ViiV Healthcare

2019 *Positive Action Southern Initiative*

Proposal

Grants for Direct Linkage & Adherence Services in:

Arkansas | Florida | Kentucky| North Carolina

South Carolina | Tennessee | Texas | Virginia

Round 11: 2019 – 2021

**PLEASE SUBMIT YOUR PROPOSAL ONLINE AT:**

[**https://viivhealthcare.fluxx.io**](https://viivhealthcare.fluxx.io)

**PROPOSALS ARE DUE BY June 21, 2019.**

*No paper or email submissions will be accepted. This document is only meant to serve as a reference to the online proposal. For directions on how to submit your proposal, please see the Positive Action Southern Initiative Request for Proposal.*

Contact Information

1. Organization:
2. Organization’s Website:
3. Organization’s Mailing Address:
   1. City:
   2. State:
   3. Zip:
4. Organization’s Billing Address (if different than mailing address)
5. City:
6. State:
7. Zip:
8. [conditional] If not physically located AR, FL, KY, NC, SC, TN, TX & VA, is your organization legally registered in one of those states?

Yes (Mandatory for eligibility).

1. Primary Contact Person for Request
   1. Name:
   2. Title:
   3. Email:
   4. Phone:
2. Secondary Contact Person for Request (if applicable)
   1. Name:
   2. Title:
   3. Email:
   4. Phone:
3. Executive Director (if not listed above)
   1. Name:
   2. Email:
4. Project Lead (if applicable)
   1. Name:
   2. Email:

Required: Verify Contact Information

TO ALL APPLICANTS *As part of the proposal submission process, we require you to complete your user record as well as your request record.    
  
To do this, click on "People" under Users on the left side of the grantee portal. Make sure your user information is complete and correct. Click “Edit” to update your user information.*

*Please verify below that you have completed your user information before filling out the proposal.*

General Organization Information

1. Organization’s Mission:
2. Year Organization Established:
3. Year Organization Began Providing HIV Support Services: [Drop down years]
4. Are you a 501(c)3 charitable organization?  Yes  No
5. Tax-Exempt ID Number (EIN)
6. Is your organization based in the United States of America or Puerto Rico?

Yes  No

* 1. [conditional – if no] Only organizations located within the United States or Puerto Rico are eligible to apply to ViiV Healthcare U.S. programs – we advise you to revisit your organization’s qualifications and reference our Request for Proposals.

1. Does your organization operate a clinic that provides direct medical care?

Yes  No

* 1. [conditional – if yes] If so, please briefly describe the role and relationship of the clinic at your organization:
  2. [conditional – if yes] If so, does the clinic hold its own 501(c3) or incorporation?  Yes  No
     1. If yes, please include the clinic’s EIN#

1. [conditional – if no] Does your organization plan to open a clinic that will provide medical care in 2019 or 2020?
   1. [conditional – if yes] What date will the clinic open?
   2. [conditional – if yes] Will the clinic hold its own 501c(3) or incorporation?  Yes  No  Unsure
      1. If yes, please include the clinic’s EIN# (as available)
2. Is your organization fully or in part organized by a Healthcare Professional or Customer of ViiV Healthcare? Examples of Healthcare Professionals or Customers include, but are not necessarily limited to, physicians, physicians’ assistants, nurses, pharmacists, residents and medical students, phlebotomists, medical case managers, adherence counselors, pharmacy and medical directors within managed care organizations, other personnel within managed care organizations, and policy advocates.  Yes  No
3. Staffing
   1. Total # Full Time Staff 
      1. # Full Time Staff Dedicated to HIV/AIDS Services
   2. Total # Part Time Staff 
      1. # Part Time Staff Dedicated to HIV/AIDS Services
4. Organizational Budget
   1. 2019 Proposed Organization Budget:
      1. % Change in Budget 2018 to 2019: [auto-calculates]

If the percent change in budget from 2018-2019 is over 25% (either increase or decrease) please elaborate:

* 1. 2018 Organization Budget: 
     1. % Change in Budget 2017 to 2018: [auto-calculates]

If the percent change in budget from 2017-2018 is over 25% (either increase or decrease) please elaborate:

* 1. 2017 Organization Budget:

1. Has your organization applied in 2019 for any other funding from ViiV Healthcare?  Yes  No (Mandatory Response for Eligibility)
   1. [conditional – drop down] If yes, what program?
      1. Positive Action Community Grants
      2. Positive Action for Youth Amp Grant
      3. Positive Action for Youth Mentorship Grants
      4. Positive Action Southern Initiative
      5. Positive Action for Women
      6. Other
   2. [conditional – if yes] What amount was requested?
2. Has ViiV Healthcare committed funds to your organization for the 2019 calendar year?  Yes  No
   1. [conditional] If yes, what program/amount was received?
3. Organization’s Top Five Funders- please list your organization’s top funders for 2018.

|  |  |
| --- | --- |
| * Name | * Total Gift – 2018 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Organization’s Top Three Corporate Donors:

|  |  |
| --- | --- |
| * Name | * Total Gift – 2018 |
|  |  |
|  |  |
|  |  |

1. Does your organization publish an annual report (online or in print)?

Yes  No

1. Organization’s Core Activities: (Please describe your organization’s core activities, including intended beneficiaries, your organization’s geographic reach, key programs and intended outcomes).
2. **Does this application include a Fiscal Sponsor?**

Yes  No

**If yes, Fiscal Sponsor and Applicant representative are required to work together to complete this application (Please note: this section applies to Fiscal Agent only)**

* 1. [conditional] Fiscal Sponsor Organization Information
     1. Organization Name
     2. Street Address
     3. City
     4. State
     5. Zip
  2. Fiscal Sponsor Contact Information
     1. Contact Name
     2. Contact Email
     3. Contact Phone
  3. Is your fiscal sponsor based in the United States of America or Puerto Rico?  Yes  No
     1. [conditional – if yes] Only organizations located within the United States or Puerto Rico are eligible to apply to ViiV Healthcare U.S. programs – we advise you to revisit your organization’s qualifications and reference our Request for Proposals [linked].
  4. Does your fiscal sponsor operate a clinic that provides direct medical care?  Yes  No
     1. [conditional – if yes] If so, please briefly describe the role and relationship of your fiscal sponsor’s clinic:
     2. [conditional – if yes] If so, does the clinic hold its own 501(c3) or incorporation?  Yes  No
        1. If yes, please include the clinic’s EIN#
  5. [conditional – if no] Does your fiscal sponsor plan to open a clinic that will provide medical care in 2019 or 2020?  Yes  No
     1. [conditional – if yes] What date will the clinic open?
     2. [conditional – if yes] Will the clinic hold its own 501c(3) or incorporation?  Yes  No  Unsure
        1. If yes, please include the clinic’s EIN# (as available)
  6. Is your organization fully or in part organized by a Healthcare Professional or Customer of ViiV Healthcare? Examples of Healthcare Professionals or Customers include, but are not necessarily limited to, physicians, physicians’ assistants, nurses, pharmacists, residents and medical students, phlebotomists, medical case managers, adherence counselors, pharmacy and medical directors within managed care organizations, other personnel within managed care organizations, and policy advocates.  Yes  No
  7. Fiscal Sponsor Organizational Budget
     1. 2019 Proposed Organization Budget:
        1. % Change in Budget 2018 to 2019: [auto-calculates]

If the percent change in budget from 2018-2019 is over 25% (either increase or decrease) please elaborate:

* + 1. 2018 Organization Budget:
       1. % Change in Budget 2017 to 2018: [auto-calculates]

If the percent change in budget from 2017-2018 is over 25% (either increase or decrease) please elaborate:

* + 1. 2017 Organization Budget:
  1. Fiscal Sponsor Top Five Funders - please list your Fiscal Sponsor’s top funders for 2018.

|  |  |
| --- | --- |
| * Name | * Total Gift – 2018 |
|  |  |
|  |  |
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|  |  |

* 1. Fiscal Sponsor Top Three Corporate Donors:

|  |  |
| --- | --- |
| * Name | * Total Gift – 2018 |
|  |  |
|  |  |
|  |  |

Required: Verify Organization Information

TO ALL APPLICANTS *As part of the proposal submission process, we require you to complete your organization record as well as your request record.   
  
To do this, click on "Organizations" on the left side of the grantee portal. Make sure your organization information is complete and correct. Click “Edit” to update your organization information.   
  
Please verify below that you have completed the organization information before filling out the proposal.*

*Positive Action Southern Initiative* Grant Request Information

1. Grant Request Type:

Linkages/ReLinkages to Care

Adherence to Treatment

1. Project Name:
2. Project Location (AR, FL, KY, NC, SC, TN, TX, VA): [drop down menu]
3. 2019 Grant Request Amount:
4. 2020 Grant Request Amount:
5. 2019 Total Project Budget (ViiV Healthcare Funding and other funding, if applicable):
6. Request % of Organizations 2018 Operating Budget: [auto-calculates]
7. Request % of Organization’s 2017 Operating Budget (Requests exceeding 25% of Organization’s FY2017 Operating Budget are ineligible): [auto-calculates]
8. Has this project existed for at least 12 months?  Yes  No
9. Does your organization/will your organization have dedicated staff to manage this project?  Yes  No
10. Please provide a brief description of the proposed project and grant request (250 words maximum):
11. Select All Project Strategies that Apply:

Linkage and Navigation

Expanding Networks and Collaboration

Mental Health and Substance Use

Empowerment

## Proposal Narrative

All sections of the Proposal Narrative must be addressed to be considered eligible. Please answer the following questions and submit your proposal by June 21, 2019. Responses should be no more than eight to ten pages or 5,000 words, excluding the budget template.

### Section 1 – Organizational Capacity

1. **Organization Overview:** Briefly describe your organization, including mission, programs, key populations reached and key accomplishments. Please highlight your organization’s role in the current HIV landscape in your community.
2. **Organization Status:**
   * Please describe any major changes your organization has undergone in the past year (i.e. leadership or staff changes, project changes, etc).
   * **Financial Status:** Describe your organization’s financial status. Elaborate on any special financial issues and/or significant recent changes in your financial position. Please use this section to highlight your organization’s financial strengths and weaknesses, including any possible issues in your IRS Form 990 and/or audited financial statements.
     + **2018 budget, proposed 2019 budget and most recent IRS Form 990 are required attachments.**

### Section 2 – Project Approach

1. **Project Description**:

* Please describe the current expansion or enhancement project and the key project strategies you will be using to close linkage or adherence gaps in your community. Please include why there is a need to expand/enhance the project, and how this project expansion/enhancement will address that need.
* Were you funded for this work by *PASI* through Round 9 2017-2018 funding?  Yes  No
* Please describe your organization’s previous success with this program.
* Why is your organization well positioned to implement the proposed program expansions or enhancements?
* Stigma Reduction: How do you work to reduce stigma through your proposed project? With who? How? What tools or resources would help this *PASI* project advance in its approach to stigma reduction work?

1. **Community Informed**: Describe the opportunities community will have to provide insights and input, and guide and engage in this project’s development.
2. **Reach**:

* Describe who your project will reach.
* Please tell us more about the potential reach of your proposed efforts.
  + **Number of people living with HIV directly served by project:**

2019 (Actuals):

Year 1 (10/2019 – 9/2020) Projections:

Year 2 (10/2020 – 9 2021) Projections:

* **Number of people affected by HIV/AIDS directly served by project):**

2019 (Actuals):

Year 1 (10/2019 – 9/2020) Projections:

Year 2 (10/2020 – 9 2021) Projections:

1. **Collaborations**

* Will you work with partner organizations on this project?  Yes  No
* [conditional, if yes] Describe the collaboration(s) you will hold as part of the project, including a description of partner(s), roles and responsibilities of each partner, and how collaboration will be coordinated and managed.

1. Please select the social services you link PLWHA to through your *PASI* project.

* Education/GED
* Employment/Workforce Development
* Food Programs
* Housing
* Language
* Mental Health – including substance abuse and addiction services
* Transportation
* Other:
* Other:
* Other:

1. **Staffing**

* Describe how the project will be staffed and/or managed.
* Please include a list of **key staff biographies** as an attachment to this application.

### Section 3 – Goals, Outcomes and Implementation Plan

1. **Goals**: What are the goals of your project for people living with HIV? For others (if applicable)? For the community (if applicable)?
2. **Implementation Plan:** 
   * Complete the attached **implementation plan** – outlining the key outcomes, objectives, activities and metrics.
   * If you have a **logic model for your organization, or the proposed** **project, please include it as an attachment.**

### Section 4 – Evaluation Plan and Capacity

Knowing at least 5% of your grant request must be used to assess the project:

1. **Metrics**: How will you measure the impact of your work? How will you gather feedback from clients?
2. **Plan:** Please describe your evaluation plan, and outline the following:

* Who will conduct your evaluation?
* Who will you collect information from, and what tools will be used to collect information about project progress and impact? How frequently will you collect data?

1. **Learning**

* How will you use the information you collect to inform program updates and evolution?

### Section 5 – Project Budget

1. Please describe how your organization will use and/or leverage ViiV Healthcare funds to support the project. In particular, highlight and provide further detail on the top five (5) major budget items and/or any unusual items.

* Information provided here should support the budget worksheet, which is a required attachment. Use template provided.

### Section 6 – Conclusion

1. Please include here any other relevant information not covered in the other sections or in the attachments of this application. If nothing applies, please write “No additional comments.”

Client Information and Project Reach

*To the best of your ability, please complete the following information regarding your client populations for the ViiV Healthcare Positive Action Southern Initiative project. Please tell us about the total unique number of participants in each category that you plan to serve.*

*Notes:*

* *If you do not have the data, please enter “0” in the field.*
* *Year One constitutes the total people you anticipate reaching between October 2019 and September 2020.*
* *Year Two constitutes the total people you anticipate reaching between October 2020 and September 2021.*

**Questions**

1. Please share the following information related to the linkage and adherence projects you propose through *PASI* funding in year one.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Total # Reached baseline (current annual reach) | Total Projected # PLWHA in Project Year 1 | Total Projected # PLWHA in Project Year 2 |
| **Total: PLWHA Newly Linked to Medical Care** |  |  |  |
| **Total: PLWHA Re-Linked to Medical Care** |  |  |  |
| **Total: PLWHA Retained in Medical Care** **through Adherence Support Services**  (2+ visits with a medical doctor per year) |  |  |  |

Linkage rate: [To be calculated automatically by Fluxx based on # linked + relinked/total #PLWHA served]

Medical Care Retention Rate: [To be calculated automatically by Fluxx based on # retained/total #PLWHA served]

1. Does your organization have access to CD4 cell count data for your proposed *PASI* project participants?
   * Yes, we have access to medical data through CAREWare or another medical database
   * Yes, we collect self-reported data
   * No, we do not collect data on CD4 cell count
2. Does your organization have access to HIV viral load data for you *PASI* project participants?
   * Yes, we have access to medical data through CAREWare or another medical database
   * Yes, we collect self-reported data
   * No, we do not collect data on HIV viral load
3. Which of these outcomes is your project targeting? Which others are there?

|  |  |
| --- | --- |
| **□** | **Improved knowledge of HIV prevention and treatment** |
| **□** | **Reduced risky sexual behaviors** |
| **□** | **Improved disease management** (i.e. following treatment plan(s), taking medication, etc. |
| **□** | **Improved ability to navigate healthcare and support systems** (i.e. making appointments, obtaining insurance, finding specialists, etc.) |
| **□** | **Improved ability to communicate /advocate for themselves with health providers** |
| **□** | **Improved health status** |
| **□** | **Improved feelings of self-worth** |
| **□** | **Reduced internalized stigma** |

1. To the best of your ability, please complete the following information regarding your client populations. Please tell us about the cumulative total number of unique participants that you serve living with HIV.

* *Check all the boxes for all demographic served by your program. If checked include total number reached by demographic*
* *Please note that a single participant may be counted for more than one category.­*
* *If you have any questions, please reach out to your grants administrator at viivhealthcare@tccgrp.com*

*Total People Affected by HIV/AIDS Reached (All people reached by programming who are not living with HIV/AIDS):*

Each client should be represented once, only, in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Check if you serve this population |  | Total Projected # PLWHA in Project Year 1 | Total Projected # PLWHA in Project Year 2 |
| **□** | Asian American |  |  |
| **□** | Black/African American |  |  |
| **□** | Hispanic/Latino – Black/ African American |  |  |
| **□** | Hispanic/ Latino – Other |  |  |
| **□** | Multiple Races |  |  |
| **□** | Native American |  |  |
| **□** | Native Hawaiian/Other Pacific Islander |  |  |
| **□** | White |  |  |
| **□** | Other – Define: |  |  |
|  | Total PLWHA Reached [auto calculates] |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Check if you serve this population |  | Total Projected # PLWHA in Project Year 1 | Total Projected # PLWHA in Project Year 2 |
| **□** | * Children (0-12) - Total   Cis Male  Cis Female  Transgender MtF  Transgender FtM |  |  |
| **□** | * Youth (13-24) - Total   Cis Male  Cis Female  Transgender MtF  Transgender FtM |  |  |
| **□** | * Adults (25 – 55) -Total   Cis Male  Cis Female  Transgender MtF  Transgender FtM |  |  |
| **□** | * Adults over 55 - Total   Cis Male  Cis Female  Transgender MtF  Transgender FtM |  |  |
| **□** | MSM - Total |  |  |
| **□** | MSM of Color- Total |  |  |
| **□** | Women of Color – Total  Cis  Trans |  |  |
| **□** | Heterosexual Men - Total |  |  |
| **□** | Incarcerated/ Recently Incarcerated |  |  |
| **□** | People experiencing homelessness |  |  |
| **□** | People who use drugs |  |  |
| **□** | Rural Populations |  |  |
| **□** | Sex Workers |  |  |
|  | Other - Define: |  |  |

# *Positive Action Southern Initiative*

# 2019-2021 Implementation Plan

**Please complete the implementation plan below by including outcomes and metrics over time for the duration of the two-year grant period, to the best of your ability.**

Outcomes describe the change that occurs as a result of the project.

Metrics identify what the project achieves.

|  |  |  |  |
| --- | --- | --- | --- |
| **Project Primary Goal** |  | | |
|  | **Short-term Outcome 1**  **(by end of year 2)** | **Short-term Outcome 2**  **(by end of year 2)** | **Short-term Outcome 3**  **(by end of year 2)** |
| **Outcome Description** |  |  |  |
| *Include up to three relevant metrics* | **Priority Metric(s) per Outcome** | | |
| **Metric Description** |  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Key Activities Timeline **Project Launch: October 1, 2019**  *Describe the activities that will occur during each quarter in order to accomplish aforementioned outcomes.* | |
| **Q4 2019** |  |
| **Q1 2020** |  |
| **Q2 2020** |  |
| **Q3 2020** |  |
| **Q4 2020** |  |
| **Q1 2021** |  |
| **Q2 2021** |  |
| **Q3 2021** |  |

Grantee Requirements

Each *Positive Action Southern Initiative* recipient organization will be expected to fulfill the following requirements:

* **Submit Signed Letter of Agreement, Conflict of Interest Declaration and Contributions Verification Form** that confirms youwillabide by the funding requirements, any potential conflict of interest can be identified openly and appropriately managed, and that the funds represent a gift to the organization. This must be received prior to payment being sent.
* **Submit Signed Omnibus Budget Reconciliation Act (OBRA) form** that confirms receipt of check, agreement to abide by funding requirements and that the funds represents a gift to the organization. Must be submitted within two weeks of check receipt.
* **Actively participate in the *Positive Action Southern Initiative’s* evaluation** with ViiV Healthcare’s designated third party, including quarterly meetings, input on evaluation process, an interim report due during year one, and a final report is due within 26 months of the grant date.
* **Submit an Interim Report** that outlines the successes and challenges faced by your organization and relevant to the ViiV funding over the year. The report will include a narrative of how funding was used, progress towards your organizational and/or project goals connected to the grant, as well as data on who was reached through project efforts. It will also forecast the implementation of year two, and serve as the renewal submission for the year two grant payment. Interim reports will be due within 8 months of the grant date.
* **Submit a Year Two Final Report** that outlines the successes and challenges faced by your organization and relevant to the ViiV funding over the year. The report will include a narrative of how funding was used, progress towards your organizational and/or project goals connected to the grant, as well as data on who was reached through project efforts. Year-end reports will be due within 26 months of the grant date.
* **Agree to not directly or indirectly publish, approve or issue** any advertising, sales promotion, press release or public statement relating to this grant without the prior written approval of a ViiV Healthcare’s authorized representative. Please contact us if you would like to obtain our logo or other materials to recognize this funding support from ViiV Healthcare in written materials, verbal acknowledgment and published reports. We encourage you to use this award as an opportunity to increase awareness of your project. If you wish to issue a press release about this community grant, please allow five full working days for ViiV Healthcare to review the release and return it to you with any comments/approval.
* **Agree to actively participate in *Positive Action Southern Initiative* evaluations conducted by an external evaluator.** This includes possible site visits and/or interviews, and supplemental evaluation data collection training and support. In addition, as part of the ViiV Healthcare *Positive Action Southern Initiative*, all finalists are encouraged (but not required) to participate in annual in person meeting, as well as grantee calls.
* **Acknowledge ViiV Healthcare Support.** ViiV Healthcare will list our *Positive Action Southern Initiative* charitable contributions on our website. To that end, charitable contributions will be given under the condition that the recipient organization consents to public disclosure. Details disclosed may include but are not limited to the recipient organization's name, the community grant purpose, and the amount of the community grant.

Proposal Checklist

Only *complete* proposals will be reviewed by the External Review Committee. A complete proposal includes *all* of the following documents:

* **Completed ViiV Healthcare Proposal via online grants system** [**www.viivhealthcare.fluxx.io**](http://www.viivhealthcare.fluxx.io)
* **Copy of your organization’s budget for the most recent, completed operating year (2018).** The operating budget should include the total revenue *and* expenditures for the entire organization.
* **Copy of your organization’s proposed budget for the current fiscal year (2019),** including total revenue and expenses
* **Most recently completed IRS 990 Form**
* **IRS 501(c)(3) Non-Profit Determination Letter**
* **List of Directors and Officers (including specification of anyone who is a healthcare professional or government official)**
* **Draft budget for first year of** **project– use attached budget template.**
* **Biographies of project staff related to the *Positive Action Southern Initiative* project.** Limit to one page and do not include resumes.
* **[conditional] If you have a fiscal sponsor, please include the following documents:**
* **[conditional] Fiscal- 2018 Organization Budget**
* **[conditional] Fiscal- 2019 Proposed Organization Budget**
* **[conditional] Fiscal- IRS 990**
* **[conditional] Fiscal- IRS 501(c)(3) Non-Profit Determination Letter**
* **[conditional] Fiscal- List of Directors and Officers (including specification of anyone who is a healthcare professional or government official)**

Additionally, if applicable, please provide the following:

* **Letters of Support and MOUs with established, partners**
* **Organization and/or Project Logic Model(s)**
* A copy or online link to your organization’s most recent **Annual Report**

Please submit all proposals and supporting documents via the Online Grantee Portal (Fluxx). Proposals must be received via email by June 21, 2019 at 5pm ET.

Verification

*If our organization is selected to participate in the ViiV Healthcare’s Positive Action Southern Initiative, I certify we will adhere to the grantee requirements stated above, that the grant will be used as stated in this request form, and that the information provided in this proposal is true to the best of my knowledge.*

***I understand that failure to comply with grantee requirements will lead to discontinued funding.***

**(Print Name) (Title)\***

**(Signature)\* (Date)**

\* Signature must be from an executive of the applicant organization, such as Executive Director, Board Chair or Chief Operating Officer.