**Public Health Solutions**

**Request for Proposals: Ryan White Part A Services in the Tri-County Region**

**Solicitation #: 2018.05.HIV.03.01**

**PROPOSAL CHECKLIST (revised 07.31.2018)**

|  |
| --- |
| **Organization Name:**  |

**Indicate the Service Category/ies you are submitting a proposal for using the checkbox below**:

[ ]  Service Category 1: Food and Nutrition Services

[ ]  Service Category 2: Housing/Short Term Assistance Services

[ ]  Service Category 3: Medical Case Management Services

[ ]  Service Category 4: Mental Health Services

[ ]  Service Category 5: Oral Health Care Services

[ ]  Service Category 6: Psychosocial Support Services

[ ]  Service Category 7: Medical Transportation Services

[ ]  Service Category 8: Emergency Financial Services

**General Organizational Eligibility Requirements** *(indicate that your organization meets the eligibility requirements by checking the corresponding Yes/No check boxes below)*:

1. **Yes** [ ]  **No** [ ]  **Is your organization** legally incorporated by the State of New York as a not-for-profit Corporation?
2. **Yes** [ ]  **No** [ ]  **Does your organization** havefederal tax-exempt status under Section 501(c)(3) of the Internal Revenue Code (IRS)?
3. **Yes** [ ]  **No** [ ]  **Is your organization** currently operating with a brick-and-mortar site in Westchester, Rockland or Putnam counties?

*Facilities must comply with the Americans with Disability Act (ADA) and be accessible by public transportation. Although any individual applicant agency does not have to serve clients from all eight counties in the New York EMA (the five boroughs in NYC and three counties in Tri-County), funded agencies should have the capacity to serve clients from throughout the New York EMA.*

Applicants must have demonstrated experience providing related services to PLWH. Applicants should meet the following experience requirements to be eligible for funding under this RFP. Organizations must:

1. Have demonstrated experience providing the designated service to people living with HIV equivalent to:

**Yes** [ ]  **No** [ ]  **Does your organization** have at least 2 years of experience serving PLWH?

**Yes** [ ]  **No** [ ]  **Does your organization** have at least 1 year of experience providing the designated service(s) you are submitting proposal(s) for funding?

2a. **Yes** [ ]  **No** [ ]  **Is your organization/will your organization** be co-located with service programs to refer patients for needed medical and/or social support services?

**OR**;

2b. **Yes** [ ]  **No** [ ]  ***If no to 2a.,* does your organization** have established Linkage Agreement (LA) or Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) with service programs to refer patients for needed medical and/or social support services?

1. **Yes** [ ]  **No** [ ]  **Is your organization** able to address, either directly or through referral, the needs of clients with physical, behavioral, psychosocial, or sensory impairments?
2. **Yes** [ ]  **No** [ ]  **Is your organization** able to bill Medicaid for services that are billable to Medicaid?

*Agencies must ensure that staff members have HIV knowledge, training, and cultural sensitivity appropriate to the populations that they serve. Agencies must have the capacity to provide services in the languages spoken by the populations served.*

*For-profit organizations are not eligible for funding through this RFP. HRSA guidance prohibits not-for-profit organizations from serving as conduits that pass awards to for-profit entities.*

***All applicants must meet the General Organizational Eligibility Requirements outlined in this section AND any Program Specific Agency Eligibility Requirements outlined in the specific service category in this RFP.***

**Program Specific Agency Eligibility Requirements**

*In addition* to the General Organizational Eligibility Requirements listed above, applicants must meet *all* of the following requirements to be eligible for funding under the specific category for which a proposal is being submitted. Please indicate if you meet the eligibility requirements by checking the corresponding Yes/No check boxes below.

**Service Category 1: Food and Nutrition Services**:

1. **Yes** [ ]  **No** [ ] Does your agency conform to food industry standards for food preparation, storage, and handling?

2a. **Yes** [ ]  **No** [ ] Is your agency offering prepared meals?

2b. **Yes** [ ]  **No** [ ] *If yes to 2a.,* does your agency meet both local and state food safety regulations? See New York State food handling regulations,

[*https://www.health.ny.gov/environmental/indoors/food\_safety/regs.htm*](https://www.health.ny.gov/environmental/indoors/food_safety/regs.htm)

**Service Category 2: Housing/Short Term Assistance Services**:

1. **Yes** [ ]  **No** [ ]  Does your agency have experience serving HIV-positive individuals?

***AND***

**Yes** [ ]  **No** [ ]  Does your agency have experience reaching out to and engaging individuals who are out of care, sporadically in care, or in need of self-management support?

2a. **Yes** [ ]  **No** [ ]  Is your agency/will your agency be co-located with medical and non-medical case management programs to refer participants for other needed medical and/or social support services?

***OR***

2b. **Yes** [ ]  **No** [ ]  *If no to 2a.,* does your agency have established linkages with medical and non-medical case management programs to refer participants for other needed medical and/or social support services?

1. **Yes** [ ]  **No** [ ]  Ensure that staff members are appropriately credentialed to provide the services listed and have HIV knowledge, training, and cultural sensitivity appropriate to the populations served; and
2. **Yes** [ ]  **No** [ ]  Have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the entire NY EMA.

**Service Category 3: Medical Case Management Services**:

1a. **Yes** [ ]  **No** [ ]  Does your agency have a medical provider on-site that has agreed to coordinate care?

***OR***

1b. **Yes** [ ]  **No** [ ]  *If no to 1a.,* does your agency have a memorandum of understanding (MOU) with a medical provider that has agreed to coordinate care?

* + 1. The MOU should detail the process for making referrals to the program and how medical information and MCM program information will be shared among providers.
1. **Yes** [ ]  **No** [ ]  Does your agency have demonstrated experience providing medical case management services to PLWH?
2. **Yes** [ ]  **No** [ ]  Does your agency have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the NY EMA?

**Service Category 4: Mental Health Services**:

1a. **Yes** [ ]  **No** [ ]  Is your agency a NYS licensed Article 28 facility?

***OR***

1b. **Yes** [ ]  **No** [ ]  *If no to 1a.,* is your agency a NYS licensed Article 31 facility?

1. **Yes** [ ]  **No** [ ]  Can your agency demonstrate that these funds will be Payer of Last Resort (POLR)?

***AND***

**Yes** [ ]  **No** [ ]  Does your agency have the capacity to bill Medicaid for those clients with Medicaid?

**Service Category 5: Oral Health Care Services**:

1. **Yes** [ ]  **No** [ ]  Is your agency a health center authorized to bill NYS Medicaid such as a NYS licensed Article 28 facility?
2. **Yes** [ ]  **No** [ ]  Does your agency have, or obtain, the ability to bill the New York State HIV Uninsured Care Program for dental services?

**Service Category 6: Psychosocial Support Services**:

1. **Yes** [ ]  **No** [ ]  Does your agency have experience serving PLWH?
2. **Yes** [ ]  **No** [ ]  Does your agency have experience engaging individuals who are out of care or sporadically in care or in need of self-management support?
3. **Yes** [ ]  **No** [ ]  Is your agency/will your agency be co-located with medical and social service programs to refer participants?
4. **Yes** [ ]  **No** [ ]  Does your agency have established linkages with medical and social service programs to refer participants?
5. **Yes** [ ]  **No** [ ]  Will your agency ensure that staff members are appropriately credentialed to provide the services listed?

***AND***

**Yes** [ ]  **No** [ ]  Will your agency ensure that staff members have HIV knowledge, training, and cultural sensitivity appropriate to the populations served?

1. **Yes** [ ]  **No** [ ]  Does your agency have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the entire NY EMA?

**Service Category 7: Medical Transportation Services**:

1. **Yes** [ ]  **No** [ ]  Does your agency have experience serving PLWH?
2. **Yes** [ ]  **No** [ ]  Does your agency have policies and procedures to follow up and resolve client-vendor disputes?
3. **Yes** [ ]  **No** [ ]  Does your agency have staff members (both program staff and drivers) that respect and maintain rider confidentiality?
4. **Yes** [ ]  **No** [ ]  Does your agency have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the NY EMA?

**Service Category 8: Emergency Financial Services**:

1. **Yes** [ ]  **No** [ ]  Does your agency have experience working with a wide-range of individuals, including those living with HIV and those in need of emergency financial assistance?
2. **Yes** [ ]  **No** [ ]  Is your agency able to address, either directly or through referral, the needs of clients with physical, behavioral, psychosocial, or sensory impairments?

3a. **Yes** [ ]  **No** [ ]  Is your agency/will your agency be co-located with programs providing early intervention services, medical care, mental health, alcohol and substance use services, medically appropriate housing programs, food and nutrition services, and other unmet social needs including non-medical case management, supportive counseling and family stabilization services, health education and risk reduction, and navigation, linkage, and reengagement services?

***OR***

3b. **Yes** [ ]  **No** [ ]  *If no to 3a.,* does your agency have established linkages with programs providing early intervention services, medical care, mental health, alcohol and substance use services, medically appropriate housing programs, food and nutrition services, and other unmet social needs including non-medical case management, supportive counseling and family stabilization services, health education and risk reduction, and navigation, linkage, and reengagement services?

1. **Yes** [ ]  **No** [ ]  Does your agency have service sites geographically located within Tri-County, accessible to, and able to service clients from throughout the NY EMA?
2. **Yes** [ ]  **No** [ ]  Does your agency have procedures and protections in place to manage effective accounting of payments made through an EFS program and ensure EFA resources are available to clients throughout the contract year?

**Proposal Package**

The following required forms must be download from the Public Health Solutions’ RFP website, [**https://www.healthsolutions.org/get-funding/request-for-proposals/**](https://www.healthsolutions.org/get-funding/request-for-proposals/) :

1. Proposal Checklist
2. Organization Information Cover Page
3. Proposal Narrative Form
4. Attachment A – Program Information
5. Budget Form and Budget Instructions
6. Board of Directors’ Statement
7. Government Contracting Experience/References
8. Proposal Format Form
9. Notice of Intent to Respond Form
10. Sharing Documents to PHS in the Document Vault

**Required Components of a Complete Proposal**

***One electronic copy*** *of the following required components of each proposal submitted via the* CAMS Contracting Portal on Public Health Solutions’ website at [*https://mer.healthsolutions.org*](https://mer.healthsolutions.org)

Please check the corresponding check box to indicate that the document is included in your **proposal package submission**:

1. [ ]  **Proposal Checklist** – signed and dated by the CEO/Executive Director/President

1. [ ]  **Organization Information Cover Sheet** *(must be submitted in MS Word)*

1. [ ]  **Proposal Narrative(s) *and* all attachments referenced in the Proposal Narrative section** *(must be submitted in MS Word)*

1. [ ]  **Attachment A – Program Information for Proposed Program(s)** *(must be submitted in MS Excel)*
* Program Staff
* Service Site Locations

1. [ ]  **Budget(s) including Budget Justification(s)** *(must be submitted in MS Excel)*
2. [ ]  **Organization Chart for Proposed Program(s)**
3. [ ]  **Curricula Vitae or Resumes of Key Staff** *(leadership and program level)*
4. [ ]  **If any, Linkage Agreement (LA) / Memorandum of Understanding (MOU) / Memorandum of Agreement (MOA) with collaborative partner organization(s)**

1. [ ]  **Proposal Format Form**

*Proposals missing the Proposal Narrative(s) or the Budget(s) will be deemed non-responsive and ineligible for review*.

**Required Administrative Documents**

*In addition to the Required Components of the Complete Proposal,* ***one set*** of the following Required Administrative Documents must be submitted with the Complete Proposal. *Please check the corresponding check box to indicate if the document is included in your proposal package submission.*

1. [ ]  **\*Internal Revenue Service 501(c)(3) Determination Letter**

1. [ ]  **\*New York State Certificate of Incorporation** *(full copy, including any amendments)*

1. [ ]  **\*Current Board of Directors List**

1. [ ]  **\*Most recent audited annual Financial Statement**; *if total expenditures associated with federal funding exceed $750,000 a year, a Single Audit report is required*
2. [ ]  **Board of Directors’ Statement** *–* *written on your letterhead and signed by the Chair/President or Secretary of the Board of Directors (see sample statement provided)*

1. [ ]  **Government Contracting Experience/References** *(see template provided)*
2. [ ]  **\*New York State Article 28 License***, if applicable*
3. [ ]  **\*New York State Article 31 License***, if applicable*

*Note that you may transmit the Required Administrative Documents which are marked with an asterisk (\*), to Public Health Solutions via the NYC HHS Accelerator, New York City’s contracting information system for health and human services. Organizations registered with the NYC HHS Accelerator must designate Public Health Solutions as a funder authorized to download the administrative documents. (Download the instructions, “Sharing Documents to PHS in the Document Vault” from Public Health Solutions’ RFP website.)*

*Please indicate on the Proposal Checklist whether you intend to transmit the asterisked (\*) Required Administrative Documents via the NYC HHS Accelerator (indicate below) or if you are including them with your proposal package submission via the CAMS Contracting Portal (indicate above). For more information on the NYC HHS Accelerator and to register, go to:*

[*~~http://www.nyc.gov/html/hhsaccelerator/html/home/home.shtml~~*](http://www.nyc.gov/html/hhsaccelerator/html/home/home.shtml)

*<https://www1.nyc.gov/site/mocs/systems/about-go-to-hhs-accelerator.page>*

**Administrative Documents Submission via the NYC HHS Accelerator**

*Please indicate whether you have transmitted the asterisked (\*) Required Administrative Documents via the NYC HHS Accelerator (and have not included them with your proposal package submission via the CAMS Contracting Portal).*

[ ]  My applicable required “administrative” documents are available via the NYC HHS Accelerator *(remember to elect to share documents with Public Health Solutions in the NYC HHS Accelerator system).*

**Executive Director/CEO Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_