New Jersey Department of Health
Division of HIV, STD and TB Services
Request for Applications – Care and Treatment Services - State

Key Dates

<table>
<thead>
<tr>
<th>Event</th>
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<tr>
<td>Release Date</td>
<td>February 9, 2016</td>
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<tr>
<td>Pre-Proposal Conference</td>
<td>February 17, 2016 10am or 1pm</td>
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<tr>
<td>Sage Open Date</td>
<td>March 17, 2016</td>
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<td>Sage Closing Date</td>
<td>April 7, 2016 at 3:00 p.m.</td>
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<td>Contract start date</td>
<td>July 1, 2016</td>
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For security purposes each pre-proposal attendee must RSVP with name and affiliation to:
Nikki.Phillips@doh.nj.gov

The location of the pre-proposal conference is:

3 Schwarzkopf Drive; Ewing, New Jersey 08638

Directions:
DIRECTIONS TO THE STATE LAB MAYBE FOUND ON PAGE 26

APPLICATIONS MUST BE SUBMITTED IN SAGE GRANTS BY

April 7, 2016 at 3:00 PM EASTERN TIME

THE SAGE GRANTS SYSTEM IS SET TO CLOSE AT EXACTLY 3:00 PM ON THE DUE DATE

The New Jersey Department of Health – Division of HIV, STD and TB Services may, in its sole discretion, extend the application deadline or reissue the application if insufficient qualified applications are received. Applications received after the due date and time may be deemed non-responsive and, therefore, subject to rejection.
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I. Introduction
People living with HIV once experienced obstacles in getting health coverage, were dropped from coverage, or avoided seeking coverage for fear of being denied. Now they can get covered and get the care they need. The Affordable Care Act and Medicaid Expansion provides people living with HIV (PLWHs), who meet the eligibility threshold, with access to the ten essential health benefits critical to treated the whole person.

DHSTS anticipates a significant reduction in cost associated with core services that are now billable to insurance companies. Redirecting these dollars to address the patchwork of safety net programs can now be addressed. DHSTS can shift direction raising the possibility that refocused State Care funding will work in tandem with linkage/access/retention/adherence, support services, and health insurance reforms to improve the care of people living with HIV. Creating a seamless coordination of services on a continuum is our goal.

II. Purpose
The purpose of this Request for Application (RFA) is to expand and fill gaps identified by New Jersey HIV planning bodies with high quality medical care and support services for persons living with HIV/AIDS in New Jersey regardless of age, race, gender, class, sexual orientation, ethnic background, immigrant status, or religious/political affiliation.

III. Background
The National HIV/AIDS Strategy (NHAS) focuses on four objectives: 1) reducing new infections; 2) increasing access to care and improving outcomes for people living with HIV/AIDS, 3) reducing HIV-related health disparities, and 4) achieving a more coordinated national response to the HIV epidemic. The NHAS’s vision is that “The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”

In July 2015, the National HIV/AIDS Strategy for the US was updated to 2020. This RFA reflects those changes in the “Program Model” section.

The National HIV Care Continuum initiative, which was launched in 2013, provides the framework for achieving the goals of NHAS. The care continuum aims to increase the impact of HIV diagnosis and care efforts by focusing resources and services to where they would have the most impact. Central to NHAS is the concept “Treatment is Prevention”, which asserts that new infections can be sharply reduced by ensuring everyone with HIV is aware of his/her infection, is linked to care, prescribed anti-retroviral therapy, and is virally suppressed; which overall leads to lower HIV transmission rate. As HRSA states it, “The continuum of interventions begins with outreach and testing and concludes with HIV viral load suppression. The Continuum of Care includes diagnosis of HIV, linkage to medical care, lifelong retention in HIV medical care, appropriate prescription of ART; and ultimately HIV viral load suppression.” (Ryan White Part B
Of utmost importance are interventions to systematically identify and re-engage people living with HIV.

This RFA is developed in alignment with the New Jersey HIV Prevention and Care Service Plan, 2014 – 2016. (https://hpcpdel.rutgers.edu/NJHPG/publications.php). The HIV Prevention and Care Service Plan is congruent with NHAS goals as it integrates HIV prevention and care services. The Plan describes an ideal continuum of care and proposes the following four strategies be implemented to create a more integrated approach to HIV services: “Test and Treat” through a seamless linkage to care system within the same or next business day, “Treatment as Prevention,” Early Identification of Individuals with HIV/AIDS (EIHA), and Program Collaboration Services Integration (PCSI). The prevention benefit of treatment across the continuum can only be realized with effective treatment, which requires linkage to and retention in care, and adherence to antiretroviral therapy resulting in viral suppression.

A. Overview of the New Jersey HIV epidemic

Nearly 80,000 New Jersey residents have been reported with HIV/AIDS and 37,905 were currently living with HIV/AIDS as of June 30, 2014. In addition, it is estimated that 21% (one in every five) of New Jerseyans who are living with HIV/AIDS do not know that they are infected and are not yet included in these statistics.

Nationally, New Jersey ranks fifth in overall cumulative AIDS cases, third in cumulative pediatric AIDS cases, and has one of the highest proportions of women among those living with AIDS. Ten counties account for 84% of persons living with HIV/AIDS in the state with Essex and Hudson Counties having the highest proportions. Twenty-eight percent of persons living with HIV/AIDS are between the ages of 25 and 44 years of age, however, in (July 2013 - June 2014) thirty-six percent of newly reported HIV/AIDS cases occurred in individuals 45 years of age and older.

There were 12,462 women living with HIV/AIDS in New Jersey as of June 30, 2014. This represents 33% of all adult/adolescent persons living with HIV infection in the state. The corresponding national percentage of women among adult/adolescent persons is 24%. Most women (65%) living with HIV/AIDS were exposed by heterosexual transmission and 1.7% of these women were known to be sexual partners of injection drug users. Of women reported with HIV/AIDS in 2013, over half were age 40 and over.

Women of color, particularly African Americans, have been especially hard hit and represent the majority of the infections among women. During 2011-2012 the rate of HIV/AIDS diagnosis among African American women was 22 times higher than the rate among non-Hispanic White women, and among Hispanic women the rate was 6 times higher than the rate among non-Hispanic White women. The racial disparity among women is greater than it is among men.

More persons living with HIV/AIDS as of June 30, 2014 were exposed through sexual contact (male-to-male or male to-female sex), than through other modes of exposure.

In 2012, New Jersey ranked 7th in the number of new HIV/AIDS diagnoses among the states with mature confidential name-based HIV reporting systems. The rate of HIV infection was
21.6/100,000 compared to the national rate of 15.3/100,000.

In 2012, New Jersey ranked 9th in the rate of AIDS diagnoses with a rate of 10.2/100,000 versus 8.9/100,000 for the nation. Cumulatively, New Jersey ranked 5th in the nation in the total number of AIDS cases and 3rd in the number of pediatric AIDS cases. New Jersey accounted for 5% of the estimated cumulative national AIDS cases.

Prevalence: at the end of 2012, New Jersey ranked 4th in the rate of adults/adolescents living with HIV/AIDS with a rate of 492.5/100,000 versus a national rate of 339.4/100,000.

**Trends**

- Trends in new HIV infection diagnoses in recent years show a 29% decline from a peak of 1,981 in 2003 to 1,411 in 2012.
- Among African-Americans, the decline in new diagnoses for the same time period was 39%, compared to 23% among White non-Hispanics and 13% among Hispanics.
- In the year 2002, the incidence rate (per 100,000 population) for African Americans was 13 times higher than the incidence rate among White non-Hispanics; for Hispanics, the incidence rate in 2002 was 5 times higher than for White non-Hispanics. In the year 2012, the incidence rate (per 100,000 population) for African Americans was still 11 times higher than the incidence rate among White non-Hispanics; for Hispanics, the incidence rate in 2012 increased to 5 times higher than for White non-Hispanics.
- The number of annual deaths due to HIV disease has declined over the past decade; however, in 2009, HIV/AIDS still remains the 3rd leading cause of deaths for African American males 25-54 years old
- Advances in treatment have led to a decline in the number of pediatric infections; have slowed the progression from HIV to AIDS, and enhanced survival after AIDS diagnosis.

**HIV/AIDS Statistics for Minority Women and Youth**

**Trends in HIV/AIDS Diagnoses 2003 to 2012**

- Cumulatively, 80,370 cases of HIV/AIDS have been reported in New Jersey. As of June 30, 2014, 37,905 of these individuals were still known to be alive and residing in New Jersey; this count includes 17,783 persons living with HIV and 20,122 persons living with AIDS. Between 2003 and 2012, the number of new HIV/AIDS diagnoses among all adult/adolescents decreased from 1,962 to 1,402, a decline of approximately 29%.
- New Jersey has historically had one of the highest proportions of women living with AIDS, although this may be changing. New Jersey ranked 2nd among states in the percentage of prevalent female HIV cases through 2010 (33% versus 25%) and 11th in the percentage of new female HIV cases diagnosed in 2011. In recent years, about one-fifth of new HIV diagnoses nationally were in females. The number of new HIV/AIDS cases annually diagnosed among females in New Jersey decreased 45% from 2003 to 2012, declining from 662 cases in 2003 to 361 cases in 2012. Diagnoses among females as a percentage of all diagnoses by sex peaked at 34% in 2003. Since then, the percentage has steadily and consistently decreased and was at 26% in 2012. As of June 30, 2014, 33% of persons living with HIV/AIDS in New Jersey were female.
A great disparity persists with regard to the proportion of new cases occurring among minority populations. Diagnoses among Blacks comprised nearly half of HIV/AIDS cases (48%) in 2012, and diagnoses among Hispanics comprised 28% of cases in 2012. In other words, diagnoses occurring among minority populations accounted for three-quarters (76%) of all new cases in 2012. Women of color still represent the majority of new diagnoses among all women with eighty-five percent of new diagnoses in 2012 among women occurring in women of color.

B. Reimbursement Requirements
In response to the Affordable Care Act (ACA) implementation and Medicaid Expansion, applicants are expected to vigorously pursue and rigorously document eligibility for other funding sources (e.g., Medicaid, Marketplace, CHIP, Medicare, employer-sponsored health insurance coverage, and/or other private health insurance, etc.)

C. Key Program Changes

Affordable Care Act
The ACA has many implications for HIV care services. A significant number of clients will be enrolled in public and private health insurance, providing them with a new source of coverage. Many will be eligible for assistance to help pay for the cost of coverage such as through the ADDP program administered by DHSTS. State funding will continue to provide support for necessary services that are not covered by other insurance.

The State of New Jersey implemented a federally run Marketplace wherein eligible individuals can shop for and purchase private health insurance plans or enroll in Medicaid and CHIP, if eligible. Grantees are required to make clients aware of the penalties for not enrolling in a health care plan. Subsidies and advanced tax credits will be available to help low income individuals afford health insurance. With the ACA fully implemented on January 1, 2014, nearly all uninsured or underinsured New Jersey residents will have access to public or private health insurance coverage. Those under 138% of the Federal Poverty Level (FPL) will be eligible for public coverage in Medicaid Expansion. Once eligible for Medicaid, all eligible services will be billed to Medicaid; retroactive billing up to three months will be submitted to Medicaid and the proceeds reported as program income and placed back into the program funds (refer to the Program Income Section).

Program Model Requirements
The Implementation of the HIV Care Continuum (refer to Attachment I) calls for coordinated action in response to data that has been released with the National HIV/AIDS Strategy in 2010, showing only a quarter of people living with HIV in the United States have achieved the treatment goal of controlling the HIV virus. To achieve a comprehensive continuum DHSTS requires grantees to develop collaborative, partnering and coordinating relationships between multiple sources of HIV testing, treatment, care, and prevention service provider agencies on the state and local levels. A continuum for HIV prevention and care addresses the needs of PLWHA across all life stages, from those unaware of their HIV status, through HIV testing, linkage to care, retention in care and treatment adherence. The New Jersey HIV Continuum of Care is found at: http://www.state.nj.us/health/aids/documents/njhiv_care_continuum_living_2013.pdf

- women, specifically models for trauma-informed primary care to improve health outcomes. The principles of trauma-specific interventions are designed to address the consequences of trauma in the woman and to facilitate healing.
- stigma and discrimination, the NHAS emphasizes that HIV stigma is complicated with stigma associated with drug use, mental health, sexual orientation, gender identity, race/ethnicity, or sex work. DHSTS is mobilizing New Jersey to address stigma; applicants shall be supportive of these efforts through cooperative participation.
- patient-centered care to include addressing co-occurring conditions and challenges of meeting the patient’s basic needs.
- strong cooperation and collaboration between care and support service providers.
- mechanisms to work with partners of people living with HIV with appropriate linkages to PrEP resources.

DHSTS calls for implementation of a single continuous care plan that follows the individual living with HIV/AIDS through every stage towards reaching viral suppression. In order to achieve this, prevention, care, and support services must be population-based, clearly defined and coordinated to ensure that people who are infected with HIV are aware of their status, are linked to and actively engaged in care.

Science-based and evidence-based models of care will be supported through this RFA that are consistent with the goals of the NHAS and the HIV Continuum of Care. One example of science-based methodology is “The START” HIV Treatment Study findings (http://www.niaid.nih.gov/news/QA/Pages/STARTqa.aspx). Applications incorporating innovative linkage, adherence, retention, re-engagement and other strategies addressing each HIV Care Continuum (e.g., the integration of behavioral health with HIV care), are encouraged.

Other available resources include the Healthy NJ 2020; the New Jersey State Health Improvement Plan (SHIP); and the New Jersey State Health Assessment (SHA) http://www.state.nj.us/health/accreditation/documents/ship2012-2015.pdf; http://www.state.nj.us/health/chs/hnj2020/index.shtml.

IV. Eligibility Requirements for Applicants – there are no geographic boundaries for this RFA, it is open statewide.
This RFA describes eligible program activities, priority program activities, guidance in developing and submitting applications, and informs applicants of key dates.

The awarding of grants is on a competitive basis and is contingent on applications deemed fundable according to a review of public health officials and compliance with:

- The NJDHS Terms and Conditions for Administration of Grants
- Applicable Federal Cost Principles – Addendum to Terms and Conditions for Administration of Grants
- General and Specific Compliance Requirements – All applicants must adhere to

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specific guidance for Monitoring Expectations for State Monitoring Standards.

**Entities and organizations eligible to apply include:** appropriately licensed non-profit hospitals, Community-Based Organizations (CBOs), AIDS Service Organizations (ASOs), Medical Centers, community health centers, substance use treatment centers, homeless health centers, and mental health programs serving populations in need of HIV care services. Attach a copy of the facility license. Agencies must document nonprofit status (501-3C) and be in full compliance with all tax exempt 501-3C requirements and in full compliance with fiscal and programmatic requirements as indicated.

Any non-profit agency applying under this RFA must have been certified by the federal Internal Revenue Service (IRS) as a 501(c)(3) organization prior to January 1, 2015. A copy of the IRS certificate of non-profit status must be included as an attachment to this proposal. Proposals from non-profit organizations that are lacking documentation of tax exempt status will not be reviewed and will be ineligible to receive funding under this RFA.

All applicants must adhere to all NJDOH reporting requirements (N.J.A.C.8:57-2) for HIV infection and AIDS (http://nj.gov/health/cd/documents/njac857.pdf) and future revisions. In addition, approved applicants must adhere to the program and administrative specifications outlined within the Attachment C to be developed jointly by DHSTS and the applicant following the issue of Letters of Intent to Fund.

All grantees are required to participate in local Quality Management activities and linkage to care collaborations. This includes but is not limited to the Cross Part Collaborative, the Quality Management Steering Committee, Statewide Linkage to Care Meetings, regional collaborations, EIIAHs, and ERICs. DHSTS expects formal, signed MOAs with collaborators to ensure commitment.

Applicant agencies must demonstrate that they currently provide or have the capacity to provide extensive high quality, culturally competent, patient-centered services for which the agency is seeking funding. The agency must be located in areas where services will be provided and have provided the services requested in that area for at least the past two years.

Applicants must supply the credentials for each funded position requested. If a position is listed a vacant on Schedule C, please indicate the credentials required for the position.

All applicants must adhere to all New Jersey Department of Health reporting requirements (N.J.A.C.8:57-2) for HIV infection and AIDS (http://nj.gov/health/cd/njac857.pdf).

V. Pre-Proposal Conference

Applicants will be required to attend the mandatory pre-proposal conference in person, it is advisable to have a program and fiscal person attend. Pre-proposal Conferences have been scheduled for this RFA. The purpose of the Pre-Proposal Conference is to provide an overview of this RFA, describe the application review process, and answer prospective applicants’ questions. Organizations planning to apply for funding are strongly encouraged to participate in
a Pre-Proposal Conference.

The Pre-Proposal Conferences will be held at the following location, date and times:
371 Schwarzkopf Drive, Ewing, New Jersey 08628
In-person Pre-Proposal Conference, (two sessions 10:00 AM – Noon or 2 PM – 4PM)

Grant Period
The three-year funding cycle will run from July 1, 2016 to June 30, 2019 with annual grant renewal contingent upon the availability of funds, performance, and the continuation of program need.

VI. Eligible Services
This competitive RFA will fund an array of service categories along a continuum of comprehensive and coordinated HIV care services through state funds. The amount requested must correlate with the number of underserved PLWH who will be enrolled in and receive services from the applicant network as well as the scope of the proposal/project.

A. Service Categories
State Care and Treatment funding includes five (5) core medical services, and eight (8) support services that facilitate “People Living with HIV/AIDS’s (PLWA)” ability to access and remain in primary medical care and improve their medical outcomes. Ambulatory care will not be funded through this RFA. All services must be consistent with U.S. Department of Health and Human Services (HHS) treatment guidelines, the New Jersey Standards and Measures, and all other applicable professional regulations and licensure requirements. See http://www.aidsinfo.nih.gov for the recommended HHS treatment guidelines. The following core services listed below will be included in this RFA:

Core Services:
- **Medical Copays and Deductibles** – this service will provide financial assistance for ADDP eligible and active individuals living with HIV for medical copays and deductibles. Copay and deductible payment components will require the following:
  - Applicants must have a policy on Payer of Last Report that request change information from the patient at each interaction.
  - Applicants must have expertise in the Affordable Care Act; the Marketplace; Medicaid Expansion, and other third party payers.
  - Applicants must detail the methodology to interface with Managed Care Organizations (MCOs) and understand coverage.
  - Applicant must show evidence of a payment tracking system payable to various HIV clinics, FQHCs, laboratories, specialty service providers and a detailed the mechanism to track co-pays and deductibles that demonstrates sound accounting principles as it applies to all aspects of billing, reimbursement and reconciliation.
- **Medical Case Management** (MCM) (settings include community health clinics, and medical center facilities where the MCM is part of a clinical management team). Medical Case Management services must be provided by trained professionals (i.e., LSW) or medically credentialed, who provide a range of client- centered services that result in a coordinated care
plan which links clients to medical care and other supportive services. Credentials for all requested MCM personnel must be included in the attachments.

MCMs must be trained applications counselors and Medicaid assistors. These services ensure timely and coordinated access to medically appropriate levels of health and support services. Medical case management must include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) request for changes to the patient’s insurance, income, marital status, etc. at each visit and documented in the patient chart.

- **Medical Nutrition Therapy** – provides medical nutritional therapy by a licensed registered dietitian outside of an outpatient/ambulatory medical care visit. Food may be provided pursuant to a physician’s recommendation and a nutritional plan developed by a licensed, registered dietitian. Nutritional services and nutritional supplements not provided by a licensed, registered dietitian will be considered a support service. Additional services may include individual counseling and group counseling. The credentials of the nutritionist must be included in the required attachments.

- **Mental Health Services** - provides psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. Credentials for mental health professionals must be included in the required attachments.

- **Oral Health Care Services** - provides diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers. Credential of professional staff must be included in the required attachments.

The following support services listed below are included in this RFA:

**Support Services**

- **Case Management – Non-medical** - includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does, however, a cooperative and collaborative relationship between the Medical Case Manager and the Non-medical Case Manager is required for coordination of medical and support services.

- **Emergency Financial Assistance** - provides limited one-time or short-term payments to assist clients with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
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 funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

- **Food Bank/Home Delivered Meals** – refers to the provision of actual food items, hot meals, or a food voucher program to purchase food. This also includes the provision of non-food items that are limited to the following: personal hygiene products and household. Unallowable costs include household appliances, pet foods and other non-essential products.

- **Housing Services** - provides short-term assistance (up to 2 years) to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

- **Legal Services** – provides services to individuals are limited to powers of attorney, do not resuscitate orders and 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 Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. It does not include civil litigation not related to HIV such as divorces. Legal services may include: assistance with public benefits such as Social Security Disability Insurance (SSDI); interventions to ensure access to eligible benefits; including discrimination or breach of confidentiality litigation as it relates to HIV; preparation of power of attorney, durable powers of attorney, living wills. Permanency planning and income tax preparation that are required by the Affordable Care Act for all individuals receiving premium tax credits.

- **Medical Transportation Services** – provides for conveyance services directly or through voucher, to a client so that he or she may access HIV-related health care and supportive services.

- **Outreach** – DHSTS will fund Community Health Workers (CHWs) - Trained CHWs’ role in the community varies and depends on locale. CHWs’ activities are tailored to meet the unique needs of their communities. Community Health Workers (CHWs) shall be lay members of communities working in formal collaborations with the local health care system in both urban and/or rural environments who share HIV status, ethnicity, language, socioeconomic status, and life experiences with the community members they serve. CHWs will outreach to those lost to care via telephone or home visits; identify people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding); treatment adherence; offer interpretation and translation services; provide culturally appropriate health education and information; assist people in receiving the care they need; give informal counseling and guidance on health behaviors, advocate for individual and community health needs. Community Health Worker will covers provision of non-medical counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by nonmedical personnel outside of the medical case management and clinical setting.
• **Psychosocial Support Services** - provides support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a nonregistered dietitian but excludes the provision of nutritional supplements.

**Unallowable Services and/or Expenses:**
Examples of services that are not allowable include: (Please note this list is not exhaustive, if you are not sure if an item is covered, contact DHSTS.)

- HIV prevention/risk reduction for HIV-negative or at-risk individuals.
- Funds should NOT be used for off-premise social/recreational activities or to pay for a client's gym membership. Ryan White funds cannot support parties, picnics, structured socialization, athletics, etc.
- Non-client-specific or non-service-specific advocacy activities.
- Services for incarcerated persons, except transitional case management, per HRSA policy Notice 7 04.
- Costs associated with operating clinical trials.
- Funeral, burial, cremation or related expenses.
- Funds awarded under the State Program may NOT be used for direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees. This restriction does not apply to vehicles operated by organizations for program purposes.
- Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Criminal defense or class action suits unrelated to access to services eligible for funding under Ryan White.
- In no case may State Program funds be used to make direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Grantees are advised to administer voucher programs in a manner which assures that vouchers cannot be used for anything other than the allowable service, and that systems are in place to account for disbursed vouchers.
- Inpatient services.
- Installation of permanent systems for filtration of all water entering a private residence.
- Professional licensure or to meet program licensure requirements.
- Fund raising. Federal funds cannot be used for organized fund raising, including financial campaigns, solicitation of gifts and bequests, expenses related to raising capital or contributions, or the costs of meetings or other events related to fund raising or other organizational activities, such as the costs of displays, demonstrations, and exhibits, the cost of meeting rooms, and other special facilities used in conjunction with shows or other special events, and costs of promotional items and memorabilia, including gifts and souvenirs. These costs are unallowable regardless of the purpose for which the funds, gifts or contributions will be used.
• Transportation for any purpose other than acquiring medical services or acquiring support services that are linked to medical outcomes associated with HIV clinical status.
• Transportation for personal errands, such as grocery shopping, other shopping, banking, social/recreational events, restaurants, or family gatherings is not allowed.

B. Funding Requirements
All Care and treatment clients must be linked to or are receiving ambulatory/outpatient medical care. All applicants must describe how they will ensure and document this requirement. Inpatient services will not be funded. Applicants must describe how they ensure the medical care they provide is consistent with the most current HHS standards of care and treatment guidelines and all other applicable professional standards. For more information about the most recent HHS guidelines visit: http://www.aidsinfo.nih.gov/Guidelines.

Applicant agencies must demonstrate how they will collaborate and coordinate care with support and prevention services provided by AIDS Service Organizations (ASOs) and Community-Based Organizations (CBOs). Letters of Support from collaborating agencies are required to demonstrate meaningful patient-centered relationships between agencies.

C. Program and Fiscal Monitoring Standards
DHSTS requires that all Care and Treatment grantees meet all responsibilities outlined in the New Jersey Fiscal Standards Manual.

Applicants shall meet all DHSTS service definitions, standards and measures.

Any grantee found to be non-compliant with the standards at any time will be held responsible and required by DHSTS to restore any damages and/or costs associated with grantee noncompliance.

Program Income:
DHSTS requires that service delivery efforts are coordinated with all public funding for HIV/AIDS to:
1) ensure client is appropriately screened for service eligibility using Ryan White Part B/ADDP eligibility standards, 2) maximize the number and accessibility of services available, and 3) reduce any duplication.
• Applicants shall report funding from other sources, to include Part A, that supplement the services requested in the application Applicants shall provide a justification for the additional funding.
• Grantees are expected to vigorously pursue Medicaid enrollment for individuals who are likely eligible for coverage, to seek payment from Medicaid when they provide a Medicaid-covered service for Medicaid beneficiaries, and to back-bill Medicaid for Ryan White-funded services provided for all Medicaid-eligible clients upon determination. Medicaid coverage may start retroactively for up to 3 months prior to the month of application. Grantees must make every effort to expeditiously enroll individuals in Medicaid if eligible and inform clients about any consequences for not enrolling. DHSTS funded Medical Case Managers must be Certified Applications Counselors (CACs) for the Marketplace
and trained to complete Medicaid applications to better facilitate health care coverage. Once an individual is enrolled in Medicaid, grant funds may be used to pay for any medically necessary services which Medicaid does not cover or only partially covers, as well as premiums, co-pays, and deductibles if required. Certificates of completion for CAC online or other courses must be included in the required attachments.

**Indirect Cost Rate**
Indirect costs mean those costs incurred for a common purpose. Indirect costs benefit more than one cost objective and are not directly assignable to those cost objectives that are specifically benefitted. An approved federal indirect cost rate can be applied equitably across all of the State Care activities, according to the benefits each gains from them. Indirect costs must be reasonable and will be subject to negotiation, allowable and allocable to the grant. Applicants must provide a detailed list for indirect cost. All associated costs must be specified within the line item budget. The grantee must submit a copy and keep on file an HHS-negotiated, federally approved Certificate of Cost Allocation Plan or Certificate of Indirect Costs. Indirect costs may include but are not limited to:

- Office space rental;
- Utilities;
- Costs of management oversight including program coordination;
- Salaries for clerical, financial, and management staff not directly related to patient care;
- Program evaluation;
- Liability insurance;
- Audits; and
- Computer hardware/software not directly related to patient care.

**Administrative Cost**
Administrative costs must be reasonable and itemized in the budget section of the application. Administrative costs must be reasonable, allowable and allocable to the grant and will be reviewed prior to any grant award. Administrative costs may include but are not limited to:

- Routine grant administration and monitoring activities, including the development of applications and the receipt and disbursal of program funds;
- Development and establishment of reimbursement and accounting systems;
- Preparation of routine programmatic and financial reports;
- Compliance with grant conditions and audit requirements;
- All activities associated with the subrecipient’s contract award procedures, including the development of requests for proposals, grantee and contract proposal review activities, negotiation and awarding of contracts;
- Subrecipient monitoring activities including telephone consultation, written documentation, and onsite visits;
- Reporting on contracts, and funding reallocation activities; and
- Related payroll, audit and general legal services.
Administrative costs may include but are not limited to:

- Routine grant administration and monitoring activities, including the development of applications and the receipt and disbursal of program funds;
- Development and establishment of reimbursement and accounting systems;
- Preparation of routine programmatic and financial reports;
- Compliance with grant conditions and audit requirements;
- All activities associated with the recipient’s (grantee's) contract award procedures, including the development of requests for proposals, grantee and contract proposal review activities, negotiation and awarding of contracts;
- Grantee monitoring activities including telephone consultation, written documentation, and onsite visits;
- Reporting on contracts, and funding reallocation activities; and
- Related payroll, audit and general legal services.

State funded grantees are responsible for establishing and maintaining written procedures for allocating and tracking funds applicable detailing a reasonable administrative cost and program income that meet New Jersey Fiscal Standards. I will check with Steve we are using the same language

D. Unallowable Expenses
Stipends are not an allowable expense for care and treatment program funds. Funds may not be used to make cash payments to recipients of services. Funds may not be used to make payment for any item or service if payment has already been made or can be paid under any state compensation program. Funds may not be used to purchase or improve land or to purchase, construct or make permanent improvement to any building

E. Data Collection and Reporting
All state care and treatment providers must be able to track and report unduplicated client-level demographic, medical and other service data in CAREWare. Failure to do so may result in the suspension or termination of your grant with DHSTS. All providers will be required to complete HIV/AIDS Program Services Report) and any other State-identified reports that may be required. All providers will be required to collaborate with and share clinical information with the coordinated medical case management system. Medical Case Management must be co-located within the clinical setting and medical case managers must have access to the Electronic Medical Records and participate in interdisciplinary case conferences. In addition, all providers will be required to provide DHSTS with timely and accurate client level data. Failure to comply with data requirements can result in the termination of an agency’s contract with DHSTS.

F. Quality Management
DHSTS expects Care and Treatment Program grantees to establish quality management programs to improve quality of care for the PLWH. HRSA provides information related to quality management may be found online at: http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html.
State applicants can access HRSA technical assistance in selecting appropriate service and client-level outcomes is available online at: ftp://ftp.hrsa.gov/hab/oehowfin.pdf or http://careacttarget.org.

DHSTS will evaluate the QM Plans on an annual basis, including rating the completeness of goals and key activities undertaken during the year, and results are used to:

a. Determine the effectiveness of the QM Plan infrastructure and activities;
b. Review annual grantee goals for Attachment C, identify those that have not been met, as well as the reasons these goals were not met, and assess possible strategies to meet them before the next review. DHSTS will refine strategies for the following year.

Grantees will be required to select one Quality Improvement Project per year addressing any one of the items from a recent PSDA or one selected by the clinical team. Regular feedback regarding overall QI is critical in sustaining improvements over time. Examples include but are not limited to: patient satisfaction, health insurance literacy, retention, adherence, re-engagement, etc.

Support service providers will be required to select one QI project annually addressing an area of program improvement.

G. Payer of Last Resort
As with Ryan White funding standards, State funded providers are required to coordinate their services and seek payment from other sources before State funds are used. Major payers include, for example, Medicaid, Medicare, the Children’s Health Insurance Program (CHIP), and private health insurance. Medical and non-medical case managers are required to be health insurance applications counselors and familiar with all aspects of health literacy. Failure to do so may result to the suspension or termination of your grant with DHSTS.

H. Cultural and Linguistic Competence
Applicants are advised that all service providers must deliver services in a manner that is culturally and linguistically competent, which includes addressing the limited English proficiency (LEP) and health literacy needs of clients. HRSA defines cultural and linguistic competence as "a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural and linguistically diverse situations."

Healthcare providers funded via state grants need to be alert to the importance of cross-cultural and language appropriate communications and general health literacy issues. DHSTS supports and promotes a unified health communication perspective that addresses cultural competency, limited English proficiency, and health literacy in an integrated approach in order to develop the skills and abilities needed by State-funded providers and staff to deliver the best quality health care effectively to the diverse populations they serve.
For additional information on HHS guidelines on cultural competency, see the Office of Minority Health National Standards on Culturally and Linguistically Appropriate Services (CLAS) at: https://www.thinkculturalhealth.hhs.gov/content/about_tch.asp.

Health Literacy, to include Health Insurance Literacy - many PLWHAs will not grasp basic insurance terms. A study of people eligible to enroll in the marketplaces showed that many were not confident in their understanding of a premium (36%), deductible (31%), copayment (28%), coinsurance (48%), maximum annual out-of-pocket spending (38%), provider network (36%), covered services (35%), annual limits on services (39%) or excluded services (40%). People with lower incomes were even less likely to understand the key elements of insurance.

DHSTS requires that all state funded employees be trained in Health Literacy and that routine Health Literacy discussions take place and are documented in the client’s chart. Health Literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate decisions about their care and services need to prevent or treat illness. Health Literacy is lowest among the more vulnerable members of our communities. HRSA’s two course online training in Health Literacy is found at www.train.org and proof of successful completion of the series is a requirement for all state funded position, and must be submitted to Rutgers, Bloustein.

I. Joint Proposals
Non-clinical community-based testing sites continue to identify new infections among those who identify as members of a high-risk group, e.g., gay men, and should augment HIV screening in clinical settings. These non-clinical sites contribute to lowering rates of unknown HIV infection by reaching individuals who seek testing outside medical settings for any number of reasons, including an affinity with the testing site or organization, physical or psychological safety, privacy, and/or convenience.

DHSTS is committed to the concept of a cooperative and collaborative system of care that achieves seamless services across HIV Care and HIV Prevention meeting all of the client’s needs in an effective and efficient manner.

DHSTS strives for improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration between clinical and non-clinical entities thereby offering opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) enabling service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies.

In order to ensure a seamless HIV Care Continuum, DHSTS encourages linkages and collaborations between service providers and to promote co-location of services, an organization may submit a proposal on behalf of other organizations, consortia, or coalitions. The organization that submits the proposal will be designated as the lead organization to contract with DHSTS, should funding be awarded.
An organization that submits a proposal as the lead agency on behalf of multiple providers cannot submit another proposal within that same service category. An organization that is included as a subcontractor or non-lead participant in a multi-provider proposal must not submit a proposal as a lead or sole applicant in that service category.

VII. Submission Guidelines
DHSTS will accept one application from a single entity

A. Required Format for Proposal Program Narrative
All proposals must include a separate program narrative for each care service. Program narratives must include the following: a documented and detailed program plan including an organizational history, an assessment of need, program goals and objectives, program methods, program evaluation plan and staffing/management plan, and a line-item budget with full justification on forms provided and supporting documents attached as appendices. Materials in the appendices are limited to required attachments and supporting documentation for statements made in the narrative. Information that should be part of the basic program plan will not be considered for review if placed in the appendices rather than in the program narrative.

B. Application Content
All applications must contain the following sections:

1. The page limit for the narrative is 20 double spaced pages at Calibri 12-point font and standard 1 inch margins. Applications that exceed 20 pages will not be reviewed. Required attachments and budget pages will not be counted against the 20 page limit.

2. A Project Abstract (page limit: one page single spaced, Calibri 12 point, 1-inch margins) must be completed, and must contain a summary of the proposed activity suitable for dissemination to the public.

3. History of applicant (10 points): State why your organization is well equipped to make the proposed program work. Described within this section formal and informal agreements that exist, or that will be established with providers, other agencies, and community-based organizations to further the accomplishments of the objectives of the program.

4. Needs assessment (20 points): Describe the particular service preference and unmet needs of the proposed population and the manner in which these needs were determined and verified. Also provide data on the existing medical and social services available to address the health problems of those infected with HIV/AIDS. Identify the gaps in services. Explain why the data presented justify the funding of the applicant’s program in the target area.

5. Goals and objectives (20 points): Describe the overall goals (outcomes) for the proposed project and the specific, measurable objectives (process and outcome) to be followed in achieving each goal. SMART objectives are required, objectives must be Specific, Measurable, Achievable, Realistic, and Time scaled. At a minimum, the applicant must include, as an objective, the number of unduplicated clients to be enrolled in the
program year per service. In addition, the application must include the number of service units to be provided during the year as well (e.g., visits, overnight stays, encounters, etc.). All objectives must include specific and measurable indicators of performance.

6. **Methods** (20 points): Each objective must have a corresponding method. Describe how the applicant will establish and provide program activities in a setting that is culturally appropriate and safe space.
   a. Describe how members of the target population(s) will be involved in planning and implementing the proposed services and how the applicant will ensure that services continue to be responsive to the needs of the target population. For example, include results from satisfaction surveys, focus groups, etc.
   b. Describe the activities you will engage in to accomplish each process and outcome objective described above.
   c. Detail the hours and days of operation and the credentials of staff providing the service.

7. **Management and staffing plan** (10 points): Describe how the proposed project will be managed and staffed to best achieve desired goals and objectives.

8. **Evaluation and quality assurance** (10 points): Each method must have a corresponding evaluation component. Describe how you will evaluate the success of each service and ensure that required data are submitted to DHSTS through CAREWare. If the services are already in place and funded include the Quality Improvement Plan for each service.

9. **Budget justification** (10 points): Describe and justify the necessity and reasonableness of all funds requested. All grantees must adhere to the State Fiscal Monitoring Standards.

10. **Attachments** (not scored) but will be assessed for completeness.

Specific guidance for HIV Care and Treatment eligible services will be provided during the TA session, additional resources are listed below:

- [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5804a1.htm?s_cid=rr5804a1e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5804a1.htm?s_cid=rr5804a1e)
- [http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html](http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html)
- [http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html](http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html)

Applications for case management service must adhere to the DHSTS Case Management Standards (documents will be provided during TA session).

Applications not adhering to the above guidelines will be deemed ineligible and will not be reviewed.

**C. Review Criteria**
An RFA Review Committee will review proposals according to the criteria described below. The DHSTS reserves the right to render final decisions on the awarding of Health Service Grants under this RFA. Among the questions to be considered when scoring applications are the following:
History of The Applicant Organization (10 points)
Does the proposal include a relevant discussion of the applicant’s primary mission, scope of services and achievements, and longevity of service provision in the targeted catchment area? Does it describe their organizational structure and personnel and indicate where within that structure the proposed program will fit?

Does the applicant explain and provide documentation to substantiate that the organization currently services the target population for which they are applying to serve?

Does the agency provide substantiated data regarding previous levels of client HIV services? That is, do they demonstrate their history with regard to previous HIV services by including in their appendices copies of program process and outcome data that they have previously submitted to a funder?

Does the applicant provide evidence of their history and ability to work with a variety of organizations and governmental programs, especially with those agencies providing services to people living with HIV?

Does the applicant demonstrate evidence of cultural competency, patient-centeredness in providing HIV services to the target populations? Has the applicant referenced the Office of Minority Health National Standards on Culturally and Linguistically Appropriate Services (CLAS) at: https://www.thinkculturalhealth.hhs.gov/content/about_tch.asp?

Needs Assessment (20 points)
Has the applicant characterized the geographic locale (e.g., county, neighborhood, section of town, etc.) within the project catchment area?

How well has the applicant characterized the proposed target population in demographic terms (e.g., race, ethnicity, gender, age, social-economic factors, etc.)?

How well has the applicant characterized the proposed target population’s current behavioral risk factors, HIV test seeking behavior, and or access and utilization of care services? Did applicant include documentation on how these factors were determined?

Has the applicant described barriers to HIV service delivery within the community and/or the largest population that may reduce the effectiveness of the proposed interventions and/or service delivery, and has the agency adequately explained how it will overcome these barriers?

How well has the applicant described the HIV program preferences (e.g., hours of the day when services are available, setting(s) in which services are made available)?

How well has the applicant described the level of current care and treatment available within the proposed geographic locale? Has the applicant identified the other agencies that are providing HIV prevention or counseling and testing services and clearly stated how the proposed program will
relate to those existing services, identifying what specific service gaps this proposed program will seek to meet?

Goals and Objectives (20 points)
Has the applicant clearly specified the program goal(s) to be achieved during the grant year? Are the goals reasonable and achievable?

Has the applicant clearly specified the program process objectives for the proposed grant year and are they specific, realistic, time-framed, and measurable.

Has the applicant clearly specified the program outcome objectives for the grant year and are they specific, realistic, time-framed, and measurable?

Methods (20 points)
Is a clear and reasonable method detailed for each process and outcome method specified above?

Does the applicant provide a time table for implementation of proposed methods?

Does the applicant specify the number of clients that each service is intended to reach during the grant year?

Are the proposed methods adequate to document that referrals made are kept by clients?

How adequate are the proposed means by which clients will be recruited for services (i.e., how and where will the specified target population be accessed by staff of the proposed program)?

Does the applicant detail how it will market the program in the community, and is that marketing plan adequate?

Does the applicant specify the means by which client retention issues will be addressed and resolved, and are those means adequate?

Does the applicant show evidence and concurrence with the NHAS 2010 and 2020?

Does the applicant address each element of the HIV Continuum with emphasis on re-engagement and retention, refer to Attachment 1?

How adequate is the applicant’s plan for accessing and enrolling people living with HIV/AIDS into the proposed services?

Does the applicant demonstrate a clear and workable plan for integrating other co-morbidities into the proposed program?

Has the applicant provided an adequate plan for ensuring that services will be delivered in a culturally competent manner that meets the specific needs of the proposed target population?
Does the applicant address the social determinants of health and cooperative/collaborative approaches to address the social determinants?

Does the applicant demonstrate how services will be delivered in a culturally competent, patient-centered manner with attention to the co-occurring conditions that impact stigma, to include but not limited to drug use, mental illness, sexual orientation, gender identity, race/ethnicity, or sex work?

Does the applicant describe how stigma and discrimination is addressed systemically within the agency?

Does the applicant describe how Health Literacy will be routinely integrated in patient care?

Has the applicant provided the agency’s overall current operating budget and sources of other HIV funding?

Does the applicant have a comprehensive method of verifying that all clients receiving state sponsored core and/or support services have no other means of acquiring (i.e., insurance, public entitlement) these services? Has the applicant provided the specifics inclusive of how often the verification process will be conducted throughout the grant year? (The verification process must be held at least every six months but preferably more often.)

Does the applicant describe compliance to all HIPAA requirements and methods to ensure that client confidentiality will be protected?

Management and Staffing Plan (10 points)
Does the proposed staffing plan include adequate full-time employees of the applicant agency who will be working on the proposed project 100% of their time to ensure the success of the project?
Does the applicant specify hours per week devoted to the project, their proposed titles, their roles and responsibilities, required education and/or experience, and determined and listed a supervisor for each staff member?

Does the proposed staffing plan include adequate part-time employees of the applicant agency to assist full-time staff in meeting stated goals and objectives? And, does the applicant specify their hours per week devoted to the project, their proposed titles, their roles and responsibilities, any required education and/or experience, and who will supervise each one?

To what extent has the applicant committed any in-kind activities to be provided by existing staff of the applicant agency that will support the proposed program? Has the applicant included process objectives relating to program staffing and recruitment for the first six months of the proposed program and included the names and qualifications of any proposed staff member who may already be identified at the time of writing this application?
Has the applicant specified the capacity building and training needs of the proposed staff and provided an adequate plan to meet those needs?

**Evaluation and Quality Assurance Plan (10 points)**
Does the applicant describe how it will measure the specific proposed program outcomes referred to in the Goals and Objectives section of this program narrative? Is a description of the instrument, data analysis, and dissemination plan included?

Does the applicant describe how it will measure the proposed process milestones referred to in the Goals and Objectives section of the program narrative?

Does the applicant address the ten NHAS indicators?

Does the applicant specify which agency staff member(s) will be responsible for completing and submitting required client-level data collection forms to the DHSTS utilizing CAREWare?

Does the applicant specify which agency staff member(s) will be responsible for evaluating the progress toward meeting the program narrative’s stated goals and objectives, including the need to alter program activities, communicating with DHSTS regarding proposed changes, and implementing approved program changes?

Does the applicant clearly state that it will comply with all data collection and evaluation protocols specified and outlined by the DHSTS (i.e., CAREWare).

**Budget and Justification including Budget Allocation Worksheet (BAW) (10 points)**
Is the Budget Allocation Worksheet (BAW) completed?

Does the proposal clearly show that funds will not be used to replace existing program costs?

Has the applicant adequately justified all operating expenses in relation to stated objectives and planned activities? Are there any expenses included in the budget that do not clearly relate to the goals, objectives, and methods included in the proposal?

Has the applicant provided a job description for each key position, specifying job title, function, general duties, activities, and level of effort and percentage of time spent on activities relating to the proposed program? If the identity of any key personnel who will fill a proposed position is known, has his/her name and resume been included in the appendices?

If the identity of staff is unknown, has the applicant provided a detailed recruitment plan?

**D. Review Procedures**
Applications will be screened for completeness. Screening tools that will be used to evaluate an application’s completeness, including a checklist and a fiscal guidance document. The checklist will be provided during the TA session. Only those proposals deemed to be complete and in
compliance with the programmatic and fiscal requirements will be sent to the RFA review committee.

An RFA review committee is comprised of representatives of several different divisions of state government. Outside reviewers may be utilized as requested or as deemed appropriate. Proposals will be rated on criteria, which appear in the “Review Criteria” section of this document. The DHSTS reserves the right to render final decisions on the awarding of state 2016 care and treatment funds under this RFA.

Submission of Applications
If you are a first time applicant whose organization has never registered in NJSAGE, you must contact the Grants Management Officer, complete a New Agency form, and submit it to NJDOH. NJDOH will verify certain information to ensure you satisfy NJDOH requirements. When the requirements are met, the organization will be validated in NJSAGE. In order to initiate an application after agency approval, you must have permission to access the application. Please see below and contact the Grant Management Officer specified for access.

E. Instructions for New Agency:
1. Complete the FORM for Adding Agency Organizations into NJSAGE
2. Identify your validated Authorized Official, or if none, have the Authorized Official register as a new user. The new user (Authorized Official) will be validated when the organization is validated and assigned to the organization.
3. Sign a hard copy of the FORM For Adding Agency Organizations Into NJSAGE and submit via a FAX or as an email attachment to Cynthia Satchell
   a. FAX – 609-633-1705
   b. Email: Cynthia.Satchell@doh.nj.gov

NOTE: If you have previously applied in NJSAGE, please do not reapply. Your Organization information has already been established.
THE BAR BEFORE THE BARS

Overall:
Of all Americans diagnosed with HIV, only 25% are virally suppressed.

Stigma and other social determinants influence the HIV care continuum before a diagnosis is even made.

NASTAD
According to CDC estimates, only 37 percent of people living with HIV are engaged in care, thereby minimizing rates of viral suppression in the United States (gray). Ongoing research, implementation, and evaluation of strategies to successfully link, retain, and reengage people in care are critical to improving outcomes across the continuum (red).
DIRECTIONS
Public Health Environmental and Agricultural Laboratory (PHEAL)
New Jersey State Police Headquarters Complex

All Employees, Couriers, Vendors and Visitors
USE ALTERNATE ENTRANCE
6:00 AM – 6:00 PM,
Monday – Friday (non-holidays)

Directions to ALTERNATE ENTRANCE

From I-195 West (OPTION A)
Take I-195 West to I-95 North. I-95 North becomes I-95 South (one continuous road). Follow I-95 South to Exit 2, (Rte. 579 Trenton-Mercer Airport). At the exit ramp bear right toward West Trenton. At the second light, make a right on Upper Ferry Road. Follow Upper Ferry Road about 3/4 mile to State Police Entrance, on your right. Note: Entrance is shortly after the large brick church on the left. Proceed to the guard station and show ID. At the STOP sign adjacent to the guard station, make a right and proceed up the hill to the second driveway on the left. The large glass building on your left is the PHEAL building.

From I-195 West (OPTION B)
Take I-195 West, continue straight at the interchange with I-295, and bear left as the road divides to continue on Route 29. After the Route 29 tunnel by the Riverfront Park baseball stadium, proceed 6 miles north along the Delaware River to the stop light for Upper Ferry Road (Route 175) and turn right, following the sign for the State Police Headquarters. Proceed past Villa Victoria Academy on your left and stay straight on Upper Ferry Road, not turning left on Route 175/River Road (do not follow the Route 175 sign) for 3/4 mile to the State Police Complex Entrance. Paulie's Restaurant will be on your left just before the State Police Complex Entrance. Turn left and proceed to the guard station and show ID. At the STOP sign adjacent to the guard station, make a right and proceed up the hill to the second driveway on the left. The large glass building on your left is the PHEAL building.

From NJ Turnpike (north or southbound)
Take turnpike to exit 7A West. Follow signs for I-195 West. Follow OPTION A or OPTION B above.

From the South via Rte 206 North
Take Route 206 North to I-195 West. Follow OPTION A or OPTION B above.

From the West and South via Pennsylvania Turnpike/ I-95 North:
Take PA Turnpike East to Exit 28 North. This will put you on Route 1 North. Follow Route 1 North to Interstate I-95 North. Take Interstate I-95 North and proceed across Scudder’s Falls Bridge. Take Exit 1 (which exits before the bridge ends) and get onto Route 29 South. Make a left turn at the first traffic light (175 North). Continue less than one mile on Route 175 North past Villa Victoria Academy. Stay straight – onto Upper Ferry Road. (Route 175 North/River Road bends to the left – do not follow the 175 sign.) Turn left at State Police Complex Entrance, just past Paulie’s Restaurant. Proceed to the guard station and show ID. At the STOP sign make a right and proceed up the hill, to the second driveway on the left. The large glass building on your left is the PHEAL building.