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# 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\_RWA\_ModelRedesign\_10.01.21** | **RFA Title:** | **FY 2022 Ryan White Part A** |
| **Release Date:**  | 10/01/21 | **DOH Administrative Unit:** | **HIV/AIDS, Hepatitis, STD Tuberculosis Administration (HAHSTA)**  |
| **Due Date:**  | 11/12/21 | **Fund Authorization:** | Ryan White HIV/AIDS Treatment Act of 2009, H89HA00012 |
|  |
|  |
| **The following documents must 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 Areas:** | **Funding Request:** |
| 1. EMA-Wide Ryan White Core Medical and Support Services: a.Care Coordination Bundleb. Fee For Value Programc. Oral Health |  |
|  | 2. Jurisdictional Ryan White Core and Support Servicesa. Washington, DCb.Suburban Marylandc.West Virginia (Jefferson & Berkely Counties) |  |
|  | 3.Emergency Financial Assistance (EFA) |  |
|  | 4.Minority AIDS Initiative (MAI) – Youth Reach |  |
| **Proposal Description:**  |
| Enter Name & Title of Authorized Representative Date |

# Attachment B: Linkages Summary Table

**Instructions**

1. Applicants must complete Attachment B to detail their ability to assure a continuum of care.
2. Applicants should pay particular attention to the specific linkage requirements noted for each service category in the service category descriptions section. 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 whom 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**

| ApplicantAgency: |  |
| --- | --- |
| **Service Category** | **Provide Directly** | **Provide Through Linkage(Name Organizations)** | **Established MOU/A (Yes/No)** | **Signed Contract****(Yes/No)** |
| 1. Outpatient Ambulatory Health Services
 |  |  |  |  |
| 1. Oral Health Care
 |  |  |  |  |
| 1. Early Intervention Services AIDS
 |  |  |  |  |
| 1. Health Insurance Premium and Cost Sharing
 |  |  |  |  |
| 1. Home and Community-Based Health Services
 |  |  |  |  |
| 1. Medical Nutrition Therapy
 |  |  |  |  |
| 1. Medical Case Management
 |  |  |  |  |
| 1. Substance (Ab)Use Services
 |  |  |  |  |
| 1. Mental Health Services
 |  |  |  |  |
| 1. Non-Medical Case Management
 |  |  |  |  |
| 1. Emergency Financial Assistance
 |  |  |  |  |
| 1. Food Bank/Home Delivered Meals
 |  |  |  |  |
| 1. Linguistic Services
 |  |  |  |  |
| 1. Medical Transportation Services
 |  |  |  |  |
| 1. Outreach Services
 |  |  |  |  |
| 1. Other Professional Services
 |  |  |  |  |
| 1. Psychosocial Support Services
 |  |  |  |  |
|  |  |  |  |  |

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# Attachment C: Work Plan (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

Applicants must complete the work plan (Attachment C) for each proposed Service Category. The work plan should include proposed targets and the goals and objectives for the proposed program.

All work plans should be labeled clearly by Service Category.

Applications must develop goals and objectives for the proposed project that are clearly defined, measurable, time-specific and responsive to service area specific goals and priorities.

# Attachment D: Budget Worksheet and Budget Narrative(see separate attachment)

|  |  |
| --- | --- |
| ApplicantAgency: |  |

All Applicants applying for services must use the HAHSTA approved budget forms. The forms are available as a separate Microsoft Excel file. The workbook consists of several tabs. Applicants may not change made the format or content areas of the Excel workbook. Applicants must input budget projections for each project description submitted.

Applicants must provide a detailed line-item budget and budget narrative that includes the type and number of staff necessary to successfully provide your proposed services. All applicants applying for services must use the HAHSTA approved budget forms. The forms are posted electronically as a separate Microsoft Excel file alongside this RFA. There cannot be any changes made to the format or content areas of the Excel workbook.

Applicants must provide a budget for each Service Category submitted.

HAHSTA reserves the right to not approve or fund all proposed activities. For the budget justification, provide as much detail as possible to support each requested budget item. List each cost separately when possible. Provide a brief description for each staff position including job title, general duties and activities related to this grant, including the rate of pay and whether it is hourly, or salary and the level of effort expressed as how much time will be spent on proposed activities for each staff position. Describe this “time spent” as a percentage of full time equivalent or FTE (e.g., 50% FTE for evaluation activities).

***A maximum of ten percent (10%) of the amount budgeted for direct services is permitted for all administrative or indirect costs activities.***

# Attachment E: Other Funding Source (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

Attachment E, is a required attachment that illustrates all other sources of funding received by the applicant organization. Note the date on the attachment which indicates the applicable time frame.

# Attachment F: Medicaid Certification

Organizations funded to provide one or more services that are reimbursable by Medicaid are required to:

* Screen clients for Medicaid eligibility
* Assist clients to enroll in Medicaid
* Bill Medicaid for all Medicaid-included services provided to Medicaid-eligible clients
* Collect and report Medicaid revenue as “program income.”

**Instructions**

1. Column 1 lists the various service categories funded under this RFA
2. In Column 2 list the Medicaid number used by the organization to bill for Medicaid. In the event of multiple provider numbers, list the number most frequently used..
3. In Column 3, indicate by “yes” or “no” whether the organizations is authorized to bill for the particular service category.
4. In column 4, applicants should list the name of the Medicaid Managed Care Organizations (MCO) with which they participate for the particular service category.
5. For all Medicaid numbers provided in column 2, you must include copies all corresponding Medicaid certification documentation in the application’s assurance package.
6. Please add rows as needed

**Attachment F: Medicaid Certification**

|  |  |
| --- | --- |
| ApplicantAgency: |  |

| **Service Category** | **Medicaid Number** | **Certified to Bill for Services****(Yes / No)** | **MCO Participation** |
| --- | --- | --- | --- |
| Outpatient Ambulatory Health |  |  |  |
| Oral Health Care |  |  |  |
| Medical Case Management |  |  |  |
| Mental Health Services |  |  |  |
| Substance (Ab)Use Services |  |  |  |

# Attachment G: Scope of Work (Table A) (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

The Service Categories Scope of Work (Table A’s) is tool used by the Ryan White Program (RWP) to highlight and report on how grant awards and subrecipients contribute to strategic goals and a comprehensive system of care.

# For the purposes of this RFA applicants are required to complete a Table A for each service category where funds are requested. The Table A’s submitted should be accurate, competitive and contain realistic targets that are in alignment with the applicant’s proposed workplan, linkage summary and overall program proposal.

# Attachment H: Staffing Plan (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

The Service Categories Scope of Work (Table A’s) is tool used by the Ryan White Attachment H, is a required attachment which illustrates how the positions/roles of program manager, data manager, quality management and financial management (accounts payable, accounts receivable and reconciliation) will be filled to meet the staffing levels required to administer these grant funds*. See administrative requirements section of this RFA for additional details.*

# Attachment I: Notice of Intent to Apply

Please submit this Notice of Intent to Apply via email at HAHSTARFAS@dc.gov to Ebony Fortune. No notices will not be accepted at the pre-application conference.

Attachments for RFA #HAHSTA\_RWA\_ModelRedesign\_10.01.21

|  |  |
| --- | --- |
| **Applicant Name** |  |
| **Mailing Address** |  |
| **City, State, Zip** |  |
| **Contact Person Name and Title** |  |
| **E-mail** |  |
| **Phone** |  |

My organization intends to apply for the service categories listed under Request for Application RFA #HAHSTA\_RWA\_ModelRedesign\_10.01.21

Please make a selection from the list of Service Categories on the following page.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Service Category Requesting (Check all that apply)** | **Funding Requested** |
| **Service Area 1:** EMA-Wide Ryan White Core Medical and Support Services: a. Care Coordination Bundleb. Fee For Value Programc. Oral Health  |  |
| **Service Area 2:** Jurisdictional Ryan White Core and Support Servicesa. Washington, DCb.Suburban Marylandc.West Virginia (Jefferson & Berkely Counties) |  |
| **Service Area 3:** Emergency Financial Assistance (EFA) |  |
| **Service Area 4:** Minority AIDS Initiative (MAI) – Youth Reach |  |
|  |  |
| TOTAL Requested | $ |

 |

**Signature Date**

# Attachment J: Redesign Capacity Assessment (RCAT) Tool Evidence Submission (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

# The inaugural RCAT will be conducted as a part of the application review process. In order for HAHSTA staff to conduct the assessment, applicants must submit support documents as evidence to support RCAT rating. Failure to submit support documents for each question will default to the lowest rating on the RCAT.

# During its inaugural use, the HAHSTA will permit applicants to use their discretion to provide the best documents to optimize their rating. To assist, the HAHSTA provides examples of support documents that may be used in response to the questions. Applicants are encouraged to review the RCAT and examples of support documents (Attachment J row h).

# Additionally, applicants must gather support documents, clearly label which question(s) the documents respond to and scan them all into one PDF document labeled “RCAT Evidence”. *The document must be uploaded in EGMS as an attachment to the application. Any criterion that is missing evidence will default to the lowest rating on the RCAT for that question.*

# Failure to comply with RCAT Evidence submission instructions will prevent staff from conducting the review and assigning a capacity level to the application, thereby disqualifying the applicant from receiving funding.

# Attachment L: DC Health RFA Dispute Resolution (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

# Attachment M: Organizational Chart (see separate attachment)

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| --- | --- |
| ApplicantAgency: |  |

The Attachment M, is a required attachment that illustrates the organization structure of the applicant organization.

**Assurance Checklist**

***Certifications, Licenses and Assurances Required When Submitting Applications***

1. Federal and District and DC Health Statements of Assurances and Certifications (SIGNED COPY)
* Certifications Regarding, Lobbying, Debarment and Suspension, Other Responsibility Matters, and Requirements for a Drug-Free Workplace
* Federal Assurances
* DC HEALTH Statement of Certification
1. Current Business License/Certificate of Licensure or proof to transact business in local jurisdiction

**Department of Consumer and Regulatory Affairs (DCRA)** (DCRA is for the DC based providers)

1100- 4th Street, S.W. Contact 202-442-4400 Or [www.dcra.dc.gov](http://www.dcra.dc.gov)

1. Current Certificate of Clean Hands [DC Office of Tax & Revenue](file:///C%3A%5CUsers%5Cpratsj%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CAOXV4D22%5Cmytax.dc.gov) (OTR) - Dated within 60 days of application deadline*).*
2. 501(c)3 Certification Letter for Non-Profits Organizations. For Non-Profit Organizations
3. Certificate of Cyber Policy
4. Certificate of Insurance
5. List of Board of Directors, on letterhead, for current year, signed and dated by a certified official from the Board.(This Cannot be the Executive Director)
6. All Applicable Medicaid Certifications.

It is the Responsibility of the Applicant to determine the extent to which the services proposed are reimbursable by Medicaid in each relevant jurisdiction. It is also the responsibility of the applicant to submit documentation of certification to bill and collect revenue from Medicaid in each jurisdiction which Medicaid reimbursement is available.