**Organization name: ###**

**Application instructions:**

You must submit your application by email: [ID.RFARyanWhite@doh.wa.gov](mailto:ID.RFARyanWhite@doh.wa.gov). Your application must be received by the RFA Coordinator before the application deadline of 5:00 pm PST on Monday, June 5, 2023. Any delay in the delivery of your application is your risk; we do not take responsibility for delays in email delivery. You may not send your application by fax.

We will not accept late applications and will disqualify them from further consideration. All applications and any accompanying documentation become the property of the DOH and will not be returned.

As a reminder, information provided in application documents is subject to public disclosure per section 3.3 of this RFA. Do not include information in your response that you do not want disclosed to the public.

Be sure to reference additional requirements and scoring in the full RFA, found on our website: [Funding Opportunities | Washington State Department of Health](https://doh.wa.gov/about-us/programs-and-services/executive-office-health-and-science/disease-control-and-health-statistics/funding-opportunities).

Please keep the application packet materials in the same order they appear when you download and maintain original formatting for narrative responses (letter-sized (8 ½ x 11 inch) format, with 1-inch margins, single spacing, and use either Arial, Calibri, or Times New Roman, in a minimum of 12-point font). When you submit the application packet, please be sure the name of the document includes the name of your organization and the service category you are applying for.

On any section that requires a signature, you can sign with an electronic/digital signature format: /s/First name Last name. (Example: /s/John Doe.)

You may apply for more than one service category.

**Application contents and checklist (optional):**

|  |  |  |
| --- | --- | --- |
| **Section** | **To do/include:** | **Check when done:** |
| **Service category description and requirements** | Review full description and all requirements before starting your application. |  |
| **Submission Cover Form** | Respond to all questions and have legal representative sign and date. |  |
| **Signed RFA certifications and Assurances** | Have legal representative sign these forms:   * Bid certifications and assurances * Contractor Certification – wage theft prevention * Workers’ rights – Washington state goods & services contracts certification |  |
| **Organizational Background** | Respond to all questions |  |
| **Proposal: Program Approach** | Respond to all questions |  |
| **Proposal: Outcomes** | Respond to all questions |  |
| **Qualifications: Staffing** | Respond to all questions, and attach:   * Completed Staffing Capacity Form * Positions descriptions for all funded positions (including existing and new staff) * Organizational chart |  |
| **Qualifications: Partnerships** | Respond to all questions, and attach:   * LOS or MOUs (if applicable) |  |
| **Budget** | Complete Budget Template |  |

**Service category description and requirements:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Category** | | **Minimal required elements** | | **Optional enhancements** | | |
| Medical Case Management | | Provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Includes all types of case management encounters with or on behalf of a client (face-to-face, phone contact, or any other forms of communication).  Activities may include:   1. Initial assessment of need. 2. Development of individualized care plan. 3. Coordinated access to health and support services. 4. Client monitoring to assess the care plan. 5. Re-evaluation of the care plan. 6. Ongoing assessment of the client's needs. 7. Treatment adherence counseling. 8. Client-specific advocacy or review of use of services. 9. Benefits counseling.   Ryan White must be payor of last resort. Contractor must bill HCA monthly for any Title XIX eligible clients and report to DOH. | | * Case Management that touches other syndemics (Viral Hepatitis, Drug User Health, mental health, etc., in addition to HIV,.), or is low barrier case management. * Service provided in Spanish to clients by Spanish-speaking case managers. * Agencies with designated Locating Out of Care (LOOC). (Either designated case manager or specific job functions which can be quantified and documented.) | | |
| **Service Category** | **Minimal required elements** | | | | **Optional enhancements** | |
| Peer Navigation  *Outreach Services* | Outreach Services provide the following activities:   1. Linkage or re-engagement of PLWH who know their status to HRSA RWHAP services and/or medical care. 2. Referral to appropriate supportive services.     Outreach Services provided to an individual or in small group settings cannot be delivered anonymously. | | | | * Peer positions that touch other syndemics and lived experience (HCV, DUH, housing, mental health, etc.). * Services provided in Spanish to clients by Spanish-speaking Peer Navigators. * Peers intentionally tasked to provide services to people historically marginalized by systems (e.g., justice-involved; non-binary/gender fluid/trans; female identifying ). | |
| Housing  (Ryan White) | Provision of limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services. Housing services are accompanied by a strategy to identify, relocate, or ensure the client is moved to, or capable of maintaining a long-term, stable living situation. Financial services within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client’s linkage to permanent housing.  Housing must be linked to client gaining or maintaining compliance with HIV-related health services and treatment.  *Rent and utilities* – One-time payments are unallowable and must be reported under emergency financial assistance task category. | | | |  | |
| **Service Category** | | | **Minimal required elements** | | | **Optional enhancements** |
| Clinical Quality Management  Mandatory Service | | | Implement specific RW Part B CQM program activities for their service area. These specific CQM program activities should be documented in the recipient’s CQM plan. Specific CQM program activities include a performance measure portfolio, frequency of performance measure data collection, and identification of quality improvement activities, among other items.  *CQM must be a part of any HCS.* | | | Additional points will be given for coordination of CQM activities for all Ryan White funds within an agency (Part A, C & D). |
| Emergency Financial Assistance | | | Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes. Items and services include utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. | | |  |
| Food Bank/Home Delivered Meals | | | Provision of actual food items, hot meals, or a voucher program to purchase food. This also includes providing essential non-food items (limited to personal hygiene products, household cleaning supplies, and water filtration in communities where issues of water safety exist). | | |  |

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| Linguistic Services | Provision of interpretation and translation services (both oral and written) to eligible clients. Services are provided by a qualified linguistic services provider as a part of HIV service delivery between the healthcare provider and the client. Services are provided when necessary to facilitate communication between the provider and client or to support the delivery of HIV Community Services.  *Note: Budgets are required to have a line item in the budget for translation or interpretation.* |  |
| Medical Transportation | Provision of non-emergency transportation services that enable an eligible client to access or be retained in medical and support services.  May be provided by:   1. Providers of transportation services. 2. Mileage reimbursement (non-cash) that does not exceed the established rates for federal programs. 3. Organization and use of volunteer drivers through programs with insurance and other liability issues specifically addressed. 4. Voucher or token system. |  |
| Mental Health | Provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services. Services will be based on a treatment plan and may be conducted in an outpatient group or individual session. Services must be provided by a mental health professional (psychiatrist, psychologist, and/or mental health practitioner or clinical social worker) licensed by the State of Washington. |  |
| Non-Medical Case Management | Provision of a range of client-centered activities focused on improving access to and retention of needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children’s Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans.  NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).  Key activities include:   1. Initial assessment of service needs. 2. Development of a comprehensive, individualized care plan. 3. Timely and coordinated access to medically appropriate levels of health and support services and continuity of care. 4. Client-specific advocacy and/or review of use of services. 5. Continuous client monitoring to assess if the care plan met the client needs. | Agencies with designated care coordination functions. (Either designated non-medical case manager or specific job functions which can be quantified and documented.) |

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| Psychosocial Support | Provision of a group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include bereavement counseling, child abuse, and neglect counseling, HIV support groups, nutrition counseling by a non-registered dietitian, and pastoral care/counseling services. |  |
| Substance Use Outpatient Care | Provision of outpatient services for the treatment of drug or alcohol disorders. Services include:   1. Screening. 2. Assessment. 3. Diagnosis. 4. Treatment (recovery readiness, harm reduction, behavioral health counseling, outpatient drug-free treatment, medication-assisted therapy, neuro-psychiatric pharmaceuticals, relapse prevention). |  |

**Submission cover form:**

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| 1. **Name of applicant (organization, firm, or entity):** |
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| 1. **Address and phone number:** |
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| 1. **Name and email address of primary contact:** |
|  |
| 1. **Name and email of person authorized to legally bind the applicant in a contractual relationship:** |
|  |
| 1. **Legal status of entity (ownership):** |
|  |
| 1. **Are you applying for any other service categories under the Syndemic RFA or the Ryan White RFA? If so, which ones?** |
|  |
| 1. **Applicant’s Federal Employer Tax Identification number:** |
|  |
| 1. **Applicant’s Washington Uniform Business Identification (UBI) number:**   *(note: If none exists, initial below to affirm that it will be provided prior to contract signing)* |
|  |
| 1. **Is the applicant organization a Certified Minority-Owned or Certified Women-Owned firm?**   *(note: If yes, please provide proof of certification issued by the Washington State Office of Minority and Women’s business Enterprises.)* |
|  |
| 1. **Has the applicant ever had a contract terminated for default in the last five years?**   *(Note: If yes, please describe such incident and full details of the terms for default, including the other party's name, address, and phone number.  The DOH will evaluate the facts and may, at its sole discretion, reject the RFA on the grounds of the Applicant’s past experience.)* |
|  |

*Signature and date by a person authorized to legally bind the applicant in a contractual relationship, e.g., the president or executive director of a corporation, the managing partner of a partnership, or the proprietor of a sole proprietorship.*

**Print name:**

**Signature:**

*(Use E-signature format: /s/First name Last name)*

**Date:**

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| **Board of Directors** |
| **Example: Name, Board Position -** Biography |
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| **Staffing Plan and Job Descriptions for Key Personnel** |
| **Example: Name, Executive Director –** Job description |
| **Example: Name, Program Manager –** Job description |
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**Staffing Capacity Form:**

**BID CERTIFICATIONS AND ASSURANCES**

I/we make the following certifications and assurances as a required element of the bid to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. I/we declare that all answers and statements made in the bid are true and correct.
2. The prices and/or cost data have been determined independently, without consultation, communication, or agreement with others for the purpose of restricting competition.  However, I/we may freely join with other persons or organizations for the purpose of presenting a single bid.
3. The attached bid is a firm offer for a period of 60 days following receipt, and it may be accepted by the DOH without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 60-day period.
4. In preparing this bid, I/we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this bid or prospective contract, and who was assisting in other than his or her official, public capacity.  (Any exceptions to these assurances are described in full detail on a separate page and attached to this document.)
5. I/we understand that the DOH will not reimburse me/us for any costs incurred in the preparation of this bid.  All bids become the property of the DOH, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this proposal.
6. Unless otherwise required by law, the prices and/or cost data that have been submitted have not been knowingly disclosed by the Bidder and will not knowingly be disclosed by him/her prior to opening, directly or indirectly to any other Bidder or to any competitor.
7. I/we agree that submission of the attached proposal constitutes acceptance of the solicitation contents and the attached sample contract and general terms and conditions.  If there are any exceptions to these terms, I/we have described those exceptions in detail on a page attached to this document.
8. No attempt has been made or will be made by the Bidder to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.
9. Information that has been determined to be proprietary or confidential has been clearly marked and included in this bid as a separate document.
10. If any staff member(s) who will perform work on this contract has retired from the State of Washington under the provisions of the 2008 Early Retirement Factors legislation, his/her name(s) is noted on a separately attached page.
11. I/we declare that we are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded in any Federal department or agency from participating in transactions.

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| --- | --- |
|  |  |
| Signature of Bidder  *(Use E-signature format: /s/First name Last name)* |  |
|  |  |
| Title | Date |

**Contractor Certification**

**Wage Theft Prevention – Responsible Bidder Criteria**

**Washington State Goods & Services Contracts**

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|  | | *Prior to awarding a contract, agencies are required to determine that a bidder is a ‘responsible bidder.’  See RCW 39.26.160(2) & (4).  Pursuant to legislative enactment in 2017, the responsible bidder criteria include a contractor certification that the contractor has not willfully violated Washington’s wage laws.  See Chap. 258, 2017 Laws (enacting SSB 5301).* | | | | | |  |
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|  | | | Procurement Solicitation Dated: | | |  |  | |
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| I hereby certify, on behalf of the firm identified below, as follows (check one): | | | | | | | | |
|  |  | **No Wage Violations.** This firm has NOT been determined by a final and binding citation and notice of assessment issued by the Washington Department of Labor and Industries or through a civil judgement entered by a court of limited or general jurisdiction to have willfully violated, as defined in RCW 49.48.082, any provision of RCW chapters 49.45, 49.48, or 49.52 within three (3) years prior to the date of the above-referenced procurement or solicitation date. | | | | | | |
|  |  |  | | | | |  | |
|  |  | **OR** | | | | |  | |
|  |  |  | | | | |  | |
|  |  | **Violations of Wage Laws.** This firm has been determined by a final and binding citation and notice of assessment issued by the Washington Department of Labor and Industries or through a civil judgement entered by a court of limited or general jurisdiction to have willfully violated, as defined in RCW 49.48.082, any provision of RCW chapters 49.45, 49.48, or 49.52 within three (3) years prior to the date of the above-referenced procurement or solicitation date. | | | | | | |
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| I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.     |  |  | | --- | --- | | Firm name: |  | |  | Name of Contractor/Bidder – Full legal entity name of firm | | Signature: |  | |  | Signature of authorized person *(Use E-signature format: /s/First name Last name)* | | Name: |  | |  | Name of person making certifications for firm | | Title: |  | |  | Title of person signing certificate | | Date: |  | |  | Date when signed | | Place: |  | |  | City and state where signed | |

**EXECUTIVE ORDER 18-03 – WORKERS’ RIGHTS**

**WASHINGTON STATE GOODS & SERVICES CONTRACTS CERTIFICATION**

Pursuant to the Washington State Governor’s Executive Order 18-03 (dated June 12, 2018), the Washington State Department of Health is seeking to contract with qualified entities and business owners who certify that their employees are not, as a condition of employment, subject to mandatory individual arbitration clauses and class or collective action waivers.

**Procurement No.: RFA SFY2024 Office of Infectious Disease**

I hereby certify, on behalf of the firm identified below, as follows (check one):

**o  NO MANDATORY INDIVIDUAL ARBITRATION CLAUSES AND CLASS OR COLLECTIVE ACTION WAIVERS FOR EMPLOYEES.** This firm does NOT require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waivers.

**OR**

**o  MANDATORY INDIVIDUAL ARBITRATION CLAUSES AND CLASS OR COLLECTIVE ACTION WAIVERS FOR EMPLOYEES.** This firm requires its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waivers.

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.

|  |  |
| --- | --- |
| Firm name: |  |
|  | Name of Contractor/Bidder – Full legal entity name of firm |
| Signature: |  |
|  | Signature of authorized person *(Use E-signature format: /s/First name Last name)* |
| Name: |  |
|  | Name of person making certifications for firm |
| Title: |  |
|  | Title of person signing certificate |
| Date: |  |
|  | Date when signed |
| Place: |  |
|  | City and state where signed |

**Organizational Background (2 pages maximum)**

Who are you?

* Applicant’s mission or vision statement
* Board of directors (including name and contact of board chair)
* Experience providing Ryan White funded programs or similar services
* Community engagement/connection to the proposed service area
* Community engagement/connection to communities historically underserved or mis-served communities, including but not limited to BIPOC communities within the service area.
* Brief explanation of your organization’s commitment to providing equitable services. (You can provide your organization’s equity statement, or some examples of policies you have implemented to improve equity.

**Proposal:**

**a. Project Approach: Why are you the right people to do the work? (3 page maximum)**

Briefly describe your programmatic vision by addressing each of the following questions:

* What work do you plan to implement/carry out with this grant?
* Please be as descriptive as possible about your work plan so there is a clear idea of what you are proposing - including key activities, counties to be served, and priority populations.
* List and describe any enhancements you plan to include.

**b. Outcomes: What outcomes do you expect and how will you measure them? (4 page maximum)**

* How will the services you propose improve health outcomes, engage in care, or improve viral suppression for the clients you serve?
* Include how these outcomes will be monitored and measured.
* Make sure to identify the number of clients you expect to serve by each service category.

**Qualifications (2 page maximum, not including attachments):**

**a. Staffing: Who will do the work?**

1. Experience - Please describe your staff’s experience.

* Describe the background and relevant experience of the key staff that will be working on this proposed program.
* This section must include information that demonstrates an understanding of the type of services proposed, HIV-related health disparities in the service region, and how the proposed staffing plan will ensure implementation of the services as described in the Proposal section.

1. Staffing Capacity - Fill out Staffing Capacity Form (above)

* List staff who will carry out activities for this project. Describe the experience and qualifications of current staff who will work on this project, including project role and title.  If new staff will be hired, please describe these proposed positions.
* *Attach position descriptions for all funded positions, including existing staff and proposed new hires, as attachments to your submission.*
* *Attach an organizational chart that includes all positions in this proposal. You may include the agency org chart but please indicate which are to be funded by this grant and which are not.*

**b. Partnerships: Who else will you involve?**

* List organizations you will partner with to ensure comprehensive service delivery for priority populations.
* Briefly describe what services each partner would provide. Sub-contracting is not allowed in this RFA but DOH strongly supports documented partnerships to ensure whole person approaches to all service activities.
* *If you plan to pursue new partnerships as part of these program activities, please include a Letter of Support from each partner and plan to develop MOUs or MOAs during contract negotiation.*

**Budget (download and complete budget template here)**