STATE SERVICES RENEWAL PROCESS FORMS

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RENEWAL APPLICATION CHECKLIST

Legal Name of Applicant	

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

DESCRIPTION	Included		Not Applicable
Renewal Application Checklist completed and included	☐		
Contact Person Information completed and included	☐		
Performance Measures included	☐		
Work Plan included	☐		
Categorical Budget Justification included	☐		
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.	☐		
Assurances only applicable if signature authority has changed			
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.	☐		
HIV Contractor Assurances	☐		
Contractor Assurance Regarding Pharmacy Notification	☐		
Assurance of Compliance with CDC and DSHS Requirements for Contents of HIV/STD-Related Written Educational Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions	☐		
Assurance Regarding HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services	☐		
Tables 1 and 2 are due NO LATER THAN OCTOBER 1, 2006			
Table 1: Services Priorities, Allocations, and Objectives Due no later than October 1, 2006	☐		
Table 2: State Services Planned Allocations Due no later than October 1, 2006	☐		

CONTACT PERSON INFORMATION

Legal Name of Applicant: ______________________________

This form provides information about the appropriate program contacts in the applicant's organization. If any of the following information changes during the term of the contract, please notify the HIV/STD Comprehensive Services Branch.

Executive Director: ____________________
Title: ____________________
Phone: ____________________ Ext.
Fax: ____________________
E-mail: ____________________

Mailing Address (incl. street, city, county, state, & zip):

Project Contact: ____________________
Title: ____________________
Phone: ____________________ Ext.
Fax: ____________________
E-mail: ____________________

Mailing Address (incl. street, city, county, state, & zip):

Financial Reporting Contact: ____________________
Title: ____________________
Phone: ____________________ Ext.
Fax: ____________________
E-mail: ____________________

Mailing Address (incl. street, city, county, state, & zip):

Data Reporting Contact: ____________________
Title: ____________________
Phone: ____________________ Ext.
Fax: ____________________
E-mail: ____________________

Mailing Address (incl. street, city, county, state, & zip):

Clinical Services Contact: ____________________
Title: ____________________
Phone: ____________________ Ext.
Fax: ____________________
E-mail: ____________________

Mailing Address (incl. street, city, county, state, & zip):

Board Chairperson: ____________________
Title: ____________________
Phone: ____________________ Ext.
Fax: ____________________
E-mail: ____________________

Mailing Address (incl. street, city, county, state, & zip):

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. ***A maximum of 3 additional pages may be attached if needed.***

WORK PLAN

Applicant 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. ***A maximum of ten additional pages may be attached if needed.***

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 (see Appendix C, *Minimum Computer Equipment Specifications*).

Contractor Name: ____

Scope of Work: ____

Contr act Number: _______________________**Contract Term:** _____________________

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

ALL APPLICANTS REQUESTING FUNDS FOR EQUUIPMENT 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 res ults 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? Is 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:

1. If equipment is for an Administrative Agency or its subcontractor, does it match the service priorities established by the local Planning Assembly? 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?

2. If requesting computer equipment, will the computer be used for reporting client data through ARIES?

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

TABLE 1: SERVICES PRIORITIES, ALLOCATIONS AND OBJECTIVES BY HIV SERVICE DELIVERY AREA (HSDA)

Administrative Agency Name: ____

HIV Service Delivery Area: ____

Date of Service Delivery Plan: ____

Instructions: Table 1 must be completed for EACH HSDA within the Administrative Agency's area. Use this table to reflect the service priorities established as a result of your last needs assessment process. Place the ranking number of each prioritized service in column 2. Assign a ranking only to those services you have prioritized. Leave the rest of the service categories blank. Use columns 3 and 4 to show your numerical objective for each priority. In column 3, show the number of units to be provided and in column 4 show the number of persons to be served In column 5, state the budget amount allocated to that service category (includes administrative costs of delivering the service), and in column 6 indicate what percentage of the total Title II award is allocated to that service category.

SERVICE CATEGORY*	RANKING	OBJECTIVE		SS ALLOCATION FOR HSDA	% OF TOTAL SS ALLOCATION
		Units*	Persons		
1. Ambulatory/Outpatient Medical Care				$	%
2. Mental Health Services				$	%
3. Oral Health				$	%
4. Substance Abuse Services - Outpatient				$	%
5. Substance Abuse Services - Residential				$	%
6. Rehabilitation Services				$	%
7. Home health care – Para-professional				$	%
8. Home health care – Professional				$	%
9. Home health care – Specialized				$	%
10. Case Management				$	%
11. Residential or In-home Hospice Care				$	%
12. Treatment Adherence Counseling				$	%
13. Buddy/Companion Service				$	%
14. Client Advocacy				$	%
15. Legal Services				$	%
16. Day or Respite Care for Adults				$	%
17. Emergency Financial Assistance				$	%
18. Housing Assistance & Housing-related Services				$	%
19. Food Bank/Home-delivered Meals				$	%
20. Nutritional Counseling				$	%
21. Transportation Services				$	%

TABLE 1/2

22. Outreach Services				$	%
23. Counseling and Testing Services to PLWHA (Early Intervention Services for Title I & II)				$	%
24. Psychosocial Support Services				$	%
25. Permanency Planning				$	%
26. Child Care Services				$	%
27. Child Welfare Services				$	%
28. Health Education/Risk reduction				$	%
29. Referral to Health Care/Supportive Services				$	%
30. Referral to Clinical Research				$	%
31. Developmental Assessment/Early Intervention Services of Infants and Children				$	%
32. Drug Reimbursement – Local/Consortium				$	%
33. Health Insurance				$	%
34. Other Direct Support Services (**Attach sheet detailing services**)[1]				$	%
35. TOTAL DIRECT SERVICES				$	%
36. Capacity Building (AA only)[2]				$	%
37. Needs Assessment/Planning[2] /Evaluation (AA only)				$	%
38. Quality Management Plan (AA only)[2]				$	%
39. Grantee Administrative Costs[2](AA only)				$	%
40. TOTAL GRANT BUDGET[3]				$	100%

I verify that the service priorities and resource allocations listed on this form are accurate and have been submitted to DSHS Planning Group for a second review.

RWAA Planner Signature: _______________________________ Date:____________

1A Glossary of HIV-Related Service Categories and Administrative Services is included in the FY2007 Renewal Application.

2 The sum of lines 36, 37, 38, and 29 cannot exceed the allowable non-service costs from the Administrative Agency's home HSDA.

3 Amount should match the total amount allocated to your Administrative Agency by DSHS based on the formulary and as shown in the Allocations table for this renewal application.

TABLE 2: STATE SERVICES PLANNED ALLOCATIONS
SUMMARY FOR ALL HSDA'S

Administrative Agency Name: ____

HIV Service Delivery Area(s): ____

Date of Service Delivery Plan:
____

Instructions: Use this table to report the total planned allocations by service category for all HSDA's administered by your agency. Note that subcontractor administrative costs must be shown as a separate allocation (see line 36). The allocation amount shown for each service category must not include administrative costs of delivering the service.

SERVICE CATEGORY	SS ALLOCATION FOR ALL HSDA'S	% OF TOTAL SS ALLOCATION
1. Ambulatory/Outpatient Medical Care	$	%
2. Mental Health Services	$	%
3. Oral Health	$	%
4. Substance Abuse Services - Outpatient	$	%
5. Substance Abuse Services - Residential	$	%
6. Rehabilitation Services	$	%
7. Home health care – Para-professional	$	%
8. Home health care – Professional	$	%
9. Home health care – Specialized	$	%
10. Case Management	$	%
11. Residential or In-home Hospice Care	$	%
12. Treatment Adherence Counseling	$	%
13. Buddy/Companion Service	$	%
14. Client Advocacy	$	%
15. Legal Services	$	%
16. Day or Respite Care for Adults	$	%
17. Emergency Financial Assistance	$	%
18. Housing Assistance & Housing-related Services	$	%
19. Food Bank/Home-delivered Meals	$	%
20. Nutritional Counseling	$	%
21. Transportation Services	$	%
22. Outreach Services	$	%

23. Counseling and Testing Services to PLWHA (Early Intervention Services for Title I & II)	$	%
24. Psychosocial Support Services	$	%
25. Permanency Planning	$	%
26. Child Care Services	$	%
27. Child Welfare Services	$	%
28. Health Education/Risk reduction	$	%
29. Referral to Health Care/Supportive Services	$	%
30. Referral to Clinical Research	$	%
31. Developmental Assessment/Early Intervention Services of Infants and Children	$	%
32. Drug Reimbursement – Local/Consortium	$	%
33. Health Insurance	$	%
34. Other Direct Support Services (**Must be a service Attach sheet detailing services provided.)**[1]	$	%
35. TOTAL DIRECT SERVICES	$	%
36. Subcontractor administrative costs[2]	$	%
37. Capacity Building (AA only)[3]	$	%
38. Needs Assessment/Planning /Evaluation (AA only)[3]	$	
39. Quality Management Plan (AA only)[3]	$	%
40. Grantee Administrative Costs[3] (AA only)	$	%
42. TOTAL SS CONTRACT BUDGET[4]	$	100%

I verify that the service and administrative costs listed on this form are accurate.

RWAA Planner Signature: ________________________________ Date:_____________

1A Glossary of HIV-Related Service Categories and Administrative Services is included in the FY2007 Renewal Application.
2 Amount may not exceed 10% of line 35.
3 The sum of lines 37, 38, 39, and 40 may not exceed the allowable non-service costs from the Administrative Agency's home HSDA.
4 Amount should match the total amount allocated to your Administrative Agency by DSHS based on the formulary and as shown in the Allocations table for this renewal application.

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.

HIV Contractor Assurances

1. ADVOCATE AND PROMOTE

The applicant agency assures that it does not advocate or promote conduct that violates state law, in compliance with the HIV Services Act, Texas Health and Safety Code, Section 85.011, as follows:

> "Grants may not be awarded to an entity or community organization that advocates or promotes conduct that violates state law. This subsection does not prohibit the award of a grant to an entity or community organization that provides accurate information about ways to reduce the risk of exposure to or transmission of HIV."

2. CONFIDENTIALITY

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Department of State Health Services that confidentiality of all records shall be maintained. No information obtained in connection with the examination, care, or provision of programs or services to any person with HIV shall be disclosed without the individual's consent, except as may be required by law, such as for the reporting of communicable diseases. Information may be disclosed in statistical or other summary form, but only if the identity of the individuals diagnosed or provided care is not disclosed.

We are aware that the Health and Safety Code, §81.103, provides for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law. Furthermore, all employees and volunteers who provide direct client care services or handle direct care records wherein they may be informed of a client's HIV status or any other information related to the client's care, are required to sign a statement of confidentiality assuring compliance with the law. An entity that does not adopt a confidentiality policy as required by law is not eligible to receive state funds until the policy is developed and implemented.

3. CONFLICT OF INTEREST

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Department of State Health Services that no person who is an employee, agent, consultant, officer, board member, or elected or appointed official of this agency, and, therefore, in a position to obtain a financial interest or benefit from an activity, or an interest in any contract, subcontract, or agreement with respect thereto, or the proceeds thereunder, either for himself or herself or for those with whom he or she has family or business ties, during his or her tenure or for one year thereafter shall participate in the decision making process or use inside information with regard to such activity. Furthermore, this agency will adopt procedural rules which require the affected person to withdraw from his or her functions and responsibilities or the decision-making process with respect to the specific assisted activity from which they would derive benefit.

4. TUBERCULOSIS COLLABORATION

The applicant agency assures the DSHS that it maintains collaborative efforts with local Tuberculosis (TB) Control programs in order to insure that HIV and TB treatment and prevention services are provided to persons at risk of HIV and TB.

5. DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing a drug-free awareness program to inform employees about-
- (1) The dangers of drug abuse in the workplace;
- (2) The grantee's policy of maintaining a drug-free workplace;
- (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the

workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will-
  (1) Abide by the terms of the statement; and
  (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later that five days after such conviction;

(e) Notifying the agency within ten days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted-
  (1) Taking appropriate personnel action against such an employee, up to and including termination; or
  (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

6. POLICIES OF THE BUREAU OF HIV & STD PREVENTION

The applicant agency assures the DSHS that it will abide by all policies of the HIV/STD Comprehensive Services Branch that apply to the programs being provided. A list of policies applicable to all HIV and STD contractors is provided at the Bureau website at http://www.tdh.state.tx.us/hivstd/policy/default.htm.

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Applicant Organization	

Department of State Health Services
HIV/STD Comprehensive Services Branch

CONTRACTOR ASSURANCE REGARDING PHARMACY NOTIFICATION

To ensure that pharmacies providing prescriptions to HIV services clients do not fill medications on deceased clients, the applicant agency provides assurance to the Department of State Health Services that it will notify the client's pharmacy when a client dies.

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Organization	

Department of State Health Services
HIV/STD Comprehensive Services Branch

ASSURANCE OF COMPLIANCE WITH CDC AND DSHS REQUIREMENTS FOR CONTENTS OF HIV/STD-RELATED WRITTEN EDUCATIONAL MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS

The applicant agency certifies that its Project Director and Authorized Business Official:
have received a copy of the *Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control Assistance Programs,* dated June, 1992, and its *Preface*, and DSHS HIV/STD Policy 500.005, *Contractor Review of HIV/AIDS and STD Written and/or Pictorial Materials Intended for Public Use;*

- have read them;
- accept them;
- agree to comply with all particulars and specifications set forth;
- agree to comply with all specifications, INCLUDING THOSE SET FORTH during the program year;
- agree that all specified materials shall be submitted to the local program materials review panel and subject to the CDC and DSHS guidelines set forth; and
- agree to ensure that the local program materials review panel shall reasonably reflect the views of the entire community it serves, not just those of any one population, and that all panelists shall read and abide by all CDC and DSHS guidelines for materials review panels.

If you **do not** use HIV/STD-related educational materials outlined in the CDC and DSHS guidelines, or if you only use materials developed by CDC and/or DSHS, you do not need to convene a local panel. Please circle one of the following statements and sign/date this page.

1. I certify that this program does not use HIV/STD educational materials outlined in the CDC and DSHS guidelines.
2. I certify that this program only uses HIV/STD educational materials developed by CDC and/or DSHS.

If you **do** use HIV/STD-related educational materials outlined in the CDC and DSHS guidelines, please attach a page listing the **name, occupation, affiliation, gender, race/ethnicity, mailing address, phone number and e-mail (if applicable)** of all proposed local panel members and sign/date below. You must have at least five members on your panel and one member must be an employee of the local health department.

Applicant Agency

Signature of Authorized Official　　　　　　　　　　Date

Department of State Health Services
HIV/STD Comprehensive Services Branch

Assurance Regarding HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services

This agency assures the Department of State Health Services that it will comply with HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services (Standards) as promulgated by the HIV/STD Comprehensive Services Branch. The Standards are available at

www.dshs.state.tx.us/hivstd/clinical/pdf/stvs3_01.pdf

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Organization	

SUBCONTRACTOR DATA SHEET

Contract Beginning Date ____________________ Contract Ending Date_________________

Check source of funding: ____ Ryan White ____ State Services ____ Early Intervention

Subcontractor Name:____

Mail Address: ____

Street Address: ____

City, State, Zip: ____

Phone Number: __________________________ Fax Number:______________________

E-mail address: ___________________________

Executive Director: ____

Contact Person & Title: ____

Estimated Number of Persons to be Served: ___________________

Services Categories to be provided:*____

*(Attach Table 1 if more than one service is to be provided)

CATEGORICAL BUDGET INFORMATION

Personnel: $_____________

Fringes: $_____________

Travel: $_____________

Equipment: $_____________

Supplies: $_____________

Contractual: $_____________

Other: $_____________

Total Direct Costs (DC): $_____________

Indirect Costs (IC): $_____________

Total Subcontract Amount (DC + IC): **$**_____________

IF THE CONTRACT IS FOR MORE THAN $25,000, ATTACH A CATEGORICAL BUDGET JUSTIFICATION FOR THE ABOVE ITEMS.

FEE-FOR- SERVICE/UNIT COST CONTRACT

If the subcontract is a fee-for-service or unit cost contract, provide the maximum amount that can be charged under the contract and attach the Fee-For-Service form.

AMOUNT: $____________

Name of Administrative Agency:____

Selection Process:__Competitive Bid__Sole Source__Single Source

Minority Organization?* _________**Yes** _________**No**

Minority Provider?** _________**Yes** _________**No**

Faith-based Organization? _________**Yes** _________**No**

HUB Certified? _________**Yes** _________**No**

Does your agency collect sliding-scale fees from clients? _________**Yes** _________**No**

Does your agency collect co-payments from clients? _________**Yes** _________**No**

*Organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

**For the purposes of HRSA's Consolidated List of Contracts report, an organization/agency must meet the following criteria to be considered a minority provider:

A. have a documented history of providing service to the targeted racial/ethnic minority community(ies) to be served; and
B. are located in or near the targeted racial/ethnic minority community they are intended to serve; and
C. have documented linkages to the targeted racial/ethnic minority populations, so that they can help close the gap in access to services for highly impacted communities of color; and
D. provide services in a manner that is culturally and linguistically appropriate.

FEE-FOR-SERVICE FORM

1. Name of Provider :____

2. Type of Service/Service Category:____

3. Provide a Narrative Justification with sufficient detail to define how the fee-for-service or unit cost was established and the rationale for the number of clients proposed. This narrative description should include the Who, What, Where, When and Why to justify the unit cost.

4. Fee Charged Per Unit of Service:____
5. Number of Units to be Provided:____
6. Maximum Charges for this Contract:____

7. COMPIS Definition of the Unit of Service:

8. Unit Cost or Fee-for-Service reimbursement contracts **MUST** report: the precise unit cost, and the proportion of the unit cost represented by each of the object class categories listed below:*

Personnel:
Fringe Benefits:
Travel:
Equipment:
Supplies:
Contractual:
Other:
Indirect Costs:
TOTAL BUDGET: _______
Divided by # of Units of Service:__
Equals Fee per Unit of Service:

*NOTE: The budget breakdown is NOT required for unit costs that use a Medicaid approved rate. If you are using a Medicaid approved rate, check the box below:

? Medicaid Approved Rate Used

Rev. 6/18/01

CONTRACT/SUBCONTRACT REVIEW CERTIFICATION (CRC) FORM

GRANTEE NAME:____

CONTRACTOR/SUBCONTRACTOR NAME:______________________________

CONTRACTOR ADDRESS (street, city, state, 9 digit zip code):___________________

____

CONTRACTOR 9 DIGIT Employer Identification Number (EIN):_______________

IS THE CONTRACTOR A MINORITY PROVIDER?*________

IS THE CONTRACTOR A FAITH-BASED ORGANIZATION? _____

FY 2005 STATE SERVICES AMOUNT AWARDED:_______________

DATE FUNDS AWARDED: ___________

PURPOSE AND SCOPE OF CONTRACT (activities and services to be provided): Use ONLY the HRSA service categories. (Attach Table 1 showing categories and amounts budgeted for each category.)

____

____

____

Does the contractor/subcontractor provide direct client services as opposed to grant administration or program support services?_____________

A. PROGRAM REVIEW: I certify that the purpose and scope of the contract has been reviewed and found to be in compliance with any existing policies of the Division of HIV Services, HIV/AIDS Bureau (HAB) in effect at the time this contract was executed.

Project Director (signature): ________________________ Date: __________

B. ADMINISTRATIVE/FISCAL REVIEW

1. I certify that the procedures used to advertise and award these funds meet the minimum standards required by the Office of Management and Budget (OMB) in the following Circular (check one only).

   ___ A-102 (Administrative requirements applicable to grants to State and local governments) codified by DHHS in 45 CFR Part 92.

   ____ A-110 (Administrative requirements applicable to grants to Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations) codified by DHHS in 45 CFR Part 74.

2. I certify that the costs have been determined allowable according to principles and standards established by OMB in the following Circulars (check one only).

   ___ A-122, Cost Principles for Non-Profit Organizations.

   ___ A-87, Cost Principles for State, Local, and Indian Tribal Governments

   ___ A-21, Cost Principles for Educational Institutions.

   ____ 48 CFR Part 31, For-Profit Organizations

3. I certify that there are no mathematical errors in the budget of this contract.

   ADMINISTRATIVE/BUDGET OFFICER (FISCAL):_________________________