Request for Proposals (RFP)

for HIV Client Services

RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT PART A

FY 2016

HIV Client Services:

Medical Case Management
Medical Transportation
Psychosocial Support (Peer Support)

HIV/AIDS Services Division
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118

Section II:
Application

TABLE OF CONTENTS

INSTRUCTIONS FOR PREPARING AND SUBMITTING THE FY 2016 PROPOSAL

GENERAL PREPARATION INSTRUCTIONS

- One proposal must be submitted for each service category.
- Applications must be in English.
- Submit all copies of the proposal bound by binder clips. *Do not staple*.
- Use standard black type, such as Times New Roman. The text and table portions of the application must be submitted in 12 point font. For charts, graphs, footnotes and budget tables, applicants may use a different size font, not less than 10 point.
- Use 8½ by 11 inch white paper.
- Top, bottom, left, and right margins may not be less than one inch each.
- Text may be either 1½- or double-spaced.
- Number all pages of the application consecutively, beginning with the Abstract.
- Include the name of the agency and service category on the top of each page of the proposal.
- Do not include photos, pamphlets, folded or over-sized documents.
- The proposal narrative should not exceed 25 pages. Attachments, tables, and budget are not included in this page limit.
- Included are suggested page lengths for Sections B-H. These limits may be adjusted as long as the total length for Sections B-H does not exceed 25 pages.
- For Section H and the corresponding service-specific questions, a maximum page limit of 10 pages is available for one proposed service. If applying for multiple service categories, 5 additional pages may be added to this section.
- One (1) complete signed single-sided original and fifteen (15) double-sided signed copies must be submitted.
- *In addition* to the hard copies, agencies are also encouraged to submit a CD or flash drive version of the application. Acceptable formats include MS Word, MS Excel (budget only), or PDF. These items will not be returned.
- The organization of the proposal must be consistent with the order of the Proposal Checklist (page 5).

SUBMISSION INSTRUCTIONS

- The deadline for submitting the Fiscal Year (FY) 2016 Part A HIV Client Services proposal is:

FRIDAY, JULY 22ND, 2016, 12:00 PM

- Submit proposals to the attention of:

Mr. Eric Thai, Interim Director
HIV/AIDS Services Division
Boston Public Health Commission
1010 Massachusetts Ave., 2nd Floor
Boston, MA 02118

THERE WILL BE NO EXCEPTIONS TO THE July 22nd, 2016, 12:00 PM (NOON) DEADLINE!
Proposals will be time stamped in order to assure proper receipt. The responsibility for submitting a response to this proposal to Boston Public Health Commission on or before the stated time and date will rest solely and strictly with the applicant. BPHC will in no way be responsible for delays in delivery caused by the U.S. Postal Service or by any other occurrence.

LETTER OF INTENT TO APPLY FOR
RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT
PART A FUNDING
FISCAL YEAR 2016

Please return Letter of Intent by:
Tuesday, JULY 5th, 2016

To: **Eric Thai, Interim Director**
HIV/AIDS Services Division
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118

Fax #: **(857) 288-2194**

Re: ***Letter of Intent*** **to apply for Ryan White HIV/AIDS Treatment Extension Act, HIV Health Services Funds, FY 2016**

APPLICANT INFORMATION

Legal Name of Agency:	
Executive Director:	
Street Address:	
City, State and Zip Code:	
Telephone:	
Fax:	
E-mail Address:	
Contact Person and Title:	

Our agency intends to apply for funding for the following service(s):

Please check all that apply.

Medical Case Management	Medical Transportation	Psychosocial Support (Peer Support)
❒	❒	❒

PROPOSAL CHECKLIST

The proposal, tables, and attachments must be submitted in the following order. **Complete and attach this checklist to confirm that all required submission items are included.**

PROPOSAL

_____ A. Cover Page
_____ B. Abstract
_____ C. Organization Description
_____ D. Staffing Description
_____ E. Target Population
_____ F. Program Data, Outcomes, & Evaluation
_____ G. Agency/Program Specific Procedures
_____ H. Service Description
H1. Medical Case Management _____
H2. Psychosocial Support (Peer Support) _____
H3. Medical Transportation _____
_____ I. Cost Effectiveness & Budget Justification

TABLES *(Tables do not count towards proposal page limit.)*

_____ Table C.1 Organization Diversity Table – Board and Staff
_____ Table C2. Organization Diversity Table – Current Clients
_____ Table C3. HIV and Related Funding & Contracts
_____ Table E Target Population
_____ Table H1. Program Linkages
_____ Table H2. Service Delivery Table(s)

PROGRAM ATTACHMENTS *(Attachments do not count towards proposal page limit.)*

_____ Attachment 1: Organizational Chart(s)
_____ Attachment 2: Mission Statement
_____ Attachment 3: Board of Directors list
_____ Attachment 4: Job Descriptions (for positions supported by proposed budget)
_____ Attachment 5: Agency Licensure and/or Certifications (if applicable)
_____ Attachment 6: Budget(s)
_____ Attachment 7: Budget justification narrative(s)
_____ Attachment 8: Verification of 501(c) (3) status
_____ Attachment 9: Most recent A-133 or Independent Audit
_____ Attachment 10: Collaborative Relationship Chart (if applicable)
_____ Attachment 11: Collaborative Letters of Agreement (if applicable)

LEGAL AND FINANCIAL ATTACHMENTS (Attachments do not count towards proposal page limit.)

_____ Attachment 12: Ryan White Program Assurances Form
_____ Attachment 13: Boston Public Health Commission Contract Forms
_____ Attachment 14: Certificate of Authority Form
_____ Attachment 15: Available Appropriation Form
_____ Attachment 16: Federal Assurances - Non-Construction Programs Form
_____ Attachment 17: Federal Certifications Form
_____ Attachment 18: BPHC Business Associate Agreement Form

Failure to submit all of the above information may result in disqualification from the review process.

Signature of individual authorized to sign contracts for agency:

Signature: _____ Date: _____

A. COVER PAGE

FY 2016 RYAN WHITE PART A PROPOSAL

Legal name of applicant organization:	
Address:	
Telephone:	
Fax:	
E-mail Address:	
FIN#	
DUNS#	
Executive Director:	

Service(s) proposed	Amount requested
Medical Case Management	$
Medical Transportation	$
Psychosocial Support (Peer Support)	$
Total	$

If submitted as a Collaborative Proposal, list the name(s) of collaborating agency or agencies:	

Submission of the proposal and signature below indicate the intention of the applicant to comply with the goals, guidelines, and other elements of the HIV Health Services Request for Proposals.

Name and Title of individual authorized to sign contracts and grants, as noted on the Certificate of Authority:

Authorized signature: **Date:**

Program/reporting contact:_____

Fiscal contact:_____

B. ABSTRACT

Page limit: 1 page

Provide a one (1) page summary the proposal. This summary should include the following:

- Description of the proposed service(s) to be offered, including how clients will be linked to the Part A continuum of care, and how clients will be supported in accessing treatment and achieving and maintaining viral suppression.
- A general statement of how funds will be used.
- The target population, the number of people to be served, and past experience providing this or similar services.

C. ORGANIZATION DESCRIPTION

Total Possible Points: **5**

Suggested page length: 4 pages, not including tables and attachments.

1. Describe the organization and its mission. Describe how the proposed program will link with the mission and programs described in the agency's mission statement. Attach an organizational chart that shows the location of the proposed program within the agency and the organization's most recent mission statement.

   ☐ Organization chart is attached.
   ☐ Most recent mission statement is attached.

2. Describe the demographic profile of the current client base of the agency. If there is currently an HIV-specific program, describe the number of active clients and the demographics of these clients.

   ☐ Organization diversity table for Current Clients is attached.

3. Summarize the agency's experience in serving PLWH. If the agency does not currently provide the proposed service(s) to the intended client population, explain any related experience that would demonstrate the agency's competency in delivering the services.

4. Describe the demographic make-up of the organization, including the board, management, and professional staff.

   ☐ Organization diversity table for Board and Staff is attached.
   ☐ Board of directors list is attached.

5. Provide an overview of HIV-related funding sources that the agency currently has received in Fiscal Years 2013, 2014, and 2015. Sources can include Part A, other Ryan White Parts, other federal, state/local, and general operating/private funds. Include a description of how long the agency has received such support and overall increases or decreases in funding and impact to agency, programs, or services; and any plans to secure additional funding to support the agency's HIV-related services.

   ☐ HIV and Related Funding & Contracts table is attached.

For collaborative proposals only:

6. Please describe the relationship between collaborating agencies, specifying the lead agency for funding and reporting purposes.

   ☐ Collaborative relationship chart is attached.
   ☐ Collaborative letters of agreement are attached.

D. STAFFING DESCRIPTION

Total Possible Points: **10**

Suggested page length: 2 pages, not including attachments.

1. Explain how the agency will ensure that each staff member related to the proposed program is qualified and adequately trained to perform job functions. Please describe staff members' experience in serving PLWH. Please identify all staff members and/or positions that are new to the proposed model.

2. Describe the agency's administrative supervision policy and how administrative supervision is provided at the agency. Please specify roles, responsibilities, and frequency.

3. Describe how the agency ensures that the entire staff receives ongoing training in HIV -specific issues. List the training topics that the program plans on providing to program-funded staff during FY 2016.

4. Submit job descriptions and resumes for each position supported by the proposed budget(s).

   ☐ Job descriptions are attached.

E. TARGET POPULATION

Total Possible Points: **10**

Suggested page length: 2 pages.

1. Describe the geographic service area for this proposal.

2. Identify and describe the population(s) intended to receive the program's services. Include specific demographic information such as age, gender, transmission category, race, ethnicity, and primary language. Project the number of unique individuals within each demographic category that will be served by the program. If applicable, describe how the program's target population differs from the Boston EMA's epidemiological and service profiles, which are included in Appendix B1 and B2 in Section I of this RFP.

   ☐ Target population table is completed and attached for each service proposed.

3. Describe the unmet needs of the target population. Discuss this population's barriers to accessing and maintaining access to medical care and other health-related support services. The challenges described may relate (but are not limited) to the topics of homelessness, mental health issues, and substance abuse. Describe how the proposed program will help PLWH address these barriers to achieve viral suppression.

4. Describe how the proposed service will be delivered with cultural and linguistic competence to the target population(s).

F. PROGRAM DATA, OUTCOMES, & EVALUATION Total Possible Points: 5

Suggested page length: 2 pages

1. Describe the agency's plan to improve client health outcomes throughout the EMA. Summarize the agency's plan and strategies to:
   - Enhance the quality of services.
   - Link social support and medical services so that barriers to achieving viral suppression are achieved in a timely fashion
   - Adapt programming in response to unmet needs that result in failure to achieve and maintain viral suppression.
   - Prioritize and plan, using epidemiological, quality management, and outcomes data.

2. Describe the program's strategic plan to evaluate clients' access to adequate care and the program's delivery of services. Provide detail on the frequency and methods of the evaluation. Describe activities the program has or will take to make improvements in these areas, including targeting underserved or hard-to-reach populations.

3. Describe how the program uses or will use systems like e2Boston for developing, monitoring, and updating delivered service(s).Describe how demographic, utilization, and outcomes data will be used in each of these processes.

4. Describe how the program uses or will use consumer feedback for developing, monitoring, and updating delivered service(s).

G. AGENCY/PROGRAM SPECIFIC PROCEDURES

Total Possible Points: **5**

Suggested page length: 3 pages.

See *Section I Appendix D: HRSA and BPHC Policies and Procedures* to answer the following questions.

1. Describe how the program will ensure that Ryan White Part A funds will be utilized as the payer of last resort. Describe how the agency plans to track clients by funding stream (including other parts of Ryan White), and to report units of service that are specific to Part A funding.

2. Outline the policy and procedures that the agency has in place to ensure that clients' eligibility for Part A funds is determined and verified in accordance with BPHC guidelines. Provide details for the following client status certifications:

    - HIV positive diagnosis (once)
    - Residency in the Boston EMA (every 6 months)
    - Insurance enrollment (every 6 months)
    - Income at or below 500% of the Federal Poverty Level (FPL) (every 6 months)

3. Describe policies and procedures to ensure security and confidentiality of client information and records, including storage and handling of client records, electronic data systems, and transmission of any client identifying information internally and externally.

4. Describe the policies and procedures that the agency employs or will employ to ensure client files will contain, at a minimum, the items listed in the BPHC Maintenance of Client Files Policy.

5. Describe the program or agency consumer grievance procedures that clients served through this program will use to resolve grievances.

H. SERVICE DESCRIPTION

Total Possible Points: **55**

Page limit: 10 pages, not including tables and attachments.

Questions on this page must be answered by all applicants, regardless of service categories.

Client Recruitment, Referral, & Linkages: Refer to the "Description of Funded Services" from Section I of this RFP to answer the following questions.

1. Describe the process for recruitment of the target population for the proposed service. Describe any referral sources and outreach efforts. Be specific when describing how the program intends to reach the target population(s).

2. Describe any specific strategies that the program will use to reach those within the target population who know their HIV status but are not in medical care.

3. Describe how the program will support PLWH in achieving and maintaining viral suppression. For agencies that do not provide primary care, how will clients be supported in their efforts to access ongoing primary health care services and health insurance?

4. Describe how the proposed service(s) will be linked programmatically to other services and programs **within** the agency.

5. Describe how the program will be linked to **external** agencies within the HIV continuum of care, how it will ensure coordination of care for clients, and how it will avoid duplication of services. Describe the referral and follow-up process.

☐ Program linkages table is attached.

H1. MEDICAL CASE MANAGEMENT

Complete Section H1. if applying for Medical Case Management (MCM):

1. Describe the proposed service including how clients' needs and barriers to care will be identified and addressed to achieve and maintain viral suppression. Include in the description how the agency's programs and services support the goals of the National HIV/AIDS Strategy (NHAS) and are linked with efforts related to Early Identification of Individuals with HIV/AIDS (EIIHA).*(Refer to overviews of the NHAS and EIIHA in Section I.)* Include specific information on how issues related to substance use, mental illness and homelessness will be evaluated and addressed in a timely fashion.

2. Describe the service delivery model, including each service element of the proposed program. Include delineation of roles and responsibilities of staff and activities performed for each service element. Describe how services will be delivered in either an office or clinical setting *and* in the community (including home or similar visits).

   ☐ Service Delivery – MCM table is attached.

3. Describe the program's process for hiring, orientation, supervision, and training of Medical Case Managers. List training topics and activities that the program staff will engage in.

4. If the proposed MCM program incorporates clinical staff, peer leaders, or any specialized roles as part of a multidisciplinary team, please describe the program's process for hiring, orientation, supervision, and training of staff members in these roles. If the proposed program does not integrate Peer Leaders, please describe the referral mechanism for clients in need of peer support services.

5. Describe how the Standards of Care established by the Boston EMA Planning Council are integrated into how the agency provides services. Please provide examples of how the program will meet or exceed the Standards of Care. If the program does not currently provide the proposed service, explain how the program plans to meet or exceed the Standards of Care.

6. Describe the proposed program staff members' experience and capacity in regard to providing MCM services in accordance with service category definitions by HRSA and the Boston EMA Planning Council. Include expertise in working with PLWH who face challenges with substance use, mental illness, or housing instability. Include experience working with populations that have particular cultural or linguistic needs.

7. Describe the administrative process to screen clients for program eligibility and to maintain eligibility documentation. Describe the process for assessing client eligibility for appropriate insurance and benefits coverage to ensure that Ryan White Part A is payer of last resort.

8. Describe the process for determining caseload assignment and prioritization based on clients' acute needs, such as medical, financial, psychosocial, etc.

9. Describe the programs' process for defining and determining client activity, inactivity, and discharge status. Describe efforts to improve client engagement and re-engagement, including outreach in the community.

10. Describe the setting(s) where the proposed program will deliver services. If the program is located in multiple locations, describe how each will be coordinated effectively to meet clients' service needs. Describe how team members will be trained to provide services in the community, including home visits.

H2. PSYCHOSOCIAL SUPPORT (PEER SUPPORT)

Complete Section H2. if applying for Psychosocial Support (Peer Support):

1. Describe the proposed service including how the service will identify and address barriers to achieving and maintaining viral suppression among PLWH. Explain why Ryan White funds are needed for the proposed service. Include in the description how the agency's programs and services support the goals of the National HIV/AIDS Strategy (NHAS) and are linked with efforts related to Early Identification of Individuals with HIV/AIDS (EIIHA). *(Refer to overviews of the NHAS and EIIHA in Section I.)*

2. Describe the service delivery model, including each service element of the proposed program. Include delineation of roles and responsibilities of staff and activities performed for each service element. Clearly describe how the service will link PLWH to other HIV related services; provide applicable MOAs.

   ☐ Service Delivery – Psychosocial Support (Peer Support) table is attached.

3. Describe how the Standards of Care established by the Planning Council are integrated into the way the agency provides services. Please provide examples of how the program will meet or exceed the Standards of Care. If the program does not currently provide the proposed service, explain how the program would plan to meet or exceed the Standards of Care.

4. Describe the proposed program staff members' experience and capacity in regard to providing peer support services in accordance with Boston EMA Planning Council and HRSA service category definitions, and with JRI Peer Support Guidelines. Include expertise in working with PLWH who face challenges with substance use, mental illness, or housing instability. Include experience working with populations that have particular cultural or linguistic needs.

5. Describe the program's process for hiring, orientation, supervision, and training of Peer Support staff members. List training topics and activities that will engage the program staff.

6. Describe the proposed program's coordination of services with other HIV MCM programs; include those not funded and not funded by Ryan White Part A.

7. Describe the programs' process for defining and determining client activity, inactivity, and discharge status. Describe efforts to improve client engagement and re-engagement, and adherence to HIV medicine to achieve and maintain viral suppression.

8. Describe the setting(s) where the proposed program will deliver services. If the program is located in multiple locations, describe how each will be coordinated effectively to meet clients' service needs. Describe how visits will be conducted in the community, including homes and similar settings.

H3. MEDICAL TRANSPORTATION

Complete Section H3. if applying for standalone Medical Transportation

1. Describe the proposed service including how the service will fill a current gap and why Ryan White funds are needed for the proposed service. Include in the description how the agency's programs and services support the goals of the National HIV/AIDS Strategy (NHAS) and are linked with efforts related to Early Identification of Individuals with HIV/AIDS (EIIHA). *(Overviews of NHAS and EIIHA are provided in Section I of the RFP.)*

2. Describe the service delivery model, including each service element of the proposed program. Include delineation of roles and responsibilities of staff and activities performed for each service element.

   ☐ Service Delivery – Medical Transportation table is attached.

3. Describe client challenges that require transportation assistance.

4. Describe the transportation resources of the client population of residents of the service region. Explain why the method selected is the most cost-effective.

5. How does the program ensure that clients are properly assessed and utilize other transportation assistance programs (e.g., PT-1, the Ride, etc.)?

I. COST EFFECTIVNESS & BUDGET JUSTIFICATION

Total Possible Points: **5**

The section does not count toward the page limit.

1. Submit a 12-month budget for each proposed service, as well as a budget justification that explains the proposed budget(s). Instructions and sample budgets are provided on pages 30-34.

   ☐ Budget(s) for proposed service(s) is attached.
   ☐ Budget justification narrative for each proposed budget(s) is attached.

2. Provide an estimated cost per client for the proposed service. Include a detailed description of the method or formula used to derive this cost per client.

3. Submit documentation of the agency's 501(c)(3) status.

   ☐ Documentation of 501(c)(3) status is attached.

4. Submit documentation of the agency's audited internal fringe rate and indirect rate.

   ☐ Documentation of audited internal fringe rate is attached.
   ☐ Documentation of audited indirect rate is attached.

5. Submit documentation of the agency's most recent annual operating budget to verify fiscal viability. All applicants must have an operating budget of at least $500,000 for eligibility to directly apply for Part A funding. Agencies with an annual operating budget of less than $500,000 may apply only through a sponsor agency which meets the requirement. The sponsor agency will apply as the lead agency with a clearly defined relationship for fiscal oversight and programmatic compatibility.

   ☐ Copy of most recent single independent audit report is attached.

REQUIRED TABLES & ATTACHMENTS

Tables and attachments do not count toward the page limit.

Tables

C1. Organization Diversity Table for Board and Staff
C2. Organization Diversity Table for Current Clients
C3. Summary of HIV-related agency funding
C4. HIV and Related Funding & Contracts Table
E. Target Population Table
H1. Program Linkages table
H2. Service Delivery Table(s)

Attachments

Organization Chart
Mission Statement
Board of Directors List
Collaborative Relationship Chart (if applicable)
Collaborative Letters of Agreement (if applicable)
Job Descriptions
Agency Licensures and/or Certifications
Budget for each proposed service
Budget Justification Narrative for each proposed service
Documentation of 501(c)(3) status
Most recent Single Independent Audit Report

C1. ORGANIZATION DIVERSITY TABLE – Board and Staff

Organization Totals for Gender, Ethnicity, and Race must equal the same number. Organization Total for Other Racial or Ethnic Groups may be less than or equal to the other totals. Complete table for the ENTIRE Agency rather than for the proposed program.

	Paid Staff			SUBTOTAL Paid Staff	Board of Directors	ORGANIZATION TOTAL	
	Executive Director	Professional Staff	Support Staff			#	%
Gender: Male							
Female							
Transgender							
TOTAL:							
Ethnicity: Hispanic or Latino/a							
Not Hispanic or Latino/a							
TOTAL:							
Race: White							
Black or African American							
Asian							
Native Hawaiian/ Pacific Islander							
American Indian/ Alaskan Native							
Unknown or Unreported*							
TOTAL:							
Other Racial or Ethnic Groups: African							
Cape Verdean							
Haitian							
Brazilian							
Portuguese							
Other /Unknown							
TOTAL:							

*Unknown or Unreported includes Latinos who do not identify with any of the five Federal race categories.

C2. ORGANIZATION DIVERSITY TABLE – Current Clients

Organization Totals for Gender, Ethnicity, and Race must equal the same number. Organization Total for Other Racial or Ethnic Groups may be less than or equal to the other totals. Complete table for the ENTIRE client population rather than for the proposed program.

	TOTAL *AGENCY* CLIENTS		HIV + CLIENTS	
	#	%	#	%
Gender: Male				
Female				
Transgender				
TOTAL:				
Ethnicity: Hispanic or Latino/a				
Not Hispanic or Latino/a				
TOTAL:				
Race: White				
Black or African American				
Asian				
Native Hawaiian/Pacific Islander				
Native American/Alaskan Native				
Unknown/Unreported*				
TOTAL:				
Other Ethnicity: African				
Cape Verdean				
Haitian				
Brazilian				
Portuguese				
Other /Unknown				
TOTAL:				

*Unknown or Unreported includes Latinos who do not identify with any of the five Federal race categories.

C3. INSTRUCTIONS FOR COMPLETING HIV AND RELATED FUNDING AND CONTRACTS TABLES

Table C3. ***HIV and Related Funding and Contracts.*** Submit Table C3. following the proposal narrative. This table should include a list of all HIV and related funding and contracts ***from Fiscal Years 2013 to 2015***. The table should specify which program receives the funding, the amount of the contract, the number of funded full time equivalents (FTE) or unit rate of payment, the funding source, and the years received.

When completing the table, please include the following funders and/or funding sources:

Funding Stream	
Ryan White	Part A (including MAI), Part B (including MAI), Part C, Part D, Part F, SPNS
Other Federal	HOPWA, SAMHSA, CDC
State/Local (Include Bureau or Department name if applicable)	MDPH (OHA, BSAS), NH DHHS, BPHC, or other local health department funding
Other (Include name of funding stream in table)	General operating funds, private or foundation funding

NOTE: For collaborative applicants, Table C2. must be completed for *each* agency

C4. HIV AND RELATED FUNDING & CONTRACTS

NAME OF AGENCY: AIDS Services Organization

Program Name	Funder/Funding Source	Amount of Contract Funding	#FTE or Unit Rate	FY 2013	FY 2014	FY 2015
1. Peer Support Training	DPH/OHA	$65,000	1.5 FTEs		$60,000	$65,000
2. Residential Substance Abuse Treatment	DPH/BSAS	$200,000	$75 per bed day unit		$	
3. HIV/AIDS Prevention and Education	BPHC/Education & Outreach	$60,000	1.5 FTEs	$		
4.						
5.						

E. TARGET POPULATION

	Proposed program	Service category profile (e.g. MCM)	Boston EMA profile
Total Clients to be Served (Total unduplicated number)	#		
Gender:			
Male	%	%	%
Female	%	%	%
Transgender	%	%	%
Total:	%	%	%
Ethnicity:			
Hispanic/Latino/a	%	%	%
Not Hispanic/Latino/a	%	%	%
Total:	%	%	%
Race:			
White	%	%	%
Black or African American	%	%	%
Asian	%	%	%
Native Hawaiian/Pacific Islander	%	%	%
American Indian/Alaskan Native	%	%	%
Total:	%	%	%
Ethnic Groups:			
African	%	%	%
Cape Verdean	%	%	%
Haitian	%	%	%
Brazilian	%	%	%
Portuguese	%	%	%
Total:	%	%	%
Primary Language:			
English	%	%	%
Spanish	%	%	%
Haitian Creole	%	%	%
French	%	%	%
Portuguese	%	%	%
Crioulo (Cape Verdean)	%	%	%
Asian Languages (Specify)	%	%	%
American Sign Language	%	%	%
Other (Specify)	%	%	%
Total:	%	%	%
Mode of Transmission:			
Men who have sex with men (MSM)	%	%	%
Injection drug users (IDU)	%	%	%
MSM and IDU	%	%	%
Heterosexual contact	%	%	%
Perinatal Transmission	%	%	%
Hemophilia/Coag. disorder	%	%	%
Through blood/blood products	%	%	%
Unknown/Undetermined	%	%	%
Total:	%	%	%

H1. PROGRAM LINKAGES

Use the following codes to this table. Use additional copies of this page as needed.

FORMS OF PROGRAM LINKAGES ***(please select those that are applicable for the agencies listed below)*:**	**DESCRIPTION OF PROGRAM LINKAGES**	**POINTS OF ENTRY (*if applicable*)**
A. ***Contract:*** A legally binding agreement that imposes an obligation on one party to perform specified duties in return for financial compensation. B. ***Memorandum of Understanding/Agreement:*** This is similar to a contract, but does not involve payments; two or more parties agree to perform certain complementary functions, working toward a common goal. C. ***Letter of Support:*** Usually a statement of general support by one agency for the work of another, with no necessary commitment by the writer to fulfill a specific role.	1. Referral: Specify in, out, or both 2. Case Coordination	a) Adult and Juvenile Detention Facilities b) Case Management Programs c) Counseling and Testing Sites d) Detoxification Programs e) Emergency Rooms f) Health Centers g) Homeless Services h) Mental Health Programs i) STD Clinics j) Substance Abuse Treatment Programs k) Other

AGENCY NAME	**FORM OF LINKAGE** ***(A – C)***	**DESCRIPTION OF LINKAGE** ***(1 – 2)***	**TYPE OF POINT OF ENTRY** ***(a – k)***	**COMMENTS**

The Boston Public Health Commission reserves the right to verify the arrangements cited above by requesting and inspecting supporting documents.

H2. SERVICE DELIVERY – MEDICAL CASE MANAGEMENT

Complete this table only if applying for Medical Case Management

MEDICAL CASE MANAGEMENT			
Subservice	**Definition**	**Proposed Total Units**	**Activity Description & Responsible Staff**
Initial Intake, Started	Enter one (1) when the initial intake begins.		
Assessment, Completed	Enter one (1) when the assessment is completed.		
Visit, General*	A face-to-face session between provider and client where case management services are provided. One Unit = One Hour.		
Visit, Home-Based*	A face-to-face session between provider and client where case management services are provided in a non-office based setting, including but not limited to residential settings (i.e., independent living environment, congregate HIV/AIDS or other supportive residential programs).		
Phone, Follow-up**	Enter one (1) for any non-initial telephone encounter which provides client-centered assistance. *One Unit = One Phone Call.*		
Reassessment/Follow-up Service Plan, Completed	Enter one (1) when reassessment/follow-up service plan is completed.		
Supported Referral	Enter one (1) for each active process of facilitating a client's access to HIV Support Services and any other services necessary to reduce barriers to care.		

**** Time-based units** may be reported using increments other than one hour. For example: 1.5 units = 90 minutes, 0.5 units = 30 minutes, or .25 units = 15 minutes.
** **Phone calls** should be reported only when successful contact is made; messages left should not be reported.

H2. SERVICE DELIVERY – MEDICAL TRANSPORTATION

Complete this table only if applying for Medical Transportation.

MEDICAL TRANSPORTATION			
Subservice	**Definition**	**Proposed Total Units**	**Activity Description & Responsible Staff**
One-way Ride, Public	One-way transportation by public transport system (subway or bus passes) for client to access healthcare or support services.		
One-way Ride, Taxi/Transportation Company	One-way transportation by taxi or other similar company for client to access healthcare or support services.		
One-way Ride, Van	One-way transportation by a funded agency vehicle for client to access healthcare or support services.		
One-way Ride, Volunteer	One-way transportation by a volunteer for client to access healthcare or support services.		

H2. SERVICE DELIVERY – PSYCHOSOCIAL SUPPORT (Peer Support)

Complete this table only if applying for Psychosocial support (Peer Support)

PSYCHOSOCIAL SUPPORT (PEER SUPPORT)			
Subservice	**Definition**	**Proposed Total Units**	**Activity Description & Responsible Staff**
Peer Support Session, Group*	A regularly scheduled meeting for three or more people with HIV and facilitated by someone who is HIV-infected. One Group Unit = One Hour. **		
Peer Support Session, Individual*	Any face-to-face encounter between an HIV-infected peer advocate and client where peer support services are provided. One Unit = One Hour		
Peer Networking Peer Support Session	A regularly scheduled meeting session for three or more people with HIV where participants are provided with a range of activities that reinforce their social network and psychosocial support.		

* **Time based units** may be reported using increments other than one hour. For example: 1.5 units = 90 minutes, 0.5 units = 30 minutes, or 0.25 units = 15 minutes

** Group Units are calculated on a "client basis". This means that if three clients attend a group session, three client codes and corresponding unites must be included in the billing.

BUDGET INSTRUCTIONS

1. **Budget Instructions** *(See sample budget on pages 32-34. Submit using same MS Excel format provided online at www.bphc.org/rfp).*

- The proposed budget covers a **twelve month** period.
- Use whole dollars (no cents) in completing the budget.
- The "Item" column should list the position title.
- The "Personnel" column should list the first initial of the first name and full last name of the staff person occupying the position (e.g. J. Smith). Enter "TBD" if the position is currently vacant. Program administration positions may be funded, but only if their primary focus is on the proposed service. Ryan White funds are not to be used to pay for agency's administration.
- The "Salary" column reflects a Full Time Equivalent (1 FTE total) salary.
- The "FTE" column is the percentage of time (carried to no more than two decimals) that the position listed is paid for by Ryan White Part A funding. To meet audit requirements, employees cannot exceed a total FTE of 1.0 across all funding sources.
- The "Months" column is the number of months the position listed will be occupied in a twelve month budget period.
- The "Annual" column is the total salary amount that will be paid by Ryan White Part A in a twelve month budget period for the listed position based on the given "FTE" and "Months."

$$\frac{\text{Salary}}{12} \times \text{FTE} \times \text{Months} = \text{Annual}$$

- The "Fringe" rate must be the agency's internal audited fringe rate. Verification of this rate is subject to audit. Fringe is defined as government mandated and employer selected employee benefits including: social security, unemployment, workers and disability compensation, retirement programs, and health insurance.
- Non-personnel expense line item titles should be specific (e.g., Food, Office Supplies, Staff Training, etc. List Brochures instead of simply Supplies).
- Agency overhead cost will be considered for funding under the line item labeled "Indirect" at a maximum rate of 10% of the total direct program costs.

  Indirect costs are all expenses not directly associated with a specific program, which are necessary for the management and operation of the whole agency. It includes such expenses as management, clerical and support personnel, office materials, leasing of office equipment, advertising, postage, printing, insurance, telephones, all facility costs and other related expenses. For agencies wishing to use an indirect rate, documentation of Certificate of Indirect Costs that is **HHS-negotiated**, signed by an individual at a level no lower than Chief Financial Officer, must be provided.

  Administrative Costs are usual, recognized overhead activities, including rent, utilities, and facility costs. It also applies to costs of management and oversight of the specific program funded. Under this title it includes program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/software not directly related to patient care. Administrative Costs are funded at a maximum rate of 10% of the total direct program costs. In addition, the agency is responsible for preparing a project budget that meets administrative cost guidelines and provides expense reports that track administrative expenses.

- The total direct cost (Program Total cost) is the sum of the Personnel Total and the Expense Total.
- The budget page is available in MS Excel format and online at *www.bphc.org/rfp*.

2. <u>Budget Justification</u> (*See sample budget justification on page 35. The Budget Justification may be singled spaced.*)

Justify the proposed budget, including details of all program costs and their relationship to the delivery of services. A short description is required for:

- Each personnel and expense line item including fringe and indirect. Each explanation should be detailed and specific.
    - Personnel position explanations must include the last name of the employee (or, if vacant, the estimated date of hire), and a brief description of the position's duties and responsibilities as they relate to Ryan White funding.
    - Expense item explanations should incorporate quantities whenever possible. Explanations should state why an expense line item is necessary and how the item will be used.
- Travel expenses, which must specify who, where, when and why the travel is necessary. Travel expenses will be reimbursed at a per mile rate not to exceed the Internal Revenue Service's standard mileage rate, which is currently $0.56 per mile.
- Any other expense line items such as food, office supplies, staff training, etc.

ATTACHMENT: SAMPLE BUDGET

Ryan White HIV/AIDS Treatment Extension Act, Part A
Boston Public Health Commission
FY 2016
March 1, 2016– February 28, 2017
AIDS Service Organization
MEDICAL CASE MANAGEMENT

Item	Personnel	Salary	FTE	Months	Annual
Clinical Director	R. Jean-Louis	$100,000	0.05	12	$5,000
RN Clinical Case Manager	K. Diaz	$75,000	0.20	12	$12,000
Medical Case Manager	M. Brown	$45,000	1.00	12	$45,000
Medical Case Manager	O. Almeda	$45,000	0.50	12	$22,500
		SUBTOTAL	1.75		$84,500
		FRINGE	20%		$16,900
		PERSONNEL TOTAL			$101,400
Program Supplies					$3,000
Staff Travel					$300
Staff Training					$300
		EXPENSE TOTAL			$3,600
		PROGRAM TOTAL			$105,000
		HHS INDIRECT/ ADMINISTRATIVE		10.00%	$10,500
		TOTAL AMOUNT REQUESTED			**$115,500**

ATTACHMENT: SAMPLE BUDGET

Ryan White HIV/AIDS Treatment Extension Act, Part A
Boston Public Health Commission
FY 2016
March 1, 2016 – February 28, 2017
AIDS Service Organization
MEDICAL TRANSPORTATION

Item	Personnel	Salary	FTE	Months	Annual
		SUBTOTAL	0.00		$0
		FRINGE	0.00%		$0
		PERSONNEL TOTAL			$0
Taxi Vouchers					$30,000
Train Tickets					$800
Bus Passes					$1,000
			EXPENSE TOTAL		$31,800
			PROGRAM TOTAL		$31,800
			HHS INDIRECT/ ADMINISTRATIVE	10.00%	$3,180
			TOTAL AMOUNT REQUESTED		**$34,980**

ATTACHMENT: SAMPLE BUDGET

Ryan White HIV/AIDS Treatment Extension Act, Part A
Boston Public Health Commission
FY 2016
March 1, 2016 – February 28, 2017
AIDS Service Organization
PSYCHOSOCIAL SUPPORT (PEER SUPPORT)

Item	Personnel	Salary	FTE	Months	Annual
Program Director	S. Alvarez	$65,000	0.20	12	$13,000
Peer Leader	K. Jones	$35,000	1.00	12	$35,000
Peer Leader	M. Pham	$35,000	1.00	12	$35,000
		SUBTOTAL	1.20		$83,000
		FRINGE	20.00%		$16,600
		PERSONNEL TOTAL			$99,600
Clinical Supervision Consultant					$3,500
Support Group Meals					$5,000
Program Supplies					$1,000
Staff Training					$450
Staff Travel					$450
		EXPENSE TOTAL			$10,400
		PROGRAM TOTAL			$110,000
		HHS INDIRECT/ ADMINISTRATIVE		10.00%	$11,000
		TOTAL AMOUNT REQUESTED			**$121,000**

SAMPLE BUDGET JUSTIFICATION

Ryan White HIV/AIDS Treatment Modernization Act – Part A - FY 2016
Agency: AIDS Service Organization

Service Category: MEDICAL CASE MANAGEMENT

Clinical Director:

Incumbent (0.05 FTE) – Jean-Louis

Responsible for ensuring the day-to-day coordination of staff, interdepartmental project meetings, and work schedules, and implementing the department's continuing HIV education seminars. This position also coordinates the implementation of Clinic-Based Case Management performance measures and works with contract managers and staff around contract performance issues.

Nurse Clinical Case Manager:

Incumbent (0.20 FTE) - Diaz

Engages every client in each element of medical case management. Coordinates the primary care team's efforts to ensure that clients receive high quality care and assistance in accessing care and perform initial adherence assessments with new clients, and follow up on adherence assessments when medications are changed.

Medical Case Manager:

Incumbent (1.00 FTE) – Brown

Provides basic case management services and coordinates referrals to needed resources.

Medical Case Manager:

Incumbent (0.50 FTE) – Almeda

Provides basic case management services and coordinates referrals to needed resources.

Fringe:

Government mandated and employer selected employee benefits including: social security, unemployment, workers, and disability compensation, retirement programs, and health insurance. Requested fringe rate is 20%.

Staff Training:

Educational trainings for program staff to increase staff knowledge about current issues relating to HIV care.

Staff Travel:

Vehicle mileage is reimbursed at a per mile rate not to exceed the Internal Revenue Service's standard mileage rate, which as of January 1, 2014 is currently $0.56 per mile.

Office Supplies:

All consumable materials used by the staff and clients such as: paper, pencils, pens, notepads, message pads, staples, file folders, and stationery.

Indirect:

The overall prorated cost of managing and operating the entire agency including such expenses as management, clerical and support personnel, equipment, advertising, postage, insurance, telephones, all facility costs and other related expenses. Proposed Indirect rate is 10%.

ATTACHMENTS

THE FOLLOWING PAGES CONTAIN SEVEN (7) FORMS WHICH MUST BE SIGNED AND RETURNED WITH THE PROPOSAL.

LEGAL ATTACHMENTS

- RYAN WHITE PROGRAM ASSURANCES FORM
- BOSTON PUBLIC HEALTH COMMISSION CONTRACT FORMS
- CERTIFICATE OF AUTHORITY FORM
- AVAILABLE APPROPRIATION FORM
- FEDERAL ASSURANCES – NON CONSTRUCTION PROGRAMS FORM
- FEDERAL CERTIFICATIONS FORM
- BPHC BUSINESS ASSOCIATE AGREEMENT FORM

IN ADDITION, THE FOLLOWING DOCUMENTS MUST ALSO BE SUBMITTED AS ATTACHMENTS. THESE DOCUMENTS ARE *NOT* INCLUDED IN THIS APPLICATION.

PROGRAM ATTACHMENTS

- ORGANIZATIONAL CHART(S)
- MISSION STATEMENT
- BOARD OF DIRECTORS LIST
- BUDGET(S) FOR PROPOSED PROGRAM(S) AND BUDGET JUSTIFICATION NARRATIVE(S)
- JOB DESCRIPTIONS (FOR POSITIONS SUPPORTED BY PROPOSAL)
- COLLABORATIVE RELATIONSHIP CHART (ONLY APPLICABLE FOR COLLABORATIVE PROPOSALS)
- COLLABORATIVE LETTERS OF AGREEMENT (ONLY APPLICABLE FOR COLLABORATIVE PROPOSALS)
- AGENCY LICENSURE AND/OR CERTIFICATIONS (IF APPLICABLE)

FINANCIAL ATTACHMENTS

- VERIFICATION OF 501 (C) (3) STATUS
- DOCUMENTATION OF AUDITED FRINGE RATE
- DOCUMENTATION OF AUDITED INDIRECT RATE
- MOST RECENT SINGLE INDEPENDENT AUDIT REPORT

RYAN WHITE PROGRAM ASSURANCES

The Subcontractor, through the authorized signature below, agrees:

- To become part of the comprehensive plan for organization and delivery of HIV-related health and support services developed by the Boston HIV Services Planning Council.
- To participate in ongoing meetings or task forces aimed to increase, enhance and maintain coordination and collaboration among HIV-related health and support service providers.
- To participate in an HIV community-based continuum of care, to the extent such a continuum exists, with a community-based continuum of care defined as described in the RFP.
- To assure that Ryan White Part A grant funds will be used in compliance with all funding restrictions as described in the RFP.
- To ensure that no funding will be requested from BPHC that could be reimbursed through Medicaid, private insurance or another funding source.
- To make its services available to any eligible individual without regard to ability to pay or the current or past health condition of the individual and to make its services available in settings accessible to low-income persons.
- To ensure client eligibility for services funded by Ryan White Part A dollars by following the HIV Verification guidelines.
- To ensure client confidentiality by obtaining client consent for the visual review of files and make clients aware of HIPAA Business Partner status with BPHC. To participate in the needs assessment process.
- To participate in any evaluation conducted by and/or for BPHC or the funding source related to the dissemination and/or utilization of Ryan White Part A funds.
- To comply with monthly, quarterly, and annual reporting requirements.
- To attend mandatory meetings with other Part A Ryan White funded service providers for the purpose of training, networking, exchanging information, sharing resources, and formalizing linkages.
- To comply with all other requirements as stipulated in the RFP.

Signature of individual authorized to sign contracts for agency:

Agency Name: _____

Signature: _____ Date: _____

Name: _____Title:_____

BOSTON PUBLIC HEALTH COMMISSION
Contract Forms

Notice: Failure to provide any of the following information, unless specifically excepted in the Request for Proposals, will result in a non-responsive proposal.

Full Legal Name: _____
Place of Business: _____

Contact Person: _____ Tel: _____

To the Official, acting in the name and behalf of the Boston Public Health Commission ("BPHC"):

A. Summary of Supplies/Services Subject to RFP

The undersigned proposes to furnish the specified supplies or services and to perform all work required in the Boston Public Health Commission Request for Proposals, Advertisement, Purchase Description and Specifications and/or other contract documents,
titled:
_____(Do Not Complete)_____
_____

and dated: _____, the terms of which are incorporated herein, all of which have been provided by the BPHC.

Notice: You must itemize any deviation from original specifications on a separate sheet. Catalogs or brochures will not be accepted as sole compliance with this requirement unless they also include complete technical information.

B. Documents Included

In addition to this RFP Form, this response includes the following documents:
_____(Do Not Complete)_____

C. Price Proposed

1. The total proposed price for this contract is:
_____(Do Not Compete)_____
Notice: Complete in words and figures. You may attach a separate schedule.
2. The price components of the proposal are:
_____(Do Not Complete)_____

Notice: Complete as required in Price Requirements in the Purchase Description and Specifications, e.g., rates, price changes, first fiscal year, total contract period, etc. You may attach a separate schedule.

D. References

1. List three (3) or more contracts on which the agency served as contractor or have provided goods or services, as the case may be, within the past two (2) years (unless a lesser or greater period is specified by the Official) for work of similar character as required in the Request for Proposals.

Reference 1
Nature of Contract: _____

Company or Entity: _____

Contact Name & Phone #: _____

Amount of Contract: _____

Reference 2
Nature of Contract: _____

Company or Entity: _____

Contact Name & Phone #: _____

Amount of Contract: _____

Reference 3
Nature of Contract: _____

Company or Entity: _____

Contact Name & Phone #: _____

Amount of Contract: _____

2. ***Bank References***

Name of Bank & Phone #: _____

Name of Bank & Phone #: _____

Name of Bank & Phone #: _____

E. Legal Form of Business Entity

The entity submitting this proposal is a/an _____
(Individual, Partnership, Corporation, Joint Venture, Trust, or specify other).

1. If a Partnership, state the name and residential addresses of all general and limited partners:

_____

_____

2. If a Corporation, state the following:

Corporation is incorporated in the State of _____

President is _____

Treasurer is _____

Address of business is _____

_____

3. If a Joint Venture, state the name and business address of each person, firm or company that is party to the joint venture:

_____

_____

A copy of the joint venture agreement is on file at _____
and will be delivered to the Official on request.

4. If a Trust, state the name and residential address of each Trustee:

_____

_____

Copies of the trust documents are on file at _____
and will be delivered to the Official on request.

5. The names and addresses of all persons interested in this proposal as principals other than the undersigned are:

_____

_____

6. If the business is conducted under any title other than the real name of the owner, state the time when, and place where, the certificate required by General Laws c. 110, sec. 5 was filed:
_____

G. Taxpayer Identification Number* (the number on the Employer's Quarterly Federal Tax Return, U.S. Treasure Department Form 941) is:
_____

*If individual, use Social Security Number: _____

H. Have been in business under present business name _____ years.

I. Has the agency or any other principals ever failed to complete any work awarded? _____

If answer is yes, state circumstances: _____

_____

J. Pursuant to M.G.L. c. 62C, sec. 49A, the undersigned certifies that to the best of his/her knowledge and belief all state tax returns have been filed and that all state taxes required under law have been paid. (Notice: The Taxpayer Identification Number may be furnished to the Massachusetts Department of Revenue to determine compliance with the above-referenced law.)

K. The undersigned certifies that this proposal has been made and submitted in good faith and without collusion or fraud with any other person. As used in this certification, the word "person" shall mean any natural person, business, partnership, corporation, union, committee, club, or other organization, entity or group of individuals.

L. In furtherance of the Mayor's Executive Order "Minority and Women Business Enterprise Development" dated December 31, 1987 and the Ordinance entitled "Promoting Minority and Women Owned Business Enterprises in the City of Boston" (Ordinances of 1987, Chapter 14), it is understood and agreed by the undersigned, and the undersigned by the execution of this document so certifies, as follows, (1) That the undersigned shall actively solicit bids for the subcontracting of goods and services from certified minority and women businesses; and (2) That in reviewing substantially equal proposals the undersigned shall give additional consideration to the award of subcontracts to certified minority and women bidders.

M. *Applicable to any contract which involves costs reimbursable by the U.S. Department of Health and Human Services in which services provided have a value or cost of $10,000 or more over a twelve-month period:* Pursuant to the requirements of 42 U.S.C. sec. 1395X(v)(1)(E), as enacted by Public Law 96-499, the undersigned agrees that until the expiration of four (4) years after the furnishing of goods or services, it shall make available the contract, and books, documents and records that are necessary to certify the nature and extent of such costs to the Secretary of the Department of Health and Human Services, or to the Comptroller General, or any of their duly authorized representatives upon written request. If the undersigned carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of such goods or services pursuant to such subcontract, the related organization shall make available the subcontract, and books, documents and records of such organization that are necessary to

verify the nature and extent of such costs to the Secretary, or to the Comptroller General, or any of their duly authorized representatives upon written request.

N. In the event that the proposal submitted by the undersigned is accepted, the undersigned shall provide goods or services pursuant to the then current terms and conditions of the Boston Public Health Commission Standard Contract. A copy of the current Boston Public Health Commission Standard Contract is attached hereto.

The undersigned certifies the accuracy of the information provided herein under the penalties of perjury.

Submitted by: _____

By: _____
(Signature)

Business Address: _____
(Street)

_____
(City, State, Zip Code)

Notice: This Proposal must bear the written signature of the person submitting the proposal. If submitted by an Individual doing business under a name other than his/her own name, the bid must so state, giving the address of the Individual. If submitted by a partnership, the bid must be signed by a partner designated as such. If submitted by a corporation, trust or joint venture, the bid must be signed by a duly authorized officer or agent of such corporation, trust or joint venture.

Approved as to form by the Office of General Counsel September, 1998.
This Form is void and without legal effect if altered in any way.

Certificate of Authority

(For Corporations Only)

_____, 20__
(Current Date)

At a meeting of the Directors of the _____
(Name of Corporation)
duly called and held at _____
(address)
on the _____ day of _____, 20___, at which a quorum was present and acting, it was VOTED, that _____
(Name)
the _____ of this corporation is hereby
(Office)
authorized and empowered to make, enter into, sign, seal and deliver on behalf of this corporation a contract for _____
(Describe Service)
with the Boston Public Health Commission, and if required by such contract, a performance bond in connection therewith.

I do hereby certify that the above is a true and correct copy of the records, that said vote has not been amended or repealed and is in full force and effect as of this date, and that _____ is the duly elected
(Name)
_____.
(Office)

Of this corporation

Attest

(Affix Corporate Seal) _____
(Clerk or Secretary of the Corporation)

[corpcert.doc]

AVAILABLE APPROPRIATION

The Subcontractor understands and agrees that the Boston Public Health Commission's financial obligation under this contract is expressly subject to the availability of an appropriation. The Subcontractor further understands and agrees that notwithstanding the approval by the Boston Public Health Commission of a contract term which extends beyond the current fiscal year, this contract is null and void and without legal effect unless the Boston Public Health Commission has so notified the Subcontractor in writing, and that an appropriation is available for each (or any) successive fiscal year during which the contract is effective. In the absence of such certification and notification, this contract shall terminate as of the last day of the fiscal year in which an appropriation was certified is available.

_____

(Name and Title of Authorized Person Signing Bid or Proposal)

_____

(Signature)

_____

(Name of Business)

_____

(Date)

FEDERAL ASSURANCES - NON CONSTRUCTION PROGRAMS

To be added when converted to PDF

FEDERAL CERTIFICATIONS

To be added when converted to PDF

BOSTON PUBLIC HEALTH COMMISSION
BUSINESS ASSOCIATE AGREEMENT

FORM B

This Agreement is made effective the 1st of July 2006, by and between the Boston Public Health Commission, "BPHC", and (agency) _____ **,** hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to BPHC, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of a Covered Entity as defined in the HIPAA Privacy Rule.

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

THEREFORE, in consideration of the Parties' continuing obligations under this Agreement, compliance with the HIPAA Privacy Rule, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Privacy Rule and to protect the interests of both Parties.

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Privacy Rule, as amended, the HIPAA Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Privacy Rule, but are nonetheless permitted by the HIPAA Privacy Rule, the provisions of this Agreement shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Business Associate acknowledges and agrees that all Protected Health Information that is created or received by BPHC and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by BPHC or its operating units to Business Associate or is created or received by Business Associate on BPHC's behalf shall be subject to this Agreement.

II. CONFIDENTIALITY REQUIREMENTS

(a) Business Associate agrees:

(i) to use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom BPHC is required to disclose such information or as otherwise permitted under this Agreement, (if consistent with the HIPAA Privacy Rule), and (3) as would be permitted by the HIPAA

Privacy Rule if such use or disclosure were made by BPHC;
(ii) at termination of this Agreement, or any similar documentation of the business relationship of the Parties, or upon request of BPHC, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of BPHC that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and (iii) to ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of BPHC, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.

(b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:

(i) if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:
(A) the disclosure is required by law; or
(B) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;
(ii) for data aggregation services, if to be provided by Business Associate for the health care operations of BPHC pursuant to any agreements between the Parties evidencing their business relationship.

(c) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to use and disclosure of Protected Health Information to ensure BPHC's compliance with the terms of the HIPAA Privacy Rule. Business Associate shall report to BPHC any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

III. **AVAILABILITY OF PHI**

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Sections 164.524; 164.526 and 164.528 of the HIPAA Privacy Rule which permit the patient/client to access rights, amendment rights and an accounting of disclosures of his/her Protected Health Information.

IV. **TERMINATION**

Notwithstanding anything in this Agreement to the contrary, BPHC shall have the right to terminate this Agreement and the Arrangement Agreement immediately if BPHC determines that Business Associate has violated any material term of this Agreement. If BPHC reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, BPHC gives notice to Business Associate of such belief, and Business Associate fails to provide adequate written assurances to BPHC that it will not breach the cited term of this Agreement then BPHC shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. **MISCELLANEOUS**

Except as expressly stated herein or the HIPAA Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of

this Agreement is intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of Massachusetts. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The Parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to BPHC contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

BOSTON PUBLIC HEALTH COMMISSION: *«Agency»*

By: _____ **By: _____**

Title: _____ **Title: _____**