, 2015. This includes competing continuations, new awards, and non-competing continuations issued on or after January 1, 2015. This PCN does not prevent a recipient from adhering to current practice after the effective date. It is up to the recipient to determine how best to meet the needs of eligible RWHAP clients in compliance with RWHAP authorizing legislation, the requirements set forth in 2 CFR part 200, modifications at 2 CFR part 300, and all terms and conditions of the award.

Recipients may not apply changes outlined in this PCN to costs incurred prior to January 1, 2015. Any findings from comprehensive site visits and/or audits related to administrative cost caps before January 1, 2015 remain in effect and will require resolution as documented.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

REQUIRED LETTER OF INTENT FORM

Letter of Intent Forms are required and must be submitted by Wednesday, December 11, 2026. All Letter of Intent forms must be emailed ryanwhiterfp@unitedwayli.org.

AGENCY NAME: _____

PRIORITY APPLYING FOR: _____

Agency Address:	
Contact Name:	
Contact Title:	
Contact Address:	
Contact Phone:	
Contact Email:	
Contact Fax:	

All questions regarding the RFP must be submitted electronically to ryanwhiterfp@unitedwayli.org by December 4, 2026 by 5:00pm. Answers to the submitted questions will be sent via a distribution list and will be posted on www.unitedwayli.org by December 8, 2026. If you have additional key staff that should have access to these answers please list their names and email addresses below. Please note that once the Letter of Intent forms have been submitted, only those individuals will be put on the distribution list. It is your responsibility to share responses with any individual(s) not identified on this form.

Additional Contacts for Question and Answer Distribution:

Name	Email