United Way of Long Island

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 2023 - 2025

- **Early Intervention Services (EIS)**
- **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:	**November 15, 2022**
Written Questions Due:	**November 16, 2022 by 5:00pm EST**
Responses Posted:	**November 18, 2022**
Letters of Intent Due:	**November 21, 2022 by 5:00pm EST (Required)**
Proposals Due:	**January 13, 2023 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 November 16, 2022. *Responses will be posted on the United Way of Long Island's website by November 18, 2022.

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EXECUTIVE SUMMARY

United Way of Long Island (acting as technical support agency for Ryan White Part A and Minority AIDS Initiative (MAI) funding in Nassau and Suffolk counties) is accepting applications for fiscal years (FYs) 2023-2025 Ryan White HIV/AIDS Program (RWHAP) Program. This competition is open to non-profit agencies serving individuals in the Nassau-Suffolk EMA.

The purpose of Ryan White Part A/MAI funding is to provide primary health care and supportive services to individuals with HIV/AIDS who are disproportionately affected by the HIV epidemic. Through this competitive Request for Proposal process, Part A/MAI funds 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: **EARLY INTERVENTION SERVICES, 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**.

I. General Information

A. Introduction

United Way of Long Island's Planning and Grants Management Department (hereinafter referred to as UWLI) is requesting proposals from qualified governmental and non-profit entities (hereinafter referred to as "Proposer") to provide Ryan White Part A/MAI core medical and support services to individuals with HIV. **Services to be contracted include: Early Intervention Services, 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. Background

The Nassau-Suffolk Eligible Metropolitan Area receives RWHAP Part A and Minority AIDS Initiative federal funds under the Ryan White Treatment Extension Act of 2009. This legislation represents the largest dollar investment made by the federal government specifically for the provision of core medical and essential support services for low-income PWH who are uninsured or underinsured. The purpose of the Act is to improve the quality and availability of care for persons with HIV and their families, and to establish services for persons with HIV who would otherwise have no access to health care. U.S. Department of Health and Human Services (HSS), Health Resources and Services Administration (HRSA) administers the RWHAP Funds.

Part A and MAI Programs in Nassau – Suffolk Eligible Metropolitan Area

The Ryan White HIV/AIDS Program 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. Approximately 72% of people living with HIV are in EMAs and TGAs. 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 that are needed for individuals with HIV/AIDS to achieve their medical outcomes.

Role of the HIV Planning Council

The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) has lead responsibility for implementing the Ryan White Program. HRSA is an agency of the U.S. Department of Health and Human Services (HHS). Part A funds are awarded to a local government entity who, in collaboration with the local Part A Planning Council, assesses the unmet needs of persons with HIV. 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, which is referred to as the "Recipient". The Recipient has selected United Way of Long Island through a competitive bidding process as the administrative/fiscal agent to assist in carrying out Part A administrative activities.

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. Membership on the Council includes individuals with HIV, community based organizations, hospitals, academia, and no-elected community leaders who are appointed by the County Executives of Nassau and Suffolk Counties. The Council votes and approves the priorities and program directives that are solicited through RFPs. Funded applicants are contracted to deliver services by UWLI on behalf of Nassau and Suffolk Counties.

C. National HIV/AIDS Strategy

The *National HIV/AIDS Strategy (2022–2025)* provides stakeholders across the nation with a roadmap to accelerate efforts to end the HIV epidemic in the United States by 2030. Its four goals are to: prevent new HIV infections, improve HIV-related health outcomes of people with HIV, reduce HIV-related disparities and health inequities, and achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders. The Strategy sets bold targets for ending the HIV epidemic in the United States by 2030, including a 75% reduction in new HIV infections by 2025 and a 90% reduction by 2030.

To ensure success, the NHAS requires the Federal government and State, tribal and local governments to increase collaboration, efficiency, and innovation. Therefore, to the extent possible, Ryan White program activities should strive to support the primary goals of the National HIV/AIDS Strategy.

D. HIV Care Continuum

The HIV care continuum—sometimes also referred to as the HIV treatment cascade—is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral load suppression and shows the proportion of individuals living with HIV who are engaged at each stage.

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 –** Number and percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.
- **Retained in Care -** Number and percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.
- **Viral Suppression -** Number and percentage persons with diagnosed HIV infection whose recent HIV viral load test in the past 12 months showed that HIV viral load was suppressed.
- **Linkage to Care -** Number and percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.

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. Data from the Ryan White Services Report (RSR) as of 2020 indicate that there are better outcomes in Ryan White HIV/AIDS Program (RWHAP) funded agencies with approximately 89.4% of individuals who received RHWAP-funded medical care being virally suppressed. Such findings underscore the importance of supporting effective interventions for linking HIV-positive individuals into care, retaining them in care, and helping them adhere to their combination antiretroviral regimens.

Funded providers will be required to work with the Recipient through its administrative agent 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.

E. The HIV Epidemic in the Nassau-Suffolk Region

The Nassau-Suffolk Eligible Metropolitan Area (EMA) is defined as the two county suburban region on Long Island comprised of Nassau and Suffolk Counties. The region has a population over 2.8 million people (2,839,436 in 2020). The general population of the two-county area is primarily White

(64%), followed by Hispanic (19%), Black/African American (10%), Asian/Pacific Islander (7%), and Native American (<1%).

Demographics of HIV/AIDS population in EMA. As of December 31, 2020, there were 5,302 individuals with HIV/AIDS in the EMA. People living with HIV in the EMA are disproportionately black, Hispanic/Latino, male, and above the age of 50. The racial/ethnic composition of all PWH in the EMA is 36.8% White, 35.3% Black, 23.3% Hispanic, 3.0% Asian, .3% American Indian/Native Alaskan and 1.3% Multiracial. Racial and ethnic minorities (including persons of more than one race) account for close to 63.2%% of all PWH in the EMA. Cumulative New HIV cases from 2016-2020 as of 12/31/20 are 33.37% White, 34.4% Black, 27.6% Hispanic, 3.6% Asian Pacific Islander, .2% American Indian/Native Alaskan and .9% Multiracial. Disparities are significant for African Americans (10% of general population, 35.3% of PWH, and 34.4% HIV incidence) and Hispanics (19% of general population, 23.3% of PWH and 27.6% HIV incidence). Males make up 80% of new HIV cases and represent 69.1% of all PWH. Transmission of new cases over the five year period as of 12/31/2020 was highest among MSM (53.9%% new HIV) followed by Heterosexuals (26.1% new). New HIV Sixty percent (60%) of all PWH in the EMA are over 50.

In 2020, 28% of the newly diagnosed had already progressed to AIDS, with the majority of these cases among black and Hispanic/Latino populations. Like many health problems, there is a disproportionate impact of HIV/AIDS on certain populations in the EMA when compared to their proportions in the general population. Major issues affecting the Nassau-Suffolk EMA, including the lack of low-income or affordable housing, inadequate public transportation systems and pockets of poverty within areas of substantial affluence cause concern and directly influence the HIV/AIDS service delivery system of 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:

- The uninsured/under-insured
- Newly diagnosed
- Sporadic to Care or Out of Care
- Individuals with dual diagnoses such as a substance use disorders, mental health issues
- Those disproportionately impacted by HIV/AIDS (African Americans and Latinos)
- LGBTQ+
- Immigrants and undocumented people
- Homeless people or those unstably housed

II. AVAILABLE FUNDS

This RFP does not specify the amount that applicants may propose for individual programs, but indicates the total amount of funding that may be available in the priority area. These amounts are based on the Nassau-Suffolk HIV Health Services Planning Council's annual Priority Setting and Resource Allocation Process and are subject to change based on the EMA's final notice of award for FY23-24.

The Nassau-Suffolk HIV Health Services Planning Council has allocated Part A and MAI funding) for FY 23 as outlined below.

PRIORITY AREAS (Nassau, Suffolk, and bi-county)	Estimated amounts available for this RFP by priority	Estimated # of programs to be funded
Early Intervention Services	**$ 247, 102**	**1-2**
Emergency Financial Assistance	**$ 125, 688**	**1-2**
Medical Case Management	**$ 1,799,853**	**5-6**
Medical Nutrition Therapy	**$ 253,513**	**2-3**
Medical Transportation	**$ 615,095**	**2**
Mental Health	**$ 1,002,336**	**4-5**
Oral Health Care	**$ 307,775**	**2**
Other Professional Services-Legal	**$ 635,414**	**1**
Outpatient Ambulatory Health Services	**$ 14,768**	**1-2**

Note: Applicants under the Mental Health, Oral Health Care, Medical Nutrition Therapy and Outpatient Ambulatory Health Services priorities must have the capacity to bill Medicaid and be certified to deliver these services.

Contractual Period

Funded programs will be awarded multi-year contracts with awards for FY23, FY24 and FY25. Contracts will run from March 1st to Feb 28th of each fiscal year with final award amounts determined upon final notice of award by HRSA. Funding may be subject to modification based on the Planning Council's annual Priority Setting and Resource Allocation process.

III. 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. Coverage of Services by the Ryan White HIV/ AIDS Program

RWHAP funds may be used to fill in 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.

C. Client Eligibility

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

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

Providers must conduct annual eligibility confirmations to assess if the client's income and/or residency status has changed.

- Full recertification including supporting documentation is required every two years.

- Annual verification can include a signed client self-attestation documented in the client record.

C. Affected Individuals[1]

Non-HIV infected individuals ***may*** be appropriate candidates for Part A funds in limited situations, but these services must always have a benefit to a person with HIV infection. In the Nassau-Suffolk Eligible Metropolitan Area, **only a parent or a legal guardian of a HIV infected child under the age of eighteen (18) is considered to be an affected individual** eligible to receive limited Part A services for a limited period of time.

With permission from the Grantee, 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 period of 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.
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.

IV. WHO MAY APPLY

A. 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 with HIV in Nassau and Suffolk counties. Faith based agencies, minority-operated community-based organizations, and community groups with a focus on racial/ethnic minority populations are strongly encouraged to apply.

B. 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.

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

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.

V. PROPOSAL REQUIREMENTS

A. 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.
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. Ensure that the hours of operation for program services meet the needs of the targeted population(s) being served including: the provision of evening and weekend services.
2. Ensure that all program services are: sensitive to the needs/issues specific to racial/ethnic communities; ethnically, culturally and linguistically appropriate; and delivered at a literacy level suitable for the targeted population(s) being served.
3. Ensure that the hiring and employment practices for staff focus on seeking individuals with skills that are culturally and linguistically appropriate for the population(s) being served, and when possible, representative of individuals seeking services.
4. Ensure that persons living with, and affected by HIV/AIDS were included, and will continue to be included, in the planning and program design of the services to be offered.
5. Ensure, through a solid outreach plan that services are targeted to communities most disproportionately impacted by HIV/AIDS and/or who are underserved including: communities of color, gay, lesbian, bisexual, transgender and non-binary communities.
6. Ensure that all literature and materials developed for marketing purposes specifically state that services are confidential. This is to address the confidentiality concerns of many PWH.
7. Ensure that services address childcare needs and serve children and adolescents with HIV.

Preferences will be given to applicants that:

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

B. Submitting a Proposal

Letters of intent for this RFP **(Appendix E)** are required and are due by **5:00pm on November 21, 2022.**

Organizations that will target PWH 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 PWH being served must be residents of one of the counties.

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 13, 2023.

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

C. Requirements for Completing Proposals

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

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

2) Proposals must provide responses to all questions and statements and include a budget that is reflective of the service delivery in the priority area to the targeted population.

3) Attachments must be clearly labeled following the naming guidelines in **Appendix A**

VI. PROPOSAL CHECKLIST

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

Proposals missing any section of the program narrative and/or program budget will be deemed non-responsive and will not be considered for Part A/MAI funding for fiscal year 2023-2025.

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 of all staff positions identified in the program design and on the personnel page of the budget.**

VII. 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.

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 and proposed outcomes of the program;
d. The strategies to move clients along the cascade of HIV care (or HIV care continuum);
e. The staff that will provide the administrative, programmatic and fiscal oversight; and will be responsible for the direct delivery of services; and
f. 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. Include applicable data that supports your description.
2) Describe other programs in the targeted area(s) that provide similar services.
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, 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, and fiscal, grants, and information systems management. Attach a current organizational chart of the agency that includes a clear representation of the proposed program.
3) Describe the agency's experience in managing government grants.
4) Describe the agency's capability for collecting and reporting client-level data through computer-based programs.
5) Explain the agency's procedures and efforts to enroll clients into insurance/benefit programs, utilize third-part reimbursement and ensure that Ryan White funds payer of last resort.
6) State if the agency is a Medicaid certified provider. If so, list all services that are billed to Medicaid.
7) Describe the agency's experience providing services to persons with HIV. Include population demographics in the description (age, sex, socioeconomic status, race/ethnicity, etc.).
8) Describe the agency's experience with providing services to subpopulations within the HIV/AIDS community (e.g. gay, lesbian, bisexual, transgender, substance users, individuals with mental histories, etc.).
9) Describe how agency leadership and direct staff are reflective of the target population in terms of race/ethnicity, sexual orientation, etc.
10) Describe the ability to provide services to limited or non-English speaking, hearing, visual or physically impaired individuals.
11) Describe the extent to which the target population was involved in the development and delivery of the proposed service.
12) Describe the agency's history with working collaboratively with other regional agencies providing services in the targeted geographic area and to persons with HIV.

Section IV: Priority Specific Program Design (*Please refer to section 10 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 program 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 program startup and implementation.
3) Describe the staffing pattern for the program including licensing if applicable, cultural/linguistic makeup, and timeline for hiring or filling vacancies.
4) Include how PWH 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 PWH receive appropriate and ongoing HIV related medical care and treatment, and other supportive services not provided by this agency and/or program.
8) Describe the activities that will remove barriers to accessing program services for PWH.
9) Describe the process for ensuring and maintaining client confidentiality in accordance with Article 27F of the NYS Public Health Law[2].
10) Describe the process for making and receiving timely and appropriate referrals for PWH. (Include the activities for tracking and following up on referrals made and received.)
11) Describe the activities to promote the services of this program within the targeted area(s) and case findings to engage those clients eligible for the program.
12) Describe the activities for retaining PWH in services; and what will occur to re-engage those that have fallen out-of-care.

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 including: the staff responsible for the development, implementation and monitoring of the program's quality management plan and program specific CQI projects. Indicate the title(s) of the staff involved and their years of experience in quality assurance activities.
2) Describe the agency's quality improvement plan to evaluate, monitor and adjust the delivery of the proposed program services to ensure the needs of PWH are met. Include specific outcome indicators for the proposed program that will be used to facilitate this.
3) Describe the process of involving PWH/A in 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 -5A. Include a brief narrative of each item and the methodology used to determine costs. 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, 2023-February 29, 2024.

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

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

VIII. PROPOSAL 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 jointly convened by the Nassau County Department of Health, and the Suffolk County Department of Health Services.

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

The following process of approval will be followed for **single county proposals**:

i. The Proposal Review Committee will make recommendations for approval or rejection to the Health Commissioners.
ii. 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.
iii. 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.
iv. Upon final approval by the Health Commissioners, approved projects will be forwarded to United Way of Long Island to begin the contracting process.

The following process of approval will be followed for **bi-county proposals**:

i. The Proposal Review Committee will make recommendations for approval or rejection to the Health Commissioners.
ii. Upon final approval by the Health Commissioners, approved projects will be forwarded to United Way of Long Island to begin the contracting process.
iii. If one Commissioner rejects a proposal, the reason for rejection will be specified in writing. The proposal will be returned to the Proposal 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.
iv. If both Health Commissioners reject a proposal, it will be rejected with no further consideration.

B. Additional County Health Department Considerations

United Way of Long Island on behalf of the Nassau-Suffolk EMA, 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 in which the agency and its facilities are not familiar to the counties; or in which case the agency is new to the provision of Part A funded programs and services;
9. negotiate with successful applicants within the scope of the RFP in the best interests of the Grantee 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 Grantee/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 Grantee/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

For agencies awarded contracts as a result of this RFP process, there are several contracting and reporting expectations.

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.

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.

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.

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.

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).

B. Other Requirements

- Maintain a general ledger in accordance with generally accepted accounting principles for non-profit organizations.
- Participate in the Part A Clinical Quality Management program.
- 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.
- 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.

X. Service Category Definitions and Guidance

A. EARLY INTERVENTION SERVICES (Nassau, Suffolk, Bi-County)

HRSA Definition of Service

Early Intervention Services (EIS) are the identification, informing, referring and linking of newly diagnosed individuals to care as soon as possible (HIV/AIDS Bureau Policy 16-02).

Program Guidance

EIS must include the following four components:

1. 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
   a. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts

b. HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
2. Referral services to improve HIV care and treatment services at key points of entry
3. Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
4. Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

***Note**: At this time testing, including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures, is **not** covered under this priority as the EMA has adequate testing resources. However, coordination is expected with testing facilities.*

EIS is a short-term intervention that links clients to care as soon as possible. EIS should last no longer than 6 months unless there is a compelling need, at which time programs must get approval from the Contract Administrator on a case-by-case basis to extend the service.

N-S EMA Early Intervention Services Directives and Service Model	
CARE AND TREATMENT GOALS	Identify individuals who are unaware of their HIV status and those who are out of care, inform them of their status and the services available to them, and promptly link them to care and treatment services.
OBJECTIVES	1. Ensure newly diagnosed individuals are linked to HIV primary care as soon as possible. 2. Connect clients with necessary supportive services to maintain retention in care and treatment.
PROGRAM COMPONENTS	Early Intervention Services must clearly address each of the four areas: identification, informing, referral and linkage to care. EIS programs must have: • linkages with key points of entry and active relationships/partnerships with counseling and testing providers; • referral services providing access to care; and • health literacy education/training to help clients navigate the HIV/AIDS service delivery system. Programs may use peers for peer support and mentoring. Services should be based on best practices, evidence-based protocols, and/or community-driven initiatives. They must include the following: 1. Strategies to identify and locate individuals at risk for HIV infection, including developing formal relationships with "Points of Entry" and informal relationships with other community contacts who are engaged in the provision of HIV related services. • Points of Entry are agencies/organizations that provide HIV testing and other related services. 2. Activities, coordinated with locally funded testing and prevention programs, to ensure appropriate counseling and testing (programs will be

	expected to collect data on targeted outreach events, testing referrals and number of positive and negative test results). 3. Processes for referring HIV positive and negative individuals for needed services (including partner notification and resources to help HIV negative individuals address barriers to care and remain negative). Other activities must include but are not limited to the following: 1. Working with clients to have first HIV primary care appointment scheduled within 5 working days of assessment and following-up to ensure participation in HIV medical care. 2. Addressing barriers to care, assisting clients in linkage to care and follow up on participation in other Ryan White core medical and support services and non-Ryan White community services
EIS Specific Client Eligibility Criteria	EIS are specifically designed to be provided to PWH who are: 1. Unaware of status 2. Newly diagnosed 3. Not in care - individuals who are not in care and have not had CD4 or viral load testing in a year.

Outcome	**Measure**
By 2025, increase the percentage of people with HIV infection who know their serostatus to at least 95 percent.	Percentage of persons aged ≥13 years with HIV infection who know their serostatus. (Diagnosed)
By 2025, increase the percentage of persons with newly diagnosed HIV infection who are linked to medical care within one month of diagnosis to at least 95%.	Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load. (Linked)
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons out-of-care who were re-linked to care within one month as evidenced by a documented CD4 count or viral load. (Linked)

Tips for EIS Applicants.

Strong applications must include and clearly address all four components of EIS: identifying, informing, referring and linking HIV positive individuals and clearly address/describe:

- Strategies for identifying newly diagnosed and out-of-care individuals needing linkage to care. Describe responsible staff, targeted outreach activities, and methods/data/sources used to identify at-risk people and the availability of non-traditional work hours to reach hard to engage individuals.

- Plans for establishing memoranda of understanding (MOUs) with key points of entry to facilitate access to care for those who test positive. Explain with which programs, agencies, institutions your program expects to collaborate.
- Processes for immediate linkage to HIV primary care for the newly diagnosed and those out of care. Detail with which medical provider(s) your program will link clients.
- Methods for confirming client's receipt of first HIV primary care visit and retention in care. Explain how your program will obtain information that confirms client's receipt of care.
- Referrals for HIV positive and negative individuals that address barriers to care and resources to help the negative remain negative and the positive achieve viral suppression. Address how your program will refer to other core and support Part A services as well as community resources that will support people in their efforts to achieve optimal health.

B. EMERGENCY FINANCIAL ASSISTANCE

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

*The N-S EMA allows EFA funds to cover food cards/vouchers, personal hygiene packets and utilities 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 not permitted. (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 PWH 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 with utilities 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 and resources for on-going, longer term needs. 2. Collaborating with nutrition and other social service programs (i.e., food banks, food pantries, and social services) to ensure client has access to on-going resources. 3. Case conferencing with referring agency to a. inform them of availability of food cards, personal hygiene items and funds for utilities b. review eligibility documents c. assess statement of need to ensure client meets eligibility for emergency financial assistance services. **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 PWH who are: 1. Experiencing a documented urgent need for food, personal hygiene items, and/or utilities assistance; and 2. Ineligible for food cards, personal hygiene items or utilities assistance elsewhere.
Outcome	**Measure**

By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)

Tips for EFA Applicants.
Strong applications will clearly address/describe:

- How your 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 works with them and ho staff will determine eligibility for EFA.
- Referral and linkage process for individuals with on-going need. Describe relationships that exist between your program and food pantries, food banks and other programs that provide needed services.

C. 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 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 the medically oriented services above, 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 a comprehensive, individualized service plan
	• 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 care plan
	• Re-evaluation of the service 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
	• Education on U=U (Undetectable = Untransmittable)
	• 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	Clients receiving MCM services should be or have: • Newly diagnosed and/or new to ART • Fluctuating viral loads and/or not virally suppressed (CD4 <200 and/or VL >200) • Excessive missed appointments and/ or missed dosages of ART • Mental health and/or substance use that hinders the client's ability to access and participate in medical treatment • Food, housing and transportation instability • Opportunistic infections • Comorbidity with other STIs and/or Hepatitis • Unmanaged chronic health problems • Positive screening for intimate partner violence • Clinician's referral

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with diagnosed HIV who had a least one CD4 or viral load test during the calendar year. (Receipt)
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)
By 2025, increase the percentage of person with diagnosed HIV infection who are virally suppressed to at least 95%	Percentage of persons with diagnosed HIV infection whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. (Viral Suppression)

Tips for MCM Applicants.

Strong applications will clearly address/describe:

- Linkages for clients to primary HIV medical services. Explain how your program will ensure clients participation in HIV primary care. Describe relationships and any existing MOUs.
- 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.

- Referrals for other core medical and support services. Describe relationships and any existing MOUs.

D. 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 professional.

N-S EMA Medical Nutrition Therapy Program Directives and Service Model	
CARE AND TREATMENT GOALS	Provide eligible individuals with nutritionals services to addresses 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 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/group education sessions resulting in behavioral changes that support medical compliance and overall viral suppression. • Medical Nutrition Therapy Education • Medical Nutrition Therapy Reassessment **Other services should include but are not limited to the following:** • Referrals to other core medical and support services and food resources.
Client Eligibility Criteria	Clients receiving MNT services should be: • Referred by a medical provider

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)
By 2025, increase the percentage of person with diagnosed HIV infection who are virally suppressed to at least 95%	Percentage of persons with diagnosed HIV infection whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. (Viral Suppression)

Tips for MNT Applicants.

Strong applications will clearly address/describe:

- Strategies for providing medial nutrition therapy for Part A clients who demonstrate need. Detail outreach, recruitment and collaborative efforts to engage eligible individuals in medical nutrition therapy, including outside your organization and during non-traditional hours.
- 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 racially and ethnically 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.
- Billing procedures for covered services. Explain how your program will bill insurance for medical nutrition therapy and utilize RW funds for those services that are not covered. Describe how revenue will be tracked and returned to the program as RW income.

E. 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 PWH are able to attend and participate in core medical and support services. 2. Increase retention, decrease missed appointments and improve the 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 taxi 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 that 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

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with diagnosed HIV who had a least one CD4 or viral load test during the calendar year. (Receipt)
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at

	least 3 months apart during the calendar year. (Retained)
By 2025, increase the percentage of person with diagnosed HIV infection who are virally suppressed to at least 95%	Percentage of persons with diagnosed HIV infection whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. (Viral Suppression)

Tips for Medical Transportation Applicants.
Strong applications will clearly address/describe:

- 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 assist 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 how your program will work with transportation providers to ensure prompt rides to and from appointments and how your program will provide MetroCards and mileage reimbursement quickly to avoid interruptions in care.

F. 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 or licensed Article 28 health care providers currently certified to deliver outpatient mental health services. • 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.

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)

Tips for MH Applicants.

Strong applications will clearly address/describe:

- Strategies for identifying eligible clients whose health and quality of life is 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 utilize RW funds for those clients and services that are not covered by any other payer. Describe how revenue will be tracked and returned to the program as RW income.
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G. 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, and therapeutic dental care. 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	1. Provide preventive care, maintenance and elimination or oral pathology thereby reducing barriers to medical care. 2. Give treatment priority to pain management, infection, traumatic injury or emergency conditions. 3. 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.

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)

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 insurances 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 medical nutrition therapy and utilize RW funds for those services that are not allowable. Describe how revenue will be tracked and returned to the program as RW income.

H. 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 advance 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 counsel 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 PWH in treatment and care.

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with diagnosed HIV who had a least one CD4 or viral load test during the calendar year. (Receipt)
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)

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.

I. 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 needing health care for which there is no other payer.

Outcome	**Measure**
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with diagnosed HIV who had a least one CD4 or viral load test during the calendar year. (Receipt)
By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%.	Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. (Retained)
By 2025, increase the percentage of person with diagnosed HIV infection who are virally suppressed to at least 95%	Percentage of persons with diagnosed HIV infection whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. (Viral Suppression)
By 2025, increase the percentage of persons with newly diagnosed HIV infection who are linked to HIV medical care within one month of diagnosis to at least 95%.	Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load. (Linkage)

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. Describe procedures for confirming eligibility and how discounted pharmaceuticals (340B) will be used in the program.
- 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

2023 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):

❑	**Early Intervention Services (Nassau, Suffolk, bi-county)**
❑	**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 indirect costs.

Attachment 2

2023 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

Ryan White Part A/MAI Request For Proposals FY23-25
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

2019 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