REQUEST FOR APPLICATIONS - RFA # RW1-18

FOR

THE PROVISION OF OUTPATIENT AND AMBULATORY
HEALTH AND SUPPORT SERVICES,
FOR INDIVIDUALS WITH HIV DISEASE AND THEIR FAMILIES

AS AUTHORIZED BY THE

RYAN WHITE HIV/AIDS EXTENSION ACT

PART A
SPECIFICATION FOR THE PROVISION OF OUTPATIENT AND AMBULATORY HEALTH AND SUPPORT SERVICES, FOR THE RYAN WHITE PROGRAM

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This RFA is funded 100% by Ryan White Part A grant funds.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, September 12, 2018</td>
<td>Request For Applications (RFA) advertised and released. RFA packages may be obtained from the Hillsborough County Health Care Services Department website address: Link: <a href="http://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-white-rfa">http://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-white-rfa</a> Call 813-272-6935 with any questions.</td>
</tr>
<tr>
<td>Friday, September 21, 2018</td>
<td>RFA Pre-submittal Conference, 9:00 A.M. EST at the County Center, 601 E Kennedy Boulevard, 16th Floor Conference Room, Tampa, FL 33602, will be held to answer questions from those planning to submit Applications.</td>
</tr>
<tr>
<td>Tuesday, September 25, 2018</td>
<td>Deadline for written requests for interpretation to be included as Addenda to this RFA. E-mail Aubrey Arnold at: <a href="mailto:Arnolda@HCFLGov.net">Arnolda@HCFLGov.net</a></td>
</tr>
<tr>
<td>Tuesday, November 13, 2018</td>
<td>Deadline for submitting Applications to the Hillsborough County, Health Care Services Department, Ryan White Section, 601 E. Kennedy Blvd, 16th Floor, Tampa, FL 33602. Applications submitted after 5:00 p.m. Eastern Standard Time (EST) will not be accepted.</td>
</tr>
<tr>
<td>Tuesday, November 13, 2018</td>
<td>Applications will be opened at 5:15p.m. EST.</td>
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<tr>
<td>Wednesday, November 14, 2018</td>
<td>Applicants notified regarding qualification/disqualification.</td>
</tr>
<tr>
<td>Thursday, November 29, 2018</td>
<td>RFA Evaluation Teams finalize scoring and ranking of responses for funding recommendations.</td>
</tr>
<tr>
<td>Thursday, November 29, 2018</td>
<td>Recommendations posted in Health Care Services, the Ryan White offices, and the Public Information office. Applicants notified of recommendations and scheduled for contract review appointments.</td>
</tr>
<tr>
<td>Wednesday, December 12, 2018</td>
<td>Grievances and Appeals due no later than 5:00 p.m. EST. They must be submitted to Aubrey Arnold, Hillsborough County Health Care Services Department, 601 East Kennedy, 16th Floor, Tampa, FL 33602.</td>
</tr>
<tr>
<td>Friday, February 8, 2019*</td>
<td>Agenda Deadline: Final Contracts must be submitted to the County Administrator for inclusion on the February 2018, BOCC meeting.</td>
</tr>
<tr>
<td>At the February 20, 2019, BOCC Meeting.*</td>
<td>Contracts submitted to BOCC for approval.</td>
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If you have questions about this schedule, call Aubrey Arnold at 272-6935.

*These dates may change, as the BOCC calendar for 2019 has not been finalized.
B. INTRODUCTION AND PURPOSE

1. BACKGROUND AND STATEMENT OF NEED

Hillsborough County, a political subdivision of the State of Florida, hereafter referred to as COUNTY, is the recipient of Part A of the Ryan White Extension Act federal grant. The Ryan White program provides HIV-related health and support services within the service areas detailed below. Part A’s Eligible Metropolitan Area (EMA) is comprised of Hillsborough, Pinellas, Pasco, and Hernando counties. The Ryan White CARE Act Title I (now known as Part A) HIV Health Services Planning Council was established and designated by the COUNTY as described in the CARE Act. A similar entity was established for Title II (now known as Part B) and was known as the Consortium. The Title I HIV Health Services Planning Council and the Title II Consortium merged on September 1, 1999, and the resulting entity is known as the West Central Florida Ryan White Care Council. Hereafter, the West Central Florida Ryan White Care Council will be referred to as the Care Council. The Care Council is responsible for establishing priorities for the allocation of Part A and Part B funds. Part B funds are administered by the Florida Department of Health, Pinellas County Health Department. The priorities are based on surveillance data of the local AIDS/HIV epidemic and a comprehensive Needs Assessment. The Hillsborough County Health Care Services Department, hereafter referred to as DEPARTMENT, is responsible for administering the Part A program for the COUNTY.

The COUNTY seeks the services of qualified agencies to provide health and support services to eligible individuals and their families.

2. STATEMENT OF PURPOSE

The purpose of the Part A program is to augment the health care systems currently bearing the burden of HIV-related care. The purpose of funds awarded under this RFA is to enhance available HIV-related health and support services by funding providers to increase needed services. Hillsborough County is issuing this RFA in order to select the applicants best qualified to deliver needed services to individuals and families with HIV disease within the four county area.

3. ORGANIZATIONS/AGENCIES ELIGIBLE TO APPLY

Service providers meeting the following criteria are eligible to apply for funding under this RFA:

a. Public or nonprofit private entities, including hospitals (which may include Veterans Administration facilities), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, and homeless health centers.

For-profit agencies are eligible to be service providers ONLY in the absence of qualified nonprofit agencies able and willing to provide quality service.

b. Private entities must be incorporated, or be authorized to do business in Florida, and have a local office, representative and a local phone number.

c. Provide services to residents of Hillsborough, Pinellas, Pasco, and Hernando counties in the respective county.

d. If the service, which is being applied for, is eligible for Medicaid reimbursement, then the applicant must be a Medicaid provider at time of application. The Public Law requires that any eligible services to a Medicaid eligible patient must be billed to Medicaid rather than Ryan White. Likewise, all services covered by any other insurance policy, benefits/assistance program must be billed to that other payor. If the client does not have sufficient funds to cover his/her co-payments associated with another payor the case manager may authorize the provider to bill the COUNTY for said co-payment(s). The service providers assume the financial risk for providing services for which other sources of funding could reasonably have been anticipated or determined.

e. Perform one of the eligible services listed in this RFA.
4. CLIENT ELIGIBILITY

Client eligibility for services under this RFA and resulting HIV-Services Agreements shall be determined on the basis of verification of HIV infection, a diagnosis of AIDS, or being an affected family member of such a person. Service providers contracted under this RFA must obtain and keep on file written documentation of seropositivity of all clients or the seropositivity of family members of affected clients. Service providers contracted under this RFA shall assume the financial risk for providing services to individuals not testing HIV positive, for providing services to individuals who the service provider has not documented as HIV positive, or providing services to individuals who have no HIV-positive family member. Service providers shall also assume the financial risk for providing services for which other sources of funding could reasonably have been anticipated or determined.

The Care Council may develop additional eligibility criteria for recipients of services, provided they do not violate any state or federal law, rule or regulation. PROVIDERS assume the financial risk for providing services to individuals who do not meet the eligibility criteria. The PROVIDER will be notified of eligibility criteria or any changes and will be allowed 30 days to implement the change, if applicable.

Funds awarded under this RFA may only be used for services to affected individuals as outlined in HRSA Program Policy Notice No. 97-01, Issued February 1, 1997; see SECTION G, EXHIBIT 3, HRSA Policy Notices.

5. Strategy for Early Identification of Individuals with HIV/AIDS (EIIHA):

The 2000 legislation required a new focus on reducing unmet need – finding people who know they are HIV+ and helping them enter and remain in HIV-related medical care. The 2006 legislation maintained the requirement and added a focus on people living with HIV/non-AIDS as well as people living with AIDS. The 2006 legislation required Part A Planning Councils (or the recipient where there is no planning council) and Part B programs to:

- Determine the size and demographics of the population of individuals with HIV/AIDS;
- Assess PLWH service needs and gaps “with particular attention to individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services” and “disparities in access and services among affected subpopulations and historically underserved communities”;
- Develop a comprehensive plan for the organization and delivery of health and support services that “includes a strategy for identifying individuals who know their HIV status and are not receiving such services…”

The Ryan White HIV/AIDS Treatment Extension Act of October 2009 provided an expanded focus and new requirements on getting people with HIV/AIDS into care upon diagnosis by including “individuals who are unaware of their status” to all three requirements. The 2009 legislation also required recipients to develop a strategy for identifying individuals and enabling them to use the health and support services. To support this effort, all Providers must demonstrate how funded Part A and B services will integrate the following Early Identification of Individuals with HIV/AIDS (EIIHA) components in their service delivery:

a) Identification of Individuals Unaware of Their HIV Status
b) Inform individuals of their HIV status
c) Refer to care/services
d) Link to care

To further understand EIIHA a list of related definitions has been included:

- **EIIHA:** Early Identification of Individuals with HIV/AIDS (EIIHA) is the identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care. The goals of this initiative are:
  1. Increase the number of individuals who are aware of their HIV status; and
  2. Increase the number of HIV positive individuals who are in medical care; and
3. Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

- **Unaware of HIV Status:** Any individual who has NOT been tested for HIV in the past 12-months, any individual who has NOT been informed of their HIV result (HIV positive or HIV negative), and any HIV positive individual who has NOT been informed of their confirmatory HIV result.

- **Identification of Individuals Unaware of Their HIV Status:** The categorical breakdown of the overall unaware population into subgroups, which allow for the overall EIIHA strategy to be customized based on the needs of each subgroup, for the purposes of identifying, counseling, testing, informing, referring, and linking these individuals into care. HRSA now distinguishes between:
  - “Parent Groups” categories that encompass a large and diverse number of individuals with a common issue (e.g., substance abuse, men who have sex with men), and
  - “Target Groups” within the Parent Group that allow the overall EIIHA strategy to be customized based on the Priority Needs and Cultural Challenges of each Target Group.

  - **Important note:** The following groups are considered Parent Groups and may NOT be listed as Target Groups. These groups must be broken down into smaller, more specific groups.
    - MSM
    - Substance Abuse/IVDU
    - Black/African American
    - Hispanics

- **Informing individuals of their HIV status:** Informing an HIV negative individual, post-test, of their appropriate HIV screening result. Informing an HIV positive individual, post-test, of their confirmatory HIV result.

- **Informing individuals of HIV Negative status:** Informing individuals of their HIV negative status and refer these HIV negative individuals to appropriate supportive services that will contribute to keep them HIV negative. However, due to their HIV negative status, these individuals are not eligible for Ryan White funded care or supportive services.

- **Referral to care/services:** The provision of timely, appropriate, and pre-established guidance to an individual that is designed to refer him/her to a specific care/service provider for the purpose of accessing care/services after the individual has been informed of their HIV status (positive or negative).

- **Linkage to medical care:** The post-referral verification that medical care/services were accessed by an HIV positive individual being referred into care. (i.e., Confirmation first scheduled care appointment occurred). The medical care visit must entail one of the following: a CD4 count, viral load test, or the provision of an HIV related prescription for medication.

6. **PROVIDER REQUIREMENTS (not inclusive):**

All agencies recommended for funding under this RFA shall be required to comply with all terms and conditions of the contract between the COUNTY and the PROVIDER. At a minimum, PROVIDERS will be required to comply with the following contract terms.

a. Medical and Non-Medical Case Management providers will be required to participate in Case Management trainings sponsored by Hillsborough County, as well as any State of Florida Department of Health sponsored training sessions.

b. Obtain proof of outpatient/ambulatory health services annually on all clients served.

c. PROVIDER must send at least one representative to every PROVIDER meeting that is scheduled by the DEPARTMENT.

d. Ensure there is a method of tracking client demographic information as well as units of service.

e. Quality Management reporting elements are established by the Quality Management provider and the PROVIDER agrees to track and report on those elements. A Quality Management program is a HRSA mandate.

f. PROVIDER agrees to comply with any and all requests for information to ensure completion of federal and state reports and grant applications.

g. PROVIDER shall be required to comply with all current and subsequent HRSA policies. A copy from the Part A HRSA manual is attached in Section G. PROVIDER is responsible for ensuring they have the most recently issues policies. They may be obtained from the HRSA website.

h. PROVIDER’s may not be reimbursed more than 25% of their contract amount within a given quarter,
without the prior written permission of the Grants Programs Services Compliance Coordinator. Outpatient/Ambulatory medical care and AIDS Pharmaceutical Assistance (local) providers are excluded from this limitation.

i. **PROVIDER** will be required to comply with the terms in the sample contract attached in Section G, Exhibit 4. However, the COUNTY reserves the right to revise the contract terms and conditions at their discretion prior to its execution.

j. Budget/Expenditure Status Report must be completed by the PROVIDER on a monthly basis, and retain for review upon request, for all fee-for-service contracts. The original budget will be the approved Condition of Award Budget. Expenditures must be in accordance with the approved budget. Under no circumstances can the administrative costs exceed 10% of the contract.

k. **PROVIDER** will be required to input information on clients served and units of service provided into e2Hillsborough, unless alternate arrangements have been approved by the Grants Program Services Compliance Coordinator.

l. **PROVIDER** must comply with any service caps per client as established by the Care Council; those limits are listed in attached Exhibits.

m. **PROVIDER** will assist in the identification of potential clients to serve as members of the Care Council or be active participants in the Care Council and its subcommittee meetings.

n. **PROVIDER** will be required to have all employees working on the program background checked as well as fingerprinted. No employees can work on the program if they have a criminal felony record.

o. **PROVIDER** agrees to utilize the U.S. Department of Homeland Security’s E-Verify system, [https://e-verify.uscis.gov/emp](https://e-verify.uscis.gov/emp), to verify the employment eligibility of all new employees. If the **PROVIDER** is permitted by the BOCC to subcontract any portion of the services, the **PROVIDER** must require the subcontractor to utilize the E-Verify to verify the employment of all new employees.

p. **PROVIDERS** must be registered in the Central Contractor Registration (CCR) and provide the DEPARTMENT with their data universal numbering system (DUNS) number. The COUNTY cannot contract with anyone who does not have a DUNS number.

q. The **PROVIDER** is obligated to be familiar and comply with all of HRSA’s newest monitoring standards and guidelines. They can be found at: [http://hab.hrsa.gov/manageyourgrant/granteebasics.html](http://hab.hrsa.gov/manageyourgrant/granteebasics.html).

r. Applicants must have a Data Universal Number System (DUNS) number as required by the Federal Government. This number is developed and regulated by Dun & Bradstreet (D&B), it is a unique numeric identifier to a single business.

7. **Reporting and Data Collection Requirements**

Providers will be required to collect and report on program performance. Reporting requirements will include both client level data and system level data elements. These requirements are comprised of HRSA’s/HIV AIDS Bureau (HAB) Ryan White Services Report (RSR) which includes Client Level Data elements, and Outcome Measures. The applicant agency will be required to report all required data elements in e2Hillsborough, or any other data collection system designated by the DEPARTMENT.

Providers will may utilize a standardized quarterly progress report format for reporting on program or fiscal performance as required.

Aggregate system-wide data consisting of the number of clients served, demographics, Federal Poverty Levels, service utilization, expenditures, service delivery outcomes and standards of care will be provided to the DOH, HRSA and the Planning Council/Care Council. Data findings will be utilized by that planning body in its planning, assessment, program evaluation, priority setting and resources allocation process, in addition to other mandated functions of that planning body.

Providers shall maintain required data collection functions for all Clients and service delivery in CAREWARE. Providers shall establish internal processes for monitoring data entry, reporting and establish quality assurance activities to maintain data integrity and accuracy. Activities shall include formal protocols for data analysis and modifications which result in data integrity issues.

Hillsborough County and/or its contracted designee maintain the right to collect data from Client records for Quality Assurance and Program Evaluation purposes. This Client data includes, but is not limited to, socio-economic data, demographics, service delivery outcomes, utilization of funding, client satisfaction
and adherence to quality care standards.

8. **Computer Capability**

Participating Providers must demonstrate an adequate management information system (MIS) capability and agree to use e2Hillsborough. To be compatible with the e2Hillsborough software, the minimum requirement is the availability of at least one Pentium processor-based personal computer (dual or quad core), Windows XP Professional, with at least 1GB of RAM. The computer must have internet access. Minimum and recommended system requirements connecting to e2Hillsborough are included below.

Upon contract award, Department personnel will, if not already done, provide access to e2Hillsborough and Department staff will train Provider staff in its use. There is no charge for access to the system, training, or use of the system. However, the Provider must have the appropriate hardware and the technical capability to utilize e2Hillsborough and upload necessary documents. County staff reserves the right to change or enhance the e2Hillsborough in use and require Providers to comply with the system changes.

<table>
<thead>
<tr>
<th>Item</th>
<th>Computer System as applicable (minimum requirements)</th>
<th>Computer Running System, as applicable (recommended)</th>
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<tbody>
<tr>
<td>Operating System</td>
<td>MS Windows XP Professional or higher, with 1 GB RAM</td>
<td>Most current XP Professional (including Service Packs) with 4 GB RAM</td>
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<tr>
<td>Printer</td>
<td>Inkjet</td>
<td>Inkjet or Laser</td>
</tr>
<tr>
<td>Power Supply</td>
<td>Uninterrupted Power Supply (UPS)</td>
<td>Uninterrupted Power Supply (UPS)</td>
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<tr>
<td>Internet Access</td>
<td>High Speed Internet Access via Cable, FiOS or T1</td>
<td>High Speed Internet Access via Cable, FiOS or T1</td>
</tr>
<tr>
<td>Microsoft Internet</td>
<td>Internet Explorer 7.0 or greater</td>
<td>Internet Explorer 7.0 or greater</td>
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<tr>
<td>Scanner</td>
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<td>Maximum resolution 600 dpi, duplex capability, max document size 8.5” x 14”</td>
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9. **Glossary**

Service category definitions and unit of service definitions are included in Section C, Eligible Services below. Other terms are defined as follows:

a. **Allocation:** The total dollar amount that may be expended for a specific service category.

b. **Application:** An agency’s plan/response for providing a proposed service.

c. **BOCC:** Board of County Commissioners.

d. **Care Council:** The West Central Florida Ryan White Care Council is the planning body for Part A and Part B funding. Care Council may also be referred to as Planning Council.

e. **Client:** An individual determined eligible as described in the Ryan White Treatment Modernization Act and by the Care Council.

f. **Early Identification of Individuals with HIV/AIDS (EIIHA):** a strategy for finding people who know they are HIV+ and helping them enter and remain in HIV-related medical care. More details are located within this document.

g. **Eligible Metropolitan Area (EMA):** Includes Hillsborough, Pinellas, Pasco and Hernando Counties.

h. **Recipient:** Hillsborough County.

i. **Grant period Ryan White Part A:** March 1 – February 28.

j. **Grant period Minority AIDS Initiative (MAI):** March 1 – February 28.

k. **COUNTY:** The Hillsborough County Board of County Commissioners.

l. **DEPARTMENT:** The Health Care Services Department of Hillsborough County government.

m. **HRSA:** Health Resources and Services Administration, the division of the Department of Health and Human Services responsible for the Ryan White Treatment Modernization Act.

n. **MAI:** Minority AIDS Initiative: Funds made available by the Congressional Black Caucus to target disproportionately infected and underserved minority populations.

o. **Passing score:** Applicant must receive at least 70 points out of 100. If for any reason the total points
available are decreased from 100 the passing score will be decreased proportionally.

p. **Unique Client Identification Number (“UCIN”):** A number that is issued by the E2Hillsborough that will substitute for the client name to help ensure client confidentiality. The number will be used when reporting and billing to the DEPARTMENT.

q. **DUNS #:** Data Universal Number System (DUNS) is developed and regulated by Dun & Bradstreet (D&B); it is a unique numeric identifier to a single business.

10. **MULTIPLE APPLICATIONS**
If applying for funding for more than one of the eligible services listed or for more than one county, a separate Application must be completed and submitted for each service category and for each County.

11. **FUNDING**

**Funding Source:** Funds for these projects are made available through Part A of the Ryan White Extension Act, The Care Council makes allocations of Part A funds.

**Funding Allocations By County:** The allocations for each county for each contract year are based on the proportion of AIDS cases in each county (as determined by the Centers for Disease Control), as a percentage of all AIDS cases in the EMA. Additionally, the amended Ryan White Extension Act requires that funds must be expended for services for women, infants, children and youth in an amount proportional to their representation in the infected population in the EMA. That proportion is 28.98% for this program year solicitation, which is an aggregate of all providers, not a specific requirement of each provider.

**Funding period:** Contracts will be effective the date approved by the BOCC and will be in effect until the date the grant contract period ends (as noted in the glossary), each contract will have 4 one-year renewal periods unless otherwise stated. However, the Recipient reserves the right to add funds under this RFA to any existing contract an applicant may have with Hillsborough County, Health Care Services Department. This option will be taken to reduce the financial burden of the PROVIDER and the Recipient of monitoring multiple contracts and processing multiple invoices for the same service under the funding source. Exercising this option will result in the PROVIDER having the contract for less than five years.

12. **RESTRICTIONS**
Cash payments to clients by service providers are prohibited.
Funds under this grant program shall be used only as a last resort for services not covered by other funding sources or programs, and cannot be used to replace local, state or federal funding for HIV health and support services.
There shall be no advance funding.

C. **ELIGIBLE SERVICES**
Decisions on allocations are the responsibility and authority of the Care Council, and cannot be changed by the Recipient, Hillsborough County. The Recipient is responsible for how and with whom to contract for the provision of the services based on the allocations of the Care Council. Other specific policy directives have been provided by Health Resources Services Administration (HRSA), Division of HIV Services (DHS), or the State of Florida Department of Health, Bureau of HIV/AIDS. Therefore, special conditions indicated in the definitions of the service categories below are not negotiable by Hillsborough County.

Applicants, who are applying to provide a service that is covered by Medicaid, must be Medicaid providers. Documentation of Medicaid participation must be included with each Application.

**HEALTH CARE SERVICES:**

**Outpatient/ Ambulatory Health Services:** 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. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:
• Medical history taking
• Physical examination
• Diagnostic testing, including laboratory testing
• Treatment and management of physical and behavioral health conditions
• Behavioral risk assessment, subsequent counseling, and referral
• Preventive care and screening
• Pediatric developmental assessment
• Prescription, and management of medication therapy
• Education and counseling on health and prevention issues
• Referral to and provision of specialty care related to HIV diagnosis

Program Guidance:
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

Ryan White funds may not be used to subsidize the difference between the PROVIDER’s actual cost and the reimbursement from Medicaid or other third party payors.

This service will be reimbursed on a fee for service basis.

<table>
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<tr>
<th>PART A FUNDING AVAILABLE:</th>
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<tr>
<td>Hernando County</td>
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<td>$85,912</td>
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Maximum reimbursement rate: The DEPARTMENT will not reimburse in excess of a 5% increase above an applicant’s existing contracted rate for the service category. If not currently funded for the service, the PROVIDER will not be reimbursed higher than 5% above the greatest contracted rate in the respective County. Billing will be based on a flat fee, but electronic submission will include all CPT codes for services that were performed during the actual office visit.

SUPPORT SERVICES

“Quality Management:
Quality Management services include, but are not limited to the following components:

a) Implementation, monitoring, and evaluating the of the Tampa-St. Petersburg EMA’s Continuous Quality Improvement (CQI) plan included here on page 123 consistent with the requirements of Part A, the Care Council, the COUNTY, funded service providers, consumers of Part A services, and other stakeholders: https://hab.hrsa.gov/clinical-quality-management

b) Refinement of current outcome and process measures for health and social support services funded under Part A and corresponding technical assistance activities as required by the QM/CQI Plan;

c) Evaluation activities to determine the quality and impact of Ryan White Part A services on the health status of persons living with HIV/AIDS; and

d) Treatment Modernization Act requires that Eligible Metropolitan Areas (EMAs) receiving Part A funds establish a quality management program to assess the extent to which HIV health services provided with grant funds are consistent with the most recent Public Health Services guidelines for the treatment of HIV disease and related opportunistic infections, and to develop strategies for ensuring that such services are consistent with the guidelines for improving access to care and the quality of HIV health services.
e) HRSA, has defined quality as follows:

“Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluations of the quality of care should consider (1) the quality of the inputs, (2) the quality of the service delivery process, and (3) the quality of outcomes, in order to continuously improve systems of care for individuals and populations.” According to standards determined by the EMA.

f) Monitoring contract provider sites for CAREWare to e2Hillsborough data migration and data accessibility, and

g) Provide oversite/technical assistance for contact providers’ internal Quality Assurance plans; and

h) Updating and reviewing area-wide Quality Management Plan.

Purposes of Quality Management (taken from the HRSA Part A Manual):
1. Assist direct service medical providers funded through the Treatment Modernization Act (formerly known as the CARE Act) in assuring that funded services adhere to established HIV clinical practice standards and Public Health Services guidelines to the extent possible.
2. Ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care.
3. Ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

A successful quality management program should (taken from the HRSA Part A Manual):
1. Be a systematic process with identified leadership, accountability, and dedicated resources available to the program; and
2. Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks; and
3. Focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement; and
4. Be a continuous process that is adaptive to change and fits within the framework of other programmatic quality assurance improvement activities (i.e., Joint Commission on the Accreditation of Hospitals Organization [JCAHO], Medicaid, and other HRSA programs); and
5. Ensure that data collected is fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes. The following link provides additional background:


Within the link above, click into the Clinical Care & Quality Management box to view HRSA’s Clinical Quality Management Policy Clarification Notice 15-02.

HIV-related morbidity has dropped dramatically due to advances in HIV/AIDS related treatment. However, reductions have been unevenly distributed across HIV-infected populations due to such factors as unequal access to care and variable quality of services (e.g., treatment regimens, client support, and provider skills). Quality management programs are designed to bring these benefits to all clients by improving the quality of care of all Ryan White Treatment Modernization Act services. Quality management programs should: 1. Support the development of higher quality care to people living with HIV disease (PLWH), 2. Identify priority needs and client populations, 3. Support effective program management, 4. Demonstrate program value quantitatively by linking outputs (amounts of services provided) to outcomes (results), 5. Identify and justify critical program
activities and resources required to meet needs, and 6. Enable local HIV service delivery networks and providers to perform better and to function as a system. A number of tested concepts can be used in quality management efforts, including quality assurance, quality improvement, continuous quality improvement (CQI), and outcomes evaluation.

The PROVIDER will continue the implementation and development of a system level Quality Management program. The description will include a clearly defined work plan identifying specific roles and responsibilities for COUNTY staff and funded agencies, targeted timeframes, methods, techniques, and tools. To assure accuracy in data collection, preference will be given to those proposers utilizing technology such as electronic survey instruments, etc. that minimize data transcription errors and assure data integrity. Specific tasks expected (but not limited to) which should be described in detail in the application consist of the following elements:

1. The established client/customer satisfaction survey program implemented in 2005 will be analyzed for perceptions of service gaps, provider performance, and/or identified barriers to care. Develop/implement methodology to use results from provider satisfaction survey; e.g. personally discuss satisfaction findings with each provider; identify 1-2 strategies to increase satisfaction; identify tracking mechanisms and reporting timeline; gather data and review changes.

2. The PROVIDER will deploy patient satisfaction surveys to Hillsborough County Health Care Plan (“HCHCP”) clients accessing primary care at 12 primary care clinics in the HCHCP network. Surveys will be deployed in both English and Spanish, and written and electronic formats. A minimum of 986 surveys will be secured to achieve a confidence level of 95% with a margin of error at +/-3%. PROVIDER will coordinate with 12 provider sites to establish procedures for survey administration and collection. Hard copy surveys will be completed on-site and deposited in a secure box designated for survey collection. Online surveys will be available if the provider site has an on-site computer for patient use. Take-away cards will be provided with a link to the on-line survey for patients wanting to complete the survey at home. PROVIDER staff will collect and replenish survey supplies at least once per week during an 8-12 week survey period. Surveys will be reviewed for completeness prior to data entry.

PROVIDER staff will also deploy provider satisfaction surveys to primary care providers engaged in providing health care services to HCHCP clients. A survey link will be deployed electronically to HCHCP contracted providers using email addresses provided by the DEPARTMENT. Client and HCHCP contracted primary care providers satisfaction survey data will be tabulated, analyzed and reported to the DEPARTMENT at the conclusion of the project. The project report will include an analysis of Health Plan call center data if available from the DEPARTMENT.

3. Continue to develop, analyze, and maintain established outcomes measures for all funded service categories.

4. Training of staff (both internal and provider) in order to assure that Quality Management standards and outcomes based measures are implemented and integrated comprehensively into the existing care delivery system. This will include training and presentations during all provider meetings could be held in any of the eight counties, however they are typically held in Hillsborough or Pinellas. Provider meetings are typically held no more than twice per year and there are typically twenty contracted service providers. Provider will arrange and facilitate all Quality Management related meetings.

5. Identification of any ongoing barriers preventing implementation of the CQI plan goals and objectives, including a corrective plan of action to address the identified barriers. Coordinate/facilitate problem solving teams who will develop resolution strategies for identified challenges that arise related to service delivery or access.

6. Assurance that the Recipient’s policies and procedures are updated according to the funding source (HRSA) standards and consistent with the EMA’s Quality Management plan.

7. Identification of possible trends or patterns of deficiency in provider’s Quality Management plans
and develop/administer appropriate provider Quality Management trainings through process and performance measurement.

8. Provide technical assistance to individual provider agencies, including program evaluation strategies, with internal mechanisms for self-monitoring identified outcomes. Provide technical assistance to providers with a need for quality management improvements.

9. Coordination of Quality Management planning and reporting with the local Care Council in order to ensure that service utilization and outcomes data is integrated into the Council’s annual Needs Assessment activities and other work products/deliverables in a timely, efficient manner. The provider will have a minimum of ninety days prior notice of any items due.

- To compare, at identified intervals, utilization data for all funded service categories by demographic and risk groups, in order to identify under-served populations and unmet needs.
- To provide oversight and authority on the local Comprehensive Plan, this serves as the basis for the Ryan White Treatment Modernization Act annual activities cycle. Assist the Care Council with the integration of quality management efforts in its Comprehensive Plan.

10. Coordination of quality management planning and implementation with COUNTY staff, who oversees the data collection/MIS.

- Implementation of contract minimum standards and required outcomes for each service category in accordance with the contract.
- To review and analyze the data results once the MIS has reported the necessary data elements, including training and developing capacity for County staff.
- To work in concert with the County staff to identify any modifications which need to be made in future core data sets mandated by Hillsborough County, provider agencies, or HRSA.
- Develop data dictionary for QM outcomes to ensure PROVIDERs are all entering the same data elements consistently for reporting purposes and analysis.
- Review data needs across all reporting sources; standardize clinical indicators and establish indicators for all service categories. Complete the QM indicators for the annual final Implementation Plan.
- Develop and implement methodology to validate data through chart reviews at PROVIDER locations.

11. Implementation of HRSA-required Quality Management activities and comply with HRSA’s reporting mandates related to quality management.

- Continuous monitoring and analysis of the system wide quality management plan, implementing updates and revisions as necessary.

12. Implement, monitor, adapt, and evaluate the Tampa-St. Petersburg Quality Management Plan, attached hereto and made a part hereof, that involves service providers, consumers, the Care Council, and the DEPARTMENT in a coordinated, CQI program. This initiative must include specific benchmarks and on-going activities such as oversight and training.

13. Collect, report on contracted providers outcome measures on a semi-annual basis. Reports must be made available to the Planning & Evaluation Committee, Health Services Advisory Committee, the Care Council and the COUNTY. Specific agency names should be omitted in public meetings, but agency names must be reported to the DEPARTMENT. Outcomes must be measurable, have the ability to document an impact on the clients, document quality care and treatment. The PROVIDER shall also be able to identify areas that need improvement and make recommendations.

14. Evaluate the existing Part A system of care, including case management and system-wide
standards of service, and identify problems in service delivery that impact the health status outcomes at the client and system levels. Based on data analysis of Quality Management Outcomes and Minimum Standards of Care established by the Care Council.

15. Evaluate the quality and effectiveness of Part A funded services and report to the County and the Care Council with recommendations on service policies, standards of care, and funding allocations.

16. PROVIDER will be required to be cooperative with the DEPARTMENT and any grant writer hired by the COUNTY to prepare sections of the application. PROVIDER will need to provide the DEPARTMENT and the grant writer with any information and data required to prepare the DEPARTMENT and the grant writer sections of the application by the dates requested by the DEPARTMENT. Every year the grant application changes therefore, the requirements may change.

17. Assist the County, as needed, with monitoring activities pertaining to service providers’ compliance with quality management and CQI requirements.

18. Develop appropriate methodologies and conduct client record reviews for Part A funded services, with concentration on case management, medical care, dental care, substance abuse treatment, mental health therapy/counseling, and outreach services. Report findings to service providers, the Care Council, and the County.

19. Collaborate with the DEPARTMENT and the contracted service providers to establish performance benchmarks and a corresponding accountability policy for providers with identified need for quality management improvement.

20. Establish community and agency-specific HRSA indicators in consultation with the provider community (viral load, ARV therapy rates, entry into care, etc.).

21. Identify opportunities for quality improvement by comparing local indicator benchmarks to National Quality Data Center benchmarks.

22. Produce multiple Quality Management components for the federal Part A grant application.

23. Produce the implementation plan for the federal Part A grant application.

This service will be billed on a monthly basis based on deliverables.

### PART A FUNDING AVAILABLE:

<table>
<thead>
<tr>
<th>County</th>
<th>Funding Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMA</td>
<td>$144,878</td>
</tr>
<tr>
<td>HCHCP Indigent Health Care Trust Fund</td>
<td>$35,000</td>
</tr>
</tbody>
</table>

### Planning Council Support (aka Care Council Support):
Hillsborough County is seeking qualified professional staff support services to the West Central Florida Ryan White Care Council. Services must be provided in an office setting with staff available during regular business hours, Monday through Friday 8pm to 5pm. Services will include: 1). General staff support functions for the Care Council, 2). staff support functions for the Care Council meetings, subcommittee meetings as well as ad-hoc committees; 3). recruit and maintain membership of the Care Council, and provide new member training as well as on-going training; 4). preparation of sections of the Ryan White Part A EMA grant applications; 5). Coordination and compilation of the final Part A Grant application and any assistance needed with its submission.

General functions of the Care Council are as follows:

1. Development of a community-wide comprehensive plan for the Care Council that is compatible with the Statewide Coordinated Statement of Need (“SCSN”).
2. Establishment of limitations on services, such as income caps, maximum amounts of services clients are eligible and qualified to receive.
3. Participate in the development of the Statewide Coordinated Statement of Need initiated by the State of Florida, Department of Health.
4. Institute methods for obtaining input on community needs and priorities, such as conducting focus groups, town hall meetings, ad-hoc meetings, community forums, etc.
5. Establish a grievance/appeal process with respect to Part A funding allocations. (This is not the grievance/appeal’s for the RFA process).
6. Abide by Bylaws and operating procedures of the West Central Florida Ryan White Care Council.
7. Promote coordination and integration of community resources.
8. Assure the provision of comprehensive outpatient health and support services.
9. Evaluate the success and cost effectiveness of the consortium/Care Council in responding to service needs.
10. Assess the efficiency of the administrative mechanism in rapidly allocating funds in accordance with Care Council recommendations within the EMA and TSA. The assessment of the administrative mechanism is funded under this allocation.

Further description of services will be outlined below.

1. **Staff support function for the planning council:**
   a. Follow Public Health Service and HRSA guidelines in the printing or production of material paid for with Ryan White funds.
   b. Submit a yearly work plan to the DEPARTMENT that indicates specific strategies, Care Council goals and objectives, timeline, completion date, and parties accountable for the work.
   c. Act as a liaison between Care Council and DEPARTMENT.
   d. Update Care Council operating procedures.
   e. Work closely with the DEPARTMENT to ensure maximum coordination between Part A and B.
   f. Provide technical assistance to Care Council members, service providers and the public regarding Care Council responsibilities and initiatives.
   g. Other duties in direct support of the Care Council as directed by the DEPARTMENT or the Care Council Chair/Vice Chair.
   h. Hire, supervise and evaluate performance of professional planning and/or clerical personnel.
   i. The PROVIDER will assure copies of all materials developed in support of the Care Council’s work be delivered to the DEPARTMENT electronically and in an MS Word or MS Excel format, or any other format required by the DEPARTMENT.
   j. All activities performed by the PROVIDER will be done under the auspices of the COUNTY for the Care Council and indicate such on all materials produced. Any written documents, brochures, reports, or information produced will reflect that the document was produced on behalf of the Care Council under contract by the County of Hillsborough, Health Care Services Department, Ryan White Program, funded by HRSA and/or the State of Florida, Department of Health.
   k. Submit to the DEPARTMENT for review, input and approval, prior to implementation, any draft surveys developed on behalf of the Care Council.
   l. Ensure opportunities for strategy deployment for cultural and linguistic standards in meeting the needs of the EMA and TSA are identified within specific recommendations to the Care Council and the DEPARTMENT.
   m. Update program evaluation requirements, based on the Care Council’s Comprehensive Plan(s), Strategic Plan, program goals and objectives, which should include key indicators or evaluation criteria to measure the extent to which pre-determined goals have been achieved. Procure, monitor and arrange payment for program evaluation services, and coordinate with the Part B Consortium to co-fund a comprehensive program evaluation covering both Part A and Part B programs. This is an ongoing project with an annual report due every December 31.
n. Develop, update and publish a Comprehensive Plan for the organization and delivery of health services described in section 2604 of the Ryan White Treatment Modernization Act that is compatible with existing State or local plans regarding the provision of health services to individuals with HIV disease, as required by the Ryan White Treatment Modernization Act.

o. Provide Care Council with data needed for establishing service priorities for the allocation of funds within the eligible area. Submit to COUNTY, in writing, the Care Council approved service category priorities by percentage or dollar amount of the total fiscal year grant award funded by the Part A grant program for each grant period. Provide Care Council with other data needed for decision making at the direction of the Care Council Chair. Due annually on July 1.

p. The PROVIDER must post all appropriate documents to the Care Council website.

2. Staff support functions for planning council meeting activities:

a. PROVIDER will be responsible for procuring meeting space for all Care Council meetings, subcommittees, and ad-hoc committee meeting on a monthly basis. Meeting space for Care Council meetings would need to accommodate up to 50 individuals. Subcommittees typically have 5-25 individuals in attendance. Meeting locations should be accessible by public transportation or the PROVIDER would need to arrange for transportation for HIV+ individuals in need of transportation. Facilities should also be accessible for individuals with disabilities as required by the Americans with Disabilities Act (ADA).

b. PROVIDER will be required to schedule all meetings as instructed by the Care Council Chair, or Co-Chair, and the Subcommittee Chairs. In addition, PROVIDER will be required to prepare meeting notices, agenda, and minutes for approval by Chairs, notify members of date, time and location of all meetings, and facilitate each committee work plan. PROVIDER must prepare action item background papers from committees for Care Council packet. PROVIDER shall secure meeting locations, publicly notice all meetings, purchase all meeting supplies, mail meeting packets to members who attend the meetings ten days prior to the meeting. PROVIDER may electronically notify members who attend meetings seven days prior. When feasible, electronic notice should be the preferred method. PROVIDER must maintain a mailing list for the Care Council members and a list of all other subcommittees. PROVIDER must provide the COUNTY with the mailing list electronically in MS Word format, or any other format required by the DEPARTMENT.

c. PROVIDER must notify the public of all meetings of the Care Council and its committees in accordance with the Government in the Sunshine Law and State public records law. PROVIDER must tape record all meetings, and produce typewritten minutes. All records must be kept for a period of no less than 6 years, which includes all written correspondence, reports, minutes and audiotapes. PROVIDER will be required to maintain a Care Council member list which must include name, mailing address, e-mail addresses, and phone numbers.

d. The PROVIDER must be able to respond to requests for information or documentation from the COUNTY within 24 hours or an agreed upon date, and must respond to public requests within five working days.

e. PROVIDER will be required to have at least one staff person at all Care Council and subcommittee meetings. Staff shall ensure that meetings are kept on schedule, ensure that Robert’s Rules of Order are followed and provide guidance to the Chair/Co-Chair(s).

f. PROVIDER will be required to provide the Department with a monthly written progress report outlining staff activities and accomplishments.

g. PROVIDER must allocate sufficient funds to reimburse PLWH with mileage ($.445 per mile or the current COUNTY rate), tolls, and child care. PROVIDER must also have funds within their budget to cover cost of at least one Care Council member to attend out-of-town meetings or conferences. Those costs shall include: ground transportation, airfare, lodging, registration fees, meals, etc. An additional 5 points will be added for amounts over $4,000 in Part A allocated to this line-item within the budget submitted.

h. Provide clerical and/or professional staff support services to the Care Council, all standing committees, and ad-hoc committees. The committees of the Care Council include: Membership, Planning & Evaluation, RPARC, SIOC, Health Services Advisory, WICYF, and Community Advisory.

CARE COUNCIL COMMITTEES

The Care Council has ten standing committees consistent with the by-laws in which the PROVIDER will be required to provide support. A description of the committees are as follows:
Membership, Nominations, Recruitment and Training Committee
This committee is responsible for understanding the membership process; ensuring that the Care Council adheres to strict legislative membership requirements; ensuring membership application and selection process is effective and administered appropriately; advises governing body in membership issues; works with staff in ensuring appropriate member recruitment, training and orientation, including retreats. A subcommittee of the Membership Committee is responsible for review and scoring of all membership applications. This committee is also responsible for the nomination and election process of the Chairperson and Vice Chairperson of all committees.

Planning & Evaluation Committee
This committee provides input to staff regarding components to be included in the annual needs assessment; ensures that the needs assessment is comprehensive and reflects the components required by the legislation, HRSA and the State; and ensures that appropriate populations are represented in data collection within time and resource constraints. This committee is responsible for developing a comprehensive, community plan for the organization and delivery of HIV/AIDS services that is compatible with existing state or local plans regarding the provision of health services to individuals with HIV disease. The committee also develops an implementation plan for the goals, objectives, strategies and evaluations which result from the final plan.

In addition, this committee develops program evaluation requirements based on Federal legislation, HRSA guidance and the Comprehensive Plan program goals and objectives. In addition, the committee ensures that requirements are met, reviews results of program evaluation and makes recommendations to the full Care Council for any action required. It revises program evaluation as needed and seeks to include key indicators or evaluation criteria to measure the extent to which pre-determined goals have been achieved, including cost and effectiveness measures and assessments of the efficiency and appropriateness of funding allocations.

Resource Prioritization and Allocation Recommendations Committee (RPARC)
This committee is responsible for developing recommendations for the Part A and II funding prioritization and allocation process. They work in close coordination with staff to assure that this process reflects the findings of the needs assessment. The recommendations are then brought to the Council for approval and presented to the Recipient. The committee also meets at various times throughout the year to re-allocate funds. The committee may also be called on to participate in SIOC issue discussions which concern funding.

Standards, Issues and Operations Committee (SIOC) This committee monitors and provides oversight for the Council. It develops systems for process review; identifies emerging issues for referral to appropriate committees, and continuously reviews the strategic plan to assure compliance with Council goals and objectives. SIOC also identifies, develops and organizes grievance policy and procedures, and as necessary, resolves or recommends means of resolution to the Council. SIOC may also convene to act on behalf of the Council to respond to emergency Part A or II program or fiscal developments.

Membership is composed of the chairs of each of the standing committees, the chair and/or vice chair of the Council and two members representing affected communities

Community Advisory Committee:
Works to ensure that the needs of minority, underserved and underrepresented communities and populations are reflected in the planning and decision-making process of the Council and networks to improve the availability and effectiveness of needed services in both urban and rural areas. The committee also seeks to provide clients with updated resource references and to create opportunities in all Council counties for PLWH participation. Finally, the committee acts as a liaison between planning and service provision by working to ensure access and to eliminate barriers to services for minorities, the underserved and underrepresented populations in both urban and rural communities.

Health Services Advisory Committee
This committee serves in an advisory capacity to the Council on issues related to primary care, dental care, medications, new treatments, adherence and other clinical issues related to the maintenance and
improvement of health. This committee is also directed to work closely with and advise the Rural Issues Committee.

**Women, Infants, Children, Youth and Families Committee (WICYF)**

This committee works to ensure the active and effective participation of women and those who represent infants, children, youth and families in the planning and decision-making process of the Council. To accomplish this, the Committee will carefully consider and seek ways to meet transportation needs of participants, to involve appropriate providers, to continuously identify individuals who are under-served or unserved and to retain these clients in the continuum of care. Finally, the committee acts as liaison between planning and service provision by working to ensure access and to eliminate barriers to services for women, infants, children, youth and families.

3. **Recruit and maintain membership of the Care Council, and provide new member training as well as on-going training:**

   a. PROVIDER will be responsible for recruiting and maintaining Care Council membership in accordance with Ryan White Treatment Modernization Act requirements. The PROVIDER will be required to carry out culturally sensitive outreach efforts with special emphasis on minorities. Duties for recruitment include:
      1. Advertising for vacancies
      2. Processing member applications
      3. Locating mentors for new members
      4. Documentation for files and completion of all appropriate reports for HRSA
      5. Distribute flyers promoting public involvement with the Care Council.
      6. Provide information to AIDS Service Organizations about the need to involve their clients in the Ryan White planning process.
      7. Plan, organize, and evaluate one full-day retreat and one half-day retreat for Care Council members.

   b. PROVIDER will be responsible for providing training for new Care Council members and will be required to provide additional training sessions for members as necessary. This will include development of all training documents, PowerPoint presentations, handouts, guest speakers/presenters, etc.

   c. PROVIDER will be required to update the Member Manual and provide updates to all members, as needed when changes occur.

   d. PROVIDER will accomplish many tasks listed above through collaboration and participation of the Membership Committee.

4. **Preparation and lead responsibility for the timely completion of the Ryan White Part A grant application including the organization, collection and compilation of the final draft document and all supporting attachments for final review and submission to the funding source by the Department.**

   a. PROVIDER will annually prepare sections of the Ryan White Part A grant application in accordance with Ryan White Extension Act requirements and deadlines following published guidance and at the direction of the DEPARTMENT. PROVIDER has the option to complete this deliverable by using the services of an external grant consultant.

   b. PROVIDER will be required to work in collaboration with the DEPARTMENT on the annual application. Any external grant consultant hired by the PROVIDER will be approved by the DEPARTMENT. PROVIDER will need to provide the DEPARTMENT (and grant consultant) with any information and data required to prepare those applicable sections of the application by the dates requested by the DEPARTMENT. Every year the grant application guidance changes, therefore, the requirements may change. The following is an example of what the Care Council support staff have been responsible for providing in prior or current year(s):
      1. Early Identification of Individuals with HIV/AIDS (EIIHA)
      2. Assessment of populations with special needs.
      3. Care Council mandated roles/responsibilities: priority setting and comprehensive planning.
      4. Description of local needs assessment and planning processes.
      5. Compatibility with Statewide Coordinated Statement of Need (SCSN).
      6. Care Council membership and representation.
7. Funding availability for services within the EMA.
8. Documentation of Demonstrated Need within the EMA.
9. HIV/AIDS Epidemiology with the EMA.
c. PROVIDER must have excellent grant writing skills and must have ability to access and assess statistical data related to HIV epidemiology within the EMA. The PROVIDER must work closely with the DEPARTMENT and any other external grant writer mutually selected, observing all deadlines. The PROVIDER and any external grant consultant will need to produce draft documents at designated deadlines established by the DEPARTMENT in order for the documents to be reviewed by the DEPARTMENT, and Care Council members. The PROVIDER and must be able and willing to quickly revise their draft submission based on input from the DEPARTMENT, and Care Council members. Grant application guidance is typically distributed in August and applications are due in October.

5. Assessment of HIV/AIDS service needs within the EMA and TSA:
a. PROVIDER is responsible for conducting and preparing the Needs Assessment for the EMA and TSA. The Needs Assessment is a fundamental part of the planning process for determining service priorities and funding allocations within the EMA and TSA. The Needs Assessment is an on-going process which includes but is not limited to the following components:
1. Focus groups
2. Survey of HIV+ individuals not receiving medical care/unmet needs assessment
3. Survey of HIV/AIDS service providers
4. Funding stream analysis
5. Analysis of HIV/AIDS epidemic within the EMA and TSA
6. Analysis of Part A service utilization, service gaps and barriers to access
7. Presentation of needs assessment data to the Care Council members and other community members
8. Analysis of the SCSN
9. Collect and analyze pertinent historical and projected data and epidemiology reports for the EMA and TSA.
10. Delineate geographical areas for analysis including sub-areas within counties.
11. Identify needed epidemiology data, and its availability in existing reports, collect and analyze data.
12. Integrate and summarize demographic and epidemiological data.
13. Estimate HIV Populations by demographic, risk group and people needing specific services.
14. Identify, obtain, and analyze pertinent historical demographic data, i.e., age, sex, sexual identity, race and income.
15. The CARE Act, re-authorization amendment of 2000 contains multiple provisions focused on enhancing access to primary medical care for persons living with HIV disease who are not in care. These new provisions also include enhancements to needs assessment requirements. The new activities will require the PROVIDER to engage in a challenging and time-consuming process of finding and determining the needs and service gaps of Persons Living With HIV ("PLWH") who are not receiving primary health care.
16. Obtain and modify, as necessary, the EMA and TSA's model continuum of AIDS services.
17. Review or develop and disseminate an inventory of AIDS services and programs. May require written or telephone survey.
18. Identify service gaps first by comparing inventory of existing services with model continuum. Integrate available findings from provider, patient surveys and focus groups into analysis.
19. PROVIDER survey duties include:
   a. Delineate information to be obtained from providers.
   b. Design survey tool to obtain delineated information, and specify coding system and database structure.
   c. Designate survey method (written, telephone, in-person) based on number of providers and information sought.
   d. Conduct survey, code responses and enter them into database.
   e. Tabulate responses, analyze results, and prepare report of PROVIDER survey.
20. Focus groups duties include:
   a. Determine specific objectives for focus groups based on prior findings.
b. Designate county locations and populations, i.e., homosexual men, women, minorities, Injections Drug users (IDU), with or w/o children, parents/families of persons with AIDS. Due to funding limitations, the number of focus groups may be limited to the most critical representative populations.

c. Designate a facilitator, locate facilities for groups, and arrange for use. All costs associated with the facilitator and the facility are the responsibility of the PROVIDER.

d. Identify individuals to participate in focus groups, and invite these individuals to focus group sessions.

e. Conduct focus groups, collect data, and prepare report of focus groups.

b. HIV/AIDS population survey duties include:

   a. Develop questionnaire and database for responses.
   b. Create sampling plan, and identify categories of persons (with assured anonymity) to survey (i.e., patients in clinics, patients of doctors in private practice, members of AIDS organizations, etc.).
   c. Pre-test survey instrument, and train interviewers to conduct survey.
   d. Conduct survey, collect data, enter responses into database.
   e. Compile, analyze responses, and prepare report of survey.

   c. PROVIDER must produce a final written needs assessment document which fully complies with all HRSA requirements and summarizes the activities and findings which will be published and provided to the COUNTY, Care Council members, RPARC members, and other individuals as requested. In addition to the analysis of the data from the needs assessments and client surveys, the PROVIDER must also present recommendations to the Care Council for consideration in the annual comprehensive planning efforts. This analysis and recommendation will ensure targeted client needs are addressed in the development of priorities, and recommendations for allocations of funding.

d. Needs assessment activities must include processes to determine the needs of those who know their HIV+ status but are not receiving ambulatory/outpatient medical care. Findings and recommendations must be made regarding individuals not in care must be incorporated in the Part A grant application, the Comprehensive Plan, and all other appropriate documents.

e. The Needs Assessment must address barriers to care in disproportionately impacted and under-served communities.

f. PROVIDER staff must have extensive research methods, data analysis and presentation, survey design and methodologies, statistical and policy analysis, health planning and knowledge of HIV/AIDS.

g. PROVIDER must also work with the DEPARTMENT and/or the Quality Management subcontracted provider to assure comprehensiveness, adequate community input and to work to improve the quality of the process and document.

6. Preparation of the Comprehensive Plan:

   a. PROVIDER must update the current Comprehensive Plan annually. The PROVIDER may update various sections each year, however over a three year period the entire document must be updated; however the PROVIDER will be required to update the Comprehensive Plan as necessary.

   b. Comprehensive Planning includes but is not limited to the following duties:

      1. Determine needs and disparity in local service delivery
      2. Develop strategies to address Unmet Need and identify those PLWH who are not in the care system currently
      3. Complete a funding stream and resource analysis
      4. Identify shared vision, goals, objectives, and strategies which link the local Comprehensive Plan with the State of Florida's Comprehensive Plan and HRSA
      5. Determine implementation plan, evaluation plan, and quality management plans
      6. Determine priorities and allocation of funds

   c. PROVIDER will be required to provide copies of the Comprehensive Plan in an MS Word or the format required by the DEPARTMENT to the DEPARTMENT and any Care Council members as required.

d. PROVIDER must also work with the DEPARTMENT and/or the Quality Management subcontracted provider in developing and including a strategic plan and incorporating it into the EMA and TSA's Comprehensive Plan.

e. PROVIDER must also work with the DEPARTMENT and/or the Quality management subcontracted provider to assure comprehensiveness, adequate community input and to work to improve the quality of the process and document.
7. Care Council website development and maintenance:
This piece will require staff support services to ensure the continuous development and maintenance of the Care Council website, the current site address is www.thecarecouncil.org. The website offers a cost effective method of disseminating information that is highly accessible to Providers, the Recipient, PLWH/A, Care Council members, community health and social service agencies. Among the types of information that shall be available on the website are:

a) Care Council meeting and subcommittee meeting agendas and meeting minutes  
b) Calendar of Care Council and subcommittee meetings  
c) Membership and recruitment efforts  
d) Needs assessment data  
e) HIV/AIDS epidemiological data  
f) Comprehensive planning documents and other reports  
g) Links to major HIV/AIDS websites  
h) Care Council membership application  
j) And other items deemed appropriate by the Care Council and the Recipient’s Office.

The provider of this service will be required to take over the hosting, maintenance, and any future enhancements and expansions of the website. The PROVIDER will be responsible for updating all content and links posted on the website. The site should remain user friendly, enable clients, providers, health care professionals and social service agencies to obtain service locations for HIV positive individuals. The provider will collect all ideas for website improvement and ensure that all are implemented that are reasonable and cost effective in accordance with the Recipient’s office.

8. (Assessment of the Administrative Mechanism):

The overarching outcome of the Assessment of the Administrative Mechanism (“AAM”) is to broaden stakeholder participation within the Resource, Prioritization, Allocations Recommendations Committee (“RPARC”) and Care Council entities, to expand on past products building on those successes as compliments to our current Quality Management program, and to allow flexibility for future AAM component expansion as deemed locally appropriate. The proposed Scope of Work that emerged contains the following activities which are included in the outline:

A. Introduction/Background: The HRSA guidelines taken out of the Ryan White Title I Manual for the Assessment of Administrative Mechanism, Effectiveness of Services in Addressing Priorities are as follows:

“The planning council assesses the efficiency of the administrative mechanism, which entails evaluation of how efficiently providers are selected and paid and how well their contracts are monitored. This assessment should also review the planning process used by the EMA prior to procurement of services and disbursement of funds. (See attached sample.) In addition, the planning council may also, at their discretion, assess how well services that are funded by the Recipient’s address the planning council’s priorities, allocations, and instructions for addressing these priorities.

Generally, assessments are based on time-framed observations of procurement, expenditure, and reimbursement processes. For example, an evaluation could identify the percent of funds obligated within a certain time period (e.g., 90 days) from the date of grant award. Similarly, reimbursement processes can be tracked from date of service delivery through invoicing to payment, with documentation of any adverse impact on clients or providers related to delayed payments. HIV/AIDS Bureau/Division of Service Systems (“HAB/DSS”) will occasionally request information about the assessment or require EMAs to submit a copy of the most recent administrative assessment as part of progress reports or grant applications.

In evaluating the administrative mechanism, communication between the Recipient’s and planning council is essential so that information can be efficiently shared. The Recipient’s must communicate back
to the planning council the results of its procurement process. The planning council may then assess the consistency of the procurement process with its stated service priorities and allocations.

If the council finds that the existing mechanism is not working effectively, it is responsible for making formal recommendations for improvement and change. The Recipient or administrative agency then needs to respond to the planning council in writing, informing it of corrective actions to be taken to improve or change the system. The planning council also has the right to bring a formal grievance if the Recipient’s disbursement of funds is inconsistent with the planning council’s priorities and resource allocations.

The planning council also has the option of evaluating the "effectiveness of the services offered in meeting identified need." This means that the planning council can assess whether the services that have been procured by the Recipient are consistent with stated planning council priorities, resource allocations, and instructions as to how to meet these priorities. However, assessing the administrative mechanism is not an evaluation of the Recipient or individual service providers, which is a Recipient responsibility.

B. Methodology: A description of the activities (including survey tools, etc.) utilized to conduct the Administrative Assessment.

C. Assessment of the Procurement Process: The assessment of rapidly allocating funds to the area of greatest need should focus on measuring the time between when the funds are allocated to the Recipient and when service contracts are finalized. In assessing the reallocation of funds during the program year, the time between when the Care Council approves a reallocation action and when the contract amendment is finalized should be the time measurement.

D. Assessment of Business Transactions: An analysis should be included with tables utilizing data collected from the Recipient measuring the time (# of days) between receipt of invoice, approval for payment, and actual receipt of payment. Established benchmarks (i.e. Florida Prompt Payment Act) should be included in this particular analysis to measure efficiency and performance. An additional activity related to the transactions analysis is an assessment of the Recipient’s efficiency in expending the awarded funds within a fiscal year. An unexpended grant award of less than 5% is considered an acceptable benchmark by HRSA.

E. Assessment of Contract Monitoring: A narrative will include an analysis of the accomplishments to include improvements/successes as well as challenges/barriers of the monitoring process (both fiscal and program monitoring) and will identify specific elements such as amounts incorrectly billed, the number of case files/records reviewed, possible corrective action trends which are identified and implemented by the Recipient, technical assistance projects provided, etc.

F. Provider Survey/Focus Groups: All contracted Ryan White providers will be offered a standardized survey tool, with weighted responses. The survey will be collected and a written analysis will be provided with observations and/or recommendations based upon the findings. The survey tool will contain sections related to all major activities of the Recipient such as procurement (RFA process), support, invoice reimbursement, communication, monitoring, and how the Recipient responds to consumer issues (i.e. grievances/complaints) related to service delivery. The preferred method of survey is in electronic media, so that results may be compiled cleanly without delay or transcription error.

In addition, a minimum of two focus groups will be held to obtain input, which will commence after the survey has been initiated and/or completed. The focus groups will be open to all RPARC and Care Council members and all contracted providers. One of the focus group meetings will be offered during evening hours and they must be held in different locations. One must take place in Hillsborough County and one in Pinellas County.

G. Accomplishments and Progress: An update will be included to respond to prior year recommendations and to recognize the work accomplished.

H. Summary of Findings: Is the Recipient meeting the responsibilities of managing the grant?
I. **Recommendations/Next Steps:** Section will include a process improvement and action plan, to align and integrate with the Quality Management framework that has been established within the EMA/TSA. Suggestions for future assessment activities (i.e. expansions based upon improvements with data collection) will be addressed and developed.

This service will be reimbursed on a line-item budget.

<table>
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<th>PART A FUNDING AVAILABLE:</th>
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<td>County</td>
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D. **SUBMISSION REQUIREMENTS and GENERAL TERMS**

1. **Hillsborough County** will conduct a pre-submittal conference concerning this present RFA at the following place and time:

   The County Center  
   Health Care Services Conference Room  
   601 E Kennedy Boulevard, 16th Floor  
   Tampa, Florida 33602  
   Friday, September 21, 2018 at 9:00 a.m. EST.

2. Service providers seeking a contract under this RFA are required to submit applications as follows:
   a. 1. One (1) original response/application.
   2. Three (3) copies of sections two (2) and three (3) only, **some attachments may need to be submitted in Sections 1, 2, and 3, provide copies in all necessary sections.**
   3. Response/application must be submitted in a sealed envelope with the applicant's name and marked: **SEALED RESPONSE FOR RFA # RW1-18.** The original signature of the service provider's authorized official must appear on the original application.
   b. Applications must be typed, double-spaced on 8 1/2" X 11" size paper only, and pages must be numbered.
   c. Applications must contain the information listed in number 22 of this section of the RFA.
   d. In order to be considered, applications must be received before the **deadline of 5:00 p.m. EST, Tuesday, November 13, 2018, at the following location:**

   Health Care Services Department  
   601 E. Kennedy Blvd, 16th Floor  
   Tampa, Florida 33602  
   Applications will not be accepted after the deadline.

   It is the Applicants responsibility to continually review the Health Care Services website to verify whether any Addendums have been issued. The website address is: [http://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-white-rfa](http://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-white-rfa)

   e. Applicants applying to provide more than one service or county must submit a separate application for each service or each county.
   f. If the applicant is awarded a contract the applicant agrees to execute a contract with the COUNTY. The contract shall be similar to the form contract included in Section G, Exhibit 4 of this RFA, except the contract to be executed shall be complete as appropriate for the service to be provided, audit language, computer databases/systems, additional financial requirements, security, confidentiality, the price per unit of service, units to be delivered, measurable outcomes, and any others deemed necessary by the COUNTY. The applicant agrees to be bound by all the terms and conditions set forth in the form contracts included in Section G of this RFA.

3. An award shall not be made to any applicant that receives more than $750,000 in federally funded contracts that has not submitted a fiscal audit of applicant’s preceding fiscal year prepared by an independent certified public accountant, that is complete and acceptable and demonstrates financial responsibility which shall be
determined at the sole discretion of County staff. For those agencies who receive less than $750,000 annually in federally funded contracts, an audited financial statement is still preferred, but an unaudited financial statement must be submitted for the County’s review. If an unaudited financial statement is submitted, the corresponding tax return should accompany the documents, in addition to any notes to the financials.

4. Awards shall not be made to parties listed on the nonprocurement portion of the General Services Administration’s “Lists of Parties Excluded form Federal Procurement or Nonprocurement Programs” in accordance with E.O.s 12549 and 12689, “Debarment and Suspension”: (See 45 CFR part 76.) This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than E.O. 12549.

5. The delivery of said application prior to the deadline is solely and strictly the responsibility of the applicant.

6. Due to funding Hillsborough County may at its sole discretion negotiate with the PROVIDER regarding the funding, units of services and any other requirements deemed necessary by the COUNTY, however, all other contract requirements in the form contracts included in this RFA are not subject to negotiations. Hillsborough County may at its sole discretion add additional terms and requirements to the form contract based on new or additional requirements from the Grantor.

7. Failure to negotiate in good faith or to perform after the contract is awarded may result in debarment from future contracts with Hillsborough County.

8. The submission of an application shall be taken as prima facie evidence that the respondent has familiarized herself/himself with the contents of this RFA.

9. The applicant understands that pursuant to Section 119.07(3)(m), Florida Statutes, all applications submitted and accepted in response to this RFA are exempt from the Florida Public Records Law for a period of ten (10) days, from the date of their opening.

10. The COUNTY’s RFA Evaluation Team reserves the sole right to request additional information and clarification of any information submitted.

11. The applicant described in the completed response shall be the person or entity who will perform the services required by this RFA and subsequent contract. Said applicant will not be considered a COUNTY employee. The successful applicant shall be an independent contractor.

12. The applicant must sign the application(s), with his/her signature in full. When a corporation is an applicant, the officer signing shall set out the corporate name in full beneath which she/he shall sign his/her name and give the title of the corporate office held. The corporate application shall also bear the seal of the corporation. Anyone signing the application as agent must file with the application legal evidence of his/her authority to do so. Applicants who are non-resident corporations shall furnish to the COUNTY a duly certified copy of their permit to transact business in the State of Florida attached to their application.

13. The applicant is solely responsible for reading and completely understanding the contracts attached in Section G. of this RFA.

14. The applicant is solely responsible for reading and completely understanding the RFA requirements. **The RFA submission deadline will be scrupulously observed. Under no circumstances will applications delivered after the specified submission date and deadline time be accepted or considered. Late applications delivered by U.S. mail or other independent carrier will be returned to the respondent unopened with the notation: "This application was received after the deadline designated for the receipt of the applications."** The delivery of said application to the Department of Health Care Services prior to the deadline for submitting application stated in the RFA schedule is solely and strictly the responsibility of the Applicant. For informational purposes, the Applicant is hereby advised that United States Postal Service delivery is made to the County’s Post Office Box. Such delivery is not made directly to the Health Care Services Department street address even if the Applicant specifies the street address and/or even if Express Mail Service is utilized, therefore, use of the United States Postal Service may cause a delay in the receipt of said application.
Applicants are cautioned to plan necessary delivery time accordingly. The COUNTY will in no way be responsible for delays caused by the United States Postal Service or for delays caused by any other occurrence. All proposals must be manually and duly signed by an authorized corporate officer, principal, or partner (as applicable). All applicants proposals must be marked:

SEALED RESPONSE FOR RFA# : RW1-18
TO BE OPENED AT DEPARTMENT OF HEALTH CARE SERVICES, RYAN WHITE SECTION
601 E KENNEDY BLVD, 16th FLOOR, TAMPA, FL 33602

15. An application may be withdrawn, on written request by the applicant in time for delivery in the normal course of business, prior to the deadline to receive applications. Negligence on the part of the applicant in preparing the application confers no right of withdrawal or modification of its application, after Hillsborough County has received the application. Applicants may not withdraw or modify a response after the designated deadline to receive applications. The applicant may not assign or otherwise transfer the application. The application will be in force for a period of 120 days after the opening date.

16. No interpretation of this Request for Applications will be made to any applicant orally. Every request for such interpretation must be in writing, addressed to the Hillsborough County Grants Programs Services Compliance Coordinator, Health Care Services Department. To be given consideration, such requests must be received at least fifteen (15) calendar days prior to the deadline fixed for submitting applications. It is the Applicants duty to determine if any addenda was issued. Such interpretations and any supplemental instructions will be in the form of a written addendum which, if issued, will be posted at Health Care Services, 601 E. Kennedy Blvd., 16th Floor, Tampa, FL 33602 and will be sent to all prospective Applicants at the respective addresses furnished for such purposes. The DEPARTMENT takes no responsibility in assuring the applicants receive the written addenda. The DEPARTMENT will make every effort to have said addenda no later than ten (10) calendar days prior to the deadline fixed for submitting the applications. In addition, Applicants should not allow the submission of any addenda, no matter when received, to prevent them from submitting the application prior to the deadline. If requested, a copy of each addendum may be obtained by the prospective applicant or his/her representative at the Health Care Services Department, 601 E. Kennedy Blvd., 16th Floor, Tampa, Florida 33602. Failure of any applicant to receive any such addendum or interpretation shall not relieve said applicant from any obligation under her/his application as submitted. All addenda so issued shall be made available to all Applicants selected for contract negotiations and shall become part of any subsequent Agreement.

17. All documents resulting from this RFA and documents resulting from all subsequent activities under the resultant contracts shall become the property of the COUNTY. Notwithstanding the foregoing, the successful applicant under contract with the COUNTY, hereafter referred to as CONTRACTOR or PROVIDER where appropriate, may provide the COUNTY photocopies of records and other documents when legal requirements require the CONTRACTOR to maintain the originals in its facility.

18. No successful applicant may make any assignment of duties, in whole or in part, to any third party under the resulting contractual agreement between the parties without the prior written authorization of Hillsborough County.

19. The cost of preparing a response to this RFA shall be borne entirely by the applicant.

20. Hillsborough County, hereby notifies all Applicants that: Disadvantaged Minority Business Enterprises (DMBE's), and Disadvantaged Women Business Enterprises (DWBE's) will be afforded a full opportunity to participate in any award made by Hillsborough County pursuant to this Request for Applications and will not be subjected to discrimination on the basis of race, color, sex, or national origin. Hillsborough County prohibits any person involved in Hillsborough County contracting and procurement activities, as defined in Ordinance 00-37, to discriminate on the basis of actual or perceived race, color, sex, age, religion, national origin, disability, marital status, sexual orientation, or gender identity or expression, in employment, public accommodations, real estate transactions and practices, County contracting and procurement activities, and credit extension practices.

21. This document together with all exhibits and attachments constitutes the entire "RFA package." Said RFA package must be the basis upon which all applications are submitted. All completed responses to this RFA must be kept together and returned intact (sealed from public view) to the Hillsborough County Health Care Services
Department at the specified time and place.

22. To apply the applicant must submit a complete application as well as any other document required by this RFA. Some items must be provided as attachments as outlined below. The Application will consist of:

1. Application Cover Sheet
2. Authorized Signature Page
3. Acknowledgement Page
4. Application Contents & Evaluation Criteria
5. Attachment I, Articles of Incorporation
6. Attachment II, Non-profit status
7. Attachment III, By-laws
8. Attachment IV, Board of Directors
9. Attachment V, Good Standing Certificate
10. Attachment Va, Partnership or Limited Partnership paperwork
11. Attachment VI, Organizational Chart
12. Attachment VII, Public Entity Crimes Statement
13. Attachment VIII & VIIIa, Civil Rights Status and Certification Regarding Lobbying
15. Attachment X, Work Force Analysis
16. Attachment XI, Equal Employment Questionnaire
17. Attachment XII, Audit/Financial Statements*
18. Attachment XIII, Summary of Funding Sources
19. Attachment XIV, Pricing Schedule
20. Attachment XV, Collaborative Agreements
21. Attachment XVI, Job Descriptions
22. Attachment XVII, Staff licensure or certifications
23. Attachment XVIII, Insurance coverage
24. Attachment XIX, Budgets (Condition of Award Budget, Categorical Budget, Budget Narrative)

*In the event an applicant receives federal funds and is otherwise required to conduct an audit in accordance with the applicable OMB Circular, Program Audit Guide or Government Auditing Standards, applicant shall submit a copy of said audit for the preceding fiscal year. In the event applicant receives state funds and is otherwise required to conduct an audit in accordance with Section 215.97, Florida Statutes, applicant shall submit a copy of said audit for the preceding fiscal year. For those agencies who receive less than $750,000 annually in federally funded contracts, an audited financial statement is still preferred, but an unaudited financial statement must be submitted for the County’s review. If an unaudited financial statement is submitted, the corresponding tax return should accompany the documents, in addition to any notes to the financials.

23. PROVIDER and staff must possess all required State of Florida licenses, as well as appropriate County licenses, and shall comply with all laws, ordinances, and regulations applicable to the services for which it is contracting.

24. Applicants understand and agree to comply with all applicable federal, state, and local laws and regulations.

25. If any term or provision of this RFA and subsequent contract is found to be illegal or unenforceable, the remainder of the contract shall remain in full force and effect and such term or provision shall be deemed stricken, provided the parties are not materially prejudiced thereby.

26. The laws, rules, and regulations of Florida shall govern this RFA; or when the services provided are funded by the United States, the laws, rules, and regulations of the United States Government shall govern this RFA.

27. All requirements, terms, attachments and exhibits contained in this RFA document are incorporated into any resulting contract with the COUNTY by this reference.

28. The award of the Application and continuation of resulting contract will be contingent upon the availability of funds to Hillsborough County.
29. In addition to all other attributes that an applicant must possess regarding the requirements detailed within the pages of this RFA and pursuant to the precepts of public bidding, the Applicant must have the capacity (including the knowledge, skill, and general ability) to fully perform. Likewise, the Applicant must possess the integrity, reliability, and other qualities as will assure good faith performance. Accordingly, the Applicant should submit (as a part of the Applicant’s application) such clear and convincing documentation and other suitable evidence as will substantiate, to the County's satisfaction, this degree of responsibleness.

30. Hillsborough County reserves the right to reject any or all applications; to re-advertise this RFA, in whole or in part; to postpone or cancel this process; to waive irregularities in the RFA process; and to change or modify the project schedule at any time.

31. Where applicants have erasures or corrections, the Applicant must initial each erasure or correction in ink. In case of unit price contracts, if an error is committed in the extension of an item, the unit price as shown in the Pricing Schedule will govern.

32. **RFA CONTACT PERSON**

Inquiries and written requests for interpretation of this Request for Applications should be directed to:

Aubrey Arnold/Grants Programs Services Compliance Coordinator
Health Care Services Department
601 E. Kennedy Blvd, 16th Floor
Tampa, Florida 33602

Tel: (813) 272-6935   E-Mail: arnolda@HCFLGov.net

E. **APPLICATIONS EVALUATION**

Evaluation of the applications accepted in response to this RFA will be conducted by an RFA Evaluation Team made up of Persons Living With HIV or AIDS, COUNTY staff, staff of other Part A or Part B administration/lead agencies, which will include personnel with expertise in health, social services, cost accounting/budgeting, and any other individuals deemed appropriate by the Grants Programs Services Compliance Coordinator. The Grants Programs Services Compliance Coordinator will supervise and monitor the evaluation process. Additional persons may be asked to participate in the RFA Evaluation Team process on an advisory basis.

Based on County Policy, the COUNTY and/or the County Administrator will determine eligibility of applications according to the Organizations/Agencies Eligible to Apply and the Disqualification Criteria. County staff will notify those applicants who do not meet the mandatory eligibility requirements.

The obligations of the RFA Evaluation Team are as follows:

1. To rate all responsive applications based on the selection criteria set forth in this RFA.
2. To (a) recommend to the COUNTY the agency/organization selected to provide services, and (b) to recommend special conditions under which funding will be granted if appropriate.
3. To review grievances and make recommendations to the County Administrator.

Applications will be evaluated based on theSelection Criteria and the Disqualification Criteria delineated in the following sections. In cases of ties in scoring, such factors as unit cost, cost per client served, matching funds committed, the proportion of administrative to direct service costs, and performance feedback from references will be used to determine funding recommendations. Applicants, who are currently under contract with the County for services funded by the Ryan White programs, will be additionally evaluated on their performance, their adherence to contract conditions, and the meeting of certain programmatic objectives. For points to be awarded for performance, it is required that all applicants be current Ryan White providers. A PROVIDER is considered current if they have had a Ryan White contract within the past two (2) fiscal years. Those service PROVIDERs whose applications are found non-responsive according to the Disqualification Criteria will receive a formal Notice of Disqualification. The RFA Evaluation Team will rate all remaining applications and the respective service PROVIDERs will receive a notification of the Evaluation Team's recommendations regarding their applications.
DISQUALIFICATION CRITERIA
Applications will be considered non-responsive for any one of the reasons listed below. Applications that are found non-responsive will be automatically disqualified from funding and will not be rated by the RFA Evaluation Team.

1. Failure to submit a response by the deadline of 5:00 p.m. EST on Tuesday, November 13, 2018.
2. Failure to propose to serve residents in one or more of the eligible counties within the eligible area.
3. Failure to apply for one of the eligible, funded services listed in this RFA.

SELECTION CRITERIA
Applications will be rated by the RFA Evaluation Team based on their responses to the requests for information in this RFA package. Additionally, if all applicants for a specific service category are current or previous (past 2 fiscal years) Ryan White PROVIDERs then the Ryan White office will assign points based upon contractual adherence.

It is the COUNTY’s intention to solicit responses from potentially qualified applicants; to evaluate their applications and their financial information; to negotiate terms, and to award one or more contracts for services upon successful negotiation.

In order to achieve maximum scores, applicants must demonstrate to the COUNTY’s Evaluation Team that they are fully qualified to provide the services required by this RFA. Fully qualified applicants will have the qualification (knowledge, education, training, expertise, and skills) and experience (documented, successful, and relevant) necessary to meet the requirements of this RFA.

It is the objective of the COUNTY to attempt to provide client choice within funding limitations, and may award contracts to one or more applicants whose applications are judged through evaluation and negotiation process to be in the best interest of the COUNTY. However, to be eligible for award, the applicant must obtain a passing score and meet the COUNTY’s financial requirements.

The DEPARTMENT may attempt to fund multiple agencies if the specific category allocation is more than $100,000 and there is more than one applicant. In some instances the DEPARTMENT will determine that a program cannot function with limited funding and the highest ranked applicant may be the only one funded. The DEPARTMENT will start negotiations with the highest ranked eligible agency and work down until the funds are completely awarded.

The DEPARTMENT will implement a formula that will proportionally fund applicants based on their score, provided the allocation is more than $100,000. If the allocation is more than $100,000 but the program cannot function with limited funding the DEPARTMENT reserves the right to determine how many providers may be funded. If deviations from the formula are needed for any reason, they will be made at the sole discretion of the DEPARTMENT. The DEPARTMENT reserves the right, in some scenarios which involve an allocation in excess of $100,000, where client choice is not paramount and the administrative costs would be significantly reduced, to recommend funding only one agency.

In summary, the COUNTY reserves the rights to:
1. Award a contract to more than one applicant.
2. Conduct pre-award discussions with any or all responsive and responsible applicants who submit proposals determined to be reasonably acceptable of being selected for award.
3. Make investigations of the qualifications of applicants as it deems appropriate.
4. Award contracts to the highest ranked applicant for the amount requested and continue to award additional applicants provided there is funding.

GRIEVANCE AND APPEAL PROCESS
Appeal Process: The appeal process is available for purposes of contesting the ranking of funding recommendations. The recommendations of the RFA Evaluation Team may be grieved using the following procedure:
A written appeal, documenting the substantive reason(s) for appeal, must be filed in writing with the Grants Programs Services Compliance Coordinator, not later than ten (10) working days after receiving notification of non-selection for funding recommendation. This process is not intended for Applicants to supplement their application or simply appeal the RFA Evaluation Team's funding recommendations. Appeals are limited to substantive issues related to the Evaluation Team's failure to follow the process for review and determination. The RFA Evaluation Team will consider timely appeals and recommendations presented to the County Administrator, or referred on to pursue the federally approved grievance procedure. Failure to comply with the appeal process time frame and requirements shall be deemed to be a waiver of applicant's right to appeal.

Grievance Procedures: Grievance procedures are only applicable for deviations from established model procedures under the Ryan White Extension Act. The four instances when a grievance is applicable are:

- Deviations from the established contracting and awards process (e.g., the selection of a particular provider in a manner inconsistent with the Recipient’s established procurement process).
- Deviations from the established process for any subsequent changes to the selection of contractors or awards (e.g., reallocations).
- Contracts and awards not consistent with Care Council established priorities and resource allocations made by the Care Council including any language regarding how to best meet those priorities.
- Contract and award changes not consistent with priorities and resource allocations made by the Care Council.

The grievance notice must be filed in writing with the Grants Programs Services Compliance Coordinator no later than ten (10) working days after public notification of the Recipient’s funding recommendations. The Grants Programs Services Compliance Coordinator makes a preliminary determination that the grievance meets criteria and provides a grievance form to the grieving party. The process further requires the grievant to return the grievance form within ten (10) working days to initiate the non-binding grievance process. If deemed ineligible, the grievant is required to notify the Recipient that it still wishes to initiate the grievance process. Failure to comply with the grievance procedure time frame and requirement shall be deemed to have waived applicant’s right to grieve.

AWARD PROCEDURE

The COUNTY shall be the final authority regarding matters of contractual fairness and reasonableness. Notwithstanding the foregoing, the COUNTY reserves the right to reject any or all applications submitted in response to this RFA and waive any informality concerning the application, whenever such rejection or waiver is in the best interest of Hillsborough County and when same is in conformance with standard competitive sealed bid procedures. The Care Council will be notified of the results of the application review process and the funding recommendations submitted to the Board of County Commissioners for contract awards. The decision of the Board of County Commissioners will be final.

This RFA does not commit Hillsborough County to award a contract or to pay any costs incurred in the preparation of an application in response to this RFA. The County reserves the right to accept or reject any or all applications received as a result of this RFA, to negotiate with any qualified source, or to cancel in part or in its entirety this RFA, if it is in the best interest of the County or the eligible and affected community.

The DEPARTMENT may attempt to fund multiple agencies if the specific category allocation is more than $100,000 and there is more than one applicant. In some instances the DEPARTMENT will determine that a program cannot function with limited funding and the highest ranked applicant may be the only one funded. The DEPARTMENT will start negotiations with the highest ranked eligible agency and work down until the funds are completely awarded. Due to funding levels, certain negotiations may be necessary for price, units of service, and outcomes.

The DEPARTMENT will implement a formula that will proportionally fund applicants based on their score, provided the allocation is more than $100,000. If the allocation is more than $100,000 but the program cannot function with limited funding the DEPARTMENT reserves the right to determine how many providers may be funded. If deviations from the formula are needed for any reason, they will be made at the sole discretion of the DEPARTMENT.
If it is in the best interest of the COUNTY, the COUNTY reserves the right to award contracts to the highest ranked applicant for the amount requested and continue to award additional applicants provided there is funding, using the follow method. Due to funding levels, certain negotiations may be necessary for price, units of service, and outcomes with the applicant(s) with highest scores prior to submitting a contract recommendation to the Board of County Commissioners. If the County staff is unable to successfully negotiate a contract with the top ranked applicant, negotiations will be entered into with the next highest ranked applicant. Negotiations will continue in descending ranked order until a fair and reasonably contract price is negotiated.

**CONTRACT AWARDS**

The final decision regarding service provider funding under the grant programs will be made by the Hillsborough County Board of County Commissioners (BOCC). A contract in the form attached in Section G. will be executed between the BOCC and the providers selected to perform the services solicited in this RFA. The contract will be effective upon execution or as stated in the agreement and terminating at the end of the applicable grant budget. Some applications may be partially funded, and some qualified applications may be approved for funding under additional grant funds, depending on availability of funds.
REQUEST FOR APPLICATIONS RFA # RW1-18
RYAN WHITE TREATMENT EXTENSION ACT PART A
APPLICATION COVER SHEET

___Original
___Copy

APPLICANT AGENCY__________________________________________________________

AGENCY ADDRESS____________________________________________________________

CONTACT PERSON____________________________________________________________

PHONE_______________________FAX_________________________

SERVICE CATEGORY OF APPLICATION____________________________________________

AGENCY TYPE: _____Government, _____Not-for-Profit, _____For Profit

AGENCY DUNS #:______________________________

WILL ANY PORTION OF THIS SERVICE BE SUBCONTRACTED OUT? ____Yes  _____No

COUNTY TO BE SERVED: _____HILLSBOROUGH, _____PINELLAS, _____PASCO, _____HERNANDO

AMOUNT OF FUNDS REQUESTED: ___________________________

CURRENT OR PRIOR PART A PROVIDER: YES ___________ NO ___________
AUTHORIZED SIGNATURE

(RFA# RW1-18)

By his/her signature, the below named applicant affirms and declares:

1. That the applicant has contractual capacity, and that no other person, firm or corporation has any interest in this application or in any subsequent potential Agreement.

2. That all information presented in this application is true and correct to best of the applicant's knowledge and belief.

3. That this application is made without any understanding, agreement, or connection with any other person, firm or corporation making an application for the same purpose, and is in all respects fair and without collusion or fraud.

4. That the applicant is not in arrears to Hillsborough County upon debt or contract and is not a defaulter, as surety or otherwise, upon any obligation to Hillsborough County.

5. That no officer or employee or person whose salary is payable in whole or in part from the COUNTY is, shall be or become interested, directly or indirectly, as surety or otherwise in this RFA, in the performance of any subsequent Agreement for the services contained in the RFA or in any portion of the profits derived therefrom.

IN WITNESS WHEREOF, this application is hereby signed and sealed as of the date indicated below.

ATTEST:                          APPLICANT:

______________________________
WITNESS                          BY: ______________________ (Seal)

AUTHORIZED INDIVIDUAL

_____________________________________
WITNESS(Printed Name of Signer)

CORPORATE SEAL
(where appropriate)

_____________________________________
Title of Signer

_____________________________________
Date
ACKNOWLEDGMENT OF PROVIDER, IF A CORPORATION

STATE OF ____________________________        COUNTY OF ____________________________

The foregoing instrument was acknowledged before me this ____________________________ by (Name of officer or agent, title of officer or agent)

(Official Notary Signature and Notary Seal)

Commission Number

Commission Expiration Date

(Name of Notary typed, printed or stamped)

ACKNOWLEDGMENT OF PROVIDER, IF A PARTNERSHIP

STATE OF ____________________________        COUNTY OF ____________________________

The foregoing instrument was acknowledged before me this ____________________________ by ____________________________, partner (Name of acknowledging partner or agent)

(Official Notary Signature and Notary Seal)

Commission Number

Commission Expiration Date

(Name of Notary typed, printed or stamped)

ACKNOWLEDGMENT OF PROVIDER, IF A GOVERNMENTAL ENTITY

STATE OF ____________________________        COUNTY OF ____________________________

The foregoing instrument was acknowledged before me this ____________________________ by ____________________________, who (Name of person acknowledging)

personally appeared before me at the time of notarization, and is personally known to me or has produced ____________________________ as identification and did certify to have knowledge (Type of Identification)

of the matters stated in the foregoing instrument and certified the same to be true in all respects. Subscribed and sworn to (or affirmed) before me this ____________________________.

(Official Notary Signature and Notary Seal)

Commission Number

Commission Expiration Date

(Name of Notary typed, printed or stamped)
THE FOLLOWING CONSTITUTE THE APPLICATION QUESTIONS ON WHICH YOUR REQUEST FOR FUNDING WILL BE RATED. PLEASE ANSWER EACH AS FULLY AS YOU CAN, ASSUMING THAT THE EVALUATORS ARE NOT FAMILIAR WITH YOUR AGENCY. PLEASE ANSWER THE QUESTIONS IN THE ORDER THEY ARE ASKED, TO ASSURE THAT YOUR ANSWER TO ANY PARTICULAR QUESTION IS NOT OVERLOOKED.

PAGE LIMITATIONS WILL BE LISTED AFTER EACH QUESTION, IF APPLICABLE. IF NO PAGE LIMITATIONS ARE ESTABLISHED, PLEASE PROVIDE THE INFORMATION REQUESTED.

SECTION 1     (10% of the points will be assigned to Section 1)

**Special note: if an applicant has responded to Section 1 by providing the requested documents within Calendar year 2017 or so far in 2018 the applicant does not need to provide the requested items under this RFA. The applicant simply needs to state which RFA number the documents were provided. If the applicant has not provided the current documents within the time frame listed then they would need to provide all documents requested.**

Section 1.1 Agency Background/History/Organization

1. Attach a copy of your organization’s Article of Incorporation, as ATTACHMENT I, if the agency has applied to the DEPARTMENT for funding within the last calendar year you do not need to attach this document as it is already on file.
2. Attach a copy of your organization’s non-profit status, as ATTACHMENT II, if the agency has applied to the DEPARTMENT for funding within the last calendar year you do not need to attach this document as it is already on file.
3. Attach a copy of your by-laws as ATTACHMENT III, and a list of your current Board of Directors as ATTACHMENT IV, if the agency has applied to the DEPARTMENT for funding within the last calendar year you do not need to attach this document as it is already on file.
4. Attach a copy of your Good Standing Certificate issued by the State of Florida, as ATTACHMENT V. If a partnership, include a copy of your partnership agreement, list of all partners, and a limited partnership a certificate of limited partnership, as ATTACHMENT Va, if applicable.
5. Submit an organization chart, as ATTACHEMENT VI. Indicate the number of paid staff and volunteers, describe any advisory groups, and explain any legal relationships linking your agency to other agencies or organizations.
6. Complete and include the Public Entity Crimes Statement, as ATTACHMENT VII.
7. Complete and include the Civil Rights Status form, as ATTACHMENT VIII, and complete and include the Certification Regarding Lobbying form as ATTACHMENT VIIIa.
8. For agencies of 15 or more employees, include your agency’s Affirmative Action Plan or Equal Opportunity Policy Statement, signed and dated by the CEO or designated official, as ATTACHMENT IX.
9. Complete the Work Force Analysis form, as ATTACHMENT X.
10. Complete and include the Equal Employment Opportunity Questionnaire, as ATTACHMENT XI. The PROVIDER agrees to comply with the Hillsborough County Equal Opportunity Clause.

Section 1.2 Fiscal Management and Stability of Agency

11. If applicant receives more than $750,000 in federally funded contracts they must submit an audit of applicant’s preceding fiscal year prepared by an independent certified public accountant, that is complete and acceptable and demonstrates financial responsibility which shall be determined at the sole discretion of County staff. For those agencies who receive less than $750,000 annually in federally funded contracts, an audited financial statement is still preferred, but an unaudited financial statement must be submitted for the County’s review. If an unaudited financial statement is submitted, the corresponding tax return should accompany the documents, in addition to any notes to the financials. Attach your audit as ATTACHMENT XII. If the audit is more than 6 months old the applicant must also provide a copy of their financial statement for their most recent quarter end and a year-end statement.
12. Describe what corrective action you have taken as a result of the audit findings and recommendations. If your organization does not have an audited financial statement, please indicate the reason why.
13. Describe any deficiencies or recent improvements in your in your fiscal management system, include the
number of employees involved in managing grants and preparing invoices.

14. What other funding does your agency have? Please list the Summary of Other Funding Sources form and attach as ATTACHMENT XIII.

15. Describe how your agency ensures that Ryan White Part A is not your agency’s sole funding source. What plans do you have for the next five years that will increase your revenue? Include items such as fundraising efforts, other grants, or new service areas.

16. If not extensive, provide your agency’s Emergency Preparedness Plan (EPP). If your EPP is extensive the APPLICANT must attest that they have a plan in place. If the APPLICANT is funded, a complete copy will be required to be submitted.

SECTION 2 (65% of the points will be assigned to Section 2)
Section 2.1 Scope of Services

1. Clearly describe the project you are proposing to be funded under this RFA, and indicate your prior experience in delivering this service. Include a description of your proposed service approach and the rationale underlying the approach to be taken in providing the service. This section must describe the intended purpose and the expected project results related to program expectations. The objectives must correspond to the assessed needs, priorities, gaps in services, and barriers to care, as well as the four primary goals of the National HIV/AIDS Strategy (NHAS). The objectives must consider an integrated service network that guides and tracks clients through a comprehensive array of clinical, mental health and social services in order to maximize access and outcomes.

2. Please describe applicant’s plan to achieve the objectives identified in the preceding question through a narrative that describes how the activities outlined in the Budget Narrative will achieve the following:
   a) Address the four primary goals of the 2020 National HIV/AIDS Strategy by reducing new HIV infections; increasing access to care and improving health outcomes for people living with HIV/AIDS; reducing HIV-related disparities and health inequities; and achieving a more coordinated response to the HIV epidemic.
   b) Address Unmet Need and reduce the number of persons out of care.
   c) Address individuals who are unaware of their HIV status with regard to identifying them, making them aware of their status, referring them to care, and linking them to care.
   d) Ensure geographic parity in access to HIV/AIDS services throughout the geographic area.
   e) Address the needs of emerging populations.

3. On the Pricing Schedule indicate how many unduplicated clients you will serve for this service category annually, the number of units of service to be provided, cost per unit, and total cost of the project annually, attach as ATTACHMENT XIV.

4. If applying for Medical Case Management (MCM) please further describe your program and how it meets the following portion of the HRSA definition of MCM: trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters. Is your MCM staff medically credentialed, if not, how is your agency meeting this objective?

5. Describe the organization’s knowledge, involvement and activities with the early identification of individuals with HIV/AIDS (ElIHA) efforts within the applicable county. This includes efforts to link clients who are aware of their HIV status to medical and support services, as well as any efforts to make people aware of their HIV status particularly highlight effort targeting the populations. Applicants must incorporate the following components of the Continuum of HIV Care in their response:
   a) HIV testing and subsequent diagnosis
   b) Linkage to HIV medical care
   c) Continuous engagement in HIV medical care (retention)
   d) Initiation of antiretroviral therapy
   e) Suppressed viral load (<200 copies/mL)

6. What innovation, creativity, standards or best practices have been implemented by your agency in delivering the proposed service category?
7. Is this a new service for your agency? If so, please provide a time table for service delivery.

Section 2.2 Cultural Competency
1. Describe your organization's guiding principles and standards addressing Cultural Competence. Describe your organization’s capabilities to respond to special client groups and to special client needs, demonstrating Cultural Competence in care planning for clients. Additionally, describe your organization’s professional development standards/staff training requirements to ensure Cultural Competence in service delivery.
2. Identify your target population by age, sex, race/ethnic group, income levels, and geographic area of the County. How will your agency provide culturally competent, culturally sensitive, and culturally linguistic services to the population? In what languages will you be able to provide services?
3. Describe your agency’s efforts to ensure cultural diversity and sensitivity, including staff trainings, ratio of direct care staff to client mix in terms of racial/ethnic demographics, and your outreach methods to minorities clients to be served under this service category.

Section 2.3 Access and Location
1. What is the address(es) of the service location? How far is the location from your target population? Is the site on a bus route?
2. What are your hours of operation? An extra 2 points will be given to applicants who are open after hours or open for business at least one hour early or late one day per week. (Must be before 8am or after 5pm Monday through Friday, or offer weekend hours)
3. Identify the data collection methods to ensure client demographics will be reported accurately. Who will be responsible for maintaining client and service delivery data?
4. Discuss how this program will be linked to other programs within the organization, as well as to external resources within the continuum of care. Provide any materials your agency gives to clients informing them of available services (agency specific and/or county-wide). The applicant should be able to refer clients effectively to other services, and be able to track the results of those referrals. Describe any collaboration agreements with other agencies, linkage and/or co-linkage agreements that have been newly developed or renewed, specifically for this project or how your organization intends to handle such needs. Describe how they improve service, increase access, increase quality, maximize resources, and save money. Copies of relevant collaborative agreement should be included as ATTACHMENT XV.

5. Explain specific barriers to the provision of services that exist in the population and area(s) proposed to be served (e.g., confidentiality and geographic barriers to services). Address how your agency plans to reduce or alleviate these barriers, and your plans to ensure client access to the services that will be provided (e.g., bilingual staff, extended/weekend hours of service, co-location service agreements, the option of in-home services, childcare, incentives, transportation, etc.).

6. HRSA requires that all providers maintain appropriate relationships with entities in the EMA that constitute key points of access to the health care system for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but who are not in care. These key points of access include emergency rooms, substance abuse treatment programs, detoxification programs, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV disease counseling and testing sites, mental health programs and homeless shelters. Discuss the key points of entry that are covered by your collaborative agreements.

Section 2.4 Staffing and Licensure
1. Provide a description of how the program will be staffed (e.g., paid staff or volunteers). Indicate how often employees are evaluated. Identify the number and type of positions needed; how they will be recruited and maintained; whether they will be full-time or part-time; and the qualifications proposed for each position, including type of experience and training required. Describe staff development and training practices, including both internal and external capacity trainings and any other relevant training. Provide job descriptions of all staff who will be billed under this grant, as ATTACHMENT XVI.

2. Provide copies of appropriate licensure and/or certification for staff, attach as ATTACHMENT XVII.
3. Provide copies of appropriate insurance coverage for the service being proposed, submit as ATTACHMENT XIX. If you do not have the current limits listed under Exhibit G #1, please provide documentation that your agency has the ability to provide the appropriate insurance coverage effective at the beginning of the contract period. Insurance limits for each service category are provided in Exhibit G.

Section 2.5 Agency Background
1. Describe the history of your agency. (2 pages)
2. List the full range of services that your organization currently provides. If your organization is part of a multi-program organization, provide a description of the parent organization and its involvement in the ongoing operation of your organization.
3. Will your agency be subcontracting any of the services out to another individual or agency? If so, state who they are and if they are non-profit or for-profit.
4. State the overall goals and objectives of your organization. (2 pages)
5. Describe your agency’s organizational and service growth since its inception. (2 pages)
   a. Any major changes that have taken place, including achievements and progress that have been made.

6. Describe how the organization is complying with the Health Insurance Portability and Accountability Act (HIPAA). Please detail your agency’s efforts to comply with HIPAA regulations to the extent that such regulations are applicable to your agency with regard to client records and conversations. If your agency does not provide services that fall under HIPAA Privacy Rules, please provide a statement to that effect.
7. Provide the qualifications and education requirements your agency uses in its hiring practices for the following positions: Executive Director, Fiscal Manager, HIV Program Manager or Supervisor. Please list the degrees required, years of experience, and specialized skills. Please answer in a concise narrative, job descriptions do not need to be attached. (2 pages)

SECTION 3 (25% of the points will be assigned to Section 3)
Section 3.1 Budget and Cost Effectiveness
1. Complete and include the Condition of Award Budget form attached as ATTACHMENT XX. Complete and include the budget narrative which describes job duties for listed staff, and descriptions of other lines. The line item budget must be completed. Administrative costs cannot exceed 10% of the budget submitted, which includes rent and utilities. Travel expenses must comply with COUNTY standards and allowance for Part A funding. Mileage shall not exceed the County rate for Part A. No out-of-state travel is allowable under this grant.
2. If the service you are applying for is to be reimbursed on a fee-for-service basis you must complete the Pricing Schedule, which includes the rate to be charged for this service. This was completed in number one of Section 2.1. Provide another copy in this section of ATTACHMENT XIV.

Section 3.2 Other funding Sources
1. If this is a current service that your agency provides, does your agency have any other funding for this specific service category?
2. Describe the procedures or billing practices that your agency will use to bill other third party payors such as Medicaid, Medicare, and Hillsborough HealthCare, to ensure Ryan White Part A is payor of last resort.

(The remainder of page intentionally left blank.)
SWORN STATEMENT UNDER SECTION 287.133(3)(a) FLORIDA STATUTES, ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICER AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to [print name of the public entity]

by [print individual's name and title]

for [print name of entity submitting sworn statement]

whose business address is

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

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

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

4. I understand that an "affiliate" as defined in Paragraph 287.133(1)(1), Florida Statutes means:

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

5. I understand that a "person" as defined in Paragraph 287.133(1)(3), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.
6. Based on information and belief, the statement, which I have marked below, is true in relation to the entity submitting this sworn statement.  [Indicate which statement applies.]

____ Neither the entity submitting this sworn statement, nor any officers, directors, executives, partners, shareholders, employees, members, or agents, who are active in the management of the entity, nor any affiliate of the entity have been charged with and convicted of a public entity crime within 3 years of signing this document.

____ The entity submitting this sworn statement, or one or more of the officers, directors, executives, partners, shareholders, employees, members, or agents, who are active in management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime within 3 years of signing this document.

____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime within 3 years of signing this document. However, there has been a subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and a final order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list.  [attach a copy of the final order.]

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH ONE (1) ABOVE IS FOR THAT PUBLIC ENTITY ONLY, AND THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED.  I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.107, FLORIDA STATUTES, FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

[Signature]

Sworn to and subscribed before me this ___________ day of ___________ 20___.

Personally known

OR Produced identification

Notary Public - State of

(Type of identification)  My commission expires

(Signature of Notary)  (Printed, typed, or stamped commissioned name of notary public)
Equal Employment Opportunity

The following two pages are Hillsborough County's Equal Employment Opportunity Clause, the provisions of which must be complied with by all contractors with the County, and the related applicable statutes, orders and regulations. Following that are the EEO/Civil Rights Status form that must be completed, a statement on sanctions and penalties, the Equal Employment Opportunity Questionnaire Instructions, and Work-Force Analysis that must be completed. It is mandatory that a copy of the agency's Affirmative Action Plan be attached(required if agency has 15 or more employees), and a copy of the agency's Affirmative Action/Equal Employment Opportunity Policy Statement is required for all applicants regardless of size. It is also very important to include the information requested concerning the ethnic makeup of the agency's Board of Directors and direct service staff.

HILLSBOROUGH COUNTY EQUAL OPPORTUNITY CLAUSE

During the performance of any Agreement resulting from this RFA, the selected applicant as CONTRACTOR agrees as follows:

1. General: The CONTRACTOR will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, age, handicap or marital status. The CONTRACTOR will take affirmative action to insure that applicants are employed and that employees are treated during employment without regard to their race, color, religion, sex, national origin, age, handicap or marital status. Such action shall include, but not be limited to: employment, upgrading, demotion, or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The CONTRACTOR agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provision of this non-discrimination clause.

2. Recruitment: The CONTRACTOR will in all solicitations or advertisements for employees placed by or on behalf of the CONTRACTOR state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, age, handicap, or marital status.

3. Unions: The CONTRACTOR will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding a notice advertising the labor union or worker's representative of the CONTRACTOR'S commitments under this assurance, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. Compliance Reports: The CONTRACTOR will maintain records and information assuring compliance with these requirements and shall submit to the designated Hillsborough County official timely, complete, and accurate compliance reports at such times and in such form containing such information as the responsible official or his designee may determine to be necessary to enable him to ascertain whether the CONTRACTOR has complied or is complying with these requirements. The CONTRACTOR will permit access to his books, records and accounts by Hillsborough County for purposes of investigation to ascertain compliance with such rules, regulations and orders. In general, the CONTRACTOR and subcontractors should have available racial and ethnic data showing the extent to which members of minority groups are beneficiaries under these contracts.

5. Sanctions: In the event of the CONTRACTOR'S non-compliance with the non-discrimination clauses of this contract or with any of such rules, regulations or orders, this contract may be canceled, terminated or suspended in whole or in part and the CONTRACTOR may be declared ineligible for further Hillsborough County contracts by rule, regulation or order of the Board of County Commissioners of Hillsborough County, or as otherwise provided by law.

6. Subcontractors: The CONTRACTOR will include the provisions of paragraphs 1 through 6 in every subcontract under this contract so that such provision will be binding upon each subcontractor. The CONTRACTOR will take such action with respect to any subcontractor as
the contracting agency may direct as a means of enforcing such provisions including sanctions for non-compliance.

(7) **Federal Requirements:** Ryan White HIV/AIDS Extension Act formerly known as, Public Law 101-381 (Ryan White Comprehensive AIDS Resources Emergency Act of 1990) established the HIV Emergency Relief Grant Program under Part A. Funds are awarded to eligible areas through the Public Health Service Application process under two separate grants. One is based on the relative need of the area as reflected in the number of reported AIDS cases. The other is based on a proposal to effectively use supplemental funds. The Health Resources and Services Administration (HRSA), under the U.S. Department of Health and Human Services administers the program.
APPLICABLE STATUTES, ORDERS AND REGULATIONS

HILLSBOROUGH COUNTY, FL

----Hillsborough County Human Rights Ordinance, Hillsborough County Code of Ordinances and Laws, Part A, Chapter 30, Article II, as amended, prohibits illegal discrimination on the basis of actual or perceived race, color, sex, age, religion, national origin, disability, marital status, sexual orientation, or gender identity or expression, in employment, public accommodations, real estate transactions and practices, County contracting and procurement activities, and credit extension practices.

----Hillsborough County Home Rule Charter, Article IX, Section 9.11, as amended, provides that no person shall be deprived of any right because of race, sex, age, national origin, religion, disability, or political affiliation. Printed in Hillsborough County Code of Ordinances and Laws, Part A.

STATE

----Florida Constitution, Preamble and Article 1, § 2 protect citizens from being deprived of inalienable rights because of race, religion, national origin, or physical disability.

----Florida Statutes § 112.042, requires nondiscrimination in employment by counties and municipalities, on the basis of race, color, national origin, sex, handicap, or religion.

----Florida Statutes § 112.043, prohibits age discrimination in employment.

----Florida Statutes § 413.08, provides for rights of an individual with a disability and prohibits discrimination against persons with disabilities in employment and housing accommodations.

----Florida Statutes § 448.07, prohibits wage rate discrimination on the basis of sex.

----Florida Civil Rights Act of 1992, Florida Statutes §§760.01 – 760.11, as amended.

----Florida Statutes §509.092, prohibits refusing access to public lodging on the basis of race, creed, color, sex, physical disability or national origin.

----Florida Statutes §725.07, prohibits discrimination on the basis of sex, marital status or race in loaning money, granting credit or providing equal pay for equal services performed.

----Florida Fair Housing Act, Florida Statutes §§760.20 – 760.37.

----Florida Statutes §760.40, provides for the confidentiality of genetic testing.

----Florida Statutes §760.50, prohibits discrimination on the basis of AIDS, AIDS-related complex, and HIV.

----Florida Statutes §760.51, provides for remedies and civil penalties for violations of civil rights.

----Florida Statutes §760.60, prohibits discriminatory practices of certain clubs.

----Florida Statutes §760.80, provides for minority representation on boards, commissions, council, and committees.

FEDERAL

----Section 1 of the Fourteenth Amendment to the United States Constitution, U.S. Const. amend. XIV, § 1.

----Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq.


----Equal Opportunity Regulations, 41 CFR § 60-1.4, as amended.


----Executive Order 12250, Leadership and Coordination of Nondiscrimination Laws.


----Section 14001 of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
---State and Local Assistance Act of 1972, as amended.
---Office of Management and Budget Circular A-102, Grants and Cooperative Agreements with State and Local Governments, as amended.
---Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance, 40 C.F.R. §§5.100 -5.605.
---Executive Order 13673, Fair Pay and Safe Workplaces.

*"The above are not intended to be a complete list of all applicable local, state, or federal statutes, orders, rules or regulations, as they may be amended from time-to-time, or added to (newly promulgated) from time-to-time, during the term of this contract."

If applicable, and required by 41 CFR 60-1.4 or other federal law or regulation, during the performance of this contract, the contractor agrees as follows:

(1) The contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following: Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

(2) The contractor will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive considerations for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(3) The contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representatives of the contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(4) The contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

(5) The contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK
APPLICANT’S FAILURE TO COMPLETE THE FOLLOWING QUESTIONNAIRE MAY RESULT IN THE REJECTION OF THE AGENCY’S APPLICATION

EQUAL OPPORTUNITY QUESTIONNAIRE

INSTRUCTIONS

All Applicants are urged to carefully review the Equal Opportunity Questionnaire, and to reflect on it in relation to your company’s employment and DM/DWBE practices.

Please note particularly that:

(a) Where federally-assisted contracts are involved, the successful Applicant is bound Executive Order 11246, as amended by Executive Orders 11375 and 12086; and Federal Contract Compliance conditions contained in this package

(b) Subsequent to notification of apparent low applicant status, the Applicant shall complete ALL forms of this Equal Opportunity Questionnaire if the total amount of this contract equals or exceeds $10,000.

(c) The Equal Opportunity Questionnaire shall be submitted with the DM/DWBE subcontracted agreements, if the submittal of such agreements are required. If DM/DWBE Program requirements are not applicable to the application, then the low applicant shall submit the Equal Opportunity Questionnaire within five days of notification of its apparent low applicant status.

If you have any questions, you may contact the Hillsborough County Economic Development Department, by telephoning (813) 272-7232.
1. Name of business establishment: ____________________________________________

2. Address (number of street): ________________________________________________

3. City, State and Zip Codes: ________________________________________________

4. Telephone number (with area code): _______________________________________

5. Name of Chief Executive Officer: _________________________________________

6. Title: ________________________________ ________________________________

7. Name and title of your Equal Employment Opportunity Officer: 

8. Do you have an Affirmation Action Plan and/or policy statement: YES [ ] NO [ ]
   If yes, does the plan cover Vietnam or Veterans and handicapped persons? YES [ ] NO [ ]

9. Do you have an Internal Compliant Procedure for investigating and resolving EEO complaints made against your company? YES [ ] NO [ ]
   If no, would you be willing to comply with and use the County's complaint procedure? YES [ ] NO [ ]

10. Who is responsible for handling complaints? ________________________________
    What is that person's title? ________________________________________________
    What is that person's telephone number? ________________________________

11. Is your compliant procedure in writing? YES [ ] NO [ ]

12. Do you provide a copy to all employees immediately after their employment? YES [ ] NO [ ]
13. Do you advise your employees of their rights and responsibilities under EEO laws and regulations?  
   YES [ ] NO [ ]

14. Are you willing to participate in EEO training provided by the Hillsborough County Economic Development Department under the Board of County Commissioners? YES [ ] NO [ ]

15. Do you display EEO posters in places about your business normally available to your employees?  
   YES [ ] NO [ ]

16. Are there any educational or formal training programs to enhance employment? YES [ ] NO [ ]

17. List the recruitment sources your company relies upon when selecting new employees.

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

18. Does your company include a nondiscrimination clause in all executed subcontracts? YES [ ] NO [ ]

19. Is your firm required to submit an EEO-1 report annually to the EEOC? YES [ ] NO [ ]

If yes, submit a copy of the most recent report with this questionnaire. (If a current annual report was previously submitted, the applicant may disregard this requirement by providing the name of the project and RFA number to which the aforementioned EEO-1 report was attached.)

20. The successful applicant must submit a copy of the firm's current Affirmative Action Plan to the Economic Development Department within thirty (30) days of the contract award, or at minimum, the successful applicant should contact the Economic Development Department for technical assistance in developing an Affirmative Action Plan.
EQUAL OPPORTUNITY QUESTIONNAIRE

THE UNDERSIGNED APPLICANT BY THE SIGNATURE BELOW REPRESENTS THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. THE UNDERSIGNED APPLICANT BY SIGNATURE BELOW PROVIDES ASSURANCE TO HILLSBOROUGH COUNTY OF ITS COMPLIANCE WITH HILLSBOROUGH COUNTY’S AFFIRMATIVE ACTION PROGRAM REQUIREMENTS.

IN WITNESS WHEREOF, the undersigned parties have caused this Equal Opportunity Questionnaire to be executed by their duly authorized representatives.

ATTEST:_________________________________________

BY:_________________________________________

WITNESS   Printed Name of Corporation or Individual
(Party)

_________________________________________

BY:_________________________________________

WITNESS   Signature of Authorized Corporate Officer
of Individual (Party)

_________________________________________

Date Signed
Civil Rights Status

THE APPLICANT'S FAILURE TO PROVIDE THE FOLLOWING INFORMATION MAY RESULT IN THE REJECTION OF THE AGENCY'S APPLICATION

HILLSBOROUGH COUNTY EQUAL EMPLOYMENT OPPORTUNITY, AFFIRMATIVE ACTION REQUIREMENTS

PROJECT: PROVISION OF HIV-RELATED HEALTH AND SUPPORT SERVICES

CIVIL RIGHTS STATUS
All respondents are requested to carefully review the following questions and provide responses as they relate to the respondent's own affirmative action and equal opportunity practices.

Please respond to the following:

(a) Provide a copy of your organization's Affirmative Action Plan or Program. (Include if not previously submitted to the COUNTY within the past twelve months.)

(b) Complete the attached Work-force Analysis by race/sex and EEO Category.

(c) If your organization receives federal, state, or local funds, please list the source and dollar amount (Disregard if reported elsewhere in this RFA).

(d) The name of the person designated as the organization's EEO representative.

(e) Is the organization receptive to on-site reviews?___Yes___No

(f) Does the organization have a procedure for resolving discrimination complaints? ___Yes___No

(g) Has your firm been charged with discrimination within the past eighteen (18) months? If yes, how many charges? What is the nature of the charges? When and where did they occur? ___Yes___No

(h) Do you anticipate hiring additional staff to perform this contract? If yes, please provide the number and type of the anticipated positions. ___Yes___No

(i) Please attach a copy of the organization's Affirmative Action/Equal Employment Opportunity Policy Statement (if agency has fewer than 15 employees), signed and dated by the firm's Chief Executive Officer or designated Authorized Official. (If not previously submitted to the COUNTY within the past twelve months.)

* A written Affirmative Action Plan or Program is required if the organization has fifteen (15) or more employees (see paragraph 3. on next page).
SANCTIONS AND PENALTIES

(a) Failure to comply with the Equal Opportunity and Affirmative Action requirements adopted by the Board of County Commissioners of Hillsborough County may result in suspension or debarment of the organizations or individuals involved. Debarment for activity contrary to Hillsborough County Equal Opportunity and Affirmative Action requirements adopted by the Board of County Commissioners will be carried out according to the debarment procedures contained in the Hillsborough County Purchasing Manual. Affected organizations will be notified by registered mail of any suspensions or debarment. Debarment or suspension appeals may be made by the affected entity in accordance with the procedure set forth in the Purchasing Manual.

(b) The Board of County Commissioners may reject any response to this RFA from entities who fail to submit the Equal Opportunity/Affirmative Action forms and documentation required therein. The Board of County Commissioners reserves the right to reject any non-responsive application.

(c) The Board of County Commissioners also reserves the right to reject any response to this RFA from entities who have previously failed to perform properly and who have done so by commission or omission of an act of such serious or compelling nature that the act indicates a serious lack of business integrity or honesty or an equally obvious unwillingness to comply with applicable laws, rules, regulations, and ordinances.

(d) Attach here a copy of the agency’s Affirmative Action Plan (if 15 or more employees) or attach a signed and dated copy of the agency’s Affirmative Action/Equal Employment Opportunity Policy Statement (if fewer than 15 employees).
WORK-FORCE ANALYSIS

COMPANY NAME: ____________________________

<table>
<thead>
<tr>
<th>JOB CATEGORY</th>
<th>**TOTAL EMPLOYEES</th>
<th>MALES</th>
<th>FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MALE</td>
<td>FEMALE</td>
<td></td>
</tr>
<tr>
<td>*Officials (Board Members) and Managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office &amp; Clerical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Craftsmen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-skilled Operatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laborers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Minority Agency: Majority of Board ethnic minority and/or: **Majority of “service delivery” staff ethnic minority.

Hisp: Hispanic*  API: Asian/Pacific Islander   AI: American Indian

The job categories used herein are those categories required by the federal government and used in federal EO (1-6) reporting requirements.
CONDITION OF AWARD BUDGET

If awarded a condensed electronic version will need to be submitted.

CONTRACTOR’S INFORMATION

MUST BE SUBMITTED WITH APPLICATION

AGENCY: __________________________________________

TYPE OF SERVICE: __________________________________________

Provide a brief description of the purpose of the contract: __________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

NUMBER OF CLIENTS TO BE SERVED THIS YEAR: ________________

ESTIMATED NUMBER OF UNITS OF SERVICE TO BE RENDERED: ________________

Case Management Average Agency Caseload: __________________________

1. Are 51% of the Board of Directors racial/ethnic minority? _______yes _______no
2. Are 51% of professional staff racial/ethnic minority? _______yes _______no
3. A categorical budget must be submitted for each application submitted. The following categories must be defined in terms of dollars and must be justified in a budget narrative. (See next page)
## CATEGORICAL BUDGET

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries*</td>
<td></td>
</tr>
<tr>
<td>Fringe Benefits**</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
</tr>
<tr>
<td>Other: 1) Food Supplies</td>
<td></td>
</tr>
<tr>
<td>2) Telephone</td>
<td></td>
</tr>
<tr>
<td>3) Rent</td>
<td></td>
</tr>
<tr>
<td>4) Printing &amp; Postage</td>
<td></td>
</tr>
<tr>
<td>5) Consultant Fees</td>
<td></td>
</tr>
<tr>
<td>6) General Liability Insurance***</td>
<td></td>
</tr>
<tr>
<td>7) Training</td>
<td></td>
</tr>
<tr>
<td>8) Accounting Services****</td>
<td></td>
</tr>
<tr>
<td>Contractual</td>
<td></td>
</tr>
</tbody>
</table>

### TOTALS

### TOTAL CONTRACT AMOUNT

* Gross Salaries

** Includes: FICA, Worker’s Compensation, Health Insurance, etc.

*** This does not include Worker’s Compensation.

**** The funds for an audit can only be used if the PROVIDER receives more than $750,000 in Federal funds annually. If at any time the PROVIDER’s Federal funding drops below $750,000 the PROVIDER must notify the DEPARTMENT, provide a revised budget within 14 days, and the cost of the audit must be paid from non-Federal funds.
BUDGET NARRATIVE

Personnel
If the position is vacant, indicate such and provide estimated date when the position will be filled. Identify which positions will be paid by this grant. Identify total salary assigned to this position, percentage of time working for the grant and portion of salary paid by this grant.

Position Title:______________________________________________
Employee’s Name:__________________________________________
Is this a New Position Yes _____No______?
Brief Description of
Duties:____________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Time devoted to this grant:
%________________________
Total salary received by employee (including salaries from other agencies)$_________________________
Portion paid by this grant:
$_________________________
Other funding sources for the position
__________________________

Position Title:______________________________________________
Employee’s Name:__________________________________________
Is this a New Position Yes _____No______?
Brief Description of
Duties:____________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Time devoted to this grant:
%________________________
Total salary received by employee (including salaries from other agencies)$_________________________
Portion paid by this grant:
$_________________________
Other funding sources for the position
__________________________

Position Title:______________________________________________
Employee’s Name:__________________________________________
Is this a New Position Yes _____No______?
Brief Description of
Duties:____________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Time devoted to this grant: %_____________________________________
Total salary received by employee (including salaries from other agencies)$_____________________________________
Portion paid by this grant: $_____________________________________
Other funding sources for the position ______________________________________________________

Position Title:______________________________________________
Employee’s Name:__________________________________________
Is this a New Position Yes _____No______?
Brief Description of Duties:____________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Time devoted to this grant: %_______
Total salary received by employee (including salaries from other agencies)$_________________________
Portion paid by this grant: $_________________________
Other funding sources for the position ______________________________________________________

TOTAL SALARIES PAID BY THIS GRANT: $_________________________

Fringe Benefits
Total FICA $_________________________
Total Life/Disability Insurance $_________________________
Total Retirement $_________________________
Total Other (Describe) $_________________________

TOTAL FRINGE BENEFITS UNDER THIS CONTRACT: $_________________________
PERCENTAGE OF FRINGE BENEFITS IN RELATION TO SALARIES: $_________________________

TRAVEL
Explain the travel that is anticipated during the budget period. Be specific.

TRAVEL MUST BE DIRECTLY BENEFICIAL TO THE GRANT.

Who is traveling? ____________________________
Where?__________________________________________________________________________

Reason:__________________________________________________________________________

(Indicate type of transportation and cost, registration fee (if required), lodging cost, meal costs ($38/day allowed), ground transportation from/to airport.)

Total Out of Town Travel $________________

Local travel, indicate number of miles @.445 per mile: $________________

TOTAL TRAVEL TO BE PAID BY THIS GRANT: $________________

EQUIPMENT

List the items of equipment to be purchased and the purchase price.

1) _________________________________________________________ $_________________

2) _________________________________________________________ $_________________

3) _________________________________________________________ $_________________

4) _________________________________________________________ $_________________

TOTAL EQUIPMENT TO BE PAID BY THIS GRANT: $________________

Why is the equipment necessary?________________________________________________________________
_________________________________________________________________________
Who will use this equipment?________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
If large dollars items, please present a cost versus lease analysis:_________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Supplies (Office supplies only)

Give a general description of the type of items classified as supplies:________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
**TOTAL SUPPLIES TO BE PAID BY THIS GRANT:**

$___________________

**Other**

This category includes items such as rent, consultant fees, printing of brochures, telephone, postage, utilities, etc., (items that are not supplies or equipment.)

1)  

$___________________

2)  

$___________________

3)  

$___________________

4)  

$___________________

5)  

$___________________

**TOTAL OTHER TO BE PAID BY THIS GRANT:**

$___________________
## SUMMARY OF FUNDING SOURCES

**NAME OF CONTRACTOR:** ____________________________________________

**PERIOD OF CONTRACT:** ____________________________________________

<table>
<thead>
<tr>
<th>OBJECT CLASS CATEGORIES</th>
<th>PART A/</th>
<th>PART B/</th>
<th>PART C</th>
<th>PART D</th>
<th>HOPWA</th>
<th>CITY AND/OR STATE</th>
<th>GENERAL OPER./ PRIVATE</th>
<th>TOTAL BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
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<tr>
<td>Fringe Benefits</td>
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<td>Other</td>
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</tbody>
</table>

**TOTAL COSTS**

1. Combine amounts from all contracts.
2. State agency full name (no acronyms).
3. Headings of columns may be changed to accommodate other funding sources.
4. Object class categories may be changed to accommodate other line items.
CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

____________________________________________________________________
Name and Address of Organization

Signature ___________________________ Date ___________________________
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
<th>Column 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Category</td>
<td>Unit of Service</td>
<td>Total number of Unduplicated clients to be served</td>
<td>Total number of units to be provided.</td>
<td>Cost per Unit</td>
<td>Total Cost (Column 4 times Column 5)</td>
</tr>
<tr>
<td>1. Outpatient/ Ambulatory Health Services</td>
<td>Per visit</td>
<td></td>
<td></td>
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</table>
### Provision of Outpatient Ambulatory Health and Support Services for HIV/AIDS Programs

<table>
<thead>
<tr>
<th>I. ITEM NO.</th>
<th>II. DESCRIPTION</th>
<th>III. UNIT OF MEASURE</th>
<th>V. UNIT PRICE IN FIGURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic Oral Examination</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0140</td>
<td>Limited Oral Evaluation - Problem Focused</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive Oral Evaluation</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - Complete Series (including bitewings)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - Periapical - First Film</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - Periapical - Each Additional Film</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - Occlusal film</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - First Film</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0260</td>
<td>Extraoral - Each Additional Film</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - Single Film</td>
<td>Each</td>
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</tr>
<tr>
<td>D0272</td>
<td>Bitewings - Two Films</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - Four Films</td>
<td>Each</td>
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<tr>
<td>D0290</td>
<td>Posterior - Anterior or Lateral Skull &amp; Facial Bone Survey</td>
<td>Each</td>
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<tr>
<td>D0330</td>
<td>Panoramic Film</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic Casts</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – Adult</td>
<td>Each</td>
<td></td>
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<tr>
<td>D1120</td>
<td>Prophylaxis</td>
<td>Each</td>
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</tr>
<tr>
<td>D1203</td>
<td>Topical Application of Fluoride (Excluding Prophylaxis)</td>
<td>Each</td>
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</tr>
<tr>
<td>D1330</td>
<td>Oral Hygiene Instruction</td>
<td>Each</td>
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</tr>
<tr>
<td>D1351</td>
<td>Sealant - Per Tooth</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2110</td>
<td>Amalgam - One Surface, Primary</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2120</td>
<td>Amalgam - Two Surfaces, Primary</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>I. ITEM NO.</td>
<td>II. DESCRIPTION</td>
<td>III. UNIT OF MEASURE</td>
<td>V. UNIT PRICE IN FIGURES</td>
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<td>------------</td>
<td>---------------------------------------------------------------</td>
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<tr>
<td>02130</td>
<td>Amalgam - Three Surfaces, Primary</td>
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<td>D2140</td>
<td>Amalgam - One Surface, Permanent</td>
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<td>D2150</td>
<td>Amalgam - Two Surfaces, Permanent</td>
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<td>Amalgam - Three Surfaces, Permanent</td>
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<td>Amalgam - Four or More Surfaces, Permanent</td>
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<tr>
<td>D2330</td>
<td>Resin - One Surface, Anterior</td>
<td>Each</td>
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<td>D2331</td>
<td>Resin - Two Surfaces, Anterior</td>
<td>Each</td>
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<td>D2332</td>
<td>Resin - Three Surfaces, Anterior</td>
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<tr>
<td>D2335</td>
<td>Resin - Four Or More Surfaces Or Involving Incisal Angle (Anterior)</td>
<td>Each</td>
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<tr>
<td>D2385</td>
<td>Resin - One Surface, Posterior – Permanent</td>
<td>Each</td>
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<tr>
<td>D2751</td>
<td>Crown, Porcelain/Base Metal</td>
<td>Each</td>
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</tr>
<tr>
<td>D2752</td>
<td>Crown, Porcelain/Noble Metal</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2791</td>
<td>Crown, Full Cast Base Metal</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2792</td>
<td>Crown, Full Cast Noble Metal</td>
<td>Each</td>
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</tr>
<tr>
<td>D2920</td>
<td>Recement Crowns</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated Stainless Steel Crown - Primary Tooth</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated Stainless Steel Crown - Permanent Tooth</td>
<td>Each</td>
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</tr>
<tr>
<td>D2940</td>
<td>Sedative Filling</td>
<td>Each</td>
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<tr>
<td>D2951</td>
<td>Pin Retention - Per Tooth In Addition To Restoration</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated Post And Core In Addition To Crown</td>
<td>Each</td>
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<tr>
<td>D2970</td>
<td>Temporary (Fractured Tooth)</td>
<td>Each</td>
<td></td>
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<tr>
<td>D3110</td>
<td>Pulp Cap - Direct (Excluding Final Restoration)</td>
<td>Each</td>
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</tr>
<tr>
<td>I. ITEM NO.</td>
<td>II. DESCRIPTION</td>
<td>III. UNIT OF MEASURE</td>
<td>V. UNIT PRICE IN FIGURES</td>
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<tr>
<td>D3120</td>
<td>Pulp Cap - Indirect (Excluding Final Restoration)</td>
<td>Each</td>
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<tr>
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<td>Therapeutic Pulpotomy (Excluding Final Restoration)</td>
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<td>D3310</td>
<td>Anterior Root Canal (Excluding Final Restoration)</td>
<td>Each</td>
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<tr>
<td>D3312</td>
<td>Bicuspid Root Canal (Excluding Final Restoration)</td>
<td>Each</td>
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<tr>
<td>D3330</td>
<td>Molar Root Canal (Excluding Final Restoration)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)</td>
<td>Each</td>
<td></td>
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<tr>
<td>D3353</td>
<td>Apexification/Recalcification - Final Visit (Includes Completed Foot Canal Therapy - Apical Closure/Calcific Repair Of Perforations, Root Restoration, Etc.)</td>
<td>Each</td>
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<tr>
<td>D3410</td>
<td>Apiceoectomy/Periradicular Surgery – Anterior</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde Filling - Per Root</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D4210</td>
<td>Gingivectomy or Gingivoplasty - Per Quadrant</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or Gingivoplasty - Per Tooth</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D4220</td>
<td>Gingival Curettage, Surgical Per Quadrant, By Report</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous Surgery (Including Flap Entry And Closure) - Per Quadrant</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal Scaling And Root Planing - Per Quadrant</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D4355</td>
<td>Full Mouth Prophy Debridement</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5110</td>
<td>Complete Denture – Maxillary</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>I. ITEM NO.</td>
<td>II. DESCRIPTION</td>
<td>III. UNIT OF MEASURE</td>
<td>V. UNIT PRICE IN FIGURES $</td>
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<tr>
<td>D5120</td>
<td>Complete Denture – Mandibular</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5211</td>
<td>Upper Partial - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5212</td>
<td>Lower Partial - Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5214</td>
<td>Lower Partial - Cast Metal Base With Resin Saddles (Including Any Conventional Clasps, Rests, Teeth)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5410</td>
<td>Adjust Complete Denture – Upper</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust Complete Denture – Lower</td>
<td>Each</td>
<td></td>
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<tr>
<td>D5421</td>
<td>Adjust Partial Denture – Upper</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust Partial Denture – Lower</td>
<td>Each</td>
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<tr>
<td>D5510</td>
<td>Repair Broken Complete Denture Base</td>
<td>Each</td>
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<tr>
<td>D5520</td>
<td>Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)</td>
<td>Each</td>
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<tr>
<td>D5610</td>
<td>Repair Resin Saddle Or Base-Partial Denture</td>
<td>Each</td>
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<tr>
<td>D5620</td>
<td>Repair Cast Framework - Partial Denture</td>
<td>Each</td>
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<tr>
<td>D5630</td>
<td>Repair Or Replace Broken Clasp - Partial Denture</td>
<td>Each</td>
<td></td>
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<tr>
<td>D5640</td>
<td>Replace Broken Teeth - Per Tooth - Partial Denture</td>
<td>Each</td>
<td></td>
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<tr>
<td>D5650</td>
<td>Add Tooth To Existing Partial Denture</td>
<td>Each</td>
<td></td>
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<tr>
<td>D5660</td>
<td>Add Clasp To Existing Partial Denture</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5730</td>
<td>Reline Upper Complete Denture (Chairside)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5731</td>
<td>Reline Lower Complete Denture (Chairside)</td>
<td>Each</td>
<td></td>
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<tr>
<td>D5740</td>
<td>Reline Upper Partial Denture (Chairside)</td>
<td>Each</td>
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<tr>
<td>D5741</td>
<td>Reline Lower Partial Denture (Chairside)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5750</td>
<td>Reline Upper Complete Denture (Laboratory)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>ITEM NO.</td>
<td>DESCRIPTION</td>
<td>UNIT OF MEASURE</td>
<td>V. UNIT PRICE IN FIGURES $</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>D5751</td>
<td>Reline Lower Complete Denture (Laboratory)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5760</td>
<td>Reline Upper Partial Denture (Laboratory)</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D5761</td>
<td>Reline Lower Partial Denture (Laboratory)</td>
<td>Each</td>
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<tr>
<td>D5820</td>
<td>Interim Partial Denture (Upper)</td>
<td>Each</td>
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</tr>
<tr>
<td>D5821</td>
<td>Interim Partial Denture (Lower)</td>
<td>Each</td>
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<tr>
<td>D7110</td>
<td>Extraction, Single Tooth</td>
<td>Each</td>
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<tr>
<td>D7120</td>
<td>Extraction, Each Additional Tooth</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D7130</td>
<td>Root Removal - Exposed Roots</td>
<td>Each</td>
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<tr>
<td>D7210</td>
<td>Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap And Removal Of Bone And/Or Section Of Tooth</td>
<td>Each</td>
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</tr>
<tr>
<td>D7220</td>
<td>Removal Of Impacted Tooth - Soft Tissue</td>
<td>Each</td>
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</tr>
<tr>
<td>D7230</td>
<td>Removal Of Impacted Tooth - Partially Bony</td>
<td>Each</td>
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<tr>
<td>D7240</td>
<td>Removal Of Impacted Tooth - Completely Bony</td>
<td>Each</td>
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<tr>
<td>D7241</td>
<td>Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications</td>
<td>Each</td>
<td></td>
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<tr>
<td>D7250</td>
<td>Surgical Removal of Residual Tooth Roots (Cutting Procedure)</td>
<td>Each</td>
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<tr>
<td>D7260</td>
<td>Oral Antral Fistula Closure</td>
<td>Each</td>
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<tr>
<td>D7270</td>
<td>Tooth Re-Implantation And/Or Stabilization Of Accidentally Avulsed Or Displaced Tooth And/Or Alveolus</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D7281</td>
<td>Surgical Exposure Of Impacted Or Unerupted Tooth To Aid Eruption</td>
<td>Each</td>
<td></td>
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<tr>
<td>D7310</td>
<td>Alveoloplasty In Conjunction With Extractions - Per Quadrant</td>
<td>Each</td>
<td></td>
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<tr>
<td>D7320</td>
<td>Alveoloplasty Not In Conjunction With Extractions</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>I. ITEM NO.</td>
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<tr>
<td></td>
<td>- Per Quadrant</td>
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<tr>
<td>D9110</td>
<td>Palliative (Emergency) Treatment Of Dental Pan-Minor Procedures</td>
<td>Each</td>
<td></td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation (Diagnostic Service Provided By Dentist Or Physician Other Than Practitioner Providing Treatment)</td>
<td>Each</td>
<td></td>
</tr>
</tbody>
</table>
INSURANCE REQUIREMENTS

PROVIDER's Liability Insurance:
The PROVIDER shall procure and maintain such insurance as will protect him from claims under Workers' Compensation laws, disability benefit laws or other similar employee benefit laws; from claims for damages because of bodily injury, occupational sickness or disease, or death of his employees including claims insured by usual personal injury liability coverage; from claims for damages because of bodily injury, sickness or disease, or death of any person other than his employees including claims insured by usual personal injury liability coverage; and from claims for injury to or destruction of tangible property including loss of use resulting therefrom, any or all of which may arise out of or result from the PROVIDER'S operations under the Contract Documents, whether such operations be by himself or by any subcontractor or anyone directly or indirectly employed by any of them or for whose acts any of them may be legally liable. This insurance shall be written for not less than any limits of liability specified in the Contract Documents or required by law, whichever is greater, and shall include contractual liability insurance. Before starting the work, the PROVIDER will file with the COUNTY certificates of such insurance, acceptable to the COUNTY; these certificates shall contain a provision for cancellation as found in paragraph 5 of Section B immediately below.

Insurance Required:

A. General
Before starting and until acceptance of the Work by the COUNTY, the PROVIDER shall procure and maintain in force insurance of the types and to the limits specified in paragraphs B. 1. through 5. below. All policies of insurance under this contract shall include Hillsborough County and its employees as additional insured. All policies shall provide for separation of insured's interests such that the insurance afforded applies separately to each insured against whom a claim is made or a suit is brought.

B. Coverage
The PROVIDER shall procure and maintain, during the life of this Contract, the following types of insurance coverages written on standard forms and placed with insurance carriers licensed by the Insurance Department of the State of Florida and approved by Hillsborough County. The amounts and type of insurance shall conform to the following requirements:

1. Professional Liability: $1,000,000 each occurrence. (For all medical care applicants).

2. Commercial General Liability: $1,000,000 each occurrence. (For all applicants).

3. Business Automobile Liability: $1,000,000 each occurrence. (For all applicants who transport clients or agencies who have owned autos).
4. **Workers Compensation:** As required by Florida Statute (For all applicants).

5. **Certificate of Insurance and Copies of Policies:** Certificates of Insurance furnished by Hillsborough County evidencing the insurance coverage specified in the previous paragraphs B. 1. through 4. inclusive, and on request of the COUNTY certified copies of the policies required shall be filed with the Health Care Services Department of the COUNTY on a timely basis. The required Certificates of Insurance not only shall list Hillsborough County as additional insured for the operations of the PROVIDER under this Contract (excluding the worker's compensation and professional liability policies), but shall name the types of policies provided and shall refer specifically to this Contract.

If the initial insurance expires prior to the completion of the Contract, renewal Certificates of Insurance shall be furnished twenty (20) days prior to the date of their expiration. Cancellation – “Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will mail thirty (30) days written notice to the certificate holder.”

Project Title: REQUEST FOR APPLICATIONS FOR THE PROVISION OF HIV-RELATED HEALTH AND SUPPORT SERVICES FOR THE HILLSBOROUGH COUNTY HEALTH CARE SERVICES DEPARTMENT.

Reviewed, Insurance and Claims Management: N/A
INSURANCE REQUIREMENTS
For State Agencies

If the PROVIDER is a state agency or subdivision as defined by section 768.28, Florida Statutes, the PROVIDER shall furnish the COUNTY, upon request, written verification of liability protection in accordance with section 768.28, Florida Statutes. Nothing herein shall be construed to extend any party's liability beyond that provided in section 768.28, Florida Statutes.

Certificate of Insurance

The PROVIDER certifies that it maintains general and professional liability protection coverage through the Florida Casualty Insurance Risk Management Trust Fund, established pursuant to section 284.30, Florida Statutes, and administered by the state of Florida, Department of Insurance, or through J. Hillis Miller Health Self-Insurance Trust Fund, the J. Hillis Miller Health Center/Jacksonville Trust Fund, self-insurance programs created pursuant to section 240.213, Florida Statutes. Such protection is as described in section 768.28, Florida Statutes. This certification of insurance satisfies the requirements of article XII of this Agreement.

Project Title: REQUEST FOR APPLICATIONS FOR THE PROVISION OF HIV-RELATED HEALTH AND SUPPORT SERVICES FOR THE HILLSBOROUGH COUNTY HEALTH CARE SERVICES DEPARTMENT.
EXHIBIT G
West Central Florida Ryan White Care Council
Minimum Standards of Care

<table>
<thead>
<tr>
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<td>Health Insurance</td>
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<tr>
<td>MEDICAL CASE MANAGEMENT SERVICES</td>
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<td>Oral Health</td>
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<td>OUTPATIENT/AMBULATORY MEDICAL CARE</td>
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<tr>
<td>Substance Abuse Services Outpatient</td>
<td>9</td>
</tr>
<tr>
<td>Treatment Adherence Counseling</td>
<td>10</td>
</tr>
</tbody>
</table>
Minimum Standards of Care  
AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A and Part B Lead Agency to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.

These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Recipient/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients’ confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Recipient/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MEASURE</th>
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</thead>
<tbody>
<tr>
<td>1. Providers shall maintain records of quarterly quality improvement meetings including pharmacy staff as required by FAC 64B16-27.300, Standards of Pharmacy Practice. These records are considered peer review documents and are not subject to discovery in civil litigation or administrative actions.</td>
<td>1. Records of meetings on file as examined by Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. Patient counseling will be provided by qualified staff as needed. Counseling shall include but not be limited to, administration, drug-drug interaction, side effects, dosage, adherence education and food-drug interactions.</td>
<td>2. Policy on file as examined by Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 11/06/02
Revised: 12/03/03, 11/1/06, 11/7/07, 6/3/09, 7/2/14
The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Since the eligible PLWH (Person Living with HIV) does not access services directly from the health insurance services provider but through a case manager, these minimum standards have been developed to reflect this unique fiscal relationship. The case management relationship ensures PLWH confidentiality and grievance procedures. These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients' confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
<tr>
<th>STANDARD</th>
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</thead>
<tbody>
<tr>
<td>1. Upon receipt of the request for payment, the service provider will notify the case manager within three working days of the outcome of the request.</td>
<td>1. Written procedure and documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. The provider will issue payments for approved requests within 30 working days of receipt of an invoice for payment.</td>
<td>2. Written procedure and documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>3. The provider will identify error-prone case management agencies and offer individualized on-site training to up to two (2) agencies annually, upon request. The provider will also provide written updates on changes in eligibility or service benefits, procedural changes and other related information to case management agencies on a timely and regular basis.</td>
<td>3. Written procedure and documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>4. The provider will establish and maintain a mechanism to assure that upon the PLWH's disenrollment, any unused portion of issued premium payments is reimbursed to the program.</td>
<td>4. Written procedure and documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 03/05/03
Revised: 8/4/04, 3/7/07, 11/7/07, 6/3/09, 6/1/11,
Minimum Standards of Care
MEDICAL CASE MANAGEMENT SERVICES

Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes 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 service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Services can take place at the client’s home, clinic and/or provider office.

Case Managers should reflect competence and experience in assessing client needs and be familiar with community as well as city, county and state resources available for clients. Case management agencies are encouraged to consider the Florida Department of Health Case Management Standards and Guidelines for items not addressed in these minimum standards.

These minimum standards, as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients’ confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
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<th>STANDARD</th>
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<tbody>
<tr>
<td>1. Case managers must contact clients as needed (based on client need) unless a specific program requirement is set by a program. Case Manager contact requirements are subject to any additional requirements set forth by Rule 64D-4, the Florida Department of Health, and the Health Resources and Services Administration. Contact is defined as phone, face-to-face, leaving a message or a mailing.</td>
<td>1. Documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. Active files must have individualized service plan reviewed by client and case manager semi-annually.</td>
<td>2. Documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>3. Active files must reflect a face-to-face visit conducted on a semi-annual basis.</td>
<td>3. Documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>4. Clients will have access to a case manager during normal business hours for the agency.</td>
<td>4. Written policy exists as examined by the Grantee/Lead Agency.</td>
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<td>5.</td>
<td>Case managers will work collaboratively with client and medical/psychosocial providers to promote adherence to treatment.</td>
</tr>
<tr>
<td>6.</td>
<td>Case managers and direct supervisors must attend training sessions as required by the Grantee/Lead Agency, Health Resources and Services Administration, and/or the Florida Department of Health. Additional training must be coordinated and/or provided by supervisory staff.</td>
</tr>
<tr>
<td>7.</td>
<td>Case managers must maintain up to date documentation on all activities with, or on behalf of clients.</td>
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<td>8.</td>
<td>Case managers must provide the client a choice of service providers if available.</td>
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<tr>
<td>9.</td>
<td>Case managers must ensure that a copy of a client's record in its entirety is sent to the receiving agency within 10 business days from receipt of original signed release.</td>
</tr>
<tr>
<td>5.</td>
<td>Written policy exists as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>6.</td>
<td>Documentation on file as examined by the Grantee/Lead Agency.</td>
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<td>7.</td>
<td>Documentation on file as examined by the Grantee/Lead Agency.</td>
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<td>8.</td>
<td>Documentation on file as examined by the Grantee/Lead Agency.</td>
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<td>9.</td>
<td>Documentation on file as examined by the Grantee/Lead Agency.</td>
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</tbody>
</table>

Adopted: 04/03/02
Revised: 12/03/03, 12/6/06, 11/7/07, 6/3/09, 7/2/14
Minimum Standards of Care  
Mental Health Services

Such services may include 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.

Mental health care for persons with HIV disease should reflect competence and experience in evaluation, formulation, and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.

These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients' confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

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<tr>
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</thead>
<tbody>
<tr>
<td>1. License-eligible staff delivering mental health services will receive direct, professional supervision by a licensed mental health provider of the type of care they are providing to individual patients/clients.</td>
<td>1. Written procedures and/or documentation on file as examined by Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. The provider must provide mechanisms for urgent care evaluation and triage.</td>
<td>2. Written statement of policy and procedures on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>3. The provider will establish procedures for continuity of mental health/psychiatric care to their patients/clients in all settings in which they may need care.</td>
<td>3. Written statement of procedures on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>4. The provider will provide referrals for continuity of substance abuse care to their patients/clients as needed.</td>
<td>4. Documentation of referrals on file as reviewed by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>5. The provider will develop and maintain client specific collaboration with primary medical care service providers.</td>
<td>5. Written documentation of collaboration on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>6. The provider will maintain an initial mental health assessment of each participating client that consists of: presenting problem(s), psychosocial history, mental status examination, differential diagnoses, treatment recommendations and signature of the licensed or license-eligible professional conducting the assessment.</td>
<td>6. Written documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 06/07/00  
Revised: 12/03/03, 3/7/07, 11/7/07, 6/3/09, 7/2/14
Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

The following minimum standards are in place to describe and establish measurable guidelines in order to offer clients the most convenient, accessible and non-discriminatory oral health services.

These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients’ confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provider shall follow nationally accepted treatment guidelines.</td>
<td>1. Written documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. Dental care shall have the primary focus of alleviating discomfort, keeping teeth and gums healthy, preventing infection and maintaining the ability to eat nutritional foods with the goal of optimizing overall health. Procedures that are for cosmetic purposes only will not be covered. Treatment must be completed within a reasonable and customary time frame.</td>
<td>2. Written documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>3. A treatment plan shall, at a minimum, include a thorough dental examination, x-rays and cleaning. Follow-up services shall include education, preventative home care instructions, and any additional services necessary to maintain dental health.</td>
<td>3. Written documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>4. Provider shall have a policy in place to address dental emergencies.</td>
<td>4. Written documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 05/01/02
Revised: 12/03/03, 12/6/06, 11/7/07, 6/3/09, 7/2/14
Minimum Standards of Care
OUTPATIENT/AMBULATORY MEDICAL CARE

Such services may include provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection included the provision of specialty care that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients' confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Providers shall follow nationally accepted treatment guidelines, i.e., Centers for Disease Control (CDC), Infectious Disease Society of America (IDSA), or Department of Health and Human Services (DHHS).</td>
<td>1. Written procedures and/or documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 07/11/01
Revised: 12/03/03, 3/7/07, 11/7/07, 6/3/09, 7/2/14
Minimum Standards of Care
Substance Abuse Services Outpatient

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, Certified Addictions Professional (CAP) Certified Associate Addictions Professional (CAAP), or by other qualified personnel.

The following minimum standards are in place to describe and establish measurable guidelines in order to offer clients the most convenient, accessible and non-discriminatory substance abuse treatment and counseling services.

These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients’ confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
<tr>
<th>STANDARD</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. The provider will provide referrals for continuity of mental health, and/or psychiatric care to their patients/clients as needed.</td>
<td>1. Documentation of referrals on file as reviewed by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. Treatment incorporates an initial assessment of client that consists of medical history and a psychosocial history with treatment recommendations.</td>
<td>2. Written procedures and/or documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>3. Outpatient treatment incorporates continuum of care strategies to provide a safe environment for a client to return to after detox or other initial intervention.</td>
<td>3. Written statement of policy and procedures on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>4. The need for mental health treatment can not preclude a client from receiving substance abuse counseling/treatment.</td>
<td>4. Written statement of this policy and procedures on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>5. Qualified professionals who possess current professional licensure or who are authorized by the state and/or their agency will participate in the care and treatment of clients as required by law.</td>
<td>5. Written documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 06/07/00
Revised: 12/03/03, 3/7/07, 11/7/07, 6/3/09, 7/2/14
**Minimum Standards of Care**  
**Treatment Adherence Counseling**

The provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

These minimum standards as developed by the Planning & Evaluation Committee have been adopted by the Care Council. Minimum standards of care are intended to establish measurable guidelines for providing convenient, accessible and non-discriminatory services. No standard will be applied retroactively. The Grantee/Lead Agency is responsible for assuring that in addition to these standards, all contracts with providers have provisions requiring the protection of clients’ confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. The Grantee/Lead Agency shall also require providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. The Grantee/Lead Agency verifies that providers meet the minimum standards established by the Care Council. The Grantee/Lead Agency will report significant and/or consistent challenges with particular Care Council approved minimum standards to the Planning & Evaluation Committee.

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providers of this service have specific experience in caring for HIV infected clients or receive appropriate training as required by Health Resources and Services Administration, the Florida Department of Health, and/or the Grantee/Lead Agency within the first 90 days of hire or as soon as training is available but not to exceed six months.</td>
<td>1. Written procedures and/or documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>2. Providers of this service will receive a minimum of 12 hours of training on HIV/AIDS, treatment adherence, psychosocial and other issues related to HIV/AIDS disease annually.</td>
<td>2. Documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
<tr>
<td>3. Staff providing treatment adherence counseling must maintain up to date documentation on all activities with, or on behalf of clients.</td>
<td>3. Documentation on file as examined by the Grantee/Lead Agency.</td>
</tr>
</tbody>
</table>

Adopted: 05/07/03  
Revised: 12/03/03, 3/7/07, 11/7/07, 6/3/09, 6/1/11, 8/1/12, 7/2/14
HRSA PROGRAM POLICY NOTICES – click link below:

Funded applicants are required to abide by all current and future program policies notices. They are currently located at: https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters but this may be changed by HRSA.
<table>
<thead>
<tr>
<th>Currently Funded Service Category</th>
<th>Cap/limit</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Bank</strong> Nutritional Supplements</td>
<td>No cap/limit established</td>
<td>HIV+, proof of residency, proof of income, income &lt;150% Federal Poverty level (FPL) which includes a provision for waiver when required.</td>
</tr>
<tr>
<td>Transportation</td>
<td>No cap/limit established</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>No cap/limit established</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>No cap/limit established</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td>Drug Reimbursement</td>
<td>No cap/limit established</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>Enrolled clients receive up to $275 $120 per month for co-pays and up to $400 $300 per month for COBRA, group and individual insurance premium payments. Co-pay requests must equal or exceed $20 per client, per request. Co-payments will not be made for HIV medication or over-the-counter (OTC) medications.</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% &lt;$300% Federal Poverty level (FPL) Grantee has the authority to increase caps when necessary to ensure all funds are utilized for the grant period.</td>
</tr>
<tr>
<td>Oral Health</td>
<td>$2000 Covered services are limited to: exams, x-rays, fillings, extractions, cleanings (prophylaxis, scaling and root planning, gross debridement), dentures (partial or full) and oral health instruction.</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL) Grantee considers exceptions on a case by case basis only if medically necessary.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>No limit on office visits or labs No more than 25% of total</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL) Babies born to HIV+ mothers (Pediatric</td>
</tr>
<tr>
<td>Service Type</td>
<td>Cap/Limit</td>
<td>Eligibility Requirements</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient Education/ Treatment Adherence*</td>
<td></td>
<td>primary care contract may be used for patient education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>indeterminate) may be served until 2 years of age. Must be receiving primary care from a Ryan White funded provider.</td>
</tr>
<tr>
<td>Treatment Adherence</td>
<td>No cap/limit</td>
<td>Available only to Minority AIDS Initiative (MAI) clients</td>
</tr>
<tr>
<td></td>
<td>established</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td>Case Management</td>
<td>$2400</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grantee considers exceptions on a case by case basis</td>
</tr>
<tr>
<td>Case Management (non-medical)</td>
<td>No cap/limit</td>
<td>HIV+, proof of residency, proof of income, income &lt;400% Federal Poverty level (FPL)</td>
</tr>
<tr>
<td></td>
<td>established</td>
<td>State Eligibility Rule 64D allows a one-time exception.</td>
</tr>
</tbody>
</table>

*The Care Council designated pregnant women, infants, children and adolescents as special populations and does not include them in the service cap for primary care patient education (revision 3/7/07)

It is the Provider’s responsibility to respond flexibly to a changing environment as long as they do not exceed the cap established for a particular service. (revision 9/2/09)

Approved 9/6/06
Revised 6/1/11; 2/6/2013
Pro-Forma Contract

HIV PART A AGREEMENT WITH XXX, INC., FOR THE PROVISION OF HIV SERVICES

This Agreement is entered into this ____ day of __________, 20___, by and between Hillsborough County, a political subdivision of the State of Florida, by and through the Board of County Commissioners, hereinafter referred to as COUNTY, whose address is 601 E. Kennedy Boulevard, Tampa, Florida 33602, and XXX, Inc., a non-profit corporation existing under the laws of the State of Florida, hereinafter referred to as PROVIDER, whose address is XXX, FL 33XXX.

WITNESSETH

WHEREAS, Hillsborough County has been designated as the grantee agency to administer funding under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, as Amended by the Ryan White Care Act Amendments of 1996 (CARE Act), 2000, 2006 (Treatment Modernization Act), and 2009 Extension Act in the Eligible Metropolitan Area (EMA) comprised of Hillsborough, Pinellas, Pasco and Hernando counties; and

WHEREAS, the COUNTY, as grantee for the United States Department of Health and Human Services, is authorized to purchase services for individuals with HIV disease and their families as defined in the CARE Act through the Hillsborough County Health Care Services, hereinafter referred to as DEPARTMENT; and

WHEREAS, the Title I HIV Health Services Planning Council and the Suncoast AIDS Network Title II Consortium merged on September 1, 1999, the merged entity is the West Central Florida Ryan White Care Council ("Care Council"). The Care Council establishes priorities for the allocation and recommendation of funds for certain services within the eight county area of Hillsborough, Pinellas, Pasco, Hernando, Polk, Hardee, Highlands, and Manatee (this includes the EMA); and

WHEREAS, the parties hereto, in recognition of their mutual responsibility for the provision of outpatient and ambulatory health and support services for individuals with HIV disease and their families within the area, desire to enter into an agreement whereby the COUNTY reimburses the PROVIDER for authorized services provided to eligible individuals; and

WHEREAS, the COUNTY believes it to be in the best interest of the citizens of the area for the COUNTY to enter into a contract with the PROVIDER for the provision of nonexclusive services to those eligible individuals; and

WHEREAS, the Ryan White CARE Act has been renamed and is now known as the Ryan White Extension Act of 2009 and Title I is now referred to as Part A, and Title II is now referred to as Part B; and

NOW, THEREFORE, in consideration of the provisions and covenants contained herein and for other valuable consideration given and received, the parties agree as follows:

ARTICLE I

Scope of Services
A. The PROVIDER will provide the nonexclusive services specified in EXHIBIT I, incorporated by this reference, to eligible persons (HIV positive persons, or the family members or caregivers of HIV positive persons if allowable) referred to the PROVIDER or acquired by the PROVIDER through a program of outreach. Services will be provided during the operating hours, and at the location(s), specified in EXHIBIT I.

B. The PROVIDER will notify the DEPARTMENT's Ryan White Program Manager, in writing, of any change in the PROVIDER staff person serving as Contract Coordinator, named in EXHIBIT I. The Contract Coordinator must be available to meet with the staff of the DEPARTMENT, to review activities on an "as needed" basis as requested by the DEPARTMENT.

C. The PROVIDER will also notify the DEPARTMENT's Ryan White Program Manager and Accountant, in writing, of any change in the PROVIDER staff person designated in EXHIBIT I as the contact person for processing of reimbursement requests.

D. As a participant in the Ryan White Extension Act, the PROVIDER agrees to participate in a coordinated continuum of care with other providers of CARE Act services and agrees not to use CARE Act funding to supplant other funding for the same or equivalent services funded herein.

E. The PROVIDER will establish internal grievance procedures in accordance with the CARE Act and approved by the DEPARTMENT, and cooperate with the Care Council, and the COUNTY in addressing all complaints and/or problems identified by clients or other care providers. A "patient bill of rights" and grievance procedure are to be posted in a conspicuous location in the lobby of service location(s) of the PROVIDER.

F. The PROVIDER understands and agrees that the DEPARTMENT will monitor program and fiscal records on a regular basis for compliance with contract terms and conditions, and that conformance to the contract will be rated and considered in future renewal and funding decisions.

G. The PROVIDER understands and agrees that the COUNTY and/or DEPARTMENT will exercise its right to modify the contract, within thirty days of notification by the DEPARTMENT, for the purpose of reallocating unexpended funds, in the event the PROVIDER is not achieving or not projected to achieve the fiscal and/or program objectives outlined in Exhibits I and II, attached hereto and made a part hereof. The DEPARTMENT may also reallocate funds based on Care Council reallocation of service dollars, regardless of whether or not the PROVIDER is meeting their program objectives, or due to a cut in funding. If federal funds are reduced or become unavailable, the DEPARTMENT shall notify the PROVIDER of such occurrence and the COUNTY may terminate this AGREEMENT upon no less then twenty-four (24) hours written notice to the PROVIDER.

H. For those PROVIDERS who conduct on-site testing, the PROVIDER shall ask each tested seropositive recipient of services if they have or have had a partner at any time within the ten-year period prior to diagnosis of HIV infection. If so, the person shall be informed of the importance of notification of the partner of potential exposure to HIV. HIV infected persons shall be offered the assistance of public health personnel in notifying any sex or needle sharing partner. The PROVIDER shall refer those individuals choosing the assistance of public health personnel to the State of Florida Department of Health's local sexually transmitted disease control program staff.

I. If applicable, the PROVIDER shall comply with the requirements of Chapter 119, Florida Statutes, with respect to any documents, papers, and records made or received by the PROVIDER in connection with this Agreement.
J. Strategy for Early Identification of Individuals with HIV/AIDS (EIIHA):
The 2000 legislation required a new focus on reducing unmet need – finding people who know they are HIV+ and helping them enter and remain in HIV-related medical care. The 2006 legislation maintained the requirement and added a focus on people living with HIV/non-AIDS as well as people living with AIDS. The 2006 legislation required Part A Planning Councils (or the grantee where there is no planning council) and Part B programs to:

- Determine the size and demographics of the population of individuals with HIV/AIDS;
- Assess PLWH service needs and gaps “with particular attention to individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services” and “disparities in access and services among affected subpopulations and historically underserved communities”;
- Develop a comprehensive plan for the organization and delivery of health and support services that “includes a strategy for identifying individuals who know their HIV status and are not receiving such services...”

The Ryan White HIV/AIDS Treatment Extension Act of October 2009 provided an expanded focus and new requirements on getting people with HIV/AIDS into care upon diagnosis by including “individuals who are unaware of their status” to all three requirements. The 2009 legislation also required grantees to develop a strategy for identifying individuals and enabling them to use the health and support services. To support this effort, all Providers must demonstrate how funded Part A and B services will integrate the following Early Identification of Individuals with HIV/AIDS (EIIHA) components in their service delivery:

- Identification of Individuals Unaware of Their HIV Status
- Inform individuals of their HIV status
- Refer to care/services
- Link to care

To further understand EIIHA a list of related definitions has been included:

- **EIIHA:** Early Identification of Individuals with HIV/AIDS (EIIHA) is the identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care. The goals of this initiative are: 1. Increase the number of individuals who are aware of their HIV status; and 2. Increase the number of HIV positive individuals who are in medical care; and 3. Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

- **Unaware of HIV Status:** Any individual who has NOT been tested for HIV in the past 12-months, any individual who has NOT been informed of their HIV result (HIV positive or HIV negative), and any HIV positive individual who has NOT been informed of their confirmatory HIV result.

- **Identification of Individuals Unaware of Their HIV Status:** The categorical breakdown of the overall unaware population into subgroups, which allow for the overall EIIHA strategy to be customized based on the needs of each subgroup, for the purposes of identifying, counseling, testing, informing, referring, and linking these individuals into care. HRSA now distinguishes between:
  - “Parent Groups” categories that encompass a large and inverse number of individuals with a common issue (e.g., substance abuse, men who have sex with men),
  - “Target Groups” within the Parent Group that allow the overall EIIHA strategy to be customized based on the Priority Needs and Cultural Challenges of each Target Group.
- Important note: The following groups are considered Parent Groups and may NOT be listed as Target Groups. These groups must be broken down into smaller, more specific groups.
  - MSM
  - Substance Abuse/IVDU
  - Black/African American
Hispanics

- **Informing individuals of their HIV status:** Informing an HIV negative individual, post-test, of their appropriate HIV screening result. Informing an HIV positive individual, post-test, of their **confirmatory** HIV result.

- **Informing individuals of HIV Negative status:** Informing individuals of their HIV negative status and refer these HIV negative individuals to appropriate supportive services that will contribute to keep them HIV negative. However, due to their HIV negative status, these individuals are **not eligible** for Ryan White funded care or supportive services.

- **Referral to care/services:** The provision of timely, appropriate, and pre-established guidance to an individual that is designed to refer him/her to a specific care/service provider for the purpose of accessing care/services after the individual has been informed of their HIV status (positive or negative).

- **Linkage to medical care:** The post-referral verification that medical care/services were accessed by an HIV positive individual being referred into care. (*i.e.*, **Confirmation first scheduled care appointment occurred**). The medical care visit must entail one of the following: a **CD4 count**, **viral load test**, or the **provision of an HIV related prescription for medication**.

K. The PROVIDER must use the U. S. Department of Homeland Security’s E-Verify system, [https://e-verify.uscis.gov/emp](https://e-verify.uscis.gov/emp), to verify the employment and eligibility of: a) all persons employed during the term hereof to perform employment duties within Florida; and b) all persons (including subcontractors) assigned by PROVIDER to perform work hereunder.

**ARTICLE II**

**Period of the Agreement**

This Agreement shall be in effect for the period beginning March 1, 2018, and will remain in full force and effect up to and including February 28, 2019. At the sole option of the COUNTY, this Agreement may be renewed at the same terms and conditions herein for an additional four (4) periods of one (1) year commencing March 1st and ending the last day of February. Any such renewals must be accomplished by a modification as described in Article V of this Agreement.

**ARTICLE III**

**Disbursement Rates and Requirements**

A. The COUNTY will reimburse authorized expenses to the PROVIDER for services rendered in accordance with the PAYMENT SCHEDULE attached as EXHIBIT II, which is incorporated by this reference. However, the PROVIDER agrees to seek reimbursement for benefits that are available from any responsible third party payor to pay for approved services provided to eligible persons pursuant to the terms set forth herein including, but not limited to, Medicare benefits, Medicaid benefits, Affordable Care Act (ACA), commercial insurance benefits, lawsuit settlements, Victims of Crime settlements; any other third party, individual, entity, or other program that is liable or may be liable to pay all or part of the charges associated with this agreement (hereinafter referred to as "third parties"). Ryan White allocated funding will be used only as a last resort for services not covered by other private or public funding sources or programs, including services provided by the "Hillsborough HealthCare" plan for qualified Hillsborough County residents, or available through other local programs funded by the State of Florida, any political subdivision of the State of Florida, or any health or social service provider for whose services
a client or his/her affected family members qualify. The PROVIDER will be required to make reasonable efforts to obtain payment from any other responsible third party payor and demonstrate to the DEPARTMENT’s satisfaction what efforts are being made or were made to seek reimbursement from third parties. The DEPARTMENT has the sole discretion to determine whether these third party reimbursement efforts are reasonable and satisfactory. Third party reimbursement efforts must include retroactive Medicaid/Medicare billing. All reimbursements made by any third party payor will be considered Program Income by the PROVIDER. The PROVIDER will be required to document all credits and propose to the DEPARTMENT how they would like to utilize these program income funds on behalf of HIV clients. The DEPARTMENT will have the sole discretion to approve the PROVIDER’s plan for how these program income funds will be spent. The PROVIDER will be required to demonstrate how program income was distributed. The PROVIDER will be required to submit reports on program income received and how funds were spent by the PROVIDER on a semi-annual basis or more frequently if deemed necessary by the DEPARTMENT. The DEPARTMENT will approve the report format. Any PROVIDER who provides a Medicaid/Medicare compensable service and who is not participating in this process will be considered in breach of contract.

If for any reason it is determined by the DEPARTMENT or HRSA that funds are not being distributed appropriately or in a manner no longer acceptable, or at the sole discretion of the DEPARTMENT, on behalf of the COUNTY, the DEPARTMENT may recover the funds from the PROVIDER immediately. Program income is defined as gross income earned by a recipient, sub-recipient, or a contractor under a grant-directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed (e.g., direct payment, or reimbursements received from Medicaid, Medicare and third-party insurance); and income a recipient or sub-recipient earns as the result of a benefit made possible by receipt of a grant or grant funds. See the HHS Grants Policy Statement [https://hab.hrsa.gov/sites/default/files/hab/Global/pcn_15-03_program_income.pdf](https://hab.hrsa.gov/sites/default/files/hab/Global/pcn_15-03_program_income.pdf), and 45 CFR 92.25 and 45 CFR 74.24.

**Reimbursement and Limitations on Use of Funds**

B. Except as otherwise provided herein, the PROVIDER understands and agrees to accept as payment in full, amounts paid by either the COUNTY or other third parties for services provided pursuant to this Agreement at the rates included herein; no other charges may be assessed to persons eligible for CARE Act services, except that the following fees may be assessed as an annual aggregate charge limitation based upon consecutive twelve (12) month periods established by the first date of service to the client:

<table>
<thead>
<tr>
<th>Annual Gross Income</th>
<th>Total Allowable Annual Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal to or below the federal poverty guideline</td>
<td>No charges permitted</td>
</tr>
<tr>
<td>101 to 200 percent of the federal poverty guideline</td>
<td>No more than 5 percent of annual gross income level</td>
</tr>
<tr>
<td>201 to 300 percent of the federal poverty guideline</td>
<td>No more than 7 percent of annual gross income level</td>
</tr>
<tr>
<td>More than 300 percent of federal poverty guideline</td>
<td>No more than 10 percent of annual gross income level</td>
</tr>
</tbody>
</table>
The term “aggregate charges” applies to the annual charges imposed for all such services without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost-sharing, co-payments, coinsurance, or other charges for services. All client charges received by the Provider must be reported on the monthly reimbursement request and deducted from the total amount requested. The PROVIDER shall not impose or collect any other supplemental fees from eligible individuals.

C. Contracted Medical Case Management providers or Eligibility staff are required to obtain proof of the client’s income, including check copies, bank statements, tax returns, etc. All in accordance with the Department of Health’s Eligibility Rule 64D as amended from time to time. The income documented will be used as the baseline by which the caps on fees will be established.

D. The PROVIDER further understands and agrees that Ryan White Extension Act funds reimbursed by the COUNTY may not be used for the following purposes:

1. To make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made by a third party payer either; (a) under a state or local compensation program, insurance policy, or any federal or state health benefits program; or (b) by an entity that provides health services on a prepaid basis.

2. To purchase or improve land, or to purchase, construct or permanently improve (other than minor remodeling) any building or other facility.

3. To make cash payments to intended recipients of services. Grocery store gift cards may be issued for the purchase of food and necessity items but the client must be required to provide the receipt of items purchased with the gift card. Moreover, the clients must be informed that alcohol and tobacco products are not allowable and the client may not receive cash back.

4. To pay for lobbying of any funding decision-making body.

E. If the services reimbursable under this Agreement are available under the state Medicaid plan the PROVIDER must be a certified Medicaid provider at the time of signing this Agreement. The PROVIDER must bill all services for Medicaid eligible clients to Medicaid instead of the COUNTY.

F. The client must meet the State of Florida, Department of Health’s Eligibility Rule requirements. This limits services to those clients who are at or below 400% of the current Federal Poverty Guidelines. The Eligibility Rule may be amended from time to time, and the PROVIDER must abide by the most current eligibility rules or limitations. Clients are not eligible for service and the PROVIDER is not eligible for reimbursement during a lapse in client eligibility.

**ARTICLE IV**

**Budgeting and Billing Requirements**

A. The following items apply to this Agreement regardless of payment method:

The PROVIDER will submit to the DEPARTMENT a categorical line-item budget for each service for each term of the Agreement, whether the reimbursement method is line-item or fee-for-service. This line-item budget must be submitted prior to the start of the grant period. If the contract amount is increased or decreased at any time during the contract period the PROVIDER must provide a revised budget within 30 days. The categorical line-item budget must be approved by the Ryan White staff Accountant, and the PROVIDER agrees to make necessary changes as recommended by the staff Accountant. No categorical line-item budget approval or amendment will increase or decrease the maximum amount payable for each service listed in EXHIBIT II, Payment Schedule.
The PROVIDER must use their approved Condition of Award Budget (which includes the categorical line-item budget) as the original budget, and all expenditures must be within the approved budget. Under no circumstances can the administrative costs exceed 10% of the contract amount. E2Hillsborough or ASI/Zenith will be used for submitting reimbursement, the billing process will be electronic, unless approved by the Program Manager.

Program income, the income received from payments on the sliding fee scale allowed in Article III, section B, must be used to enhance HIV services within the PROVIDER agency.

PROVIDER understands that these are 100% federal funds and in the event the Federal Government disallows payment for whatever reason and requires repayment, PROVIDER agrees to reimburse the COUNTY for that amount.

Travel expenses will be billed or expensed in accordance with Section 112.061, of the Florida Statutes (2016), as amended from time to time. However, if the PROVIDER's mileage reimbursement rate is less than the COUNTY rate, the PROVIDER agrees that the amount billed for mileage which is less than the COUNTY rate will be accepted as payment in full.

Failure to submit reimbursement requests by the month following the end of the month for which reimbursement is being requested and failure to submit the final invoice no later than 45 days after each budget period ends or is terminated may result in forfeiture of the claim. If the PROVIDER fails to do so, all rights to payment may be forfeited and the DEPARTMENT may not honor requests submitted after the aforesaid time period. Any payment due under the terms of this Agreement may be withheld until all reports due from the PROVIDER and necessary adjustments thereto have been approved by the DEPARTMENT.

Further, said failure may be considered a breach of this Agreement allowing the COUNTY to terminate this Agreement in addition to any other right the COUNTY may be entitled to. The DEPARTMENT reserves the right to reduce, reallocate or terminate funds for failure by the PROVIDER to achieve fiscal and/or program objectives as outlined in Exhibits I and II, in a timely manner. Such action by the DEPARTMENT will be taken only after written notice to the PROVIDER and the allowance of thirty days for the PROVIDER to remedy the failure.

B. If the Agreement contains line-item reimbursements:
Reimbursements/invoices shall be submitted monthly and all other necessary documents must contain sufficient detail verify valid expenses were incurred. Requests for reimbursement for authorized expenses must be submitted on the DEPARTMENT'S Request for Ryan White Reimbursement form attached as EXHIBIT III, incorporated by this reference. Payment will be made only after all required documents are received and the authorized expenses are approved. Following approval, the completed Request for Ryan White Reimbursement will serve as the approved budget, reimbursement request/invoice document, and cumulative expenditures/remaining funds management tool. Forms developed by the PROVIDER may also be used if they present the same information contained in EXHIBIT III and are approved for use by the DEPARTMENT.

C. If the Agreement contains, fee-for-service reimbursements:
Reimbursements/invoices shall be billed at the unit rate established in Exhibit II, Payment Schedule multiplied by the number of hours worked and/or the number of units of service provided. All current employees providing services under this contract must keep time sheets current and available for DEPARTMENT review as required from time to time. Fee-for-service billing shall be submitted through E2Hillsborough or ASI/Zenith, unless extenuating circumstances exist which prohibit electronic billing and
the Program Manager approves manual billing. Supporting documentation for payment will be the Payment Memo and Batch Detail Report, verification of service delivery and documentation will be made during program monitoring. In most cases service notes shall be entered into e2Hillsborough, if notes are not entered in e2Hillsborough then verification of service delivery will be reviewed manually during the monitoring visit or as deemed necessary by the DEPARTMENT.

The PROVIDER will complete the Budget/Expenditure Status Report, attached as EXHIBIT X, incorporated herein by reference. The report should be completed on a monthly basis and maintained at the PROVIDER offices and will be made available upon request by the DEPARTMENT and will be reviewed by fiscal staff of the Department.

ARTICLE V

Modification

This Agreement may be amended or modified by a written instrument executed by the duly authorized representatives of the parties. Similarly, no agreement that affects the provisions of this Agreement will be valid unless in writing and executed by the COUNTY and the PROVIDER, except as provided below.

The Director of the DEPARTMENT is hereby authorized to approve and execute Ryan White contract modifications for renewals of this Agreement provided the renewal is at the same terms and conditions as the original Agreement, with no intervening changes. However, the DEPARTMENT Director may approve modifications to add program requirements that are directly passed down from Health Resources and Services Administration ("HRSA"), as the funding agency.

The Director of the DEPARTMENT is hereby authorized to unilaterally approve and execute Ryan White contract modifications which reallocate funds within this Agreement or between and among various Ryan White providers’ Agreements together with the corresponding change to the number of clients and/or units, or the corresponding change to line-item if a budget contract, based on each of the following parameters:

(i). The Care Council has reallocated the funds per service category and per county based upon utilization during the program year;
(ii). If the Care Council decreases to zero or stops funding a specific service category with a county, the Director may decrease or delete funding unless such a decrease to zero has the effect of terminating this Agreement. Termination of this Agreement would require Board action; and
(iii). Any reallocated amounts shall be allocated to Ryan White providers based on documented need and shall be distributed pro rata, based on the documented need for that service category and provider.

ARTICLE VI

Termination

A. For Breach: Unless the PROVIDER’s breach is waived in writing, the COUNTY may, upon twenty-four (24) hours written notice to the PROVIDER's Contract Coordinator identified in EXHIBIT I, terminate this Agreement for said breach. Waiver of a breach of any provision of this Agreement is not a waiver of any other breach nor is it a modification of this Agreement. The aforesaid termination notice, as well as all other notices required herein, will be effective upon receipt of the written termination notice by the
PROVIDER, and delivered either in person with written proof thereof, or when received if sent certified U.S. Mail, return receipt requested.

B. For Convenience: This Agreement may be terminated by the COUNTY for convenience upon no less than thirty (30) days prior written notice to the PROVIDER. The aforesaid termination notice will be considered received by the PROVIDER when delivered as specified in the preceding paragraph. The COUNTY agrees to reimburse the PROVIDER for all authorized services rendered by the PROVIDER pursuant to this Agreement prior to the effective date of the termination, or until the end of the grant budget period, whichever is sooner.

C. Insufficient Funds: In the event Ryan White Extension Act grant funds used to finance this Agreement become unavailable during the contract period, the COUNTY may terminate this Agreement upon no less than twenty-four (24) hours written notice. The COUNTY will be the final authority as to the availability of funds for the current or any subsequent fiscal period. Notice will be given to the PROVIDER in the same manner provided in subparagraph A of this Article. The COUNTY agrees to reimburse the PROVIDER for all authorized services rendered by the PROVIDER pursuant to this Agreement for the period prior to the effective date of the termination, or until the end of the grant budget period, whichever is sooner.

D. For Failure to Satisfactorily Perform Other Agreement: Failure to have performed any other contractual obligations with the COUNTY in a manner satisfactory to the COUNTY will be sufficient cause for termination. To be terminated as a PROVIDER under this provision, the PROVIDER must have: (1) previously failed to have satisfactorily performed in any other contract with the COUNTY, been notified by the COUNTY of the unsatisfactory performance, and failed to correct the unsatisfactory performance to the satisfaction of the COUNTY; or (2) had any other contract terminated by the COUNTY for cause.

ARTICLE VII

Recordkeeping, Reporting and Evaluation Requirements

A. General Record Requirements: The PROVIDER must maintain both fiscal and programmatic records adequate to submit reports as required by the DEPARTMENT and by the United States Department of Health and Human Services. These records include those necessary to assure proper accounting of all CARE Act grant funds, those required to document the services provided through these funds, and any others deemed necessary by the DEPARTMENT or by the United States Department of Health and Human Services or the State of Florida Department of Health. These records must be made available to the COUNTY's authorized representatives as well as representatives of the Federal Government for audit, examination, excerpts, transcription, or monitoring purposes at any time during normal business hours and as often as the COUNTY may deem necessary during the period of this Agreement and during the period of six (6) years from the date the audit report is issued or until resolution of audit findings or litigation related to the terms and conditions of this contract and shall allow the United States Department of Health and Human Services, the COUNTY or its designee, access to such records upon request. The PROVIDER shall ensure that audit working papers are made available to the United States Department of Health and Human Services, upon request for a period of six (6) years from the date the audit report is issued, and PROVIDER agrees to extend said period if so requested by the United States Department of Health and Human Services or the COUNTY. The COUNTY may require that copies of all fiscal and programmatic records be surrendered to the COUNTY upon termination of this Agreement. Should services provided under this contract be transferred to another provider at any time or for any reason, the PROVIDER understands and agrees to transfer copies of the clients' records to the new provider agency or the COUNTY,
as determined by the DEPARTMENT within fifteen days of said transfer, in a manner that protects the integrity of the records and the confidentiality of the clients.

B. HIV Status and Eligibility: The PROVIDER must authenticate and record the HIV status of all clients receiving services funded by The CARE Act under this Agreement in accordance with United States Department of Health and Human Services policies and procedures. Failure to document the HIV status of clients served will be considered cause for withdrawal of funds and termination of this Agreement by the COUNTY. These records must be made available to COUNTY staff for inspection to validate eligibility of clients served. It is the PROVIDER's responsibility to obtain any required client Consent and/or Release of Medical Information forms to assure client confidentiality under current law and to allow County staff access to such records for the purposes described in this Agreement including access to the information in any Management Information System used by the PROVIDER and/or established by the DEPARTMENT. The PROVIDER must have the Express Consent Required by Florida Law to Obtain and Disclose Health Information signed by the client prior to accessing or imputing client information into E2Hillsborough. The COUNTY agrees to maintain client confidentiality to the extent required by law. Client eligibility will be determined by the PROVIDER in accordance with the policies of the CARE Act, the Care Council, and the COUNTY as grantee. Eligible residents must live within the four county EMA.

The PROVIDER shall have written procedures to ensure that staff and volunteers will maintain the confidentiality of client records related to the services provided under this contract, as specified in Sections 384.29 and 381.004(3), Florida Statutes (2016), as amended from time to time, and all applicable federal laws and/or regulations. The PROVIDER shall have each employee and volunteer with access to confidential client information, complete and date a memorandum of understanding regarding confidentiality of client information. Client records shall be kept in secured storage containers or equipment, in secured locations, within the physical location of the PROVIDER and must comply with HIPAA Security Rules and Regulations.

C. Reporting: The PROVIDER will submit the Monthly Administrative Report ("MAR") included as Exhibit IV if providing AIDS Pharmaceutical Assistance Local (medications) or Emergency Financial Assistance (medications) services, incorporated by reference, until AIDS Pharmaceutical Assistance and Emergency Financial Assistance services are electronically billed. Once electronic billing has been established MAR's will no longer be required. E2Hillsborough and/or ASI/Zenith will be the exclusive method for billing, reimbursement and reporting purposes for all other contracted services. The Monthly Administrative Report provides client-level information, including client identifier number and specific demographic data for each new client served, and summarizes the number of individuals served during the reporting period, and the units of service provided. Additional information may be required by the COUNTY or the United States Department of Health and Human Services. The COUNTY and the PROVIDER mutually agree the confidentiality of the clients served by the PROVIDER under this Agreement will be strictly observed, as required by applicable law, in any reporting, auditing, invoicing, program monitoring and evaluation. Monthly requests for reimbursement will not be processed unless accompanied by a completed Monthly Administrative Report, unless and until the reports can be obtained electronically from E2Hillsborough and/or ASI/Zenith.

Acceptance of this Agreement indicates the PROVIDER'S assurance that it will comply with data requirements of the Office of Management and Budget (OMB) approved Ryan White Annual Report. If the PROVIDER receives both Part A and Part B funding, the PROVIDER shall submit electronically one Annual Report for both funding sources. The PROVIDER is required to read the current Annual Report instructions from the Federal Government and follow them implicitly, as well as instructions from the DEPARTMENT. PROVIDER agrees to comply with any and all requests for information for State and/or Federal reports or the Federal Grant Application.
D. Any PROVIDER with more than $750,000 in total federally funded contracts is required to arrange for an independent audit of the PROVIDER’s fiscal year. The audit must be conducted in accordance with the applicable OMB Circular, Program Audit Guide, or Government Auditing Standards, and Generally Accepted Accounting Principles (GAAP). Audits must be completed no later than six (6) months after the end of the PROVIDER’s fiscal year. Audits must be submitted to the DEPARTMENT within thirty (30) days of completion and will include the management letter and corrective action plan. PROVIDER must have audits performed for each fiscal year during which Ryan White federal assistance has been received. Any PROVIDER with less than $750,000 in total federally funded contracts is required to submit an unaudited financial statement no later than two (2) months after the end of the PROVIDER’s fiscal year. The PROVIDER understands that failure to meet this requirement after written notice from the COUNTY and an opportunity to cure within the time specified in said notice, shall constitute a material breach. In addition, such failure can result in loss of current funding and disqualification from consideration for future COUNTY administered funding. Funds for an audit can only be used if the PROVIDER receives more than $750,000 in Federal funds annually. If at any time the PROVIDER’s Federal funding drops below $750,000 the PROVIDER must notify the DEPARTMENT, provide a revised budget within 14 days, and the cost of the audit must be paid from non-Federal funds. PROVIDER must complete the Federal Sub-recipient and Vendor Determination Checklist, included as Attachment A, and incorporated herein by reference.

E. Title to equipment acquired under this Agreement shall vest in the COUNTY and/or the United States Federal Government upon acquisition. All items of equipment acquired by the PROVIDER under this Agreement will be maintained, inventoried, and controlled in accordance with the equipment management requirements established by the COUNTY and in accordance with the Federal Public Health Service Grants Policy Statement. In accordance with the FY 1995 Appropriations Act (P.L.103-333) and advice from the Health Resource and Services Administration (HRSA), all equipment and products purchased with grant funds should be American-made. The PROVIDER shall not dispose of nonexpendable property purchased under this contract, except with prior written approval from the COUNTY.

F. The PROVIDER agrees to participate in evaluation studies and needs assessments sponsored by the United States Health Resources and Services Administration and/or analyses carried out by or on behalf of the COUNTY or the Care Council to assess the needs of the HIV target population or to evaluate the appropriateness and quality of services provided. This participation will, at a minimum, include permitting right of access to staff involved in such efforts to PROVIDER’s premises and records, consistent with client confidentiality requirements, and to participate in meetings scheduled for such purposes.

G. At least one authorized representative of the PROVIDER’S organization is required to attend all PROVIDER meetings held by the DEPARTMENT to exchange important contractual, fiscal and program information. Absences of PROVIDER representatives, due to emergencies, may be excused by the DEPARTMENT.

H. The PROVIDER must abide by the minimum standards of care established by the Care Council that were set forth in RFA #RW1-18. The DEPARTMENT will notify the PROVIDER of any changes made by the Care Council. The minimum standards are also maintained on Hillsborough County’s Ryan White web site, the link is: http://hcflgov.net/en/residents/social-services/health-care-plan/ryan-white-rfa

I. The PROVIDER must have the ability to provide documents requested by the DEPARTMENT in an Microsoft (“MS”) Word format, while files containing data must be submitted in an Excel format. The DEPARTMENT will notify the PROVIDER if the documents are to be provided electronically, either through County electronic mail or the County secure messaging system (“MOVE-It”) depending on the
nature of the data being requested and transferred. The PROVIDER agrees to provide the items as requested within the timeline established by the DEPARTMENT.

J. The COUNTY will only reimburse the PROVIDER for services rendered, therefore the COUNTY will not reimburse the PROVIDER for days in which they are closed excluding COUNTY holidays. Time sheets must document hours worked. The PROVIDER must notify the DEPARTMENT in writing and with 30 days prior notice of the days their offices will be closed.

K. LIQUIDATED DAMAGES:

1. If the PROVIDER fails to perform or provide for any of the items listed in paragraph three below within ten (10) business days after the DEPARTMENT has given PROVIDER written notice of PROVIDER's failure to perform; Liquidated damages shall be assessed against the PROVIDER for each calendar day that the COUNTY is harmed and will incur administrative expenses incidental to the PROVIDER's failure to perform as required.

2. Both parties agree that any liquidated damages imposed are for the harm incurred by the COUNTY administratively, which costs are difficult to quantify, and shall not be construed as a penalty. Imposition of liquidated damages will in no way limit the COUNTY's ability to pursue all other legal remedies and other substantiated costs incurred by the COUNTY.

3. COUNTY shall be entitled to assess liquidated damages and deduct same from the monthly billing of the PROVIDER for each of the following occurrences:

4. Failure to provide within the time period set forth in the Agreement any reports, audits, and/or financial statements required pursuant to Articles I, IV, VII except as expressly excluded therein, and XVI of this Agreement will be assessed $50.00 per day. Assessment of liquidated damages is in addition to any other incidental, consequential or other damages that the COUNTY may be entitled to pursuant to law.

L. WORK PRODUCT: All documents, studies, and findings resulting from this Agreement shall become property of the COUNTY and the United States Federal Government. PROVIDER shall not publish, use or provide this information to any third party excluding the Care Council without prior written consent of the COUNTY.

M. The PROVIDER must abide by the client service limit caps established by the Care Council that were set forth in RFA #RW1-18. The DEPARTMENT will notify the PROVIDER of any changes made by the Care Council and they are maintained on Hillsborough County’s Ryan White web site, the link is: http://hcflgov.net/en/residents/social-services/health-care-plan/ryan-white-program

N. Proof of Outpatient/Ambulatory Medical Care: Case Management providers must obtain proof that the client has been to an Outpatient/ambulatory medical care (“primary care”) provider at least once annually. Any services provided to a client without proof of primary care will not be eligible for reimbursement. This paragraph is excluded from the Liquidated Damages provision.

O. Case Management PROVIDERS will be required to attend case management training sessions offered under Part A, as well as any State of Florida, Department of Health sponsored training sessions, which the PROVIDER is granted access to attend.

P. Quality Management: Quality Management is a HRSA mandate. Quality Management reporting elements including measurable outcomes have been established by the Part A Quality Management
Contracted Provider. The Quality Management standards and measurable outcomes are subject to change over time. The PROVIDER must participate and fully cooperate with the Part A Quality Management Contracted Provider.

Q. All case managers, mental health counselors and medical staff must identify Hispanic and African American clients who 1) have been referred to primary care but have not accessed it, or 2) are accessing care inconsistently. The PROVIDER must obtain the proper release of information from the client and those clients identified must be referred to the Ryan White Part A contracted Health Education Risk Reduction provider(s).

R. The PROVIDER must document that they have obtained Third Party Reimbursement (“TPR”) training at least once annually, provided it is offered by HRSA. The DEPARTMENT prefers that the PROVIDER attend a HRSA sponsored TPR training session or log on to a web based training program. TPR training can be third party billing to Medicare, Medicaid, or any other third party payor.

ARTICLE VIII
Legal Governance

Unless otherwise specified, this Agreement is governed by the laws, rules, and regulations of Florida, or the laws, rules, and regulations of the United States when the services provided herein are funded by the United States government, and venue will be in Hillsborough County, Florida.

ARTICLE IX
Statement of Assurance

During the performance of this Agreement, the PROVIDER herein assures the COUNTY that said PROVIDER is in compliance with Title VII of the 1964 Civil Rights Act, as amended, and the Florida Civil Rights Act of 1992, as amended, in that the PROVIDER does not on the grounds of race, color, national origin, religion, sex, age, handicap, or marital status, discriminate in any form or manner against the PROVIDER's employees or applicants for employment. The PROVIDER understands and agrees that this agreement is conditioned upon the veracity of this Statement of Assurance. Furthermore, the PROVIDER herein assures the COUNTY that said PROVIDER will comply with Title VI of the Civil Rights Act of 1964 when federal grant funds are involved in the provision of the services required hereunder. Other applicable federal and state laws, executive orders, and regulations prohibiting the type of discrimination as herein delineated are included by this reference. This statement of assurance will be interpreted to include Vietnam Era Veterans and Disabled Veterans within its protective range of applicability. In instances where the total payments to be made to the PROVIDER by the COUNTY under this Agreement amount to $10,000 or more, the PROVIDER (as contractor) will abide by the provisions of the HILLSBOROUGH COUNTY EQUAL OPPORTUNITY CLAUSE attached as EXHIBIT V and incorporated by reference.

ARTICLE X
Assignment and Subcontracting

It is understood and agreed that this Agreement may not be assigned or subcontracted without the prior written consent of the COUNTY. All requirements of this contract must be included in all subcontracts or assignments, unless waived in writing by the COUNTY.
ARTICLE XI

Notification Requirement

Any notices required under this Agreement shall be written and delivered either in person with written proof thereof, or when received if sent certified U.S. Mail, return receipt requested. Such notice if to the COUNTY, shall be sent to the COUNTY address listed in the first paragraph of this Agreement; and if to the PROVIDER, notice shall be sent as listed in EXHIBIT I.

ARTICLE XII

Indemnification and Insurance Requirements

A. The PROVIDER will indemnify, hold harmless, and defend the COUNTY, its agents and employees from and against any and all liabilities, losses, claims, damages, demands, expenses or actions, either at law or in equity, including court costs and attorneys’ fees and expenses, that may hereafter at any time be made or brought by anyone on account of personal injury, property damage, loss of monies, or other loss, allegedly caused or incurred, in whole or in part, as a result of any negligent, wrongful, or intentional act or omission, or based on any act of fraud or defalcation by PROVIDER, its agents, subcontractors, assigns, heirs, and employees during performance under this Agreement. The extent of this indemnification is not limited in any way as to the amount or types of damages or compensation payable to the COUNTY on account of any insurance limits contained in any insurance policy procured or provided in connection with this Agreement. In any and all claims against the COUNTY or any of its agents or employees by any employee of the PROVIDER, any subcontractor, heir, assign, or anyone for whose acts any of them may be liable, the indemnification obligation under this paragraph is not limited in any way as to the amount or type of damages, compensation or benefits payable by or for the PROVIDER or any subcontractor under workers’ compensation acts, disability benefit acts or other employee benefit acts. This obligation shall survive the termination or expiration of this Agreement for a period of not less than six (6) years, or any applicable statute of limitations period, or equitable limitations doctrines, whichever is longer.

B. The PROVIDER shall, pursuant to the requirements of EXHIBIT VI, INSURANCE REQUIREMENTS, procure and maintain throughout the period of the Agreement on behalf of themselves and the COUNTY, insurance of the types listed in EXHIBIT VI and in the amounts specified. All insurance not provided by a self-insurance program shall be obtained from responsible companies duly authorized to do business in the State of Florida and each policy shall provide that the COUNTY is an additional insured party as to the actions of the PROVIDER, its employees, agents, assigns and sub-contractors, performing or providing materials and/or services to the PROVIDER during the performance of the Agreement and shall also contain a Severability of Interest provision. Every insurance policy must provide for thirty-(30) days prior written notice to the COUNTY of any cancellation, intent not to renew, or reduction in the policy coverage.

ARTICLE XIII

AUTOMATION REQUIREMENTS

The COUNTY requires all contracted providers to enter COUNTY designated information on every client into e2Hillsborough.
Additionally, if the PROVIDER terminates employment of a staff member or if the employee resigns, the PROVIDER must notify the DEPARTMENT of their employment status within 24 hours of termination/resignation in order that the access to e2Hillsborough be disabled by the DEPARTMENT.

The PROVIDER shall maintain their own computers, printers, scanners, information systems, licenses, virus protection software, passwords, networks, and other such logging and access control systems and procedures as to provide reasonable assurance as to the Privacy and Security of any Protected Health Information (“PHI”) and/or Electronic PHI (“E PHI”) that they create, maintain, store, or use in conjunction with the Ryan White Program.

The COUNTY will not provide computer resources, support and maintenance of computer hardware. All repairs, maintenance, and security mechanisms costs are the responsibility of the PROVIDER.

PROVIDER must have a mechanism of capturing, billing and reporting data required by this Agreement and HRSA. Failure to capture, bill and report required data will result in termination of this Agreement. Based on the COUNTY’s determination, the PROVIDER agrees to purchase a scanner at the PROVIDER’s expense to electronically capture forms and other required backup documents for electronic transfer to the COUNTY.

The COUNTY is considered a covered entity under Health Insurance Portability and Accountability Act (“HIPAA”) and as such all HIPAA covered electronic transmissions must be in a standard HIPAA compliant transaction format. All costs related to the PROVIDER’s programming, formatting, or submission of HIPAA Transactions through a clearinghouse or translator product will be the PROVIDER’s sole responsibility. If PROVIDER is not a covered entity under HIPAA, then PROVIDER shall transmit its billing and reporting information in the designated COUNTY format.

Furthermore, the PROVIDER agrees to comply with all HIPAA terms and regulations, if applicable, and Ryan White 2009 Extension Act guidelines applicable for Privacy, Confidentiality, Security and applicable records retention laws for any Ryan White related data in their control.

PROVIDER is responsible for securing access to computers and performing periodic review and maintenance of all hardware used for Ryan White data collection for their agency. The maintenance of these computers will include the following:

1. PROVIDER must purchase and use either a software or hardware firewall.
2. PROVIDER must purchase and use an anti-virus security software package installed on each of their personal computers.
3. PROVIDER is responsible for keeping all operating systems, firewalls and anti-virus security software products up to date as suggested by each of the appropriate software vendors. PROVIDER agrees to provide access to DEPARTMENT staff to inspect and monitor that these measures are being followed.
4. Failure to meet these requirements or keep in step with prevailing HIPAA, if applicable, Federal or State requirements for securing Ryan White data will result in termination of this Agreement.

PROVIDER shall not input in E2Hillsborough psychotherapy notes, as that term is defined in the HIPAA Rules Governing the Standards for Privacy of Individually Identifiable Health Information.

The PROVIDER shall provide all required reporting and billing data in a format that shall be designated by the COUNTY. PROVIDER agrees to modify this Article as necessary to correspond to the specific method or methods that will be used for data collection coinciding with RWIS. It is also anticipated that data collection, billing and reporting requirements may change during the life of this Agreement and
PROVIDER agrees to comply with those requirements. The PROVIDER will make the necessary adjustments in their data collection, billing and reporting systems and methodologies to continue to comply with this Article.

If PROVIDER is a covered entity under HIPAA, PROVIDER agrees to enter into a Trading Partner Agreement with the COUNTY to specify the conditions of electronic data transfers and to conform to Health Insurance Portability and Accountability Act (“HIPAA”) mandates of transaction and code sets.

If PROVIDER is not a covered entity under HIPAA, PROVIDER agrees to comply with the e2Hillsborough Protocols and Procedures as developed by the DEPARTMENT. The e2Hillsborough Protocols and Procedures will among other provisions specify the format and conditions of electronic data submissions. Electronic exchange of all Ryan White related data will employ a secure technology preapproved by the COUNTY. The COUNTY will not be responsible for costs incurred by the PROVIDER to submit electronic report and claim data.

Supporting documentation required to accompany line item claims will still be required for reconciliation and proper audit to the electronic submission. Detailed back up for eligibility determination, billings, reports, etc., may be required to accompany electronic submissions and data entry. The backup documents must be transmitted in a COUNTY approved methodology and format which may require the PROVIDER to use a scanner, fax or other electronic means to transfer the information.

Client Registration:
For billing and reporting all clients must be registered and have a number to uniquely identify said client in the E2Hillsborough.

HIPAA Covered Entities and Supported Transactions
PROVIDERS that are HIPAA Covered Entities shall submit all electronic claim data to the DEPARTMENT in HIPAA standard transaction format.

All costs related to the PROVIDER’s programming of the HIPAA Transactions or for clearinghouse submission of the HIPAA Transactions will be the PROVIDER’s sole responsibility.

The DEPARTMENT will only accept electronic claim data from a Covered Entity that is in a HIPAA standard transaction format. If the Covered Entity is working towards a compliance plan for the electronic claim submission, the PROVIDER shall certify to the COUNTY upon execution of this Agreement that it has a contingency plan and is making a good faith effort to move towards compliance within one year.

ARTICLE XIV
Severability

In the event any section, sentence, clause, or provision of this Agreement is held to be invalid or illegal, the remainder of the Agreement shall not be affected by such invalidity or illegality and shall remain in full force and effect.

ARTICLE XV
Independent Contractor Requirement

The PROVIDER will carry out, or cause to be carried out, all of the services required herein as an independent contractor. The PROVIDER will not represent itself as an agent, sub-agent, or
representative of the COUNTY. All services described herein will be carried out by persons or instrumentalities solely under the PROVIDER's control and supervision.

ARTICLE XVI

Customer Satisfaction Survey

The PROVIDER will be required to participate in the Customer Satisfaction Survey Program by distributing DEPARTMENT-approved survey forms to the clients. For the purpose of this Agreement a customer is defined as HIV positive individuals, Care Council members, Ryan White subcontracted providers, community advocates, and community leaders which consist of non-Ryan White subcontracted providers, such as hospital emergency room staff, mental health providers, homeless shelters, etc. The DEPARTMENT’s contracted Quality Management (QM) provider will administer and tabulate results and report to the PROVIDER and Ryan White staff any significant client-perceived deficiencies in performance, as well as significant positive client feedback. Client satisfaction surveys will be distributed as instructed by the QM provider. PROVIDER shall achieve 88 percent or better rating on the client satisfaction survey administered by the PROVIDER. If an 87 percent or less satisfaction rate is received on the above referenced survey a corrective action plan (“plan”) must be submitted within 30 days. If the corrective action plan is not submitted within 30 days the COUNTY will withhold reimbursement requests until the plan is submitted.

ARTICLE XVII

Political Limitations for County Contracts with Private Non-Profit Corporations

Service PROVIDERS must not participate in, or intervene in, including the publishing or distributing of statements, any political campaign on behalf of, or in opposition to, any candidate for public office. Specifically, not-for-profit corporations that receive public funding through the COUNTY shall not engage in political activities that promote or oppose a specific candidate, pursuant to BOCC policy 02.12.00.00, as amended from time to time.

ARTICLE XVIII

Public Entity Crimes Statement

If the amount of the Agreement is ten thousand dollars ($10,000) or more, the PROVIDER shall certify by sworn statement that is has not been charged and convicted of a Public Entity Crime, nor is it in violation of any state or federal law involving anti-trust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation as stated in Exhibit VII, attached hereto and made a part hereof.

ARTICLE XIX

Compliance

The PROVIDER shall comply with the requirements of all federal laws, state laws, local codes and ordinances, rules and regulations, as well as the Hillsborough County Policies and Procedures Manual (“Manual”). In the event of any conflict with the Manual and this Agreement the Manual shall control, unless it conflicts with a Federal or State Statute or regulation. If the PROVIDER notices a discrepancy between the Manual and the Agreement, the PROVIDER must immediately notify the DEPARTMENT in writing of the discrepancy. The PROVIDER represents that it has and shall maintain all the necessary licenses to
provide the services set forth in Exhibit I of this Agreement, and that the person executing this Agreement has the authority to do so. If the PROVIDER observes that any of the provisions of this Agreement are at variance therewith, the PROVIDER will give the DEPARTMENT prompt written notice. Any necessary changes to the provisions contained herein will be adjusted by an appropriate modification. PROVIDER also agrees to comply with all current and future HRSA Program Policy Notices.

ARTICLE XX
Costs

Each party shall be responsible for their respective attorneys' fees and costs, including but not limited to costs and attorneys' fees associated with administrative hearings, court proceedings and appellate proceedings.

ARTICLE XXI
Waiver

A waiver of any performance or breach by either party shall not be construed to be a continuing waiver of other breaches or non-performance of the same provision or operate as a waiver of any subsequent default of any of the terms, covenants, and conditions of this Agreement. The payment or acceptance of fees for any period after a default shall not be deemed a waiver of any right or acceptance of defective performance.

ARTICLE XXII
Additional Rights and Remedies

Nothing contained herein shall be construed as a limitation on such other rights and remedies available to the parties under or in equity which may now or in the future be applicable.

ARTICLE XXIII
Order of Precedence

In the event of any conflict between the provisions of this Agreement and the exhibits attached hereto, the contents of the exhibits shall control over the contents of the Agreement. In the event of any conflict between the provision of this Agreement and Sections A through G of RFA #RW1-12, the terms of this Agreement shall control.

ARTICLE XXIV
Survivability

Any term, condition, covenant or obligation which requires performance by either party subsequent to termination of this Agreement shall remain enforceable against such party subsequent to such termination. In the event any section, sentence, clause, or provision of this Agreement is held to be invalid, illegal or unenforceable by a court having jurisdiction over the matter, the remainder of the Agreement shall not be affected by such determination and shall remain in full force and effect.
ARTICLE XXV

P.L.103-227, Pro-Children Act of 1994

PROVIDER understands and agrees that it is in compliance with Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), and shall remain in compliance during the term of this Agreement and any renewal thereof. Provider shall certify by notarized statement its compliance on EXHIBIT VIII which is attached hereto and incorporated herein by reference.

ARTICLE XXVI

Headings

Article headings have been included in the Agreement solely for the purpose of convenience, and such headings shall not affect the interpretation of any of the terms of the Agreement.

ARTICLE XXVII

Public Notices

In accordance with the FY 1995 Appropriations Act (P.L. 103-333) and HRSA advise, when issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees and sub-grantees receiving Federal funds shall clearly state: (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

ARTICLE XXVIII

Drug Free Workplace

The Provider will assure the County it will administer, in good faith, a policy designed to ensure that the Provider is free from the illegal use, possession, or distribution of drugs or alcohol. As part of such policy, the Provider will require, as a condition of employment, that each employee notify their supervisor within five (5) days if they have been convicted under a criminal drug statute for activity occurring at the workplace or outside the workplace, if the offense could be reasonably expected to affect the Provider’s function. The PROVIDER will, in turn, immediately notify the COUNTY of the occurrence as well as any and all corrective action taken. A criminal drug statute is any law, federal, state, or local, which makes unlawful the manufacture, distribution, dispensation, or possession of any controlled substance or illegal drug.

ARTICLE XXIX

Patents, Copyrights, and Royalties

If any discovery or invention arises or is developed in the course of or as a result of work or services performed under this contract, or in any way connected herewith, the PROVIDER shall refer the discovery or invention to the Federal Government, through the COUNTY, to determine whether patent protection will be sought in the name of the Federal Government. In the event any books, manuals, films, or other copyrightable materials are produced, the PROVIDER shall notify the Federal Government. Any and all
patent rights and copyrights accruing under or in connection with the performance of this contract are hereby reserved to the Federal Government, in accordance with 37 CFR part 401. The PROVIDER, without exception, shall indemnify and hold harmless the COUNTY and the Federal Government and its employees from liability of any nature or kind, including costs and expenses for or on account of any copyrighted, patented, or unpatented invention, process, or article manufactured by the PROVIDER. If the PROVIDER uses any design, device, or materials covered by letters, patent or copyright, it is agreed and understood without exception that the fees for service shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

ARTICLE XXX

Certification Regarding Lobbying

PROVIDER understands and agrees that it is in compliance with 31 USC Section 1352, and shall remain in compliance during the term of this Agreement and any renewal thereof. Provider shall execute a certification regarding lobbying, attached as EXHIBIT IX and made a part hereof.

ARTICLE XXXI

PROVIDER understands that it is in compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act, 42 U.S.C. 7606, Section 508 of Clean Water Act (33 USC 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 CFR part 15), and 42 USC Section 7401 et seq., the Federal Water Pollution Control Act as amended 33 USC 1251 et seq., and shall remain in compliance during the term of this Agreement and any renewal thereof. Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency.

PROVIDER understands that it is in compliance with the Energy Policy and Conservation Act 45 CFR 92.36(I)(13), 45 CFR 92.37 (b), as well as Debarment and Suspension 45 CFR 74 App A (8), and shall remain in compliance during the term of this Agreement and any renewal thereof.

ARTICLE XXXII

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

PROVIDER, if a covered entity, must be in full compliance with HIPAA. This includes but is not limited to all privacy, transactions and code sets and security requirements in effect now or that may be in effect at any time in the future. Any and all associated costs for PROVIDER to comply with the HIPAA laws shall be borne by PROVIDER. All HIPAA compliance dates must be satisfied and PROVIDER must provide written assurance demonstrating the ability to meet all compliance deadlines upon request by COUNTY’s Privacy Officer. This includes maintaining a Contingency Plan to assure the continuation of operations consistent with HIPAA. This plan shall have been tested and copies made available to the COUNTY upon request. PROVIDER is required to fully cooperate with any and all audits, reviews and investigations conducted by COUNTY, Centers for Medicare & Medicaid Services (“CMS”), Office of Civil Rights or any other governmental agencies, in connection with HIPAA compliance matters.

PROVIDER, if a covered entity, may receive, use and disclose protected health information as permitted or as required by law. This includes disclosure of protected health information to the DEPARTMENT (as
a covered entity) in connection with treatment, payment or operations, including Ryan White operations and as required by this Agreement.

ARTICLE XXXIII

Data Sharing

Certain data under this Agreement is confidential and must be afforded special treatment and protection shall be made available between the parties and utilized as described herein. When confidential data received, exchanged and/or accessed can be used or disclosed only in accordance with this agreement and local, state and federal law.

1. The following Definitions shall apply to this Article only:

   a. Covered Entity: “Covered Entity” shall mean COUNTY.

   b. Trading Partner: “Trading Partner” shall mean PROVIDER.

   c. Protected Health Information. “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 CFR § 160.103.

2. Purpose of Agreement: The data specified in this agreement will be used solely for purposes of research, public health or health care payment, treatment or operations.

3. Justification for Access. This agreement is authorized by the Health Insurance Portability and Accountability Act of 1996 as the same may be amended from time to time. (HIPAA) This agreement implements HIPAA by allowing the parties to disclose protected health information (PHI) necessary to perform contractual and/or legal obligations and to provide for appropriate safeguards of PHI.

4. Description of Data. To enable Trading Partner to perform certain contractual or other legal obligations concerning PHI, Covered Entity may disclose PHI for Trading Partner’s use.

5. Point of Contact. Covered Entity designates the following individual as its point of contact for this agreement:

   Aubrey Arnold, or his successor
   Name of point of contact

   601 E Kennedy Blvd, 16th Floor
   Street address

   Tampa, FL 33602
   City / State / Zip code

   (813) 272-6935
   Phone number

   All correspondence regarding this agreement, including, but not limited to, notification of change of custodianship, uses or disclosures of the data not provided for by this agreement, requests for
access to the data, requests for accounting of disclosures of the data, disposition of the data, and termination of this agreement, shall be addressed to the point of contact.

6. **Custodial Responsibility.** Trading Partner names the following individual custodian of the data on behalf of same.

XXX  
Name of custodian

XXX  
Street Address

XXX  
City / State / Zip code

XX  
Phone number

The custodian shall be responsible on behalf of Trading Partner for monitoring all conditions of use and for the establishment and maintenance of safeguards as specified in this agreement to prevent unauthorized use. Trading Partner must notify Covered Entity in writing within thirty (30) days of any change of custodianship. Notification of change of custodianship shall be delivered by certified mail, return receipt requested, by facsimile with proof of delivery, or in person with proof of delivery.

7. **Permissible Uses and Disclosures of Trading Partner Data.** Trading Partner shall not use, release or further disclose the data specified in this agreement except as permitted by this agreement or any other contract between Trading Partner and Covered Entity or as required by local, state or federal law. Trading Partner shall establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of and to prevent unauthorized use of or access to the data specified in this agreement.

Trading Partner shall not disclose, release or allow the release of the data specified in this agreement to any persons or entities other than those listed in paragraph 8, below and as otherwise permitted by this agreement, or any other agreement between Trading Partner and Covered Entity. Trading Partner shall in all instances restrict use, disclosure or release of the data specified in this agreement to minimum number of individuals who require the information in order to perform contractually obligated functions. Trading Partner shall instruct individuals to whom the data is disclosed of all obligations under this agreement and shall require the individuals to maintain those obligations.

Trading Partner shall secure the data specified in this agreement when the data is not under the direct and immediate control of an authorized individual performing the functions of this agreement. Trading Partner shall make a good faith effort to identify any use or disclosure of the data not provided for by this agreement. Trading Partner shall notify the Covered Entity by certified mail, return receipt requested, or by facsimile with the proof of delivery or in person with proof of delivery within three (3) business days of discovery of any use or disclosure of the data not provided for by this agreement of which the Trading Partner is aware, and shall mitigate, to the extent possible, any harm caused thereby.
A violation of this section shall constitute a material breach of this agreement and notwithstanding any provision of any contract between Trading Partner and Covered Entity to the contrary, Covered Entity shall have the right to terminate its relationship with Trading Partner and to terminate this agreement, with twenty-four (24) hours written notice.

8. **Disclosure to Agents.** Trading Partner shall ensure that any agents of Trading Partner, including, but not limited to, a contractor or subcontractor, to whom Trading Partner provides data specified in this agreement agree to the same terms, conditions, and restrictions that apply to Trading Partner with respect to the data.

9. **Access to the Data.** Trading Partner shall notify the Covered Entity in writing by certified mail, return receipt requested, or by facsimile with proof of delivery or in person with proof of delivery within ten (10) days of any requests received by the Trading Partner from individuals seeking access to or copies of the data specified in this agreement.

10. **Accounting of Disclosures.** Trading Partner shall notify the Covered Entity in writing by certified mail, return receipt requested, or by facsimile with proof of delivery or in person with proof of delivery within ten (10) days of any requests received by Trading Partner from individuals seeking an accounting of disclosures of the data specified in this agreement. Trading Partner shall document all disclosures of the data as needed for Covered Entity to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. § 164.528, and shall provide the Covered Entity with such documentation upon the Covered Entity’s request.

11. **Incorporation of Amendments to the Data.** Trading Partner shall incorporate any amendments to the data specified in this agreement when and as notified by Covered Entity and shall abide by any authorized restrictions on the release, use or disclosure of PHI after notice by Covered Entity.

12. **Penalties.** Trading Partner acknowledges that failure to abide by the terms of this agreement may subject Trading Partner to penalties for wrongful disclosure of protected health information under federal law. Trading Partner shall inform all persons with authorized access to the data specified in this agreement of the penalties for wrongful disclosure of protected health information.

13. **Indemnification.** Trading Partner shall indemnify, hold harmless, and defend Covered Entity, its agents and employees from and against any and all liabilities, losses, claims, damages, demands, expenses or actions, either at law or in equity, including court costs and attorneys fees, that may hereafter at any time be made or brought by anyone on account of personal injury, property damage, loss of monies, or other loss, allegedly caused or incurred, in whole or in part, as a result of any negligent, wrongful, or intentional act or omission, or based on any act of fraud or defalcation by Trading Partner, its assigns, and heirs during performance under this Agreement. The extent of this indemnification shall not be limited in any way as to the amount or type of damages or compensation payable to Covered Entity on account of any insurance limits contained in any insurance policy procured or provided in connection with this Agreement. In any and all claims against Covered Entity or any of its agents or employees by Trading Partner, its heirs, assigns, anyone directly or indirectly employed by any of them, or anyone for whose acts any of them may be liable, the indemnification obligation under this paragraph shall not be limited in any way as to the amount or type of damages, compensation or benefits payable by or for Trading Partner under workers compensation acts, disability benefit acts or other employee benefits acts. This obligation shall survive the termination or expiration of this Agreement for a period of not less than six (6) years, or any applicable statute of limitations period, or equitable limitation, equitable limitation doctrine, whichever is longer. In accordance with Florida Statutes
Section 768.28, this section shall not apply to contracts with the state, its agencies and subdivisions as defined therein.

14. **Disposition of Data.** Trading Partner shall retain the data specified in this agreement for a period not less than six (6) years from the date Trading Partner receives or is provided access to the data, (hereinafter referred to as the retention period) unless otherwise authorized by the Covered Entity’s Privacy Officer. Upon conclusion of the retention period, Trading Partner shall destroy the data and any information derived from its contents, including all copies, modified data, or hybrid or merged databases containing the data or return it to Covered Entity if requested by the Privacy Officer after Notice by Trading Partner. Trading Partner shall provide Covered Entity with written confirmation of the destruction of the data and any information derived from its contents.

15. **Term of Agreement.** These Data Sharing Contract provisions shall be effective upon execution of this Agreement by both parties and shall remain in effect until terminated by Covered Entity. Covered Entity may, by no less than twenty-four (24) hours written notice to Trading Partner, terminate this agreement upon material breach of this agreement. This agreement may be terminated by Covered Entity without cause upon thirty (30) days written notice. Notice of termination shall be delivered by certified mail, return receipt requested or by facsimile with proof of deliver or in person with proof of delivery.

The terms of this agreement may not be waived, altered, modified, or amended except by written agreement of both parties. Both parties agree to enter into a written modification agreement or take such action as is necessary to comply with the requirements of HIPAA and any amendment thereto or to implement any changes required by law.

This agreement supersedes any and all agreements between the parties with respect to the use of the data specified in this agreement.

**ARTICLE XXXIV**

**Equal Employment Opportunity; Non-Discrimination**

The Contractor shall comply with Hillsborough County, Florida - Code of Ordinances and Laws, Part A, Chapter 30, Article II (Hillsborough County Human Rights Ordinance) as amended, which prohibits illegal discrimination on the basis of actual or perceived race, color, sex, age, religion, national origin, disability, marital status, sexual orientation, or gender identity or expression, in employment, public accommodations, real estate transactions and practices, County contracting and procurement activities, and credit extension practices.

The Contractor shall also comply with the requirements of all applicable federal, state and local laws, rules, regulations, ordinances and executive orders prohibiting and/or relating to discrimination, as amended and supplemented. All of the aforementioned laws, rules, regulations, ordinances and executive orders are incorporated herein by reference.

**ARTICLE XXXV**

For the period beginning June 6, 2017 and ending February 28, 2018, the PROVIDER acknowledges that the COUNTY, as the Grantee agency for Part A of the Ryan White Extension Act, has not received its Notice of Grant Award amount from HRSA. Until the Notice of Grant Award is received the PROVIDER can only be reimbursed for up to 1/9th of the contract amount per month based on the services provided.
The PROVIDER understands and agrees that they can only seek to be reimbursed by the COUNTY for up to 1/9th of the contract amount per month until the COUNTY receives the final award from HRSA. At that time the DEPARTMENT will notify the PROVIDER of the Notice of Grant Award amount and inform the PROVIDER as to whether or not the PROVIDER’s contract amount will remain the same. If the Notice of Grant Award amount is decreased, the PROVIDER’s contract may also be decreased pursuant to Care Council deductions to specific service categories. In the event there is a conflict between this paragraph and any other contract language regarding the amount of payment/reimbursement to PROVIDER, the provisions of this paragraph shall supersede and control.

ARTICLE XXXVI

Consideration and Limitation of Costs

For its performance under this Agreement, the PROVIDER will receive funds from the COUNTY in an amount not to exceed XXX Dollars ($XXX.00) for services provided during the Term. Furthermore, if the Agreement is for a period in excess of one year, then in no event shall the total consideration paid under this Agreement exceed XXX Dollars ($XXX.00) annually.

EXHIBIT XI, “Subaward Agreement, Federal Award Identification” and EXHIBIT XII, “Federally Required Subaward Information”, are attached hereto and made a part hereof.

(The remainder of page intentionally left blank.)
ARTICLE XXXVII

Entire Agreement

The foregoing constitutes the entire Agreement between the parties with respect to the subject matter contained herein.

IN WITNESS WHEREOF, the PROVIDER and the COUNTY have executed this Agreement the date first above written.

ATTEST: Pat Frank, Clerk of Circuit Court

COUNTY: Hillsborough County, Florida

BY: ________________________________
Deputy Clerk

BY: ________________________________
Chairman of the Board of County Commissioners

ATTEST: For the PROVIDER

PROVIDER: XXX, Inc.

BY: ________________________________
Authorized Representative

Title

Witness

Date Signed

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ACKNOWLEDGMENT OF PROVIDER, IF A CORPORATION

STATE OF __________________________ COUNTY OF __________________________

The foregoing instrument was acknowledged before me this __________________ by __________________________, (Name of officer or agent, title of officer or agent)
of __________________________ a __________________________ corporation,
(Name of corporation acknowledging) (State or place of incorporation)
on behalf of the corporation, pursuant to the powers conferred upon said officer or agent by the corporation. He/she personally appeared before me at
the time of notarization, and is personally known to me or has produced __________________________ as identifies and did certify to have knowledge of
(Type of Identification)
the matters stated in the foregoing instrument and certified the same to be true in all respects. Subscribed and sworn to (or affirmed) before me this __________________________.
(Date)

______________________________ Commission Number __________________________
(Official Notary Signature and Notary Seal)

______________________________ Commission Expiration Date __________________________
(Name of Notary typed, printed or stamped)

ACKNOWLEDGMENT OF PROVIDER, IF A PARTNERSHIP

STATE OF __________________________ COUNTY OF __________________________

The foregoing instrument was acknowledged before me this __________________ by __________________________, partner (or agent) on behalf of __________________________, a partnership. He/she personally appeared before me at the time of notarization, and is personally known to me or has produced __________________________ as identification and did certify to have knowledge of
(Type of Identification)
the matters stated in the foregoing instrument and certified the same to be true in all respects. Subscribed and sworn to (or affirmed) before me this __________________________.
(Date)

______________________________ Commission Number __________________________
(Official Notary Signature and Notary Seal)

______________________________ Commission Expiration Date __________________________
(Name of Notary typed, printed or stamped)

ACKNOWLEDGMENT OF PROVIDER, IF A GOVERNMENTAL ENTITY

STATE OF __________________________ COUNTY OF __________________________

The foregoing instrument was acknowledged before me this __________________ by __________________________, who personally appeared before me at the time of notarization, and is personally known to me or has produced __________________________ as identification and did certify to have knowledge of the matters stated in the foregoing instrument and certified the same to be true in all respects. Subscribed and sworn to (or affirmed) before me this __________________________.
(Date)

______________________________ Commission Number __________________________
(Official Notary Signature and Notary Seal)

______________________________ Commission Expiration Date __________________________
(Name of Notary typed, printed or stamped)
EXHIBIT I

SCOPE OF SERVICES

A. DEFINITIONS: Services to be rendered by the PROVIDER under this Agreement include the following provision:

   The individuals providing the services listed below must be professionals who are licensed or authorized to perform those services within the State. Ryan White funds may not be used to subsidize the difference between the PROVIDER's actual cost and the reimbursement from Medicaid or other third party payors.

XXX

B. UNIT OF SERVICE:

   A unit of XXX

C. PROVIDER's Contract Coordinator for this contract:

   1. Name: XXX
   2. Address: XXX
   3. Phone: (XXX) XXX

D. PROVIDER's contact person for processing reimbursement requests:

   1. Name: XXX
   2. Address: XXX
   3. Phone: (XXX) XXX

E. PROVIDER's service location(s):

   1. XXX
   2. XXX

F. PROVIDER's operating hours:

   XXX 4:00 PM

G. MEASURABLE OUTCOMES for this contract period are:

   XXX:
   1. A minimum of XXX unduplicated clients will be served as documented in e2H; and
   2. A minimum of XXX units of service will be provided as documented in e2H; and
   3. The PROVIDER must report on all outcomes that have been currently defined by the quality management contracted provider or implement changes made to the quality management outcomes which are approved by the Department.

H. PROVIDER’S Transportation Effort:

   At the request of the Care Council the PROVIDER shall make every effort to assist clients with the coordination of their transportation needs. However, the PROVIDER nor the COUNTY is financially responsible for the clients' transportation.
EXHIBIT II

PAYMENT SCHEDULE

A. The maximum amount payable for services by the COUNTY under this Agreement is **XXX Dollars ($XXX.00)**, and will be reimbursed at the rate of $XXX per unit.

The DEPARTMENT will not pay more than 25% of the contract amount per quarter without prior written permission from the Ryan White Program Manager. If the contract amount is decreased the remaining quarterly allocations are decreased proportionately.

B. The PROVIDER will request reimbursement from the COUNTY for actual expenditures or services on a monthly basis, based on a service unit cost or DEPARTMENT approved line-item budget. The staff Accountant may move funds within the contracts line-item budget provided the change to the line does not exceed a 20% change.

C. Any third party payments collected by the PROVIDER for eligible services for which the COUNTY has also paid pursuant to this Agreement will be reimbursed by the PROVIDER to the COUNTY up to the total amount paid by the COUNTY on behalf of any eligible individual. The usual method of reimbursement will be by credit to the PROVIDER's first billing statement following third party payment, or by reimbursement to the COUNTY upon receipt by the PROVIDER if received after termination of the contract.

D. Moreover, the PROVIDER agrees not to impose or collect supplemental fees from the aforesaid otherwise eligible individuals, except as approved by the DEPARTMENT, and in accordance with ARTICLE III, B.

(Remainder of page intentionally left blank.)
EXHIBIT III & EXHIBIT IV

(Intentionally left blank.)
EQUAL EMPLOYMENT OPPORTUNITY - APPLICABLE STATUTES, ORDERS AND REGULATIONS*

HILLSBOROUGH COUNTY, FL

---Hillsborough County Human Rights Ordinance, Hillsborough County Code of Ordinances and Laws, Part A, Chapter 30, Article II, as amended, prohibits illegal discrimination on the basis of actual or perceived race, color, sex, age, religion, national origin, disability, marital status, sexual orientation, or gender identity or expression, in employment, public accommodations, real estate transactions and practices, County contracting and procurement activities, and credit extension practices.

---Hillsborough County Home Rule Charter, Article IX, Section 9.11, as amended, provides that no person shall be deprived of any right because of race, sex, age, national origin, religion, disability, or political affiliation. Printed in Hillsborough County Code of Ordinances and Laws, Part A.

STATE

---Florida Constitution, Preamble and Article 1, § 2 protect citizens from being deprived of inalienable rights because of race, religion, national origin, or physical disability.
---Florida Statutes § 112.042, requires nondiscrimination in employment by counties and municipalities, on the basis of race, color, national origin, sex, handicap, or religion.
---Florida Statutes § 112.043, prohibits age discrimination in employment.
---Florida Statutes § 413.08, provides for rights of an individual with a disability and prohibits discrimination against persons with disabilities in employment and housing accommodations.
---Florida Statutes § 448.07, prohibits wage rate discrimination on the basis of sex.
---Florida Civil Rights Act of 1992, Florida Statutes §§760.01 – 760.11, as amended.
---Florida Statutes §509.092, prohibits refusing access to public lodging on the basis of race, creed, color, sex, physical disability or national origin.
---Florida Statutes§725.07, prohibits discrimination on the basis of sex, marital status or race in loaning money, granting credit or providing equal pay for equal services performed.
---Florida Fair Housing Act, Florida Statutes §§760.20 – 760.37.
---Florida Statutes §760.40, provides for the confidentiality of genetic testing.
---Florida Statutes §760.50, prohibits discrimination on the basis of AIDS, AIDS-related complex, and HIV.
---Florida Statutes §760.51, provides for remedies and civil penalties for violations of civil rights.
---Florida Statutes §760.60, prohibits discriminatory practices of certain clubs.
---Florida Statutes §760.80, provides for minority representation on boards, commissions, council, and committees.

FEDERAL

---Section 1 of the Fourteenth Amendment to the United States Constitution, U.S. Const. amend. XIV, § 1.
---Equal Opportunity Regulations, 41 CFR § 60-1.4, as amended.
---Standards for a Merit System of Personnel Administration, 5 CFR § 900.601 et seq.
---Executive Order 12250, Leadership and Coordination of Nondiscrimination Laws.
The above are not intended to be a complete list of all applicable local, state, or federal statutes, orders, rules or regulations, as they may be amended from time-to-time, or added to (newly promulgated) from time-to-time, during the term of this contract.

If applicable, and required by 41 CFR 60-1.4 or other federal law or regulation, during the performance of this contract, the contractor agrees as follows:

(6) The contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following: Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

(7) The contractor will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive considerations for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(8) The contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representatives of the contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(9) The contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

(10) The contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

1. In the event any section, sentence, clause, or provision of this Fourth Modification is held to be invalid, illegal or unenforceable by a court having jurisdiction over the matter, the remainder of this Fourth Modification shall not be affected by such determination and shall remain in full force and effect.

2. Any term, condition, covenant or obligation which requires performance by either party subsequent to termination of this Fourth Modification shall remain enforceable against such party subsequent to such termination.
3. The other terms and conditions of the Agreement, as modified herein, which do not conflict with this Fourth Modification, are hereby reaffirmed in their entirety. In the event of a conflict between the terms of this Fourth Modification and the terms of the Agreement, the terms of this Fourth Modification shall control.
EXHIBIT VI

INSURANCE REQUIREMENTS

PROVIDER's Liability Insurance:
The PROVIDER shall procure and maintain such insurance as will protect him/her from claims under Workers' Compensation laws, disability benefit laws or other similar employee benefit laws; from claims for damages because of bodily injury, occupational sickness or disease, or death of his employees including claims insured by usual personal injury liability coverage; from claims for damages because of bodily injury, sickness or disease, or death of any person other than his employees including claims insured by usual personal injury liability coverage; and from claims for injury to or destruction of tangible property including loss of use resulting therefrom, any or all of which may arise out of or result from the PROVIDER’S operations under the Contract Documents, whether such operations be by himself/herself or by any subcontractor or anyone directly or indirectly employed by any of them or for whose acts any of them may be legally liable. This insurance shall be written for not less than any limits of liability specified in the Contract Documents or required by law, whichever is greater, and shall include contractual liability insurance. Before starting the work, the PROVIDER will file with the COUNTY certificates of such insurance, acceptable to the COUNTY; these certificates shall contain a provision for cancellation as found in paragraph 6 of Section B immediately below.

Insurance Required:

A. General
Before starting and until acceptance of the Work by the COUNTY, the PROVIDER shall procure and maintain in force insurance of the types and to the limits specified in paragraphs B. 1. through 6. below. All policies of insurance under this contract shall include Hillsborough County and its employees as additional insured. All policies shall provide for separation of insured's interests such that the insurance afforded applies separately to each insured against whom a claim is made or a suit is brought.

B. Coverage
The PROVIDER shall procure and maintain, during the life of this Contract, the following types of insurance coverages written on standard forms and placed with insurance carriers licensed by the Insurance Department of the State of Florida and approved by Hillsborough County. The amounts and type of insurance shall conform to the following requirements:

1. Professional Liability: $1,000,000 per claim if Professional Services are provided.

2. Commercial General Liability: $1,000,000 per occurrence.

3. Business Automobile Liability: Auto coverage is required only if agency owns automobiles. If owned autos limit is $1,000,000.

4. Errors and Omissions Liability: Not required.

5. Workers Compensation: Workers Compensation limits are as required by Florida Statute. Employer's Liability is:
   - $100,000 Limit Each Accident
   - $500,000 Limit Disease Aggregate
   - $100,000 Limit Disease Each Employee

6. Certificate of Insurance and Copies of Policies: Certificates of Insurance furnished by Hillsborough County evidencing the insurance coverage specified in the previous paragraphs B. 1. through 5. inclusive, and on request of the COUNTY certified copies of the policies required shall be filed with the Family and Aging Services Department of the COUNTY on a timely basis. The required Certificates of Insurance not only shall list Hillsborough County as additional insured for the operations of the PROVIDER under this Contract (excluding the worker's compensation and professional liability policies), but shall name the types of policies provided and shall refer specifically to this Contract.
If the initial insurance expires prior to the completion of the Contract, renewal Certificates of Insurance shall be furnished twenty (20) days prior to the date of their expiration.

Cancellation – “Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will mail thirty (30) days written notice to the certificate holder.”

Project Title: REQUEST FOR APPLICATIONS FOR THE PROVISION OF HIV-RELATED HEALTH AND SUPPORT SERVICES FOR THE HILLSBOROUGH COUNTY HEALTH CARE SERVICES DEPARTMENT.
EXHIBIT VII

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

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICER AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to Hillsborough County Board of County Commissioners by ____________________________

   [print individual's name and title]

   for ____________________________

   [print name of entity submitting sworn statement]

   whose business address is ____________________________

   ____________________________

   and (if applicable its Federal Employer Identification Number (FEIN) is ____________________________)

   (if the entity has no FEN, include the Social Security Number of the individual signing this sworn statement: ____________________________ )

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

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

4. I understand that an "affiliate" as defined in Paragraph 287.133(1)(1), Florida Statutes means:

   1. A predecessor or successor of a person convicted of a public entity crime; or

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

5. I understand that a "person" as defined in Paragraph 287.133(1)(3), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person"
includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. [Indicate which statement applies.]

_____ Neither the entity submitting this sworn statement, nor any officers, directors, executives, partners, shareholders, employees, members, or agents, who are active in the management of the entity, nor any affiliate of the entity have been charged with and convicted of a public entity crime within 3 years prior to signing this document.

_____ The entity submitting this sworn statement, or one or more of the officers, directors, executives, partners, shareholders, employees, members, or agents, who are active in management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime 3 years prior to signing this document.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime within 3 years prior to signing this document. However, there has been a subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and a final order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. [attach a copy of the final order.]

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH ONE (1) ABOVE IS FOR THAT PUBLIC ENTITY ONLY, AND THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.107, FLORIDA STATUTES, FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

________________________________________

Sworn to and subscribed before me this ________ day of 20_____

Personally known

OR Produced identification

Notary Public - State of ______________________________

My commission expires ______________________________

(Type of identification)

________________________________________

(Printed, typed, or stamped
commissioned name of notary public

(Revised 06/18/92)
CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offeror/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

___________________________________       ________________________
Signature of Authorized Official                                    DATE

___________________________________
Grant-Funded Contractor Name
EXHIBIT IX

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_______________________________________  __________________________________
Signature                             Date

_______________________________________  ___________________________________
Name of Authorized Individual   Application or Contract Number

____________________________________________________________________________
Name and Address of Organization
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**Type of Service:**

**Contract Number:**

**Contract Amount:**

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I, _______________________, being an authorized agent of (contracted agency's name), hereby attest and certify that the expenditures listed in this document represent the actual expenditures incurred in providing the units of service billed for during the first ( ) second ( ) third ( ) fourth ( ) quarter of 20___ for contract number ___________. I further attest that these expenditures are within the approved budget. I certify that there are no mathematical errors in the budget of this contract.

Printed Name                        Signature                        Date
EXHIBIT XII
FEDERALLY REQUIRED SUBAWARD INFORMATION
2 CFR, PART 200.331(a)

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<th>CFDA NUMBER AND TITLE:</th>
<th>93.914HIV Emergency Relief Project Grants</th>
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<td>XXX, Inc.</td>
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<td>H89HA00024 Federal Grant #, Contract #TBD</td>
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<td>Aubrey Arnold, Grants Programs Services Compliance Coordinator</td>
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(1) Pursuant to 2 C.F.R. Section [200.331(a)(2)], All requirements imposed by the pass-through entity on the subrecipient so that the Federal award is used in accordance with Federal statutes, regulations and the terms and conditions of the Federal award are included herein (see page Article XIX Compliance).

(2) Pursuant to 2 C.F.R. Section [200.331(a)(3)], Any additional requirements that the pass-through entity imposes on the subrecipient in order for the pass-through entity to meet its own responsibility to the Federal awarding agency including identification of any required financial and performance reports are included herein (see page #6, Provider Requirements item G, from RFA that is incorporated into the Agreement by reference).

(3) Pursuant to 2 C.F.R. Section [200.331(a)(4)], An approved Federally recognized indirect cost rate negotiated between the subrecipient and the Federal Government or, if no such rate exists, either a rate negotiated between the pass-through entity and the subrecipient (in compliance with 2 C.F.R., Part 200), or a de minimis indirect cost rate as defined in of 2 C.F.R. Section §200.414(f), Indirect (F&A) costs, are included herein (see page #6, Provider Requirements item J, from RFA that is incorporated into the Agreement by reference and Section # of RFA, Budget & Cost Effectiveness).

(4) Pursuant to 2 C.F.R. Section [200.331(a)(5)], A requirement that the subrecipient permit the pass-through entity and auditors to have access to the subrecipient's records and financial statements as necessary for the pass-through entity to meet the requirements of 2 C.F.R., Part 200 are included herein (see page Article VII and Article XXXII).

(5) Pursuant to 2 C.F.R. Section [200.331(a)(6)], Appropriate terms and conditions concerning closeout of the subaward are included herein (see page Article IV).
**ATTACHMENT A**

**FEDERAL SUBRECIPIENT AND VENDOR DETERMINATION CHECKLIST**

(use when funding is Federal or Federal/State match)

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<tr>
<th>Grant Number:</th>
<th>Prepared by:</th>
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<td>CFDA Number:</td>
<td>Date:</td>
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**Subrecipient and Vendor Determinations**

(a) **General:** An auditee may be a recipient, a subrecipient, and a vendor. Federal awards expended as a recipient or a subrecipient would be subject to audit under this part. The payments received for goods or services provided as a vendor would not be considered Federal awards. The guidance in paragraphs (b) and (c) of this section should be considered in determining whether payments constitute a Federal award or a payment for goods and services.

**SUBRECIPIENT** (check YES or NO for each statement)

(b) **Federal Award:** Characteristics indicative of a Federal award received by a subrecipient are when the organization:

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**VENDOR** (check YES or NO for each statement)

(c) **Payment for goods and services:**

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(d) **Use of judgment in making determination.** There may be unusual circumstances or exceptions to the listed characteristics. In making the determination of whether a subrecipient or vendor relationship exists, the substance of the relationship is more important than the form of the agreement. It is not expected that all of the characteristics will be present and judgment should be used in determining whether an entity is a subrecipient or vendor.

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The Tampa-St. Petersburg Eligible Metropolitan Area (EMA)
Ryan White
Part A
HIV/AIDS

QUALITY MANAGEMENT PLAN

2016-2018

Prepared by the Florida Health Care Coalition
This document was produced on behalf of The Ryan White Care Council under contract with Hillsborough County Government.
Funded by HRSA.

SUNCOAST HEALTH COUNCIL
9600 Koger Blvd., Ste. 221
St. Petersburg, FL 33702
www.thehealthcouncil.org
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Executive Summary

The Tampa-St. Petersburg EMA is ultimately responsible for assuring that quality services are being delivered in tandem with our network of service providers. The goal of the Tampa-St. Petersburg EMA Quality Management Program (QMP) is to

1. Assisting HIV/AIDS service funded providers in assuring that grant supported services adhere to established HIV clinical practice standards and Public Health Services (PHS) Guidelines to the greatest extent possible;

2. Ensuring that strategies for improvements to quality medical care include the appropriate access and retention to HIV care and support for treatment adherence;

3. Ensuring that available demographic, client satisfaction, clinical and health care utilization information data is used to monitor the spectrum of HIV continuum of care.

The Tampa-St. Petersburg EMA Quality Management Plan is a written document that outlines the recipient-wide quality management program. This program provides a systematic process for assessing and monitoring quality with identified responsibilities and accountability. Meaningful data is identified, collected, and reviewed to assure that progress toward relevant evidence based benchmarks, goals and improved outcomes are realized. The program is adaptive and is able to fit within other programmatic quality assurance and quality improvement activities. Resources are dedicated to support the activities and evaluation and assessment of the program is on-going.

Quality activities are included as part of the RFA (Request For Applications) process and service contracting. This approach ensures that each individual agency establishes and maintains its own quality management program. Data from multiple providers across the EMA network are aggregated, an on-going picture of the care-continuum is established, highlighting recipient-wide patterns and providing concrete baselines for improvement activities.

The HIV/AIDS Bureau (HAB) has defined “quality” as the degree to which a health or social service meets or exceeds established professional standards and user expectation. Evaluation of the quality of care in this plan considers a) the quality of the inputs, b) the quality of the service delivery process, and c) the quality of outcomes, in order to continuously improve systems of care for individuals and populations served.

The Quality Management Program focuses on sustaining a sound quality management program that focuses on linkages, efficiencies and provider and consumer expectations in addressing outcome improvement. The process is continuous, systematic with identified leadership, accountability and dedicated resources available to the program.
Description of Quality Management

The goal of the EMA Quality Management Program is to ensure incremental and continuous performance improvement in the delivery of quality HIV medical and supportive services in the EMA. The program is designed to identify needs and gaps in services, ensure that programs and treatments are accessible and delivered in accordance with Public Health Service (PHS) treatment guidelines, assess the effects of the HIV/AIDS Treatment Modernization Act resources on the health outcomes of consumers, and ensure services are delivered in an efficient and cost effective manner. The program is driven by PHS guidelines, local Standards of Care, and Ways to Best Meet Needs as defined by the Care Council.

The EMA Quality Management Plan is based on the HRSA Quality Management Technical Assistance Manual and other HRSA guidance documents on clinical quality management. The plan outlines a collaborative effort among the Recipient Office, the Care Council, the sub-recipient/provider community, and other Ryan White funded entities in the region to enhance and improve the system of care and to be responsive to changing trends in the HIV epidemic.

The EMA’s Quality Management vision is “to create a strong and varied system of care that mirrors the diverse consumer base, promotes diverse community partnerships, maximizes resources, and ensures continuous quality in the delivery of care.” These services are to be delivered to all persons served through the achievement of the EMA mission and vision, and that services conform to the highest Standards of Care. The program is being designed to objectively and systematically assess and evaluate the quality and appropriateness of care, to pursue opportunities in improving care and to resolve identified challenges within our service delivery system. The Quality Management Program strives to continuously improve the quality of care and services in a multidisciplinary team approach and are consistent with the EMA system-wide approach to quality improvement.

Quality Statement

The mission of the Quality Management Program is to plan, assess, measure and implement performance improvements in the systems and processes which affect the quality of care and services at the Tampa-St. Petersburg EMA. The Quality Management Program strives to continuously improve the quality of care and services in a multidisciplinary team approach and are consistent with the organization-wide approach to quality improvement.

The purpose of the Quality Management Program is to ensure that underserved, vulnerable, special needs consumers of the Tampa-St. Petersburg EMA are receiving access to basic healthcare services as recommended by the Health Resources and Services Administration (HRSA) and Department of Health and Human Services.

Quality Improvement principals and methodologies are utilized as a basis for improvement of service delivery and service delivery administration. By identifying opportunities for improvement, collecting and analyzing data, developing and implementing plans and subsequently evaluating those plans processes and systems that influence consumer
outcomes are continuously improved. As the Part A recipient, the Tampa-St. Petersburg EMA provides leadership and capacity building to a network of contracted providers, receiving funding under the Ryan White Extension Act Part A legislation to improve the health and quality of life of the consumers served. The seven strategic goals serve as the organizing framework for performance measurement:

- Improve Access to Health Care
- Improve Health Outcomes
- Improve the Quality of Health Care
- Eliminate Health Disparities
- Improve Public Health and Health Care Systems
- Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Achieve Excellence in Management Practices.

**Authority and Accountability**

The Ryan White Act funding legislation requires that a recipient shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to consumers under the grant are consistent with the most recent Public Health Services (PHS) guidelines for the treatment of HIV disease and related opportunistic infection and to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

The Tampa-St. Petersburg EMA’s Recipient Office leadership is dedicated to the quality improvement process and implementation of the quality management program and has the ultimate responsibility and authority for assuring high quality of care through the development and maintenance of a flexible, comprehensive and integrated Quality Management Program. However, all staff in the recipient’s office and the provider network assume a vital role in the implementation of the quality management plan leading to excellence in service delivery, service delivery administration and consumer care.

**Resources**

The Tampa-St. Petersburg EMA has allocated 2.25% of its budget for evaluation and quality management activities.

**Quality Infrastructure**

The Tampa-St. Petersburg EMA administration is accountable, responsible and answerable for planning, directing, coordinating and improving healthcare services in the EMA. The overall responsibility and leadership for the HIV quality program lies with the Administrator, who authorizes the Quality Management Workgroup to plan, assess,
measure, and implement performance improvements throughout the provider network. The EMA’s quality management consultant, with the assistance and guidance of the Quality Management Workgroup, oversees the performance improvement plan and reviews quality improvement activities during its regular meetings.

The Quality Management Technical Workgroup provides oversight, prioritizes and directs planning, designing, measuring, assessing and improving organizational performance. Ongoing Quality improvement reports are provided to community stakeholders via the Care Council. The program is designed to address Quality Management and Quality Improvement content regarding the following major functional areas and important aspects of care:

- Clinical Primary Care
- Patient and Staff Education
- Continuity of Care
- Patient Satisfaction
- Case Management
- Oral Health
- Mental Health and Substance Abuse
- Medical Record/Information Systems
- Managed Care/Utilization Review

Consumer Input
An important goal of the Tampa-St. Petersburg EMA is meeting the needs of our consumers and ensuring their satisfaction with services rendered. The EMA incorporates feedback received from providers and suggestions from the consumer satisfaction surveys. This feedback is incorporated into service improvement initiatives.

Quality Improvement Technical Workgroup Structure and Function
The Tampa-St. Petersburg EMA Quality Management Technical Workgroup acts in the capacity of an advisory board directing and providing an oversight role in the implementation, monitoring and evaluation of the Quality Management Program. The membership of the workgroup reflects the diversity of disciplines within the EMA provider network. The members of the committee include several medical provider staff, representatives from case management agencies, representatives from other core service categories, Part B Lead Agency staff, and the QM consultant. Membership is approved by the Recipient Administrator. The Tampa-St. Petersburg EMA Quality Management Technical Workgroup meets quarterly at a time that will allow attendance by all members.

Role of the Tampa-St. Petersburg EMA Quality Management Technical Workgroup:
1. Monitor implementation of the annual Quality Improvement Plan.

2. Overseeing implementation of program and team projects

3. Oversight of the monitoring and measuring performance of service standards with regard to clinical treatment, case management and related services.

4. Oversight of the education of provider network and team members on the tenets of the QI process and implementation.

5. Authorize performance improvement initiatives and sets forth quality expectations and broad goals that merit ongoing monitoring.

6. Other activities as assigned.

The Quality Management consultant will compose the agenda consisting of:

- A review of the minutes from the previous meeting to ensure open issues have been or in the process of being resolved.
- Review current findings of ongoing projects, such as newly internally or externally acquired data, problems and corrective actions.
- Implementation and evaluation of team projects.
- Address any concerns.
- Suggestions and recommendations for new improvement projects.
- Minutes from the Technical workgroup meetings will be recorded by the Quality Management consultant.

Minutes of meetings will be kept and will be distributed to each member of the workgroup and to all necessary Tampa-St. Petersburg EMA network wide committees. A written summary of the meeting will be routinely made available for review.

**Multidisciplinary Team and Development of Improvement Plan**

Once an opportunity for improvement has been identified, the QM consultant works together with provider staff to analyze the process and develop improvement plans. In addition, the technical workgroup will be consulted. Every attempt will be made to ensure the process is collaborative. Continuous Quality Improvement Methodology will be utilized and will include but not be limited to the following:

- PDSA (Plan/Do/Study/Act)
- Client Level Data
- Brainstorming
- Activity Logs
Quality Committee/Team Meeting Record Improvement Plans will be developed and implemented by the teams. Improvements may include:

- System Redesign
- Education (Staff/Patients)
- Clinical Guidelines review, revision or development
- Procedure and policy changes
- Data collection strategies

All improvement plans will be communicated to all staff and to patients if deemed appropriate. Scheduled meetings, electronic mail, memos, informal verbal communication are all considered appropriate methods to communicate the team’s activities and improvement plans.
Performance Measurement
Quality Management Technical Workgroup Goals and Objectives

GOAL #1: Review and Implement the clinical quality management program

- Objective 1: Development of a comprehensive clinical quality management infrastructure, including routine QM meetings with cross-functional representation.
- Objective 2: Implement QM plan across agencies.
- Objective 3: Evaluate plan annually.

GOAL #2: Facilitate the implementation of QI activities in provider agencies to meet annual quality goals.

- Objective 1: Incorporate EMA performance goals into agency QI activities.
- Objective 2: Monitor implementation of improvement projects at agencies.
- Objective 3: Increase capacity for QM programs.
- Objective 4: Assess CQI activities at agency level.

GOAL #3: Assess the extent to which HIV health services are consistent with the most recent Public Health Service Guidelines for the treatment of HIV and opportunistic infections.

- Objective 1: Implement professional and best standard guidelines.
- Objective 2: Evaluate processes and effectiveness of programs.

The Tampa-St. Petersburg EMA Quality Program Cycle consists of a program cycle and a project cycle. The program cycle consists of three steps.
1. Develop and Plan a Quality Management Program
2. Facilitate the Implementation of the Quality Management Program
3. Evaluate the Quality Management Program

**PLAN**

- Create a workable and realistic plan to address identified need

**DO**

- Deploy steps of the plan

**CHECK**

- Plan is fully implemented and outcomes are desirable

1. **Plan** – Create a workable and realistic plan to address identified need. Quality Improvement Plans consist of the following:
2. **Do** – Deploy steps of the plan.

3. **Check** – Follow up to ensure plan was implemented properly and outcomes are desirable. Management follow up on quality improvement initiatives, and corrective action plans are the responsibility of the Program Manager/Supervisor and Senior Program Manager with the assistance of the Division Monitoring and Evaluation Coordinator.

4. **Act** – Plan is fully implemented and cycle begins again. At this time, the issue or need will continue to be measured and reviewed to ensure that the needs were met by the plan and action of the quality improvement team.

This team-oriented approach allows the network provider to identify corrective action methods and develop creative solutions for improvement.

The project cycle consists of six steps:

1. Review, Collect and Analyze Project Data.
2. Develop a Project Team.
3. Investigate the Process.
4. Plan and Test Changes.
5. Evaluate Results with Key Stakeholders.
6. Systematize Changes.

Quality Activities Include:

1. Client-level data review
2. Peer to Peer Review Activities
3. Data Collection to Measure HAB Performance Measures
4. Development of baseline and benchmarks based on HAB Performance Measures

5. Client satisfaction of services

6. Activities related to the development or implementation of a clinical quality management program, including the Continuous Quality Improvement survey (to be administered on an annual basis)

7. Support services that link consumers to health care outcomes.

We measure the following HAB performance measures on a semi-annual basis via CAREWare/e2Hillsborough:

- Viral Load
- CD4 Count
- Retention in Medical Care
- Viral Load Suppression Percentage
- Initial Wait Time to OAMC Access
- Prescription of HART
- HIV Risk Counseling
- Late HIV Diagnosis
- Linked to Medical Care
- Dental and Medical History
- Medical Case Management Plan
- HIV test results
- HIV Risk Counseling
- Syphilis Screening
- Client satisfaction of services

Data Collection

Semi-annual data pulls are conducted to pull the aforementioned performance measures from CAREWare/e2 and client satisfaction survey data will be received on an on-going basis. The appropriate information will be captured on data entry sheets and analyzed by quality management staff. The responsibility for generating all reports for review or analysis will fall to the Quality Management consultant. Reports will be presented to the Quality Management Technical Workgroup and the Care Council via the Administrator.

Data Collection Plan
Selection of performance measures for the major functional areas and the important aspects of care and service.

Regular review of data for performance measures from a variety of sources will occur as per the attached schedule. The Quality Management consultant will coordinate these activities. Data reports will be presented for review to the Quality Management Technical Workgroup. Data sources will include:

- Clinical and demographic data from CAREWare/e2
- Client Satisfaction Survey data
- Provider reports on Initial Wait Time
- Continuous Quality Improvement (CQI) Survey data

The timeline for data collection and reporting is as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Person(s) Responsible</th>
<th>Data Source</th>
<th>Reporting Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAB Performance Measures</td>
<td>OAMC Providers, Quality Management Staff</td>
<td>CAREWare/e2, OAMC Providers</td>
<td>June 2016, December 2016</td>
</tr>
<tr>
<td>CQI Survey</td>
<td>Providers, Quality Management Staff</td>
<td>Surveys</td>
<td>October 2016</td>
</tr>
</tbody>
</table>

**Establishment of Annual Quality Goals and Objectives**

The objectives of the EMA’s QM and CQI Plan are to:

1. Evaluate the effectiveness (outcomes) of programs and services in relation to their stated purpose, philosophy, and the effect on the lives on the lives we serve.

2. Provide the EMA’s stakeholders with objective data to assess program performance in relation to established criteria and measures of acceptability.

3. Use the data to work to ensure appropriate utilization of services, accessibility to services, and cost of services (efficiency) as well as promotion of consumer satisfaction.

4. Provide meaningful and understandable data to facilitate planning services and identify areas for improvement.

5. Monitor and evaluate progress regarding service improvement.
6. Encourage collective decision support among the workgroup and administration.

The following four steps assist the Tampa-St. Petersburg EMA recipient office to identify and establish annual goals for the HIV quality management plan:

Assess the current state: Analysis of performance measure data to identify areas of strength and weaknesses where improvements may be needed the most. Knowing this information will permit us to develop baselines and eventually benchmarks. It will point to the development of meaningful goals that both staff and stakeholders can relate to and support. Sources for data to be considered include performance measure data, client satisfaction survey results, staff input, quality management technical workgroup input and external benchmarks.

Understand the parameters: Identify the basic outline of the Tampa-St. Petersburg EMA HIV program and the community it serves. Putting together a succinct description of the program, including the aspects of HIV care currently delivered, the demographics of patients served and the external expectations of funding/regulatory agencies helps to indentify where to focus quality improvement efforts.

Identify program goals: The HAB performance measures as well as client satisfaction survey data serve as the foundation of the clinical and service goals. Additional possible annual goals will be identified as needed by QM staff and the technical workgroup.

Quantify where we want to be: Annual HIV quality goals need to be measurable. Based on the information gathered in the previous three steps, the annual quality goals need to be restated in quantitative terms such as “85% adherence to antiretroviral therapy for all HIV+ consumers receiving HART therapy” or “To reduce consumer “no shows” by 15%.”

Based on available performance measure data the technical workgroup will prioritize quality management activities.

**Participation of Stakeholders**

The Quality Management consultant will participate and facilitate the technical workgroup. Findings of quality improvement activities as well as summary reports of quality committee meetings will be shared with stakeholders to ensure open communication flow within the HIV program. Key data findings will be shared with Care Council and the Resource Prioritization and Allocation Recommendation Committee (RPARC).

Throughout the year, the QM staff will collaborate with service providers, consumers, technical workgroup members and the Care Council to continuously work together to improve care, thereby making significant changes that improve clinical outcomes and reduce cost. The EMA will share best practices and “lessons learned” and pitfalls to avoid. Everyone plays a valuable part in improving the quality of services provided to people living with HIV/AIDS in Tampa-St. Petersburg EMA. What follows is a breakdown of the various stakeholders and their prospective roles in CQM.
Administration:
The Tampa-St. Petersburg EMA Recipient has the overall administrative responsibility and accountability for the quality of care and services delivered. The Care Council will be updated on QM activities on a quarterly basis via the Recipient Report.

QM Consultant:
The Recipient Office’s Quality Management consultant serves as liaison to the committee of the Care Council that is most involved in CQM, the Resource Prioritization and Allocation Recommendations Committee (RPARC). The QM consultant will facilitate the QM Technical Workgroup.

Service Provider Staff:
Assume an active role in the implementation of quality improvement activities in their respective programs and within the EMA.

Care Council:
Review and utilize service outcome in the prioritization and allocation of Ryan White Part A awards for the Tampa-St. Petersburg EMA. The Resource, Priorities, Allocations, and Re-Allocations Committee (RPARC), which is primarily responsible for identifying gaps and needs and planning specific responses, also evaluates the processes of the Care Council itself, including the priority setting and resource allocation processes.

Consumer Responsibility:
Consumers will be active participants with the evaluation of QM activities in Tampa-St. Petersburg EMA. Their participation on RPARC, the QM technical workgroup, and the completion of client satisfaction surveys are key to informing QM activities.

Quality Management Technical Workgroup:
The Quality Management Technical Workgroup meets quarterly to discuss, plan and implement project level QM and CQI activities in the EMA. The workgroup includes representatives from OAMC providers, case management provider representatives, recipient staff, consumers, and representatives from other providers as well as Part B Lead Agency staff.

Capacity Building

Quality Improvement capacity building of providers will be assessed through the CQI survey and improvement recommendations will be tracked and reported back to providers via QM staff.

Quality Improvement activities will also be discussed during the network provider meetings. Performance measure findings in addition to Quality Improvement activities and initiatives will be shared with providers. In addition, opportunities for QI training activities, technical assistance and support for quality improvement activities will be discussed.

Evaluation
The Recipient is responsible for evaluating the annual EMA Quality Management Plan.

- Evaluation results will be derived from the program monitoring processes, client satisfaction surveys, the tracking of performance measures, and findings from the CQI survey, among other data sources.

- QM staff will review the evaluation and recommend a plan for improvement to the Care Council.

- Evaluation results and recommendations for service improvements across service categories will be made available to the Care Council and consumers in a timely manner for informational purposes.

- The QM team will report activity updates to the Care Council quarterly.

Projects will be evaluated as outlined in the Data Collection section. Performance measures will continue to be reviewed to ensure high levels of service provision. Continued monitoring and intervention will be warranted. Tampa-St. Petersburg EMA interventions include: training and education of QM and Recipient staff, review and possible revision of quality-related provider policies, and/or development of new policies. When a measured indicator reaches a satisfactory level of improvement, the project will be discontinued. Periodic monitoring of discontinued project indicators will be reviewed to ensure continued compliance with the agreed upon threshold. Assessment and evaluation of the data will be performed by QM staff to determine if the data warrants further evaluation. Based on this ongoing review, priorities will be set and opportunities for improvement identified.

**QM Plan Implementation**

The QM work plan specifies the timelines for implementation to accomplish goals, specifying who will be accountable for the implementation steps and will eventually provide milestones and associated measurable implementation objectives. The annual work plan answers the questions of what, when, where, and how a quality management plan is implemented. The following categories are included: Goals, Objectives, Key Action Steps, Target End Dates, and Parties Responsible.

**Sustaining Improvements**

Regular feedback regarding improvement projects is critical to its success in sustaining improvements over time. Once an improvement plan has been successful a regular monitoring schedule will be implemented to determine whether the plan remains successful over time.

**Process to Update QM plan**

The quality management plan will be assessed against its goals at every technical workgroup meeting to determine if any alterations should be made. All quality improvement projects will be reviewed to assess progress towards meeting those goals. This will also facilitate planning of the future quality improvement plans. An annual
organizational assessment will be performed using the most current HIV QUAL Organizational Assessment Tool.

The Quality Management Plan will receive a formal update by the Quality Management Team within 30 after the close of the grant year. The updated plan will include a draft of the updated work plan. The plan will be reviewed by the Quality Management Technical Workgroup and shared with key stakeholders – including Care Council and the Part A providers. The Tampa-St. Petersburg EMA recipient office will provide final approval of the plan.
### Outcome Indicators (Baselines and Benchmarks to be Determined)

<table>
<thead>
<tr>
<th>Category:</th>
<th>Service Goal:</th>
<th>Outcome #1:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Ambulatory Medical Care (Health Services)</strong></td>
<td>To provide financial assistance for eligible consumers to maintain continuity of health insurance or to receive medical benefits under a health insurance program, including premium payments, co-payments and deductibles.</td>
<td>Increase HIV Viral Load Suppression</td>
</tr>
<tr>
<td><strong>AIDS Pharmaceutical Assistance</strong></td>
<td>To provide HIV/AIDS medications to eligible consumers within the EMA.</td>
<td>Increase HIV Viral Load Suppression</td>
</tr>
<tr>
<td><strong>Medical Case Management</strong></td>
<td>To provide a range of consumer-centered services that result in a coordinated care plan which links consumers to medical care, psychosocial, and other services.</td>
<td>Increase HIV Viral Load Suppression</td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td>Provision of dental diagnostic, preventive and therapeutic services by general dental practitioners.</td>
<td>Dental treatment plan.</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>To ensure the availability of mental health services within the EMA.</td>
<td>Linkage to medical care.</td>
</tr>
<tr>
<td>****</td>
<td><strong>Outcome # 2:</strong> Increase Prescription of HIV Antiretroviral Therapy **</td>
<td><strong>Outcome # 2:</strong> Retention in medical care.</td>
</tr>
</tbody>
</table>
### Category: Substance Abuse Services - Outpatient

**Service Goal:** To provide outpatient drug or alcohol substance abuse treatment to foster access to and retention in care.

<table>
<thead>
<tr>
<th>Outcome #1</th>
<th>Outcome #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linkage to medical care.</td>
<td>Retention in medical care.</td>
</tr>
</tbody>
</table>

### Category: Health Insurance Premiums and Cost Sharing Assistance

**Service Goal:** To provide financial assistance for eligible consumers to maintain continuity of health insurance or to receive medical benefits under a health insurance program, including premium payments, co-payments and deductibles.

<table>
<thead>
<tr>
<th>Outcome #1</th>
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</thead>
<tbody>
<tr>
<td>Retention in medical care.</td>
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#### Quality Management Work Plan

<table>
<thead>
<tr>
<th>Goal A. Review and Implement QM Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>A-1. Develop EMA QM Plan</td>
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<tr>
<td></td>
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<tr>
<td>A-2. Implement QM plan across agencies</td>
</tr>
<tr>
<td>A-3. Evaluate QM program annually</td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td>Objectives</td>
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<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>B-1. Incorporate EMA performance goals into agency activities</td>
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<tr>
<td></td>
</tr>
</tbody>
</table>
|                                                 | B-1.c Implementation of QI Projects in Agencies to meet annual goals. Current measures include:  
|                                                 | Linkage/Retention in Care                                                        | August 2016         | QM staff, Recipient Office staff     |
|                                                 | Viral Load Suppression                                                           |                     | QM staff, Recipient Office staff     |
|                                                 | CD 4 Count                                                                      |                     | QM staff, Recipient Office staff     |
|                                                 | Viral Load                                                                      |                     | QM staff, Recipient Office staff     |
|                                                 | Dental and Medical History                                                      |                     | QM staff, Recipient Office staff     |
|                                                 | Medical Case Management Plan                                                    |                     | QM staff, Recipient Office staff     |
|                                                 | Syphilis Screening                                                              |                     | QM staff, Recipient Office staff     |
|                                                 | HIV Risk Counseling                                                             |                     | QM staff, Recipient Office staff     |
|                                                 | HIV Test Results in Record                                                      |                     | QM staff, Recipient Office staff     |
|                                                 | B-1.d Identify best practices                                                   | As needed           | QM staff, technical workgroup        |
|                                                 |  • Submission of agency QM Plans                                               | Ongoing             | QM staff, Recipient Office staff     |
|                                                 | A-3.b Monitor implementation of QM plans through engagement of providers and quarterly Technical Workgroup meetings |                     | QM staff, Recipient Office staff     |
| B.3. Increase capacity building for QM programs at the agencies | B-3.a. Conduct QM TA needs assessment                                           | October 2016        | QM staff                            |
|                                                 | B-3.b Plan and Provide one QM TA, if necessary                                 | November 2016       | QM staff                            |
|                                                 | B-3.c Communicate relevant findings to agency                                   | January 2017        | QM staff                            |
| B.4. Assess CQI activities at provider level   | B-4 a. Disseminate CQI survey to provider staff to assess the utility of CQI in agency activities | October 2016        | QM staff                            |
|                                                 | B-4 b. Analyze ad report results to providers                                  | November 2016       | QM staff                            |
|                                                 | B-4 c. Identify and implement improvement strategies with providers             | December 2016       | QM staff                            |
Goal C. Ensure that primary care and health-related support services adhere to the most recent US Health and Human Services guidelines, federal and state regulations.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Key Action Steps</th>
<th>Target End Dates</th>
<th>Parties Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-1. Implement federal and professional guidelines and best practices in HIV health care services</td>
<td>C-1.a Implement revised QM Guidelines</td>
<td>September 2016</td>
<td>QM staff, Recipient Office staff</td>
</tr>
<tr>
<td>C-2 Evaluate processes and effectiveness of HIV programs</td>
<td>C-2.a Review client satisfaction surveys</td>
<td>September 2016, December 2016, March 2017</td>
<td>QM staff, Recipient Office staff</td>
</tr>
<tr>
<td></td>
<td>C-2.b Dissemination of client satisfaction survey results to the providers, Care Council, and Technical Workgroup</td>
<td>September 2016, December 2016, March 2017</td>
<td>QM staff, Recipient Office staff</td>
</tr>
<tr>
<td></td>
<td>C-2.c FY 2016 Performance measure evaluation and benchmarking and dissemination of results to Care Council, providers, and Technical Workgroup</td>
<td>March 2017</td>
<td>QM staff, Recipient Office staff</td>
</tr>
</tbody>
</table>