Renewal Application For Prevention Services for HIV Infected Persons Projects

www.tdh.state.tx.us/hivstd

RFP HIV 0026.5

Issue Date: ***07/15/2005***

Due Date: ***08/29/2005***

HIV/STD Comprehensive Services Branch

1100 W. 49th Street

Austin, Texas 78756-3199

Eduardo J. Sanchez, M.D., M.P.H.
Commissioner

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INFORMATION

I. INTRODUCTION

The Department of State Health Services (DSHS) HIV/STD Comprehensive Services Branch announces the expected availability of calendar year 2006 funding to assure that effective and appropriate prevention services are available to HIV-infected clients and their sex and/or needle-sharing partners who may be recently released from jail, already in a community care system, or newly diagnosed with HIV. Current DSHS contractors receiving funds under RFP HIV 0026, Prevention Services for HIV Infected Persons, issued 10/01/01, are requested to submit a renewal application for the FINAL budget period within project period. Renewal contracts will begin on or about 01/01/06 and will be for a 12-month budget period.

In accordance with Health and Safety Code, §85.085, Physician Supervision of Medical Care, which ensures that a licensed physician supervises any medical care or procedure provided under a testing program, all Prevention Counseling and Partner Elicitation (PCPE) providers must operate under the standing delegation orders of a physician.

Because there is an alarming increase in HIV and syphilis co-morbidity in Texas, it is expected that when performing a venipuncture for HIV screening, a serology sample for syphilis will also be offered at the same time.

Programs should be advised that agencies might be requested to submit supporting documentation along with their monthly invoices to verify actual expenditures.

Any contract renewal is contingent upon the continued availability of funds and the satisfactory performance of the contractor during the prior budget period. Funding may vary and is subject to change each budget period. DSHS reserves the right to alter, amend or withdraw this Renewal Application at any time prior to the execution of a contract if funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or agencies, amendment of the appropriations act, health and human services agency consolidations, or any other disruption of current appropriations. If a contract has been fully executed and these circumstances arise, the provisions of the Termination Article in the contract General Provisions shall apply.

II. RENEWAL APPLICATION DEADLINE AND SUBMISSION

A. Application Deadline

The renewal application shall be received on or before the following date and time: ***2:00 P.M. C.S.T. on 08/29/05.***

B. Contact

For purposes of addressing questions concerning this Renewal Application, the contact is ***Debbie Bennett*****.** All communications concerning this Renewal Application shall include the RFP #, be addressed in writing, and sent by fax or email to:

Debbie Bennett
Client Services Contracting Unit
Room T-502
Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3199
FAX (512) 458-7351
Email : ***debbie.bennettt@dshs.state.tx.us***
RFP # : ***HIV 0026.5***

Upon issuance of this Renewal Application, other employees and representatives of DSHS will not answer questions or otherwise discuss the contents of the Renewal Application with any potential applicants or their representatives. Failure to observe this restriction may result in disqualification of any subsequent proposal. This restriction does not preclude discussions between affected parties for the purpose of conducting business unrelated to this Renewal Application.

Written inquiries or questions about this RFP shall be received no later than ***5:00 P.M. C.S.T. on 08/01/05***.

The Client Services Contracting Unit (CSCU) is the point of contact with regard to all procurement and contractual matters relating to the services described herein. CSCU is the only office authorized to clarify, modify, amend, alter, or withdraw the project requirements, terms, and conditions of this Renewal Application and any contract awarded as a result of this Renewal Application.

C. Assembly and Submission

1. Assembly

To facilitate review and processing, each renewal application should meet the following stylistic requirements:

- All pages clearly and consecutively numbered;
- Original and 3 copies unbound, but secured with binder clips or rubber bands;
- Typed (computer or typewriter);
- Single-spaced;

- 12-point font on 8 ½" x 11" paper with 1" margins;
- Blank forms provided in **SECTION IV. BLANK FORMS AND INSTRUCTIONS** shall be used (electronic reproduction of the forms is acceptable; however, all forms shall be identical to the original form(s) provided); and
- Signed in ink by an authorized official (copies must be signed but need not bear an original signature).

In addition, one (1) copy must be received by the appropriate DSHS Regional Office by the due date.

2. Submission

The originally signed renewal application and ***3*** copies shall be submitted **on or before the deadline to**:

Debbie Bennett
Client Services Contracting Unit
Room T- 502
Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3199

REF: RFP HIV 0026.5

Renewal applications may be mailed or hand-delivered to the DSHS address above. If a renewal application is sent by overnight mail or hand-delivered to the DSHS address above, the applicant should request a receipt at the time of delivery to verify that the application was received on or before the due date and time. Hand-delivered applications must be delivered to the room number identified in the address above.

If a renewal application is mailed, it is considered as meeting the deadline if it is received on or before the due date and time. DSHS will not accept renewal applications by facsimile or e-mail.

Applicants sending renewal applications by the United States Postal Service or commercial delivery services must ensure that the carrier will be able to guarantee delivery of the renewal application by the closing date and time. DSHS may make exceptions only for 1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time; or 2) significant weather delays or natural disasters. The applicant must submit to DSHS proper documentation that reflects one of the above exceptions before DSHS can consider the application as having been received by the deadline.

III. RENEWAL APPLICATION ORGANIZATION AND CONTENT

The renewal application should be organized in the following order:

A. Face Page - Renewal Application as authorized under ***RFP HIV 0026 Prevention Services for HIV Infected Persons***, issued ***10/01/01***

B. Renewal Application Checklist

C. Contact Person Information

D. Administrative Information

E. Performance Measures

F. Work Plan

G. Budget

H. Nonprofit Board of Directors and Executive Director Assurances Form

I. Memoranda of Understanding (MOU)

IV. BLANK FORMS AND INSTRUCTIONS

Tip: To use the check box, place the pointer over the box and double click the left mouse button. In the Check Box Form Field Options, change the Default Value to Checked by clicking the circle in front of it.

Unlocked Forms

To have the computer do the addition:

1. Completely fill out the column or row you are going to sum. If you are summing all of the totals, update the sum of all the columns and all the rows before updating the sum of the totals.
2. Word will **not** update the totals automatically. Select the form field for the sum in one of the following ways:
   - Use the tab key to move from field to field or place the cursor immediately in front of the "0" or previous total with gray shading.

- Drag the cursor over the “0” or previous total with gray shading so that only the number is selected. Note: If the entire table cell is selected (black), the formula will not work and you risk deleting the form field.

Tip: The first time you use the forms, the totals are all “0” with gray shading. Before updating a total, Zoom in until you can easily see the “0” and the gray shading.

3. Press the F9 key (usually at the top of the keyboard).
4. Check the results. If it looks wrong, check the numbers you put in the row or column.

Caution: Never delete the form field for the total (the “0,” or previous total, with gray shading). The formulas will not work after the form field for the total is deleted. Selecting the field and typing over it will delete the field. The Backspace key will delete the field. The Delete key will delete the field.

Tip: You must update the totals for the columns and rows each time you change a number in that column or row.

Department of State Health Services (DSHS)

FORM A: FACE PAGE – Renewal Application as authorized under RFP HIV 0026, *Prevention Services for HIV Infected Persons,* issued 10/*01/01*

This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal application and shall be completed in its entirety.

APPLICANT INFORMATION

1) LEGAL NAME:

2) MAILING Address Information (include mailing address, street, city, county, state and zip code): **Check if address change** ☐

3) PAYEE Mailing Address (if different from above): **Check if address change** ☐

4) Federal Tax ID No. (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or **Social Security Number** (9 digit) : ***The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.***

5) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

**If incorporated, provide 10-digit charter number assigned by Secretary of State:*

6) Currently operating under a HUB Subcontracting plan on file at DSHS? Yes ☐ No ☐

7) PROPOSED BUDGET PERIOD: Start Date: End Date:

8) COUNTIES SERVED BY PROJECT:

9) AMOUNT OF FUNDING REQUESTED:

10) PROJECTED EXPENDITURES

Does applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **

Yes ☐ No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.*

11) PROJECT CONTACT PERSON

Name:
Phone:
Fax:
E-mail:

12) FINANCIAL OFFICER

Name:
Phone:
Fax:
E-mail:

I, the undersigned, am the authorized representative of the applicant filing this contract renewal application. The facts contained herein are true, and the applicant is in compliance with the assurances and certifications contained in the competitive RFP identified above, which is part of the original contract and any prior renewals and amendments. I understand that this contract renewal depends on the truthfulness of this document and on the applicant's continued compliance with the original contract and all its components and amendments.

13) AUTHORIZED REPRESENTATIVE **Check if change** ☐

Name:
Title:

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

Phone: Fax:	

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

1) **LEGAL NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.

3) **PAYEE MAILING ADDRESS** - Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Texas Building and Procurement Commission (TBPC) or another entity.

MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

6) **CURRENTLY OPERATING UNDER A HUB SUBCONTRACTING PLAN ON FILE AT DSHS? YES OR NO** - Check the appropriate box to indicate whether or not the applicant is operating under a HUB Subcontracting Plan filed with DSHS under the original competitive RFP. If yes, the applicant must continue to comply with reporting requirements if a renewal contract is executed. Any changes to the budget which affect the HUB Subcontracting Plan must be communicated with the DSHS HUB Coordinator at 1-800-243-7487 or by e-mail at HUB-Contact@dshs.state.tx.us. If no is checked, no further action is required.

7) **PROPOSED BUDGET PERIOD** - Enter budget period as identified in this renewal application.

8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.

9) **AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding requested from DSHS for proposed project activities. This amount must match column (1) row J from FORM I: BUDGET SUMMARY.

10) **PROJECTED EXPENDITURES** - If applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year, applicant shall arrange for a financial and compliance audit (Single Audit).

11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.

12) **FINANCIAL OFFICER** - Enter the name, title, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.

13) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant signs in this blank.

15) **DATE** - Enter the date the person authorized to represent the applicant signed this form.

FORM B: RENEWAL APPLICATION CHECKLIST

Legal Name of Applicant: _____

This form is provided to ensure that the renewal application is complete and properly signed.

FORM	DESCRIPTION	Included	Not Applicable
A	Face Page – Renewal Application completed, and proper signatures and date included	☐	
B	Renewal Application Checklist completed and included	☐	
C	Contact Person Information completed and included	☐	
D	Administrative Information for Renewal Application completed and included (with supplemental documentation attached if required)	☐	
E	Performance Measures included	☐	
F	Work Plan included	☐	
G	Budget Summary Form completed and included	☐	
G-1–G-6	Budget Category Detail Forms completed and included	☐	
G-7	Budget Justification following example (include equipment forms if applicable)	☐	
H	Nonprofit Board of Directors and Executive Director Assurances form signed and included If the signed original of this form has been provided to the Department of State Health Services during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.	☐	☐
I	Memoranda of Understanding signed and included	☐	☐

FORM C: CONTACT PERSON INFORMATION

Legal Name of Applicant: ______________________________

This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify the HIV/STD Comprehensive Services Branch.

Contact: ____________ **Title:** ____________ **Phone:** ____ Ext. ____ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Contact: ____________ **Title:** ____________ **Phone:** ____ Ext. ____ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Contact: ____________ **Title:** ____________ **Phone:** ____ Ext. ____ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Contact: ____________ **Title:** ____________ **Phone:** ____ Ext. ____ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Contact: ____________ **Title:** ____________ **Phone:** ____ Ext. ____ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):**

FORM D: ADMINISTRATIVE INFORMATION - Renewal Application

This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information ***or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

Legal Name of Applicant: _____

Identifying Information

If there are no changes to any of the items below, check here and skip the next question in this section. ☐

1. The applicant shall attach the following information:

If a Governmental Entity

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

If a Nonprofit or For profit Corporation

- Full names (last, first, middle), addresses, telephone numbers, titles and occupation of members of the Board of Directors or any other principal officers. Indicate what offices are held by members (e.g. chairperson, president, vice-president, treasurer, etc.).
- Full names (last, first, middle), and addresses for each partner, officer, and director as well as the full names and addresses for each person who owns five percent (5%) or more of the stock if applicant is a for profit corporation.

Conflict of Interest and Contract History

If there are no changes to any of the items below, check here and skip the questions in this section. ☐

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this renewal application. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with DSHS, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this renewal application. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of DSHS, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination. If, following a review of this information, it is determined by DSHS that a conflict of interest exists, the applicant may be disqualified from further consideration for the renewal of a contract.

1. Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this renewal application?

☐ **YES** ☐ **NO**

If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the renewal application due date?

☐ **YES** ☐ **NO**

If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

3. Is applicant or any member of applicant's executive management, project management, board members or principal officers:

- Delinquent on any state, federal or other debt;
- Affiliated with an organization which is delinquent on any state, federal or other debt; or
- An default on an agreed repayment schedule with any funding organization?

☐ **YES** ☐ **NO**

If YES, please explain. (Attach no more than one additional page.)

FORM E: PERFORMANCE MEASURES

In the event a contract is renewed, applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see PERFORMANCE MEASURES Guidelines) associated with the services proposed in this renewal application. ***Additional pages may be attached if needed.***

FORM E: PERFORMANCE MEASURE Guidelines

1. Agency shall include the performance measures in the renewal application along with the proposed target levels of performance for each measure. The proposed target levels of performance and reporting frequency will be negotiated and agreed upon by the agency and DSHS.

All programs funded to provide PCPE/PCM (PBC) must include the following objectives:

a) 75% of clients testing for HIV will receive results counseling.
b) 95% of clients testing HIV-positive will receive results counseling.
c) 95% of clients who are HIV-positive and received results counseling will be successfully linked to HIV early intervention.
d) Programs will elicit at least one sex or needle-sharing partner for health department notification from 80% of HIV-positive clients who receive results counseling.
e) 90% of HIV-positive pregnant women will be successfully linked into prenatal care.
f) The program will provide (number) prevention counseling sessions by (date).
g) The program will provide (number) prevention counseling sessions to (name target population) by (date).
h) By (date), (number) clients will engage in prevention case management.
I) By (date), (number) (name population) will engage in prevention case management.
j) By (date), (number) clients will be enrolled in prevention case management.
k) By (date), (number) (name target population) will be enrolled in prevention case management.

Note: For agencies trained in Protocol-Based Counseling (PBC), the above objectives apply.

In addition to the objectives above, all entities must include any agency-specific program outcome objectives for PCPE/PCM.

All entities funded for EBIs must also provide process objectives for EBIs in the approved DSHS format.

FORM F: WORK PLAN

Applicants shall describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this renewal application. ***Additional pages may be attached.***

FORM F: WORK PLAN Guidelines

Listed below are the minimally required elements for inclusion in workplans. The form may be recreated, but all of the information must be included listed in the order below.

I. AGENCY AND INTERVENTION INFORMATION

a. Agency Name
b. Name of intervention
c. A very brief abstract/summary of the intervention which must include at a minimum:

Intervention Type: (Individual-level, Group-level, Community-level
Number of sessions:
Core elements of the intervention:
Goals of the intervention:
Groups targeted with the intervention:
Overall Service Delivery Area: (The HMAZ where the intervention will be provided; if you will serve any counties in addition to a HMAZ, please list these also. If there are any counties in a HMAZ that you won't serve, please list.)

II. SERVICES DELIVERY

a. Any tailoring that will be done to the way the intervention is implemented or the curriculum used in the interventions (changes in number of sessions, additions to the curriculum, tailoring to another target population, etc.)
b. How clients will be recruited and where they will be recruited from
c. How client participation will be maintained (if multi-session intervention)
d. How often the intervention will be offered, or how often parts of the intervention will be offered. If it is a single session intervention, when will it be available? If it is a multiple session intervention or ongoing intervention, how often will it "start over?"
e. Where will the intervention be offered
f. Describe any collaborating agencies and their roles. Clearly delineate the names of all entities involved, the nature of the collaboration, the roles of each entity, and the expected outcomes.

Collaboration activities are those that are designed to strengthen HIV prevention activities and minimize duplication of effort in the State. Collaboration activities may include but are not limited to joint participatory planning to address common areas of service need; development of recommendations for program planning and implementation; development of relevant policies, procedures, or guidelines as relative to the program; working with entities to ensure that effective referral networks are in place; and identification of specific steps for furthering collaborative efforts.

Collaborative efforts require articulation through formal agreements. All providers must develop, maintain and **submit** yearly formal agreements in the form of MOUs with the local health authority in the jurisdiction for STD and partner services. Additionally, all funded providers must develop and maintain yearly MOUs with other HIV prevention and services providers and collaborating entities. EBI providers that are not funded for PCPE must also maintain yearly MOUs with PCPE providers, STD providers, other EBI providers, and AIDS service organizations in the jurisdiction to ensure effective, coordinated HIV prevention and partner services.

g. Types of referrals and how referrals will be tracked and documented
h. How the intervention will be staffed:
   Paid FTEs and volunteers
   How staff will be trained for the intervention
   How supervisors will be trained for the intervention
i. Resources needed for the intervention
j. Describe any community assessment activities that will be conducted

III. PROCESS AND OUTCOME OBJECTIVES

Included in FORM E. No need to repeat here.

IV. QUALITY ASSURANCE ACTIVITIES

The minimum required elements for quality assurances plans are listed below. Agencies are requested to describe any changes to currently approved QA plans.

1) *A training plan for staff, paid and unpaid, who do the intervention*. The training plan must outline how intervention staff will receive appropriate training and education to ensure that they have the knowledge, skills, and abilities necessary to deliver the intervention. It must also outline the method(s) for orienting staff to programmatic guidelines, codes of conduct/ethics, program plans, and reporting requirements. Agencies must maintain a system for recording all staff training. System must include employee name as well as date, type, source, and duration of training. Copy of certificates should be kept.

2) *A description of the process used for routinely observing staff performance of the intervention. Agency must ensure that monitoring and evaluation of staff and, if applicable, **subrecipients' staff performance** is conducted and documented according to the schedule below:*

Length of time the staff member has been performing the intervention	For **group-level interventions** (including the group-level component of community-level interventions), staff must be monitored at least:	For **all other interventions** (including PCPE and PCM), staff must be monitored at least:
3 months or less	One out of every 3 sessions*	Twice a month
4 to 6 months	Twice a month	Twice a month
7 to 12 months	Monthly	Monthly
1 to 2 years	Quarterly	Quarterly
2 years or more	Every 6 months	Every 6 months

*Additionally, before conducting a **group level intervention** session on a solo basis, a staff member new to the intervention must be either: 1) observed conducting each session of the intervention by a supervisor (or more experienced facilitator); or 2) given the opportunity to co-facilitate each session with a more experienced facilitator.

Note: As discussed at the Forums, DSHS is moving towards adopting Protocol-Based Prevention Counseling as the model for the State. After attending the required trainings, agencies will be required to follow the quality assurance schedule located in this protocol. For reference, the quality assurance standards may be viewed at http://www.tdh.state.tx.us/hivstd/train/pctools/. Agencies are to utilize the Protocol-Based Prevention Counseling model and related tools, including the quality assurance schedule, only ***after*** attending the required trainings.

3) *A description of how observations will be documented and feedback given on the observations to the staff.* Observation and feedback forms should be attached to the QA plan. Observation documentation should focus on:
   a) Attainment of core elements, including coverage of activities and content objectives
   b) Quality of interaction with clients
   c) Staff's responsiveness to clients
   d) Staff's "match" of the format to the intervention session (e.g., are activities paced appropriately, are activities following the order in the curriculum, is the group size appropriate for the intervention, are discussions inclusive, are staff facilitating discussion and participation)
   e) How staff can improve performance as well as feedback on areas of particular strength

4) *A description of how feedback from staff and clients on the intervention will be gathered on at least an annual basis and used to improve the program.*

5) *A plan for monthly meetings* of the staff involved in the intervention to discuss issues specific to the intervention.

6) *A description of a plan for monitoring the intervention's process and outcome goals*: are clients completing the

intervention and are populations appropriate for the intervention being reached? Are the expected outcomes of the intervention being achieved?

V. CULTURAL COMPETENCE

Describe the agency's plan for assuring that services are culturally and linguistically appropriate.

VI. CONFIDENTIALITY AND SECURITY

Describe how you maintain client records in a confidential and secure environment.

VII. IMPLEMENTATION TIMELINE

Include a month-by-month timeline that identifies the major activities required to implement the intervention in a logical sequence including target dates for the contract year (2005-2006). At minimum the timeline must include:

a. Recruitment of clients
b. Training of participants (peers, clients, and other non-staff members)
c. Locations of where activities will occur
d. Services delivery dates including start date of pilot, start dates of full implementation
e. Evaluation activities
f. Quality assurance activities

VIII. LOGIC MODEL

All agencies must include an updated logic model for each funded intervention. Updated logic models must include the following elements:

Issues/Problems/Barriers to Prevention: Interventions are only effective if they meet the real HIV prevention needs of a population. The CPG in each community planning area conducted a needs assessment, and a summary of the issues, problems and barriers to prevention for different targeted populations. This is included in all AAPs. Each agency may also have its own assessment information about the needs and problems faced by the proposed target populations. Start the logic model by stating the issues/problems/barriers to prevention that the intervention will focus on. These issues must include the factors that put this population at risk, such as attitudes, beliefs, lack of prevention skills, relationship/interpersonal issues, social support, and access. The issues may be listed, or you can write a statement of the problem. Do not list issues/problems/barriers that the proposed intervention will not address.

Intervention Activities: This lays out how the intervention will address the issues of the population. Give enough detail so that the reader understands what will happen to the client (such as a two- session group intervention) and what kinds of activities and content focus the intervention has (discussion of role model stories that deal with beliefs about who is at risk and social stigma of condom use). If the intervention has many components, as most community –level interventions do, list all components within this model (such as small media campaign, the activities within the group intervention, and distribution of condoms). If elements are added to an established intervention to better suit a targeted population, please let the reader know which elements are being added or adapted. Regardless of the format utilized, the intervention activities must be linked to the issues they are meant to address. If there is an issue without an activity, reconsider including it in the model. If there is an activity without an issue, reconsider why you are proposing the activity. Remember that the objectives must also fit in logically with these activities, although the objectives are not shown on this model.

Immediate Outcomes: These are the immediate results of the intervention, such as changes in knowledge, attitudes, beliefs and skills. Intent to change behavior can also be an immediate outcome. Immediate outcomes are the things the program will be accountable for as outcomes of an intervention. If they are not logically related to the activities and issues, think twice about putting them in the logic model. Make the links between the outcomes and the rest of the model very clear.

Behavior Changes: These are the changes in the risk behavior that are logical extensions of the immediate outcomes of the intervention.

FORM G: BUDGET SUMMARY

Legal Name of Applicant: _____

Cost Categories	DSHS Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$	$	$	$	$	$ 0
B. Fringe Benefits	$	$	$	$	$	$ 0
C. Travel	$	$	$	$	$	$ 0
D. Equipment	$	$	$	$	$	$ 0
E. Supplies	$	$	$	$	$	$ 0
F. Contractual	$	$	$	$	$	$ 0
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0
H. Other	$	$	$	$	$	$ 0
I. Total Direct Costs	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
J. Indirect Costs	$	$	$	$	$	$ 0
K. Total (Sum of H and I)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
L. Program Income - Projected Earnings	$	$	$	$	$	$ 0

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM G-6).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with DSHS's Contract Policy & Monitoring Division.

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-DSHS state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

FORM G: BUDGET SUMMARY Instructions

An accurate budget plan is essential to achieve the performance measures and work plan set out in the narrative portion of the renewal application. All applicants shall complete the budget summary form. Be sure to refer to the appropriate sections in the renewal application for program-specific allowable and unallowable costs.

This form shall reflect funding from all sources that support the project described in this attachment. See "Detailed Budget Category Forms, General Information" for definitions of cost categories. For purposes of this form, the column headings have the following meanings:

Column 1: The amount of funds requested from the Department of State Health Services (DSHS) for this project.
Column 2: Federal funds awarded directly to applicant.
Column 3: Funds awarded to applicant from other State of Texas governmental agencies.
Column 4: Funds awarded to applicant by local governmental agencies (city, county, local health department, etc.).
Column 5: Funds from other sources not previously addressed in columns 1-4 (private foundations, donations, fund-raising, etc.).
Column 6: The sum of columns 1-5.

PROGRAM INCOME

Program Income: Projected Earnings. Applicant shall estimate the amount of program income that is expected to be generated during the budget period.

DEFINITION: Program income is the income resulting from fees or charges made by a contractor in connection with activities supported in whole or in part by a federal/state contract. Program income earned as a result of an effort which is jointly funded by DSHS and the contractor is to be shared by DSHS and the contractor. A program income allocation plan is the means by which DSHS's share is determined. The required formula for a plan is as follows:

$$\frac{\text{DSHS's Share of Funding}}{\text{DSHS's Share of Funding + Contractors Share of Funding}} \times \text{Total Program Income Collected} = \text{DSHS's Share of Program Income}$$

Contractor shall disburse program income rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting cash payments including advance payments from DSHS.

For more information about program income, refer to the Program Income Article in the General Provisions for DSHS Grants Contracts and/or request a copy of DSHS's Financial Administrative Procedures Manual on the Internet at http://www.tdh.state.tx.us/grants/form_doc.htm.

INSTRUCTIONS:
Projected Earnings. Applicant must enter on the BUDGET SUMMARY form the estimated amount of program income that is expected to be generated during the budget period.

Examples Of Program Income

- *Fees received for personal services performed in connection with and during the period of contract support;*
- *Tuition and fees when the course of instruction is developed, sponsored, and supported by the applicable contract from state or federal sources;*
- *Sale of services such as laboratory tests or computer time;*
- *Payments received from patients or third parties for medical or hospital service, such as Title XIX or Title XX reimbursements, insurance payments, or patient fees. These payments may be made under either a cost reimbursement or a fixed price agreement;*
- *Lease or rental of films or video tapes; and*
- *Rights or royalty payments resulting from patents or copyrights developed or acquired by the contractor.*

EXAMPLE

FORM G: BUDGET SUMMARY Example

Legal Name of Applicant: Apple County Health Department

Cost Categories	DSHS Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$ 27,900	$ 30,900	$ 5,000	$ 0	$ 0	$ 63,800
B. Fringe Benefits	$ 4,032	$ 5,030	$ 1,000	$ 0	$ 0	$ 10,062
C. Travel	$ 1,373	$ 2,070	$ 5,00	$ 0	$ 0	$ 3,448
D. Equipment	$ 2,060	$ 3,050	$ 2,050	$ 1,500	$ 0	$ 8,660
E. Supplies	$ 45,000	$ 46,000	$ 20,000	$ 5,500	$ 0	$ 116,500
F. Contractual	$ 41,208	$ 42,010	$ 15,000	$ 0	$ 0	$ 98,218
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0
H. Other	$ 23,000	$ 1,000	$ 500	$ 0	$ 0	$ 24,500
I. Total Direct Costs	$ 144,573	$ 130,060	$ 44,050	$ 7,000	$ 0	$ 325,683
J. Indirect Costs	$ 2,025	$ 900	$ 650	$ 0	$ 0	$ 3,575
K. Total (Sum of H and I)	$ 146,598	$ 130,960	$ 44,700	$ 7,000	$ 0	$ 329,258
L. Program Income	$ 13,200	$ 12,000	$ 4,200	$ 600	$ 0	$ 30,000

Indirect costs are based on (mark the statement that is accurate):

[x] The applicant's most recently approved indirect cost rate 7 % A copy is attached behind the OTHER Budget Category Detail Form (FORM G-6).

[ ] The applicant's most recently approved indirect cost rate _____ % which is on file with DSHS's Contract Policy & Monitoring Division.

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-DSHS state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

DETAILED BUDGET CATEGORY FORMS

General Information

Requirements for Categorical Budgets

The renewal application shall include a detailed breakdown of budget cost categories and a narrative justification. Details of each cost category shall be expressed using the budget category detail forms (G-1 to G-6), which follow. Definitions of the cost categories and instructions and examples of how to itemize the contents of each cost category are included after the budget category detail forms. Computer generated facsimiles may be substituted for any of the forms; however, the exact wording and format must be maintained.

General Information

Additional information on basic accounting and financial management systems requirements is available in DSHS's Financial Administrative Procedures Manual. Copies of the manual are available on the Internet at http://www.tdh.state.tx.us/grants/form_doc.htm.

Only those costs allowable under UGMS and any revisions thereto plus any applicable federal cost principles are eligible for reimbursement under this contract. Applicable cost principles, audit requirements, and administrative requirements are as follows:

Applicable Cost Principles	Audit Requirements	Administrative Requirements
OMB Circular A-87, State & Local Governments	OMB Circular A-133	UGMS
OMB Circular A-21, Educational Institutions	OMB Circular A-133	OMB Circular A-110
OMB Circular A-122, Non Profit Organizations	OMB Circular A-133 and UGMS	UGMS
48 CFR Part 31, For Profit Organization and other than a hospital and an organization named in OMB Circular A-122 as not subject to that circular	Program audit conducted by an independent certified public accountant must be in accordance with Governmental Auditing Standards.	

A. Allowable and Unallowable Costs

Below is a brief listing of allowable and unallowable costs as prescribed by federal cost principles or DSHS policy. Applicable federal cost principles provide additional information and guidance on allowable and unallowable costs.

An **allowable cost**, in accordance with federal cost principles, meets the following criteria:

1. It is necessary and reasonable for proper and efficient administration of the funded program;
2. It can be allocated to the funded program and is not a general expense needed to carry out the contractor's general responsibilities;
3. It is authorized or is not prohibited under applicable laws or regulations;
4. It conforms to applicable limitations or exclusions;
5. It is consistent with applicable policies and procedures;
6. It is treated consistently through the renewal application of generally accepted accounting principles appropriate to the circumstances;
7. It is not allocated or included as a cost of any other program; and
8. It is the net sum of all applicable credits.

Unallowable costs, i.e., costs that may not be paid with DSHS funds include, but are not limited to:

1. Advertising and public relations costs other than those specifically allowed by terms of the contract attachment or those incurred for the purpose of personnel recruitment, solicitation of bids and disposal of surplus materials;
2. Bad debts;
3. Construction is not allowed without the prior written approval of DSHS;
4. Contingency reserve funds;
5. Contributions and donations;
6. Entertainment costs including amusement/social activities and their related costs (meals, beverages, lodgings, rentals, transportation, and gratuities) are not allowed unless the costs are directly related to the program's purpose and DSHS has reviewed and issued prior written approval of the work plan components that relate to entertainment costs;
7. Fines, penalties, late payment fees, bank overdraft charges;
8. Fundraising;
9. Interest (unless specifically authorized by applicable cost principles or authorized by federal or state legislation);
10. Lobbying.

B. Direct Costs

Direct costs are those that can be specifically identified with a particular award, project, service, scope of work or other direct objective of an organization. These costs may be charged directly to the DSHS contract attachment (if contract is renewed). These costs may also be charged to cost objectives used to accumulate all costs pending distribution to specific contracts and other purposes. Direct cost categories include: personnel, fringe benefits, travel, equipment, supplies, contractual, and other.

C. Indirect Costs

Indirect costs are those costs related to the project that are not included in direct costs. Indirect costs are those costs incurred for a common or joint purpose benefiting more than one cost objective and not readily identified with a particular cost center and which may be paid if allowable under the funding source, e.g., depreciation and use allowances, interest, operation and maintenance expenses (janitorial and utility services, repairs and normal alterations of buildings, furniture, equipment, care of grounds, security), general administration and general expenses (central offices such as director, office of finance, business services, budget and planning, personnel, general counsel, safety and risk management, management information services).

The amount of indirect costs that may be charged to any resulting DSHS contract attachment is determined by negotiation and will be defined in the contract budget attachment. The applicant may negotiate an indirect cost rate with its federal cognizant agency or state-coordinating agency or develop a cost allocation plan that is kept on file and made available during compliance reviews.

D. Audit Requirements

If required by OMB Circular A-133 and/or UGMS, applicant or applicant's authorized contracting entity shall arrange for a financial and compliance audit (Single Audit). Applicant may include in the budget request an amount for DSHS's proportionate share of costs. The audit must be conducted by an independent CPA and must be in accordance with applicable OMB Circulars, Government Auditing Standards, and UGMS. Audit services shall be procured in compliance with state procurement procedures, as well as the provisions of UGMS.

FORM G-1: PERSONNEL Budget Category Detail Form

Legal Name of Applicant: _____

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required. Note: Applicant is responsible for understanding the potential impact of alternative Fringe Benefit options.

Salary Total	$ 0
Fringe Benefit Rate %	%
FRINGE BENEFITS TOTAL	$

EXAMPLE ORM G-1: PERSONNEL Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification
Financial Officer (E)	5%		$42,000	$2,100	N	Provides financial accountability of program
Administrative/Personnel (P)	5%		$36,000	$1,800	Y	Provides personnel services and training
Outreach Counselor (E)	100%		$24,000	$24,000	N	Provides outreach/case management services

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required. Note: Applicant is responsible for understanding the potential impact of alternative Fringe Benefit options.	Salary Total	$27,900
FICA 7.65% Worker's Comp 2.05% Retirement Plan 1.63% Health Insurance 3.12%	Fringe Benefit Rate 14.45 % FRINGE BENEFITS TOTAL	 $4,032

PERSONNEL

DEFINITION: The actual cost of salaries and wages paid to employees of the organization devoted to the DSHS funded project. These costs are allowable to the extent that they are reasonable and conform to the established, consistently applied policy of the organization and reflect no more than the time actually devoted to the project.

INSTRUCTIONS: Enter the following information for each position on the PERSONNEL Budget Category Detail Form: functional title, whether the position is existing or proposed, % of time dedicated to the project, any certification or license an individual must possess to be qualified for the position, the total annual salary, the amount of DSHS funds requested for this position's salary (% of time dedicated to the project multiplied by the annual salary), whether the position is vacant or filled, and the justification for the position. Justification may include a brief description of the position's primary responsibilities and an explanation for the % of time dedicated to the project, why the position classification is appropriate (including license/certification requirements), and an explanation of reasonableness of the annual salary.

FRINGE BENEFITS

DEFINITION: Fringe benefits are allowances and services provided by the organization to their employees as compensation in addition to regular salaries and wages. Fringe benefits include but are not limited to the cost of leave, employee insurance, pensions, and unemployment benefit plans. The cost of fringe benefits is allowable (in proportion to the amount of time or effort employees devote to the grant funded project), to the extent that the benefits are reasonable and are incurred under formally established and consistently applied policies of the organization. Note: Applicant is responsible for understanding the potential impact of alternative Fringe Benefit practices.

INSTRUCTIONS: Itemize the elements of fringe benefits and indicate the % rate on the PERSONNEL Budget Category Detail Form.

FORM G-2: TRAVEL Budget Category Detail Form

Legal Name of Applicant: _____

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$ 0	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom DSHS funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
							0	
							0	
							0	
							0	
							0	
							0	
TOTAL for Conf/Workshop TRAVEL:				$ 0	$ 0	$ 0	$ 0	

Local TRAVEL Costs: $ 0	Conf/Workshop TRAVEL Costs: $ 0	Total TRAVEL Costs: $ 0

NOTE: All contracts with the Department of State Health Services require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, DSHS's travel policy will be used.

EXAMPLE

FORM G-2: TRAVEL Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$ .31	1,068	$ 331	$ 144	$ 475	Executive Director – Travel to all site locations in the nineteen county area for review, monitor, evaluate, and oversee clinic operations.

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom DSHS funds	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
Family Planning Advisory Committee Meetings (4)	Austin	1	1,735 miles x $0.31/mile =	$538	$360	$0	$898	Clinic Services Director to attend Family Planning Committee meetings (4)
TOTAL for Conf/Workshop TRAVEL:				$538	$360	$0	$898	

Local TRAVEL Costs:	$475	Conf/Workshop TRAVEL Costs:	$898	Total TRAVEL Costs:	$1,373

NOTE: All contracts with the Department of State Health Services require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, DSHS's travel policy will be used.

TRAVEL

DEFINITION: The costs of transportation, lodging, meals and related expenses incurred by employees of the organization while performing duties relevant to the proposed project. This includes auto mileage paid to employees on the basis of a fixed mileage rate for the use of their personal vehicle. Costs related to client transportation and registration fees should be classified as "Other" expense category. Travel costs incurred by a third party under contract should be included within the terms of the contract and be budgeted under "Contractual" expense category.

INSTRUCTIONS: The TRAVEL Budget Category Detail Form requires information on local travel costs (travel and per diem) and information on conferences/workshops for which DSHS funding is being requested. For local travel, enter the reimbursement rate for automobile mileage and the estimated number of miles to be traveled for the budget period. To calculate the total estimated local travel costs, multiply the local reimbursement rate per mile by the total estimated number of automobile miles. Enter the estimated per diem costs which may be associated with local travel and show the basis for cost (15 partial days x $7 per partial day = $105). The justification should include who or what position classification(s) will be traveling and why local travel is necessary to accomplish the project. For conferences/workshops, the following must be included for all attending for whom DSHS funds are being requested: the

name and/or description of the conference/workshop, the location (city), the number of persons attending, estimated travel, per diem, other related travel costs (excluding registration fees) and total costs for all attending. The justification should include how attendance at the conference/workshop will directly benefit the project and why it is necessary to accomplish the project.

FORM G-3: EQUIPMENT Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (= $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for EQUIPMENT: $ 0.00

SAMPLE

FORM G-3: EQUIPMENT Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order.

DESCRIPTION OF ITEM (= $5,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
PhoneMaster Professional Autodialing Voice Organization-to-Client Communication System, with 2 year warranty	$5,250/1	$5,250	Phone system will confirm appointments and make autodial phone calls for outreach events. Reduction in staff time for follow-up calls and reduction in marketing/advertising expenses.
TOTAL Amount Requested for EQUIPMENT:		$ 5,250	

EQUIPMENT

DEFINITION: Equipment is defined by DSHS as non-expendable personal property with a unit cost of more than $5,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over $5,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is $500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the $500/$5,000 threshold.

INSTRUCTIONS: Enter the following information on the EQUIPMENT Budget Category Detail Form for each type of equipment item: description of each item, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), state the purpose for the item(s) and why the equipment is necessary and how the applicant determined or will determine that the cost is reasonable. Attach a complete specification or a copy of the purchase order.

EXAMPLES OF EQUIPMENT DESCRIPTIONS

Remember: Equipment is priced **per unit** including freight. If you intend to purchase 10 modems @ $95 each, this would be considered a supply item not an equipment item.

INCORRECT EXAMPLES	**CORRECT EXAMPLES**
Computer-850 Mhz Pentium 1 @ $2,150 *(insufficient description/specification)* 1 @ $250 Laser Jet Printer *(This item would be moved to supplies as it is less than $500.00).*	Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHz, .32 KB Internal Cache (L1), 100 MHZ (Pentium III) external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory. 1 @ $2,150 24" Zenith Portable TV/VCR Combination; Model #Z12345 1 @ $750

FORM G-4: SUPPLIES Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (i.e., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (= $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for SUPPLIES:		$ 0.00	

SAMPLE

FORM G-4: SUPPLIES Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (i.e., office, computer, medical, educational, janitorial, etc.).

DESCRIPTION OF ITEM (= $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Office supplies	$750/month / 12 months	$9,000	Consumable items needed to support Family Planning clinic services; no item has a unit cost greater than $499.
Pharmaceuticals	$2,500/month / 12 months	$30,000	Consumable items needed to support Family Planning clinic services; no item has a unit cost greater than $499.
TOTAL Amount Requested for SUPPLIES:		$ 39,000	

SUPPLIES

DEFINITION: Costs for materials and supplies necessary to carry out the program. This includes medical supplies, drugs, janitorial supplies, office supplies, patient educational supplies, software less than $500, plus any equipment or furniture with a purchase price including freight not to exceed $5,000 per item, except those listed in the "equipment" category.

INSTRUCTIONS: Enter the following information in the SUPPLIES Budget Category Detail Form for each general category or type of supplies: description of the items, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), and state the purpose for the item(s), why the supplies are necessary and how the applicant determined or will determine that the cost is reasonable.

FORM G-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Applicant: _____

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION
TOTAL Amount Requested for CONTRACTUAL:					$ 0	

EXAMPLE

FORM G-5: CONTRACTUAL Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION
Dr. Bob Health, D.O.	Oversees medical services	Unit Cost	month	$300	$3,600	Medical Director required by DSHS
Dr. Peter Paul, D.O.	Provides health history & physicals	Unit Cost	130 hours/ month	$3,034	$36,408	Contract physician at clinics performing medical exams
Dr. Billy Bob, D.O.	Provide professional guidance	Cost Reimburse	N/A	N/A	$1,200	Medical Consultant
				TOTAL Amount Requested for CONTRACTUAL:	$ 41,208	

CONTRACTUAL

DEFINITION: Activities identified in the scope of work that are delegated by the applicant to a third party; the cost of providing these activities is recorded in this category. Travel costs incurred by a third party while performing these activities should be included in this category. Contracts for administrative services are not included in this category; they are properly classified in the "Other " category.

If the applicant enters into grant contracts with subrecipients or procurement contracts with vendors, the documents will be in writing and will comply with the requirements specified in the Contracts with Subrecipients and Contracts for Procurement articles in the General Provisions for Department of State Health Services Grant Contracts which are available online at http://www.tdh.state.tx.us/grants/form_doc.htm.

If an applicant plans to enter into a contract which delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, the applicant must submit justification to DSHS and receive prior written approval from DSHS before entering into the contract.

INSTRUCTIONS: The CONTRACTUAL Budget Category Detail Form requires names of the individuals or organizations performing the services, a description of the services being contracted, the number of hours or units of service to be purchased, the method of reimbursement (cost reimbursement or unit cost), unit cost if applicable and total amount of each subcontract. Justification should include why applicant intends to contract for the service, why the service is necessary to perform the scope of work and how the applicant will ensure that the cost of the service is reasonable.

Justification for contracts that delegate a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, must be attached behind the CONTRACTUAL Budget Category Detail Form.

FORM G-6: OTHER Budget Category Detail Form

Legal Name of Applicant: _____

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$ 0

EXAMPLE

FORM G-6: OTHER Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

DESCRIPTION	# of units x unit cost if applicable	COST	PURPOSE & JUSTIFICATION
Telephone (23 lines)	12 months x $833.34 =	$10,000	Telephone service
Printing	12 months x $666.67 =	$8,000	Documents, forms, letters, and literature
Single Audit	1 x $5,000 =	$5,000	Single Audit (DSHS requirement)
TOTAL Amount Requested for OTHER:	$	23,000	

OTHER
DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

* contracts for administrative services;
* space and equipment rental;
* utilities and telephone expenses;
* data processing services;
* printing and reproduction expenses;
* postage and shipping;
* contract clerical or other personnel services;
* janitorial services;
* exterminating services;
* security services;
* insurance and bonds;
* equipment repairs or service maintenance agreements;
* books, periodicals, pamphlets, and memberships;
* advertising;
* registration fees;
* patient transportation;
* training costs, speakers fees and stipends.
* software less than $500

INSTRUCTIONS: The OTHER Budget Category Detail Form requires a general description of the service, and the cost. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity. The justification should also include a statement of when services will be utilized if other than the full renewal application budget period.

FORM G-7: BUDGET JUSTIFICATION

All agencies must provide a categorical budget justification for proposed HIV prevention services costs. Please refer to the guidelines on the following page when constructing budgets.

FORM G-7: BUDGET JUSTIFICATION
Guidelines

Submitted budgets must include the following categories: Personnel, Fringe, Travel, Equipment, Supplies, Contractual, Other, Total Direct Costs, Indirect Costs, and Total Budget. Additionally, items listed in the budget must bear a brief justification describing what is to be purchased. Refer to the sample categorical budget justification in the appendix. If purchasing equipment, agencies must complete and submit equipment justification forms. A sample Budget and Negotiation Tool is also included for *examples* of allowable, reasonable costs. Additional pages may be attached as needed.

Note: Agencies are instructed to include appropriate budget costs for staff to attend all trainings required through this contract. The required training schedule is attached for reference. Also, as discussed at the Forums held throughout the State, DSHS is moving towards adopting the Protocol-Based Prevention Counseling Model as the standard. Agencies should plan to budget to attend Protocol-Based Prevention Counseling trainings as well. Refer to the training schedule in the Appendix.

FORM H: NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM

If the applicant is a nonprofit organization, this form must be completed (state or other governmental agencies are not required to complete this form). The purpose of the form is to inform nonprofit board members and officers of the responsibilities and administrative oversight requirements of nonprofit applicants intending to or contracting with Department of State Health Services (DSHS).

(Name & Address Of Organization)

The persons signing on behalf of the above named organization certify that they are duly authorized to sign this Assurances form on behalf of the organization. The undersigned acknowledge and affirm:

A. That an annual budget has been approved for each contract with DSHS.

B. The Board of Directors convenes on a regularly scheduled basis (no less than quarterly) to discuss the operations of the organization.

C. Actual revenue and expenses are compared with the approved budget, variances are noted, and corrective action taken as needed (with Board approval).

D. Timely and accurate financial statements are presented by the designated financial officer on a regular basis to the board.

E. That the Board of Directors will ensure that any required financial reports and forms, whether federal or state, are filed on a current and timely basis.

F. Adequate internal controls are in place to ensure fiscal integrity and accountability and to safeguard assets.

G. The Treasurer of the Board has been fully informed of his or her responsibilities as Treasurer.

H. The Board has Audit and/or Finance Committees that convene regularly and communicate effectively with the Board Treasurer and other Board members in understanding and responding to financial developments.

I. The organization observes Generally Accepted Accounting Principles when preparing financial statements and fund accounting practices are observed to ensure integrity among specific contracts or grants.

J. If a contract is executed with DSHS, this form will be discussed in detail at the next official Board meeting and that notes of the discussion and a signed copy of this form will be included in the minutes of the meeting. A copy of the minutes will be kept at the organization and be available for inspection by DSHS staff.

K. If a contract is executed with the DSHS and the nonprofit organization has not received any funding from DSHS for the past 24 months, the Legal and Fiscal Responsibilities for Nonprofit Board of Directors Video and Guide will be viewed and a signed "tear-out" sheet will be completed and filed by each board member with the nonprofit organization no later than 45 days after contract execution. Newly appointed/elected board members will comply with these requirements no more than 45 days after taking office. All tear-out sheets will be available for inspection by DSHS staff.

L. The organization will administer any contract executed with the DSHS in accordance with applicable federal statutes and regulations, including federal grant requirements applicable to funding sources, Uniform Grant Management Standards issued by the Governor's Office, applicable Office of Management and Budget Circulars, applicable Code of Federal Regulations, and provisions of the contract document.

***Chairman of the Board Signature/Date**

***President or Executive Director Signature/Date**

*If the signed original of this form has been provided to DSHS during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.

INSTRUCTIONS AND EXAMPLES
FOR A CATEGORICAL BUDGET JUSTIFICATION

TOTAL

A. PERSONNEL **101,604**

[List each position. Give a brief job description of 50 words or less. For each position listed, multiply the monthly salary or wages by the percentage of personnel time by the number of months which the salary is to be paid from this budget.]

Example:
Executive Director (Gonzales) **1,920**
$3,200/monthly X 5% X 12 = $1920

Oversees all program activities. Ensures compliance with contract requirements. Provides program/financial information to the Board of Directors. Acts as agency personnel director and public spokesperson. supervises Program Manager.

Bookkeeper (Jones) **1,800**
$1,500/monthly X 10% X 12 = $1800

Performs full charge bookkeeping duties. Inputs transaction data and produces general ledger, income/expense statements and balance sheets. Maintains and produces payroll. Checks invoices for accuracy and prepares them to be approved for payment. Prepares accounts payable.

Program Manager (Watson) **12,384**
$2,580/monthly X 40% X 12 = $12,384

Supervises Prevention Counselor and Outreach Educator. Provides needed staff training. Coordinates prevention programming. Designs and maintains data collection system. Prepares all required program reports. Evaluates staff performance and conducts quality assurance.

HIV Prevention Counselor (McDade) **28,500**
$2,375/monthly X 100% X 12 = $28,500
Conducts HIV prevention counseling and testing through street outreach targeting IDUs, sex partners of IDUs and females who sell sex for drugs or money. collect and maintain accurate program data. Make appropriate referrals for services. Distribute condoms. Performs partner elicitation activities with HIV-positive clients.

HIV Prevention Counselor/Outreach Educator (Vacant) **28,500**
$2,375/monthly X 100% X 12 = $28,500

Conducts street outreach with UHS high-risk adolescents. Does one-on-one and small group education and risk reduction skills training at appropriate sites (hang-out street corners, juvenile detention centers, youth shelters). Provide

	TOTAL
prevention counseling and testing at these same locations. Conduct partner elicitation. Collect and maintain accurate program data. Make appropriate referrals for services. Distribute condoms.	
Outreach Educator (New position) (attach Job description) **$2,375/monthly X 100% X 12 = $28,500**	**28,500**
Conduct street outreach and small group activities with MSMs of Color. Conduct one-on-one risk reduction and education at bars, public sex environments, and other places the population congregates. Provide risk-reduction and self-esteem building small groups. Distribute condoms and make referrals. Design literature which is language and culturally appropriate. Collect and maintain accurate program data.	

B. FRINGE BENEFITS **(Total)**

[Itemize the cost of fringe benefits paid for employees, including employer contributions for Social Security, retirement, insurance and unemployment compensation. Fringe benefits requested must represent the actual benefits paid for employees.]

Example:

FICA: 0.765 x $101,604 =	**7,773**
Insurance: $2,160 x 3.55 FTEs =	**7,668**
Worker's Comp: rate x salaries = $	**$**
Unemployment: rate x salaries = $	**$**

C. STAFF TRAVEL **(Total)**

[Budget the projected costs of transportation, lodging, meals, and related expenses for official staff business travel conducted in carrying out the contract. Out of state travel is only allowed with pre-approval from the DSHS. Costs for travel to the Texas HIV/STD Conference Austin and to staff training and development meetings should be included, if applicable. NOTE: Grantees who do not have written travel reimbursement policies must use DSHS travel reimbursement rates as follows: $.345/mile, $30/day meals, $80/day lodging.]

Example:	
Mileage for Prevention Counselors in service area: **$0.345/mile X 300 miles/mo. X 12 months - $1,242**	**1,242**
Mileage for Outreach Educators in service area: **$.345 mile X 300 miles/mo. X 12 months - $1,242**	**1,242**
Expenses for 3 staff members to attend Texas HIV/STD Conferences: **Airfare @ $175 X 3 staff = $525** **Lodging @ $80 X 4 days X 3 staff = $960** **Meals @ $30 X 4 days X 3 staff = $360**	**1,845**

D. EQUIPMENT **(Total)**

[Equipment is defined by DSHS as non-expendable personal property with a unit cost of more than $5,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over $5,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is $500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the $500/$5,000 threshold.]

E. SUPPLIES **5,575**

[Costs for materials and supplies necessary to carry out the program. This includes medical supplies, drugs, janitorial supplies, office supplies, patient educational supplies, software less than $500, plus any equipment or furniture with a purchase price including freight not to exceed $5,000 per item, except those listed in the "equipment" category.]

Example:

General office supplies - $100 mo x 12 mo	**1,200**
Education Supplies - $2,800 **Includes: supplies for safer sex kits (lubricants, oral sex condoms, female condoms, etc.)**	**2,800**
Phlebotomy supplies - $1,000	**1,000**

F. CONTRACTUAL **(Total)**

Whenever the applicant intends to delegate part of the activities identified in the scope of work to a third party, the cost of providing these activities is recorded in this category. If an applicant plans to enter into a contract in which a subrecipient will receive a substantial portion of the scope of the project, i.e. $25,000 or 25% of the applicant's funding request whichever is greater, the applicant shall submit justification to TDH and receive prior written approval from DSHS before entering into the contract. A detailed eight-category budget justification or fee-for-service budget must be submitted for each proposed subcontract.

G. OTHER

(Total)

All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

1. **Space and equipment rental**
2. **Staff Development and training**
3. **Utilities and telephone expenses**
4. **Printing and reproduction expenses**
5. **Lease (not purchase) of photocopier or other equipment**

6. **Postage and shipping**
7. **Temporary staff obtained through an employment agency**
8. **Contract CPA or bookkeeping services, or other contracts not related to direct client services**
9. **Cost of external audit**
10. **Insurance and bonds**
11. **Equipment repairs or services (maintenance agreements, etc.)**
12. **Books, periodicals, pamphlets, and memberships**
13. **Advertising**
14. **Conference registration fees and other training costs**
15. **Janitorial services**
16. **Consulting fees (not allowed for preparation of grants to the DSHS). Requires prior approval from the DSHS. May include cost of preparing HIV prevention grants from other sources. May include cost of technical assistance not provided by the DSHS. Written justification must be submitted.**
17. **Contracts for administrative services.**

H. TOTAL DIRECT COSTS **(Total)**

[Enter the total of A - G above]

I. INDIRECT COSTS **(Total)**

[A copy of the current negotiated indirect cost rate must be attached, if applicable. If there is no negotiated rate, applicant may recover up to 10% of the direct salary and wage costs of providing the service, excluding overtime and fringe benefits, subject to adequate documentation of salary and wage costs.]

J. TOTAL BUDGET **(Total)**

BUDGET and NEGOTIATION TOOL FOR 2005 PREVENTION CONTRACTS

CONTRACTOR

SCOPE(S) OF WORK

This tool has been revised to focus attention on determining if budget items are allowable, reasonable, and in compliance with regulations and policies.

Note regarding "justification": several items in this tool require "adequate written justification" if the cost exceeds the guideline of reasonableness. Justification is also required for certain charges including consultant fees and subcontractors. The agency may include this written justification as part of their budget or attach it as a separate document. Approval must come from at least the Field Operations Supervisor level, and the individual approving the cost should initial in the appropriate space.

I. PERSONNEL

A. Direct Prevention Staff: Is the DSHS portion of the annual salary reasonable ***(guideline: between $22,000 & $37,000 per FTE)?***

YES _____ NO _____

DSHS will contribute a reasonable amount (up to $37,000 /yr) for this position in return for one full FTE. Contractors who wish to pay more must demonstrate why a higher salary is reasonable, or must pay the additional amount from ***unrestricted funds***. A higher salary would theoretically be reasonable if the agency were able to demonstrate a community-wide standard of salary at the higher level for this type of work. If the agency pays additional from unrestricted funds, DSHS would still expect one full FTE to be devoted to the grant.

If the salary is above $37,000 /FTE, was adequate justification received in writing? This must include an acceptable rationale (with detailed information) or assurance that any amount over $37,000 comes from unrestricted funds.

YES _____ NO _____ **Team Leader Initials:** _____

Please attach justification and provide brief summary below:

If below $22,000, please describe any questions or concerns discussed with contractor:

B. Direct supervisors of program staff: Is the DSHS portion of the annual salary reasonable ***(guideline: between $25,000 and $42,000 per FTE)?***

YES _____ NO
If above $42,000 was adequate justification received in writing (the same requirement as in item A. above)?

YES _____ NO _____ **Team Leader Initials**_____

Please attach justification and provide brief summary below:

If below $25,000, please describe any questions or concerns discussed with contractor:

C. Administrative Salary and Fringe Costs: Includes the salary for support staff, executive director, financial officer, and other administrative staff and their portion of the fringe. This does not include program staff and their direct supervisors. Is this cost reasonable (guideline: less than or equal to 10% of the total budget)?
This does not include costs from any budget category other than Personnel and Fringe (please note this is different from the HRSA-mandated 10% admin cap definition used with RW).

YES _____ NO

If no, was adequate justification received in writing?

YES _____ NO

Team Leader Initials____

Please attach justification and provide brief summary below:

Approved Personnel Amount: $
Comments:

II. FRINGE

Fringe rates must be based upon itemized costs for FICA, Insurance, etc. Allowable costs include health/life/disability insurance, retirement, workers compensation, and unemployment insurance.

Are the above requirements met? YES _____ NO
Approved Fringe Amount: $
Comments:

III. TRAVEL:

Guideline: less than 10% of the budget total

A. Local Travel (includes project work and training): Are the costs reasonable based on the job duties of the employees?

YES _____ NO

B. DSHS Conference: costs for hotel, transportation, and per diem are allowed for each FTE. Do costs fit within this guideline?

YES _____ NO

C. Street Outreach Conference: Are costs for this conference appropriate to the scope of work? If yes, costs for hotel, transportation, and per diem are allowed for each FTE. Do costs fit within this guideline?

YES _____ NO

D. Out-of-state travel: cost must be approved by the DSHS in advance. Written justification must be submitted which documents that the purpose of the travel is a specific training opportunity that is critical to the program operations and is not available in Texas.
Is out-of-state travel included?

YES _____ NO

If yes, was adequate justification received in writing?

YES _____ NO

Team Leader Initials_____

Please attach justification and provide brief summary below:

E. Other Travel: Program development opportunities.
Are costs related to program development?

YES_____ NO_____

F. For all travel: If state rates are not used for per diem, hotel and mileage, the contractor must have **a local policy which establishes their travel reimbursement rates.**
Does the contractor use state rates? Hotel $80.00 per night; Meals $30.00 per day; $.345 per mile.
YES _____ NO _____
If no, was it confirmed that they have an established local policy?

YES _____ NO

Please inform the agency that the Grants Management Division will review the policy during their monitoring visits. DONE _____ (FO Consultant initial and date)

G. If costs are above guideline was adequate justification received in writing?

YES _____ NO _____ **Team Leader Initials**_____

Please attach justification and provide brief summary below

Approved Travel Amount: $

Comments:

IV. EQUIPMENT

Manufacturer specifications including an update price will need to be submitted again, 30 (thirty) days prior to the contract execution date.

Equipment will only be approved if it is necessary for the program to meet its program reporting requirements or to conduct DSHS required activities.

Are Equipment Justification form(s) and an Equipment List from the RFP completed for requested equipment?

YES _____ NO

If the contractor is a current Texas Department of State Health Services (DSHS) HIV Prevention contractor then they must submit an inventory list, which includes all equipment purchased with DSHS HIV Prevention funds within the last 5 (five) years.

Was an inventory list included?

YES _____ NO _____

A. Computer: Up to three computers may be requested per agency every four years. Maximum cost is $1,700 desktop; $2,900 laptop. Equipment must meet the attached specifications. Because computer costs tend to fluctuate, refer to the website to acquire current price listings on the ***Bureau Web-page www.tdh.state.tx.us/hivstd, click on Funding Information, then click on Common Forms and Documents, finally, click on PCSPECS.***
If the contractor is requesting more than three computers to be purchased, has the program submitted adequate justification?

YES _____ NO _____ **Team Leader Initials** _____

If computer is being purchased, has program submitted written specifications and prices from the manufacturer, which meet standards?

YES _____ NO _____

Did the Data and Technical Support Branch approve the specifications?

YES _____ NO _____ Staff member:

Is cost less than or equal to $1,700 for desktop?

YES _____ NO _____

Is cost less than or equal to $2,900 for laptop?

YES _____ NO _____

B. Fax Machine: One fax machine is allowed per agency if a plain paper fax has not been purchased for the program in the past four years. Is the cost reasonable (guideline: less than $2,000)?

If fax machine is purchased:

Is cost less than or equal to $2,000?

YES _____ NO

If the program is a current DSHS HIV prevention contractor, has the agency purchased another plain paper fax in the past 4 years?

YES ___ NO _____

If yes, was adequate justification for a new machine received in writing?

YES _____ NO _____ **Team Leader Initials**_____

Please attach justification and provide brief description below:

C. Other equipment (VCR, TV, printer etc.) must be approved by the DSHS. Article 19 of the contract General Provisions defines equipment as "tangible non-expendable property with an acquisition cost of over $1000 and a useful life of more than one year with the following exceptions: fax machines, stereo systems, cameras, video recorder/players, microcomputers, and printers. These exception items will still be considered equipment if their unit cost is over $500."

Does the other equipment request relate to the contractor's workplan, and are the costs reasonable?

YES _____ NO _____ N/A

Approved Equipment Amount: $
Comments:

V. SUPPLIES

A. Office supplies:
1. New FTE's funded under the contract: (guideline: up to $1000 per year per FTE). This cost includes one-time expenditures such as office furniture.
2. Existing FTE's: (guideline: up to $500 per year per FTE).

B. Project Supplies: all participant supplies must be itemized and related to the workplan (guideline: should be less than 10% of the total budget).

Are the costs for office supplies and project supplies reasonable?

YES _____ NO

If costs are above guideline was adequate justification received in writing?

YES _____ NO _____ **Team Leader Initials**

Please attach justification and provide brief summary below:

Approved Supplies Amount: $

Comments:

VI. CONTRACTUAL

ALL SUBCONTRACTORS MUST BE NAMED

Adequate written justification is required for a provider to contract with another agency for the provision of services. The following documentation must be submitted:

1) Subcontractor data sheets for each subcontractor and
2) Subcontractor budgets.

If agency subcontracts services, have the above requirements been met?

YES _____ NO _____ **Team Leader Initials**

SUBCONTRACTOR	AMOUNT
1.	
2.	
3.	
TOTAL	

Approved Contractual Amount: $

Comments:

VII. OTHER

A. Training costs including speaker's fees and stipends are reasonable (guideline: up to $500 per year per DSHS-funded FTE).

Costs are reasonable?

YES _____ NO _____ N/A

Please attach justification and include brief summary below if costs are over guideline.

B. Registration fees for training courses, including DSHS conferences and or Outreach Conference, are allowable ***(guideline: up to $500 per year per FTE).***

Costs are reasonable? YES _____ NO _____ N/A

Please attach justification and include brief summary below if costs are over guideline.

C. Consultant Fees

-The costs for consultant fees and services listed below are allowed:

-Charges for hiring consultants to prepare applications for other funding sources if the proposed activities are consistent with the DSHS contract scope of work.

-Any management studies to improve management effectiveness and efficiency for ongoing programs.

-The costs of professional and consultant services necessary to successfully carry out the program objectives and/or the administrative responsibilities of the provider. These services may include activities such as analysis and improvement of work systems or management systems, installation and training on accounting software, and similar activities.

-The following costs for consultant fees and services are not allowed:

-Consultant cost related to performing program evaluation.

-Consultant costs related to providing technical assistance when the technical assistance needs can be met by DSHS staff.

-Costs for legal, accounting and consulting services and related costs incurred in connection with defense of an antitrust suit or prosecution of claims against the state or federal government, and

-Costs of consulting services and related costs incurred in connection with patent infringement litigation.

Consultant fees are requested?

YES _____ NO

If YES, does the contractor have a copy of HIV/STD Policy #520.001, **Consultant Services and Consulting Fees Paid By a Contractor Through Direct Costs?**

YES _____ NO _____ If NO, mailed copy to contractor - Initials

Please attach justification for consultant fees/services.

D. Other costs (rent/utilities, telephone, accounting/audit expenses, liability insurance, etc.) should be based on a cost allocation plan if contractor has multiple funding sources.

Does contractor have a cost allocation plan? (The contractor does not have to send you the plan, but should indicate whether they have one.)

YES _____ NO _____

If no, refer contractor to GMD for telephone technical assistance.

E. Are client tangible reinforcements (incentives) included?

YES _____ NO_____

If yes, answer the following:

1. Does the applicant have guidelines and systems in place to accurately account for the use/distribution of the tangible reinforcement? **If no, tangible reinforcements should not be allowed.**

YES _____ NO_____

2. Are the cost of the tangible reinforcements reasonable?

YES _____ NO _____

3. Is the tangible reinforcement a specific line item in the budget with the amount and/or unit cost described?

   YES _____ NO_____

4. Are there descriptions for each different type of tangible reinforcement?

   YES _____ NO _____

F. Do "Other" costs appear reasonable?

YES _____ NO _____ If no, request justification.

G. Any required justifications for the Other category (A-E above) have been received, reviewed, and approved?

YES _____ NO_____ Team Leader Initials

Approved Other Amount: $

Comments:

VIII. INDIRECT

Agency must have approved rate or use 10% or less of total cost in the Personnel category.

Standard met?

YES _____ NO _____ N/A

Approved Indirect Amount: $

Comments:

TOTAL BUDGET AMOUNT APPROVED: $

REVIEWER: _____ DATE:_____

AGENCY:

EQUIPMENT LIST

(To be completed if more than one item of equipment will be purchased.)

Equipment is defined by DSHS as non-expendable personal property with a unit cost of more than $5,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over $5,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is $500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the $500/$5,000 threshold

ITEM (≥ $5000 or Exceptions)	**UNIT COST**	**TOTAL PER ITEM (unit cost X no. of units)**	**PURPOSE**
TOTAL REQUEST			

JUSTIFICATION FOR REQUEST FOR EQUIPMENT PURCHASES

Instructions: Use one Justification form for each item listed on the Equipment List. Attach copies of specifications and/or other pertinent documentation. For computer equipment, complete specifications must be attached.

Contractor Name: _____

Scope of Work: _____

Contract Number: _____ Contract Term: _____

Description of Equipment Requested (attach additional sheets if necessary and copies of specifications and/or other pertinent documentation):

ALL APPLICANTS MUST COMPLETE THIS SECTION:

1. Does the cost include shipping and handling?

2. Does the cost include a warranty?

3. Does the cost include a maintenance agreement? Describe any special maintenance needs, service contracts, insurance, repair costs, etc. related to the proposed equipment. How will these expenses be supported over time?

4. Does the cost include training in the use of the equipment?

5. Why is the equipment needed? What is the purpose of the equipment?

6. Estimate the expected results of the equipment purchase. Who will benefit and how?

7. How many clients will be served with the equipment?

8. What administrative or other activities will be accomplished as a result of the equipment purchase?

9. Where will it be located?

10. Who will use the equipment? Are the necessary staff in place to support the proper use of the equipment (e.g., if a van is requested, is there funding already in place to pay for a driver)?

11. Will the equipment replace any existing equipment? If so, please justify the replacement of existing equipment.

12. Will the equipment be purchased and owned by the administrative agency or by one of its current subcontractors?

13. Why is this equipment more appropriate than other alternatives considered or a less expensive piece of equipment? If the equipment has special or optional features, explain why they are necessary.

14. If the equipment is a lease-to-purchase agreement, is a copy of the agreement attached?

15. If the equipment is being leased with no option to buy, explain the benefit(s).

16. If lease-purchase costs are spread across several funding sources, other than DSHS, who are the other funding sources and what is their percent of funding?

HIV SERVICES PROVIDERS ONLY:

17. If equipment is for an Administrative Agency or its subcontractor, does it match the service priorities established by the local consortia? Will the equipment be used to directly provide a prioritized client service? If not, how will the equipment either indirectly support client services and/or support necessary administrative functions?

18. If requesting computer equipment, does the program use the COMPIS program?

19. If yes, what is the memory capacity of the computer equipment currently used for COMPIS activity?

20. Does the computer requested have a larger memory capacity than the current COMPIS equipment?

21. What enhancements will the new computer(s) provide?

Required Trainings

ACTIVITY	COURSE TITLE	PARTICIPANTS *	PREREQUISITE	REQUIREMENTS
PCPE-PCM	Prevention Counseling and Partner Elicitation training (PCPE) Course	PCPE, PCM and applicable EBI program staff (e.g. SMART and Turning Point).	Successful completion of self-study PCPE pre-course	Successful completion of RECEIVING AGENCY recognized course within six (6) months of employment.
ALL	Supervisor's Course	ALL PCPE, PCM and EBI Supervisors	PCPE and PCM Supervisors must complete PCPE and PCM training. EBI supervisors must complete Bridging Theory	ALL Supervisors shall attend this course within one (1) year of becoming a supervisor.
PCPE-PCM	Prevention Case Management (PCM) Course	ALL PCM Case Managers and Supervisors	N/A	Successful completion within one year of becoming a PCM or supervising a PCM
ALL	Bridging Theory and Practice	EBI Program staff required. PCPE-PCM staff recommended.	N/A	Complete training within one (1) year of employment.
ALL	Community Assessment Methods	All EBI Program staff and PCPE-PCM Supervisors	N/A	Complete training within one (1) year of employment.
EBI	Introduction to Facilitation	All EBI Program staff	N/A	Complete training within one (1) year of employment.
ALL	Cultural Competency Training DSHS provided or approved training	All PERFORMING AGENCY staff supported by this contract Attachment	N/A	Successful completion within one (1) year of employment. Course shall be repeated as necessary based upon PCPE-PCM supervisor evaluation of PERFORMING AGENCY staff.
ALL	STD Facts and Fallacies	PERFORMING AGENCY Program staff	N/A	Complete training within two years of employment.

*Program staff include those conducting the intervention and their supervisors.

Protocol-Based Prevention Counseling Training Schedule

Week 1	Supervisor Mega Training Austin (**5-day training for supervisors and team leaders in Austin Texas**)
Week 2	Practice at Local Office (No travel required)
Week 3	TA/Observation of Supervisors (No travel required)
Week 4	TA/Observation of Supervisors (No travel required)
Week 5	Staff preceptorships begin (No travel required)
Week 6	Staff preceptorships (No travel required)
Week 7	Training of Group A (**4-day training for half of agency staff**)
Week 8	Training of Group B (**4-day training for second half of agency staff);** TA/Observation of Group A
Week 9	TA/Observation of Group B [and Group A as needed] (No travel required)
Week 10	Final Week of TA/Observations if needed (No travel required)
Week 11	Follow-up phone calls; TA/Observations as needed (No travel required)