City of Chicago Department of Public Health
Request for Proposals (RFP) for HIV Prevention Projects
RFP #DA-41-3350-11-2014-003

Question: For Category A1, how should a respondent indicate regions if they plan to provide services citywide?
Answer: The respondent should indicate one or more regions in the city, north, south, or west, and then identify target populations within each region.

Question: For Category A1 in the RFP, can a respondent combine all of the target populations for which we are applying in one proposal? If that’s the case, does this extend the page limit?
Answer: Multiple target populations may be included in one proposal for Category A1. The page limit is not extended in this case. A respondent should not submit more than one application for A1.

Question: Does the eligibility requirement that a respondent have three years of experience providing HIV prevention services apply specifically to HIV testing, the proposed services, or to HIV Prevention services in general?
Answer: Respondents are required to have at least three years of experience providing HIV prevention services or HIV care services. They do not have to be the exact services described in the respondent’s proposal.

Question: Is a copy of Economic Disclosure Statement required as part of the application?
Answer: It is required at the time of contract, but not at the time of application.

Question: Category A1 has multiple geographic regions. Does a respondent have to submit two different applications?
Answer: No. Only one application should be submitted for Category A1. A respondent may indicate that they are proposing to serve more than one region.

Question: If our agency currently has multiple grants for HIV counseling and testing, and the total award amounts add up to more than $175,000, do we have to stay under the $175,000 range for Category A1?
Answer: Yes. A respondent cannot request more than $175,000 for Category A1.

Question: Is there room for CDPH to fund part of a proposal?
Answer: CDPH will base final awards and amount funded to ensure adequate geographic and high-risk coverage.

Question: Is CDPH willing to fund staff for Partner Services?
Answer: Yes, but only under Category A3. In this Category, a respondent may budget for staff that provides Partner Services.

Question: Is Walgreens considered a Community-Based Organization (CBO)?
Answer: No. They are considered a company, business or corporation and not a community-based organization. If a respondent is considering having Walgreens or this type of company play a role in their program, the respondent should list all partners (funded and non-funder, CBO and other) in the program narrative and explain their roles in the proposed project.
**Question:** There are Logic Model factors that may impact stigma. Are we expected to address how we are going to deal with stigma?

**Answer:** The Logic Model presented was an example. It was meant to show how assumptions and external factors (such as stigma) impact program planning. In the program narrative, respondents are expected to explain barriers to their program and how they may be overcome. Stigma is an example of a barrier. However, respondents may describe numerous barriers and plans for overcoming them based on their proposed target population and program plan.

**Question:** In the CDC high impact prevention funding opportunity [for Comprehensive High-Impact Prevention Projects for Community-Based Organizations (CDC-RFA-PS1502)], they talk about how many positives have to be identified. If you fail to identify them will funding will be taken away?

**Answer:** For A1, A2, and A3, the CDPH RFP lists number of positives to be identified. The numbers are a goal, and successful applicants are expected to meet these goals. This is a two year program. CDPH will work with agencies to meet the numbers if they don’t meet them in year one. Performance is considered a factor in renewing and extending contracts.

**Question:** Do agencies applying for more than one funding category submit one CD or separate CD’s for each category?

**Answer:** Separate. Respondents should submit a separate CD or member device for each category submission.

**Question:** How flexible is the A3 model?

**Answer:** A successful respondent is expected to meet each of the four eligibility factors and to deliver each of the services/components listed.

**Question:** Do you recommend that large health care systems get individual MOU’s with partner agencies.

**Answer:** Yes, if they are an active part of your proposed program and services.

**Question:** What is the agreed upon definition of Linkage to Care?

**Answer:** The RFP is using the CDC’s definition; persons who receive their HIV + test results are linked to medical care and attend their first appointment within three months of diagnosis.

**Question:** Has CDPH set a concrete date for letting agencies know of their award letters? How committed are they sticking to that date?

**Answer:** CDPH is planning on issuing award letters before the end of the year. The goal is December 19, 2014.

**Question:** How do you differentiate between Administration costs/budget and Program costs/budget for managers or directors on a budget?

**Answer:** This should be based on tasks they are performing and cost allocation. If the position is actively contributing the program delivery/services, they can be included as a direct services cost on the program budget. The percent of time charged to a program budget should be based on the agency’s cost allocation. If a manager or director level position is not contributing directly to the program, they should not be included on the direct services costs/program budget, but may be included as a cost on
the administrative budget. The total administrative budget cannot exceed 10% of the direct services costs/program budget.

**Question:** Why does the Evaluator (Category E) have to be associated with an academic institution vs. an evaluation firm?
**Answer:** The RFP specifies that the evaluator be an academic institution. CDPH is looking for economies of scale, varied staff expertise, and data dissemination/publication of evaluation findings.

**Question:** Can an agency use social networking strategy in Category A-1?
**Answer:** Yes, SNS can be used as part of the outreach strategy in A1. However, a respondent that is specifically focusing on SNS for MSM or Transgender populations may apply under Category A-2.

**Question:** Is there a minimum amount or percentage of people residing in targeted communities who need to be addressed in the demonstration projects?
**Answer:** There is no minimum amount/percentage, but respondents are encouraged to maximize prevention resources and reach those in need of services to decrease new HIV infections.

**Question:** Why is there a 50+ category only for MSM?
**Answer:** Target populations (listed on p.7, including Non-Hispanic Black MSM 50+ and Non-Hispanic White MSM 50+) were determined based on populations with the highest number of HIV diagnoses and prevalence as identified through surveillance data.

**Question:** Explain the separate budgets for program costs and administrative costs. Is there a format?
**Answer:** Administrative costs should not exceed 10% of direct program/services cost. There is a not a specific format for administrative costs or a different type of budget template. The budget forms are the same for services costs and administrative costs. A respondent should complete two sets of budget forms with each application: one for services costs and one for administrative costs.

**Question:** If we take the 10% Admin, do you expect us to have a cost allocation plan?
**Answer:** Yes. There are narrative questions that ask how you do your cost allocation plan.

**Question:** If we take indirect costs, how should we handle them in the budget?
**Answer:** Indirect costs should be included as part of the administrative budget

**Question:** Is it acceptable to just take direct program costs?
**Answer:** Yes. A respondent is not required to budget for or request administrative costs. However, if administrative costs are requested, they cannot exceed 10% of services costs and a separate administrative budget must be completed.

**Question:** If we choose to list flat 10% indirect as admin, will we be required to include federally approved indirect cost rate.
**Answer:** Yes.

**Question:** For Prevention with Positives, C-1, START is listed as a CDC-supported behavioral intervention. However, it is not listed under D3 as a behavioral intervention. Why not?
Answer: The CDC supported interventions are taken directly from CDC’s funding announcement PS1502-02. START is intended for prevention with positives. It is not listed as an intervention for HIV negative individuals. CDPH is aligning with CDC-supported behavioral interventions.

Question: Does the Logic Model have to include outcomes for every input?
Answer: The Logic Model provided was an example. In the example, each input wasn’t mapped directly to a short, medium and long term outcome. It was meant to be a high-level example. The respondent should show how all of the components of the Logic Model relate to each other in the program design. An input or activity does not need to be labeled in a way so that it can be tracked across the model. An ideal response would show the logic of how assumptions, external factors, inputs, and outputs all impact the intervention’s outcomes.

Question: For the partnerships that are encouraged, is there a preference for them to be funded or non-funded?
Answer: No. There is no preference. Under each Category’s questions, there is a section on partnerships that asks the respondents list all partnerships and if there are funded or non-funded. The importance is that the work gets done and there is a commitment from a collaborating organization, regardless of the funding situation.

Question: In the target populations for A1, non-Hispanic African American heterosexual men are not listed. Are they not a target group?
Answer: They are not considered for A1. The groups were determined based on those more likely to infect and/or transmit HIV based on the most recent surveillance data.

Question: The CDC RESPECT intervention is not listed in RFP. Are respondents limited to the behavioral interventions listed in the RFP?
Answer: Category C1 is limited to the CDC-supported behavioral interventions for HIV positive persons, which are specifically listed in the RFP. For Category D3, a respondent proposing to provide a CDC supported behavioral intervention for high-risk HIV negative persons is limited to those CDC behavioral interventions listed in the RFP. The CDC supported interventions listed in the CDPH RFP are taken directly from CDC’s listing in their recent Funding Opportunity Announcement PS1502-02.

Question: Can you speak to the reference to third-party payers. Is this something new related to the Affordable Care Act? For HIV prevention programs and testing, there is very little that Medicare or Medicaid cover.
Answer: There is a statement on p. 6 of the RFP that, when appropriate and feasible, respondents are expected to explore options for third-party billing and reimbursement. CDPH is working to align with CDC’s prevention approach. For the RFP, if a CBO is working with a clinical provider or if the respondent is a clinical provider, who can bill for some services, grant funds should not be used to support such services. There are several components where clinical activities, such as confirmatory testing, STI testing and Hepatitis testing, are required and where third party billing can be conducted by a clinical provider or partner.

Question: What are examples of unallowable costs?
Answer: In general, funds should not support services outside of the city of Chicago or services that are not allowed through the RFP. Approved cost categories are listed in the RFP. CDPH does not allow for
purchase of medications under this RFP. Only costs directly related to the program should be listed in the direct services costs. Administrative costs are limited to 10% of direct costs.

**Question:** Should scopes be outlined in the Work Program?
**Answer:** The Work Program is very similar to scopes. It should be completed to show a timeline for activities and to list key activities and deliverables.

**Question:** When and how will scopes be determined? How will scopes be determined for the demonstration projects?
**Answer:** In order to get selected agencies under contract, CDPH will need completed budget and scopes forms. Successful respondents for demonstration project categories will work with the Evaluator to finalize intervention design, program outcomes and data collection measures within the first three months. More detailed plans for outcome measures and evaluation will be developed during the first three months of the project for these demonstration projects.

**Question:** Is the Evaluation Category restricted to academic institution?
**Answer:** Yes

**Question:** Is it possible for non-academic institutions to apply in conjunction with an academic institution?
**Answer:** Collaboration is encouraged for all program categories. In this situation, the academic institution would apply as the lead.

**Question:** In, A1 post-incarcerated individuals are listed as a special concerns population. Can this include male and female?
**Answer:** Yes. Post incarcerated can include male as well as female. In the program narrative, the respondent should justify their target population based on need.

**Question:** Do post-incarcerated males need to be MSM?
**Answer:** No

**Question:** If using a DEBI in A1, does it need to be a currently sanctioned CDC DEBI?
**Answer:** No, but any intervention used should be evidence-informed. The respondent should justify the services proposed.

**Question:** Does CDPH anticipate any changes in billing?
**Answer:** The City is moving toward vouchering in the Cyber Grants system. In 2014, Cyber Grants has been used for vouchering only for CDBG-funded programs. In the future, the City will move toward Cyber Grants being used to voucher for all grant-funded programs. CDPH is also working on being more efficient and timely with contracting and vouchering.

**Question:** Does CDPH anticipate any changes in reporting?
**Answer:** CDPH anticipates maintaining quarterly reporting. However, reports may be updated, since we have updated program categories. CDPH also anticipates agencies submitting counseling and testing data to us in spreadsheets for individual testing events the way that is currently done now.

**Question:** Does CDPH anticipate issuing award letters before the end of the year?
Answer: Yes.

Question: For those agencies that applied to the CDC under 1502, we are to state how the services to be requested in the CDPH grant will be coordinated with proposed CDC-supported services. Given the number of agencies in Chicago applying under 1502 and the limited number of awards, most agencies applying will not receive an award through 1502. Will our application to CDPH for Prevention be looked on unfavorably if the target population identified in the application and the services for that population are the same as for what we applied for under 1502?
Answer: No, but should the respondent receive CDC funding, they will need to provide a written explanation of how their work under this RFP will be coordinated and enhance the CDC grant activities.

Question: If we get an award from CDPH to serve a target population and get an award from the CDC under 1502 for the same target population would we need to turn down the CDC award even though it is for more money and a longer time period in order to avoid supplanting CDPH funds?
Answer: No. CDPH would not require a successful respondent that is awarded both CDC and CDPH funds to turn down the CDC award. However, the respondent will need to provide a written explanation of how their work under this RFP will be coordinated and enhance the CDC grant activities.

Question: Would it be possible that we could accept the CDC funds and CDPH would reallocate their funds.
Answer: If a respondent is successfully awarded both CDC and CDPH funds for HIV Prevention, CDPH will work with the applicant organization to determine how to coordinate the awards and whether the CDPH funding would need to be repurposed or reallocated.

Question: Will you be providing a template for the appendix pages (budgets, logic model) or so we have to recreate those to match best we can?
Answer: Yes. The Appendices have been posted online as Word or Excel documents.

Question: Please confirm that you only need a one year budget
Answer: Yes. The budget submitted with the application should be for one year, January 1, 2015 – December 31, 2015.

Question: Do MOU’s need to be finalized or can there be a template with a list of organizations and a description of what the MOUs will cover with each organization?
Answer: CDPH preference is for MOU’s to be finalized at the time of application. If MOU are not finalized at the time of application, the respondent organization should state this in their narrative response. If MOU are not included with the application, the applicant organization can submit a listing of organizations with which the respondent plans to develop MOU. However, preference is for actual, executed MOU’s to be included with the application.

Question: Can you confirm that the page limit for D3- Outreach & Engagement is 1 page? It was 2 pages for all other categories.
Answer: Respondents may utilize up to 2 pages for their response to the questions listed under Category D2 Outreach and engagement.

Question: Should an evaluation site budget for participant payments? I couldn’t locate any clear language in the RFP that outlined how the data collection procedures for the evaluation site would
operate in conjunction with the demonstration project procedures. Should we include participant payments in our budget to allow for collection on individual-level measures pertinent to the overall evaluation plan, or will this be included in the demonstration site funds?

**Answer:** Agencies applying for Demonstration project categories are allowed to budget for incentives to promote and/or compensate for participation in the proposed intervention. The Category E Evaluator may budget for incentives to promote and/or compensate participation in evaluation-related activities. During the three month start-up period, the Category E Evaluator and successful respondents will finalize their program plans, including need for and role of incentives.

**Question:** In Category C1 (prevention for positives), in Appendix B there is no mention of positives over age 49.

**Answer:** Both Non-Hispanic Black MSM 50+ and Non-Hispanic White MSM 50+ are listed as target populations in the C1 chart in Appendix B (p. 51 of the RFP).

**Question:** Regarding D3 target population. We are defining high risk negatives as people who attend our STD clinic 3 or more times in a 12-month period. Will that suffice for the indicated target population definition?

**Answer:** The respondent should justify why the population they are proposing to serve is high-risk and in need of HIV Prevention services.

**Question:** Question 44 in Category A1 regarding describing criteria for selecting partners seems to be written from the point of view of a testing organization selecting a clinic partner. We are a provider with an outreach program, and will partner with some CBOs to help with testing, but not sure how to answer this question, especially sub-part 4)-types of services for positive and negative persons to access.

**Answer:** A clinical provider may partner with one or more community-based organizations to perform key services such as outreach and recruitment, HIV testing, linkage to care/patient navigation for persons identified as positive, and assessments for and linkage to support services for persons identified as negative. We are requesting that the respondent describe their rationale for selecting partnering organizations and how collaborators will help ensure access to required service components.

**Question:** Can MOU’s refer to multiple grants or do partners need to complete a separate MOU for each grant on which we are collaborating or providing referral support?

**Answer:** MOU’s can refer to multiple grants/projects but should be specific about the various activities to be provided on the multiple grants.

**Question:** RFP page 8 and 4 address the changes and services under A1. Can you explain “Prevention and support services for high-risk negatives”? In the past we have provided group education. Can we still provide this service under Category A1?

**Answer:** Yes. Group education can be considered a service for high-risk negatives under Category A1. The respondent should describe the rationale for selecting the proposed services.

**Question:** For the Logic Model, does participation mean the number of clients who participated? What should I fill out for Assumption at the bottom?

**Answer:** Participation refers to different participants and stakeholders involved in your program. It can include descriptions of participants served, staff, community stakeholders, etc. It does not need to include numbers of individuals in each of these groups. Assumptions should include various assumptions that informed the design of your program. This will vary by program and program design.
**Question:** Is there a support system to absorb the costs of Hepatitis C or HIV testing kits?  
**Answer:** CBOs conducting testing during outreach can request HIV test kits from CDPH. Clinical providers should be able to bill third party payors for the cost of HIV testing and testing for STI, Hepatitis and other testing. CBO/clinic collaborations allow for partnering with a clinical provider that may perform and bill for some key functions, including confirmatory HIV testing and testing for Hepatitis, STI, and TB.

**Question:** Can agencies submit multiple proposals under a specific category?  
**Answer:** Agencies should not submit more than one proposal per Category unless the respondents are from different programs within the agency and are proposing separate and distinct interventions.

**Question:** Does the target population have to reside in the area? Or does the testing take place in the area?  
**Answer:** Geographic regions were identified based on residence of people diagnosed and living with HIV. For the purpose of geographic targeting, a respondent may consider where people reside, where testing will be conducted, and/or where services will be delivered. Proposals should clearly specify the rationale for the proposed geographic area based on maximizing reach of the target population.

**Question:** If applying to provide HIV Testing, will CDPH supply test kits or will agency need to factor this into their budget?  
**Answer:** Respondents should justify their choice of testing technology in their application. If the proposed technology is supported by CDPH, test kits will be provided based on availability. Agencies should attempt to cover expenses for confirmatory testing through their partnership with clinical providers. If test kits and/or confirmatory HIV testing cannot be covered by provider, respondents should describe the circumstances and add this expense to their budget.

**Question:** Do we need to use the NIH salary cap?  
**Answer:** The salary cap to be used is $199,700 (Executive Level II). Senior Executive Level II salary can be found at the Office of Personnel Management web site: [http://www.opm.gov/oca/12tables/indexSES.asp](http://www.opm.gov/oca/12tables/indexSES.asp)

**Question:** We see our hospital as best fitting into Category A1; however we do test more than 4500 clients per year. Are we still eligible to apply under Category A1?  
**Answer:** Yes. However, in your application you should describe how your targeting approach under category A1 is the best fit for your program and why this approach will produce a greater yield than routine opt-out testing.

**Question:** With regard to target populations—we see a wide range of people who come through our emergency department; however, for purposes of outreach and recruitment we would like to specify three target populations from your priority list—we are assuming that makes sense as a strategy?  
**Answer:** For A1 this would be acceptable. A main difference between A1 and A3 is that A1 is intended for targeted HIV testing (which may take place in a community-based, mobile, clinic or other type of setting) whereas A3 is intended for routine, opt-out HIV testing in a clinical setting. Even though you are a clinical setting, if you are proposing targeted HIV testing as opposed to routine, opt-out testing, your
proposed targeting strategy fits under A1 instead of A3. Another main difference between A1 and A3 is that successful respondents under A3 will be required to provide Partner Services.

**Question:** The target population for Category C1 and C2 are PLWHA, correct? So we don’t have to say MSM or ages, right?

**Answer:** A respondent for C1 and C2 (Prevention with Positives Projects) should describe and justify their selection of the target population based on surveillance data and need in their narrative response. If proposing to serve any of the target populations listed in the chart in the Title Page/Appendix B for C1 or C2, the respondent should indicate this in submission of their Title Page. However, populations proposed to be served may be broader than those listed in the chart.

**Question:** For category A3, we do about 400 rapid HIV tests per month in the screening clinic. If funded, will CDPH be providing the test kits (we use) unigold?

**Answer:** An expectation of a clinical provider funded under A3 is that they be able to bill third parties for HIV, STI, TB and Hepatitis testing, including the cost of test kits. Funded agencies will not be performing direct key entry of HIV Testing data into Eval Web. CDPH will provide the successful applicant with a template of required data elements appropriate for clinical settings to be submitted to CDPH.

**Question:** We are looking to submit a proposal for this RFP under category A3. We have a question regarding the "integrated testing for STIs, viral Hepatitis, and TB" component mentioned in the description of this category. Does this mean that all patients tested for HIV would also be routinely screened for all of those other diseases? Or does the integrated testing just refer to testing services that must be provided to all those who test positive for HIV? I appreciate your help clarifying this issue.

**Answer:** Yes. STI, Viral Hepatitis and TB testing should be conducted in coordination with HIV testing.

**Question:** I understand that Category A1 can serve multiple target populations under one application. For the other Categories, what constitutes one population per application? Is one population MSM and another population heterosexual Black females; or is it Black MSM, Latino MSM, etc.; or is it Black MSM 13 – 19, Black MSM 20 – 29.

**Answer:** It depends on the category as some are more specific than others (see Table 1). Respondent should provide rationale for selection of the target population based on surveillance data, population need and maximization of client reach.

**Question:** In budget section-RFP page 20, question 50 asks “percentage of budget that will support HIV testing”. Testing kits are currently provided by CDPH. What do you mean by this question or do we need to budget for testing kits?

**Answer:** CDPH is requesting an estimate of the total A1 budget that supports HIV testing activities. This should describe staff that conduct outreach and testing, as opposed to staff that provide linkage to care or services to persons who test HIV negative. The budget can include kits and other supplies with proper justification as to why these costs cannot be billed to a third party.

**Question:** We have used pictures before in applications, are they allowed in these narratives?

**Answer:** Pictures and graphs are allowable, but do not exceed page limits for each section.
Question: We have used tables before, are they allowed in the narrative?
Answer: Tables are allowed, but do not exceed page limits for each section.

Question: We are proposing an innovative, locally developed intervention, would it be acceptable to submit example activities from the curriculum or the entire curriculum with the application as an attachment? We realize the entire curriculum would be very cumbersome, but we wanted to show some examples.
Answer: Please do not include any attachments other than the required attachments that are listed in the RFP.

Question: Do we have to use the logic model format that you provide, or can we use our own?
Answer: Use the Logic Model template included in the RFP. A Word version is available on the CDPH web site.

Question: Pertaining to C-1, the RFP list Partnership for Health, as a biomedical Intervention option. At current, the CDC has released new biomedical interventions to support medical and Treatment adherence for HIV positives. Can applicants use other biomedical interventions listed on the Effective Interventions.org compendium to support prevention with positives, Such as HEART, Peer Support and Every Day, Every Dose, etc.,
Answer: For C-1, respondents should only apply to provide the CDC-supported behavioral interventions specifically listed in the CDPH RFP.