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\* denotes separate template

# Attachment A: Applicant Profile

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **C:\Users\scrogginsd\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6DLBWGDL\DC Health Header (003).png** | **Department of Health District of Columbia**  **Application for Grant Funding** | | | |
| **RFA #** | **HAHSTA\_CBDIS\_07.09.21** | **RFA Title:** | | **Community Based DIS Services** |
| **Release Date:** | 7/09/21 | **DOH Administrative Unit:** | | **HIV/AIDS, Hepatitis, STD Tuberculosis Administration (HAHSTA)** |
| **Due Date:** | 8/9/21 | **Fund Authorization:** | |  |
| **☒ New Application** 🞎 Supplemental 🞎 Competitive Continuation 🞎 Non-competitive Continuation | | | | |
|  | | | | |
| The following documents should be submitted to complete the Application Package:  Narrative section  All required attachments  Assurance package  Certifications and assurances accepted and submitted in EGMS | | | | |
| Complete the Sections Below. All information requested is mandatory. | | | | |
| **1. Applicant Profile:** | | | **2. Contact Information:** | |
| Legal Agency Name: |  | | Agency Head: |  |
| Street Address: |  | | Telephone #: |  |
| City/State/Zip |  |  | Email Address: |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  | |  |  |
| Main Telephone #: |  | | Project Manager: |  |
| Main Fax #: |  | | Telephone #: |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
| Vendor/Tax ID: |  | | Email Address: |  |
| DUNS No.: |  | |  |  |
|  |  | |  |  |
|  |  | | | |
| **3. Application Profile:** | | | | |
|  | **Program Area:** | | | **Funding Request:** |
| Dr. Ron Simmons Wellness Program \_\_\_\_\_  Community DIS \_\_\_\_\_ | | |  |
| **Proposal Description:** | | | | |
| Enter Name & Title of Authorized Representative Date | | | | |

# Attachment D: Linkages Summary (Required)

**Instructions**

1. Applicants must complete Attachment D to detail their ability to assure a continuum of care. The information on the attached table will be verified during the site visit, if applicable.
2. Applicants should pay particular attention to the specific linkage requirements noted for each service area. If a linkage is not required and/or not provided, please indicate “NA” (for not applicable) in the space provided.
3. Applicants may use additional sheets to list linkages if necessary.
4. Column 1 lists the various service categories funded by HAHSTA.
5. In Column 2, applicants should place a check mark in the space provided if they provide or propose to provide that service directly. If they do not provide the service directly, leave the space blank.
6. In Column 3, applicants should list both Ryan White funded and non-Ryan White funded organizations with which they have collaborative agreements and linkages for the given service categories.
7. In Column 4, the applicant should type “yes” or “no,” indicating whether or not there is an established Memorandum Of Understanding/Agreement (MOU/A) with the listed agency or individual.
8. In Column 5, the applicant should type “yes” or “no,” indicating whether or not there is an established contract with the listed agency or individual.

**Linkages Summary Table**

| Applicant Agency: |  | | | | |
| --- | --- | --- | --- | --- | --- |
| **Service Category** | | **Provide Directly** | **Provide Through Linkage (Name Organizations)** | **Established MOU/A (Yes/No)** | **Signed Contract**  **(Yes/No)** |
| 1. Outpatient Ambulatory Medical Care | |  |  |  |  |
| 1. AIDS Drug Assistance Program (ADAP) | |  |  |  |  |
| 1. AIDS Pharmaceutical Assistance (local) | |  |  |  |  |
| 1. Oral Health Care | |  |  |  |  |
| 1. Early Intervention Services | |  |  |  |  |
| 1. Health Insurance Premium and Cost Sharing | |  |  |  |  |
| 1. Home Health Care | |  |  |  |  |
| 1. Home and Community-Based Health Services | |  |  |  |  |
| 1. Hospice Services | |  |  |  |  |
| 1. Mental Health Services | |  |  |  |  |
| 1. Medical Nutrition Therapy | |  |  |  |  |
| 1. Medical Case Management | |  |  |  |  |
| 1. Substance Abuse Services | |  |  |  |  |
| 1. Case Management (non-Medical) | |  |  |  |  |
| 1. Childcare Services | |  |  |  |  |
| 1. Emergency Financial Assistance | |  |  |  |  |
| 1. Food Bank/Home Delivered Meals | |  |  |  |  |
| 1. Health Education/Risk Reduction | |  |  |  |  |
| 1. Housing Services | |  |  |  |  |
| 1. Other Professional Services | |  |  |  |  |
| 1. Linguistic Services | |  |  |  |  |
| 1. Medical Transportation Services | |  |  |  |  |
| 1. Outreach Services | |  |  |  |  |
| 1. Psychosocial Support Services | |  |  |  |  |
| 1. Referral for Healthcare/supportive Services | |  |  |  |  |
| 1. Rehabilitation Services | |  |  |  |  |
| 1. Respite Care | |  |  |  |  |
| 1. Substance Abuse Services (residential) | |  |  |  |  |

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