New Jersey Department of Health
Division of HIV, STD and TB Services
Request for Applications – Ryan White Supplemental Part B Housing Project for HIV positive Women Victims of Sexual Abuse and Intimate Partner Violence

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<td>Release Date</td>
<td>October 6, 2017</td>
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<tr>
<td>Pre-Proposal Conference Call</td>
<td>October 13, 2017 at 2:00 p.m.</td>
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<td>Sage Closing Date</td>
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For security purposes, each pre-proposal attendee must RSVP with name and affiliation to: nikki.phillips@doh.nj.gov

The call numbers for the pre-proposal conference call are:

888-251-2909
Access number: 9846328

APPLICATIONS MUST BE SUBMITTED IN SAGE GRANTS BY

October 30, 2017 at 3:00 PM EASTERN TIME

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

The New Jersey Department of Health – Division of HIV, STD and TB Services may, in its sole discretion, extend the application deadline or reissue the application if insufficient qualified applications are received. Applications received after the due date and time may be deemed non-responsive and, therefore, subject to rejection.
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I. Program Authority

The Ryan White Part B program is authorized by Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87).

II. Purpose

Recognizing the role of housing in supporting the health care needs of Persons Living with HIV (PLWH), this initiative seeks to address the gaps in housing services for homeless HIV-positive women and the intersection of substance use, post trauma care and mental health counseling. There are no exclusionary admission criteria, however, the RFA particularly focuses on the specific needs impacting HIV-positive women of color who were victims of early childhood sexual abuse or have experienced intimate partner violence (IPV). The purpose of this funding is to provide nurturing, comprehensive, coordinated, patient-centered care for HIV-positive victimized women so that they will be better able to benefit from medical treatment.

Transitional housing assistance cannot be permanent housing and must be accompanied by a strategy to identify, relocate, and/or ensure the individual is moved to, or capable of maintaining, a long-term, and stable living situation. This RFA will support communal living arrangements, not scattered housing or motel stays, in Essex County.

III. Background

Ryan White HIV/AIDS legislation enacted in 1990 was intended to improve the quality and availability of care for low income, uninsured, and underinsured individuals and families affected by HIV disease. The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on HIV/AIDS care. The program is for individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to get the care they need for their HIV disease. As such, the Ryan White HIV/AIDS Program fills gaps in care not covered by other funding sources. In addition to core medical services, Ryan White funding provides a range of supportive services intended to remove barriers that prevent individuals from accessing and maintaining care, to ultimately improve client level health outcomes. Supportive housing is one of these services. The Division of HIV, STD, and TB Services recognizes the fact that without stable housing the probability of retention in care and viral suppression is severely compromised.

This RFA reflects the statement that “housing is treatment.” Evidence has shown there is a direct connection between housing and improved treatment outcomes for PLWH. It has long been evidenced that access to housing is an important precursor to getting many people into a stable treatment regimen. The National HIV/AIDS Strategy 2020 states that “Individuals living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy.” Significant disparities have been identified in research studies in HIV treatment access, retention and health outcomes between PLWH who are homeless and unstably housed and those who are stably housed (Source: U.S. Department of Housing and Urban Development. HIV Care Continuum: The Connection between Housing and Improved Outcomes along the HIV Care Continuum, HUD white paper, 2014).
The impact of trauma, if left untreated, will affect a person's ability to sustain improved outcomes in HIV care. By addressing violence and trauma, and factors that increase the risk of violence for women and girls living with trauma, we are better positioned to treat HIV. Further, both women and men with HIV can be at risk for IVP and post-traumatic stress disorder (PTSD), which can impede adherence to HIV medication regimens and engagement in HIV care. The women targeted are at risk of continual re-traumatization, creating barriers to engagement in HIV care that further erodes their overall physical and emotional wellbeing. The principles of a trauma-informed approach to care, which seek to minimize the chances of re-traumatizing someone who is trying to heal, may be applicable in HIV care settings.

IV. HIV Trends in New Jersey:

New Jersey historically has had one of the highest proportions of HIV infection occurring in females, accounting for 26.9% of the adult/adolescent HIV/AIDS diagnoses in the state, in comparison to the 19% of new diagnoses nationally. Minority women represent 33% of all persons aged 13 and older living with HIV/AIDS in NJ in 2016. The 2016 Women Living with HIV Fact Sheet shows that 42% were between the ages of 20-49; 86% were minorities; 37% among injection drug users; and 56% acquired HIV through heterosexual contact.

The prevalence rate among Black women in 2016 was 18.6 times higher than the rate among White women and 5.7 times higher than the rate among Latino women. The racial disparity among women has increased from previous years and the disparity is greater among women than men. The diagnosis rate in 2014 was 22.2 times higher amongst Black women than Non-Hispanic White women. As stated above, Black women show a considerably faster progression from HIV to AIDS and have the poorest survival from AIDS diagnosis to death among female AIDS patients in New Jersey.

The NHAS 2020 calls for the “support of comprehensive, coordinated, patient-centered care for people living with HIV, including a successful access to care that is often precluded by unmet basic needs such as housing.” Proposals must recognize and address untreated trauma and its effect on a woman’s ability to sustain improved outcomes in HIV care. Proposals must also demonstrate that the benefits of intervening and holistically treating this population will result in improved viral suppression rates and reduced transmission of HIV. To achieve this, DHSTS will provide funding for up to fifteen (15) HIV-positive women, meeting the criteria described above, in structured transitional housing with access to a continuum of health services and life skills opportunities for a period up to twenty-four months, contingent upon available funds. Stable housing, with the goal of independent permanent housing, is essential to engaging these women in health services, overcoming trauma, maintaining sobriety, and maintaining their adherence to care. The goal of this placement is to stabilize a disruptive lifestyle pattern and provide the services that support healthy lifestyle choices and on-going adherence in medical care and treatment leading to an independent, productive life.

Proposals must demonstrate the knowledge and the ability to address the intersectionality of early childhood sexual trauma, IPV and HIV/AIDS (both clinical and social factors). “Early sexual abuse increases the likelihood of engaging in HIV risk behaviors, including sexual relationships with high-risk partners, substance abuse, reduced ability to assess individual risk and safety,” (HRSA Care Action, September 2009). Co-morbidities such as mental illness, substance abuse, hepatitis, STDs, obesity, and unwanted pregnancies compound recovery leaving the women stuck and helpless.
V. Program Objectives

1. Provide structured transitional housing assistance for a period of 6 to 24 months, to HIV-positive homeless women who were victims of early childhood abuse or are victims of intimate partner violence. Eligibility will include a behavioral contract indicating the individual’s agreement to participate in all program components determined by an individualized staging of the applicant’s motivation to change.

2. Provide, on-site, a full complement of mental and behavioral health services determined by matching individual risk and needs factors to ultimately support long term change. The model of cognitive behavioral therapy recommended is yet to be determined.

3. Facilitate, cooperate and collaborate with medical/dental care and treatment adherence to ensure viral suppression;

4. Co-location of HIV prevention services;

5. Co-location of educational and vocational services;

6. Promote self-efficacy and independence by assisting HIV-positive homeless or unstably housed women in making lifelong safe and healthy life choices coupled with career development promoting for long term health maintenance with permanent housing and employment options.

VI. Project Management

Awardees are expected to be proficient in, and follow treatment modalities consistent with, forms of cognitive behavioral therapy that has been proven effective with this population. Services will be provided by certified clinicians, licensed professionals and trained support staff.

DHSTS expects coordinated health care and other essential services to be provided on site with collaborative MOUs with local medical clinics. The housing site shall contract with a nurse practitioner or other medical professional specializing in women’s health that provides regular visits to promote HIV engagement and treatment adherence, taking a holistic approach. Transportation to and from the medical clinic will be provided by the transitional housing site. Providers must be culturally competent in the culture of disenfranchised minority women and demonstrates behaviors, knowledge, and policies that enable them to work effectively with this population.

Service Components/activities shall include:

1. Communal setting housing with meals that is reflective of a social structure to support growth and development in a culturally competent environment;

2. Intake process: for the purpose of accessing initial service needs, each applicant will complete an intake assessment with the assistance of a social work case manager;

3. Treatment plan that includes the goal of stable permanent housing and coordination of health care services;

4. Case management, medical and non-medical, will assist with initial intake and social service needs, and ensure third party payers are vigorously pursued. Masters level social workers or licensed medical professionals shall serve as medical case managers. Case managers will collaborate with ASO’s and CBO’s to coordinate ongoing medical and social service needs as part of the discharge
5. Utilize Prochaska and DiClementi’s Transtheoretical Change Theory and Miller and Rollick’s Motivational Interviewing to assess and match client’s treatment needs. Treatment plans will be developed based on the individual’s motivation to change;

6. Provide behavioral therapy utilizing cognitive behavioral approaches, tailored for this population, as the therapeutic model to address the multitude of co-occurring conditions, as well as the psychosocial effect of treatment. Therapy will include weekly therapeutic group sessions and individual therapy sessions;

7. In-Kind Education and Career Development: provide skills building classes in a safe and supportive environment including:
   a. GED classes and diploma attainment- including instructional material, readiness tests, using NJ Department of Education’s approved education assessment and providers
   b. College and vocational school placement,
   c. Employment counseling and job placement;

8. Mental health assessment and therapy;
9. Treatment Adherence counseling will be a mandatory component of medical case management;
10. Transportation to medical appointments;
11. Plan for permanent housing placement: including advocacy, search and placement in permanent stable housing.

Expected outcomes:
Indicators*

- **Housing Status**: Percent of housing clients referred to and achieved independent permanent housing;
- **Linkage to HIV Medical Care**: expectation of 100% of housing clients will be linked to care;
- **Retention in HIV Medical Care**: Percent of housing clients with doctor visits every three months or as prescribed;
- **Antiretroviral Therapy (ART)**: Percent of housing clients prescribed ART;
- **Viral Load Suppression**: Percent of housing clients with a viral load <200 copies/mL at 3, 6, 9 and 12 months.

*Additional measures should be considered, including but not limited to, HAB Performance Measures. (Source:HHS Common HIV Indicators can be viewed at: [https://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf](https://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf))

VII. Eligible Applicants

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

- Housing sites that are licensed by the State of New Jersey as meeting all codes and regulations [http://www.state.nj.us/dca/divisions/codes/codreg/](http://www.state.nj.us/dca/divisions/codes/codreg/);
- The NJDOH Terms and Conditions for Administration of Grants;
- Applicable Federal Cost Principles – Addendum to Terms and Conditions for Administration of Grants;
**Entities and organizations eligible to apply include:** non-profit hospitals, Community-Based Organizations (CBOs), AIDS Service Organizations (ASOs), homeless health centers, and mental health programs serving populations in need of HIV care services. Agencies must document nonprofit status (501-3C) and be in full compliance with all tax exempt 501-3C requirements. Any non-profit agency applying under this RFA must have been certified by the federal Internal Revenue Service (IRS) as a 501(c)(3) organizations prior to January 1, 2015. A copy of the IRS certificate of non-profit status must be included as an attachment to this proposal. Proposals from non-profit organizations that are lacking documentation of tax exempt status will not be reviewed and will be ineligible to receive funding under this RFA. **For-profit entities are not eligible to apply for Ryan White funds.**

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

Applicant agencies must demonstrate that they currently provide or have the capacity to provide extensive quality, culturally competent, patient-centered services for which the agency is seeking funding. The agency must demonstrate collaborative and cooperative relationship with HIV clinical and support services.

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

**Program Specifications:**

1. Housing-related referral services including housing assessment, search, placement, advocacy, and the fees associated with them;
2. Provisions and description of the protocol for emergency placements;
3. Policy on admission timeline from referral to placement;
4. The provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual PLWH to gain or maintain medical care. Housing related referrals are provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs;
5. Each client receives assistance designed to help them obtain stable long-term housing, through a strategy to identify, re-locate, and/or ensure the individual is moved to or capable of maintaining a stable long-term living situation and maintain access and compliance with HIV-related medical care and treatment;
6. Client rules and rights shall be established and adhered to;
7. Mechanisms are in place to allow newly identified HIV-positive clients access to housing services;
8. Policies and procedures to provide individualized written housing plans, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services;
9. No funds are used for direct payments to recipients of services for rent or mortgages;
10. No funds are to be used for construction or renovations;
11. Policies and procedures in place to assure codes, regulations, safety, and client rights.
Program Requirements

1. DHSTS adheres to the HUD definition on duration limits to provide transitional and emergency housing services. HUD defines transitional housing as 24 months;
2. Services provided, including number of clients served, duration of housing services, types of housing provided, and housing referral services are measures of performance and must be tracked.
3. Staff providing counseling and case management services shall hold advanced degrees and are professionals who possess a comprehensive knowledge of local, state, and federal housing programs and how to access those programs;
4. Maintain client records that document:
   a. Client eligibility;
   b. Housing services, including referral services provided;
   c. Mechanisms are in place to allow newly HIV diagnosed clients access to housing services;
   d. Individualized written housing plans are available, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services;
   e. Assistance provided to clients to help them obtain stable long-term housing;
   f. Provide a policy to assure that no Ryan White funds are used to provide direct payments to clients for rent or mortgages;
   g. Mechanisms shall be in place to allow newly identified clients access to housing services;
   h. Policies and procedures to provide individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, Ryan White as payer of last report, vigorous pursuit of third party payment, transitional and emergency housing services.

Required Format for Proposal Program Narrative

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

Application Content
All applications must contain the following sections:

1. Abstract (not scored): Summary of the program described in the application. Not to exceed one page.
2. History of applicant (10 points): State why your organization is well equipped to make the proposed program work. Described within this section formal and informal agreements that exist, or that will be established with providers, other agencies, and community-based organizations to further the accomplishments of the objectives of the program. Special attention should be devoted to relationships with the regional outpatient/ambulatory care clinics serving the medical needs of those infected with the disease and county board of social services agencies fundamental in accessing public entitlements.
3. Needs assessment (20 points): Describe the particular service preference and unmet needs of the proposed population and the manner in which these needs were determined and verified. Also provide data on the existing medical and social services available to address the health problems of those infected with HIV/AIDS. Identify the gaps in services. Explain why the data presented justify the funding of the applicant’s program in the target area.

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

5. Methods (20 points): Describe the activities you will engage in to accomplish each process and outcome objective described above.

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

7. Evaluation and quality assurance (10 points): Describe how you will evaluate the success of the proposed program and ensure that required data are submitted to DHSTS through CAREWare.

8. Budget justification (10 points): Describe and justify the necessity and reasonableness of all funds requested. All grantees must adhere to the Ryan White Part B Fiscal Monitoring Standards (http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf)

9. Attachments (not scored).

I. Review Criteria

An RFA Review Committee will review proposals according to the criteria described below. The DHSTS reserves the right to render final decisions on the awarding of Health Service Grants under this RFA. Among the questions to be considered when scoring applications are the following:

History of The Applicant Organization (10 points)

Does the proposal include a relevant discussion of the applicant’s primary mission, scope of services and achievements, and longevity of service provision in the targeted catchment area? Does it describe their organizational structure and personnel and indicate where within that structure the proposed program will fit?

Does the applicant explain and provide documentation to substantiate that the organization currently services the housing needs of the target population, or has the capacity to provide the housing services described?

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

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

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

**Needs Assessment (20 points)**

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

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

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

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

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

**Goals and Objectives (20 points)**

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

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

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

**Methods (20 points)**

Is a clear and reasonable method detailed for each process and outcome method specified above?

Does the applicant provide a time table for implementation of proposed methods?
Does the applicant specify the number of clients that each service is intended to reach during the grant year?

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

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

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

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

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

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

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

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

Has the applicant provided an adequate plan for ensuring that services will be delivered in a culturally competent manner that meets the specific needs of the proposed target population?

Does the applicant address the social determinants of health and cooperative/collaborative approaches to address the social determinants?

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

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

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

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

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

Management and Staffing Plan (10 points)

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

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

Does the proposed staffing plan include consultants on Cognitive Behavior Therapy and women’s health?

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

Has the applicant specified the capacity building and training needs of the proposed staff and provided an adequate plan to meet those needs?

Evaluation and Quality Assurance Plan (10 points)

Does the applicant describe how it will measure the specific proposed program outcomes referred to in the Goals and Objectives section of this program narrative? Is a description of the instrument, data analysis, and dissemination plan included?

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

Does the applicant address the ten NHAS indicators?

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

Does the applicant specify which agency staff member(s) will be responsible for evaluating the progress toward meeting the program narrative’s stated goals and objectives, including the need to alter program activities, communicating with DHSTS regarding proposed changes, and implementing approved program changes?
Does the applicant clearly state that it will comply with all data collection and evaluation protocols specified and outlined by the DHSTS (i.e., CAREWare).

Does the applicant of ambulatory/medical care services clearly outline how the delivery of medical care treatment will comply with the Health Resources and Services Administration HIV/AIDS Bureau’s quality indicators to improve the care of those infected with HIV/AIDS?

Does the applicant of ambulatory/medical care services include performance measure indicators that can be used to monitor quality of care and to improve service delivery and clinical health outcomes of HIV/AIDS infected patients?

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

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

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

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

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

Review Procedures
Applications will be screened for completeness. The checklist that will be used to evaluate completeness will be provided during the TA session. Only those proposals deemed to be complete and in compliance will be sent to the RFA review committee.

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

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

Instructions for New Agency:
1. Complete the FORM for Adding Agency Organizations into NJSAGE
2. Identify your validated Authorized Official, or if non, have the Authorized Official register as a new user. The new user (Authorized Official) will be validated when the organization is validated and assigned to the organization.

3. Sign a **hard copy** of the **FORM For Adding Agency Organizations Into NJSAGE** and submit via a FAX or as an email attachment to Cynthia Satchell
   a. FAX – 609-633-1705
   b. Email: [Cynthia.Satchell@doh.state.nj.us](mailto:Cynthia.Satchell@doh.state.nj.us)

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