Amendment II made 6.27.12 to the following Section:

- ***Page 61, Intergovernmental Review - Executive Order 12372 does apply to this program. Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (E.O.) 12372. The order sets up a system for State and local governmental review of proposed Federal assistance applications. Applicants should contact their State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each State affected. Click on the following link to get the current SPOC list http://www.whitehouse.gov/omb/grants/spoc.html.***

Amendment made 6.11.12 to the following Section:

- ***Page 46 – Under the paragraph beginning with "A Project Narrative must be submitted…", second paragraph, changed first bullet to read "Maximum total number of pages: 35 (this does not include optional activities under component A)".***
- ***Page 46, same paragraph, added bullet after first bullet in list to read as follows:***
  - ***Maximum number for pages for each optional activity: 5 (e.g. if the applicant applies for all three optional activities, the maximum number of pages will be 15)***

    Maximum number of pages for Molecular HIV Surveillance: 5

    Maximum number of pages for Perinatal HIV exposure Surveillance: 5

    Maximum number of pages for Geocoding and Census Data Linkage: 5

    If the narrative exceeds the page limit in an optional activity, only the first pages which are within the page limit will be reviewed.

THIS AMENDMENT IS TO CORRECT/CLARIFY THE FOLLOWING:

- ***Page 17, Item 13, "of specimens" has been removed.***
- ***Pages 24 and 28, under Geocoding and Data Linkage Optional Activity, Tier 3 should reflect 28 areas and Los Angeles is moved from Tier 3 to Tier 4, increasing Tier 4 to 11 areas.***
- ***A revised web link was added to page 27 at CDC guidelines for Direct Financial Assistance***
- ***Page 28, the language under "Note" applies only to Perinatal HIV Exposure Surveillance.***

- ***Page 30, incidence eligibility information was removed and is reflected in the Eligibility Section beginning on page 41.***
- ***The statutory authority for Component B at Section I. Funding Opportunity Description for Component B (Incidence Surveillance) on page 34 is corrected to "Sections 317(k) (2) and 318(c) of the Public Health Service Act [42 U.S.C. Sections 247b (k) (2) and 247c(c)], as amended."***
- ***The following are the tier award amounts for the HIV Incidence Surveillance, page 40: Tier 1 = $245,865; Tier 2 = $279,165; Tier 3 = $334,665; and Tier 4 = $379,065.***
- ***Tier 4 for Incidence Surveillance – Component B awards under Section II. Award Information, page 41, is corrected to HIV diagnosed cases greater than 3000.***
- ***Page 45, "objectives" was added to the last sentence under "Project Narrative for Component A (HIV Case Surveillance)."***
- ***Program Objectives have been moved from page 51 to page 45, under "Project Narrative for Component A (HIV Case Surveillance)."***
- ***Additional descriptive language added0 under Project Narrative for Component B (HIV Incidence Surveillance), Item 3, plan and timeline, page 54.***
- ***Page 60, under Criteria, Grantee Activities has been changed from "Grantee Activities 1-17" to "Grantee Activities 1-16."***
- ***"Community planning group(s)" is replaced with "HIV planning group(s)" throughout the funding opportunity announcement.***
- ***A Sample Letter of Agreement has been added as Appendix B.***
- ***Corrected Data Security and Confidentiality Guidelines reference throughout the FOA.***

Table of Contents

PART 1. OVERVIEW INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Agency Name: Federal Centers for Disease Control and Prevention (CDC)

Funding Opportunity Title: NATIONAL HIV SURVEILLANCE SYSTEM (NHSS)

Announcement Type: New – Type 1

Agency Funding Opportunity Number: CDC-RFA–PS13-1302

Catalog of Federal Domestic Assistance Number: 93.944, Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance

Key Dates:
To receive notification of any changes to PS13-1302, return to the synopsis page of this announcement at: www.grants.gov and click on the "Send Me Change Notification Emails" link. An email address is needed for this service.

Application Deadline Date: ***August 1, 2012*** on Grants.gov, 11:59pm U.S. Eastern Standard Time.

Executive Summary:

The National HIV Surveillance System (NHSS) is the mechanism through which the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of HIV/AIDS Prevention, HIV Incidence and Case Surveillance Branch (NCHHSTP/DHAP/ HICSB) monitors trends in HIV infection in the United States to guide the characteristics of the HIV burden in the US public health action at the Federal, state, and local levels. The NHSS is comprised of two components: **Component A** - Case surveillance is to be conducted in all state health departments, six independently funded local health departments (Chicago, Houston, Los Angeles, New York City, the City of Philadelphia and San Francisco), the District of Columbia, the Commonwealth of Puerto Rico, and the U.S Virgin Islands. Optional activities under component A:

1. **Molecular HIV Surveillance (MHS)**
2. **Perinatal HIV Exposure Surveillance**

3. Geocoding and Data Linkage

Component B – Incidence surveillance will be conducted in the 25 health departments previously funded for HIV Incidence Surveillance under FOA PS-08-802.

The purpose of the program is to monitor the HIV burden through national surveillance of persons infected with HIV (i.e., routine reporting of persons diagnosed with HIV infection; HIV incidence surveillance; perinatal HIV exposure surveillance; molecular HIV surveillance reporting; and geocoding to spatially display data and to enhance understanding of social determinants of health affecting communities impacted by HIV, etc.).

Measurable outcomes of the program will be in alignment with one (or more) of the following performance goal(s) for the CDC: Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs. (Additional information is available at: http://intra-apps.cdc.gov/fmo/appropriations_budget_formulation/appropriations_budget_form_pdf/FY2012_CDC_CJ_Final.pdf)

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address: http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

Health Equity

This FOA supports efforts to improve the health of populations disproportionately affected by HIV by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity consistent with the NHAS. Health disparities in HIV are inextricably linked to a complex blend of social determinants that influence populations most severely affected by this disease. Health equity is a desirable

goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage (definitions of health disparity, social determinants of health and health equity are available at: http://healthypeople.gov/2020/about/disparitiesAbout.aspx).

Applicants should use epidemiologic and social determinants data to identify communities disproportionately affected by HIV and related diseases and conditions within their jurisdictions. Likewise, applicants should use data describing the social determinants of diseases in their coverage areas to accurately focus activities for reducing health disparities and to identify strategies to promote health equity. In collaboration with partners and appropriate sectors of the community, applicants should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and use culturally appropriate interventions that are tailored for the communities for which they are intended.

Programs should use data, including social determinants data, to identify communities within their jurisdictions that are disproportionately affected by HIV, viral hepatitis, STDs and TB and related diseases and conditions, and plan activities to help eliminate health disparities. In collaboration with partners and appropriate sectors of the community, programs should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and use culturally appropriate interventions that are tailored for the communities for which they are intended. Details of the health equity strategy and approach are outlined in the NCHHSTP Social Determinants of Health White Paper (http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf).

Program Collaboration and Service Integration

This FOA supports the NCHHSTP program imperative calling for Program Collaboration and Service Integration (PCSI). PCSI promotes improved integrated HIV, viral hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration at the health department jurisdictional level, as well as organizational

program level, thereby offering opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) improve operations through the use of shared data, enabling service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies.

Populations disproportionately affected by HIV are also affected by other infections including TB, hepatitis C virus (HCV), hepatitis B virus (HBV), and STDs. This announcement encourages better assessment of HIV co-infections and precursors of HIV infection to support integration of diagnostic and prevention services for these diseases and other infections because of CDC's greater understanding of the extent to which:

- STDs increase the risk for acquisition and transmission of HIV.
- Control of TB, viral hepatitis, and STDs is needed to protect the health of HIV-infected persons.
- HIV, viral hepatitis, and STDs share common risks and modes of transmission.
- Risks for acquiring these diseases are associated with similar behaviors and environmental conditions and have reciprocal or interdependent effects.
- Clinical course and outcomes of these diseases are influenced by co-infection (e.g., TB is a leading cause of mortality for people with HIV, and TB accelerates HIV disease progression).
- Populations disproportionately affected by HIV are also disproportionately affected by infections with TB, HCV, HBV, and STDs.

Details of this strategy and approach are outlined in the NCHHSTP PCSI White Paper (http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf).

Advancing a Public Health Approach to Improve Sexual Health

The program supports efforts to improve program impact for prevention of HIV, STD, and viral hepatitis by enhancing traditional disease-specific control efforts with a holistic health promotion framework that more comprehensively addresses broader issues of

health and wellness, including sexual health. Sexual health is considered to be a state of physical, emotional, mental, and social well-being in relation to sexuality. Although it is inextricably bound to both physical and mental health, it is not limited to the absence of disease and dysfunction and is an important component of health across the lifespan. It includes the ability to understand and weigh the risks, responsibilities, outcomes, and impacts of sexual actions, and requires a positive and respectful approach to sexuality and sexual relationships, and a respect for sexual rights.

HIV, STD, and viral hepatitis are highly stigmatized conditions, associated with sensitive behaviors, and are often concentrated among socially marginalized populations. Consequently, use of a broader sexual health-focused framework has the potential for reducing the fear, discrimination, and stigma associated with these conditions, enabling better reach of prevention programs to the general public, populations at risk, and health care providers. A more holistic and comprehensive health-focused framework may also help facilitate more open and honest societal dialogue around sensitive issues that are critically important to comprehensively address, such as human sexuality, relationships, and sexual behavior. This approach is consistent with the National Prevention Strategy with its vision to move the nation from a focus based on sickness and disease to one based on prevention and wellness and its designation of reproductive and sexual health as one of its highest priority areas of focus. This approach is also consistent with the National HIV/AIDS Strategy (NHAS) which calls for more comprehensive and holistic approaches to reduce HIV incidence in the United States and provides an opportunity for working together to advance a public health approach to sexual health that includes HIV prevention as one component.

PART 2. FULL TEXT

I. FUNDING OPPORTUNITY DESCRIPTION FOR COMPONENT A (Case Surveillance)

Statutory Authority

This program is authorized under Sections 317(k) (2) and 318(c) of the Public Health Service Act [42 U.S.C. Sections 247b (k) (2) and 247c(c)], as amended.

Background

According to the National HIV/AIDS Strategy for the United States (http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf):

> "the quality of information that we have to understand the epidemic we face and how it is changing depends on having an effective HIV surveillance system. The National HIV Surveillance System is the primary source of data used to monitor the epidemic in the United States. HIV surveillance data are used extensively to target and evaluate HIV prevention and care programs. Therefore, completeness and timeliness of the data are critical. Surveillance of HIV disease necessitates a complex system of reporting from providers, laboratories, and State and local health departments to coordinate accurate, complete and timely reporting."

Supporting existing surveillance methods to identify populations at greatest risk that need to be targeted for HIV prevention services is central to the National HIV/AIDS Strategy for the United States. Confidential, name-based HIV case surveillance is conducted in all states, the District of Columbia and U.S. territories, and the separately-funded cities of Chicago, Houston, Los Angeles, New York, Philadelphia, and San Francisco.

Purpose

The purpose of the program is to provide funding to the state, local, and territorial health departments to collect and report HIV case surveillance data to the National HIV Surveillance System. This program addresses the HIV-13 objective for HIV of "Healthy People 2020" available at http://www.healthypeople.gov/2020/topicsobjective/objectiveslist.aspx?topicId=22.

Program Implementation – Case Surveillance: Component A

Recipient (Grantee) Activities

1. Identify and report persons with HIV

Grantees shall implement and maintain a system to identify all newly diagnosed and prevalent cases of HIV in accordance with their local laws and the *Technical Guidance for HIV Surveillance Programs* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information). The system should include both active and passive reporting components and include all medical providers and laboratories.

2. Conduct death ascertainment

   Grantees shall conduct death ascertainment activities annually in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Death Ascertainment, Volume 1, Section 4* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

3. Conduct intrastate de-duplication of HIV cases

   Grantees shall conduct intrastate de-duplication activities in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Duplicate Review, Volume 1, Section 7* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

4. Participate in routine interstate de-duplicate review (RIDR) of HIV cases

   Grantees shall conduct interstate de-duplication activities in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Duplicate Review, Volume 1, Section 7* and *Case Residency, Volume 1, Section 6* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information). More detailed guidance tailored to each round of RIDR will be disseminated by CDC to state and local staff twice per year and must be followed.

5. Conduct risk factor ascertainment

   Grantees shall conduct risk factor ascertainment activities in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Risk Factor Ascertainment, Volume 1, Section 3* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

6. Collect HIV laboratory reports

   As allowed by law and in accordance with *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Electronic Reporting, Volume 1, Section 5* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx ; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information), grantees shall collect all laboratory data indicative of HIV infection, including the collection of all CD4 data regardless of level, and all results from Viral Load tests, whether detectable or undetectable. The preferred mode of receipt of these laboratory values is electronic, and Grantees shall develop and implement electronic laboratory reporting systems to process electronic data in multiple formats, perform data cleaning, conduct quality assurance procedures, format and upload and transmit on a monthly basis all laboratory results into the enhanced HIV/AIDS Reporting System (eHARS), and provide feedback to reporting laboratories.

   Grantees must not only implement laboratory reporting,but must maintain complete laboratory reporting. Additionally, grantees may focus on the implementation of revising policies that support reporting all CD4 and viral load test reports by laboratories. This effort would lead to increased reporting and enhanced completeness and timeliness of HIV surveillance data. Grantees may focus also on building the capacity of staff and data management systems to handle the influx laboratory data.

7. Investigate cases of public health importance (COPHI)

   Grantees shall conduct COPHI activities in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Risk Factor Ascertainment, Volume 1, Section 3* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx ; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

8. Conduct evaluation of the HIV Surveillance System

   To achieve high quality data, surveillance programs shall routinely evaluate their systems using the process and outcome standards (measurable objectives) detailed in the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures* document (contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

9. Conduct analysis of HIV surveillance data and disseminate findings

   Grantees shall conduct data analysis and dissemination activities including annual reports and epidemiologic profiles in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Data Analysis and Dissemination, Volume 1, Section 14* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information) and the *Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning.* The guidance is available at http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/index.htm.

10. Report data to CDC

    Grantees shall ensure that data collection forms and electronic data formats used to submit case reports from laboratories, clinical records, and medical providers

contain the required data elements as outlined in the *Technical Guidance for HIV Surveillance Programs Volume II: Data Collection Resources and Reporting* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx ; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information). Grantees shall submit data monthly or as specified by the CDC using eHARS software or according to data submission standards established by CDC. Grantee shall use secure data transfer as approved by CDC.

11. Integrate case and incidence surveillance (where applicable)

    Grantees funded for incidence surveillance shall integrate data collection and dissemination activities with case surveillance and other program activities to build a seamless surveillance system and maximize efficient use of resources.

12. Integrate program activities to enhance efficiency and improve outcomes

    This FOA supports the NCHHSTP program imperative calling for program collaboration and service integration (PCSI). PCSI promotes improved integrated HIV, viral hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration at the health department jurisdictional level, as well as organizational program level, thereby offering opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) improve operations through the use of shared data, enabling service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies.

13. Attend CDC-sponsored conferences and meetings

    Grantees shall attend CDC-sponsored conferences and meetings consistent with the funded activities. Budget allocations consistent with this requirement will be reviewed and approved annually as a part of the award continuation process.

14. Adhere to security and confidentiality procedures

Grantees must ensure that all program activities adhere to the security and confidentiality guidelines as outlined in the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm) In keeping with the stated purpose of these guidelines, grantees should implement these activities in a way that strengthens the ability to use HIV surveillance data across disease areas and integrate services that are provided by programs for prevention of HIV/AIDS, viral hepatitis, other STDs, and tuberculosis.

Optional activities - Case Surveillance: Component A

The following activities will be funded if funds are available. Optional activities for which a grantee may apply include:

(1) Conduct Molecular HIV Surveillance (optional)

Grantees shall collect, from all persons diagnosed with HIV infection, HIV nucleotide sequences generated from HIV genotype antiretroviral drug resistance tests. For newly diagnosed persons, Grantees shall also collect dates of their antiretroviral drug use (starting and ending dates, if any) and shall report these data using the testing and treatment history [TTH] document in eHARS in accordance with the Technical Guidance for HIV Surveillance Programs – Policies and Procedures for Molecular HIV Surveillance and the Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures for TTH collection (both documents are available at https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

(2) Conduct perinatal HIV exposure surveillance (optional)

Where laws and regulations allow for collection of perinatal HIV exposure

surveillance, Grantees shall identify and collect data on infants exposed to HIV positive mothers in accordance with the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Pediatric HIV Surveillance, Volume 1, Section 11* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

(3) Conduct Geocoding and Census Data Linkage (optional)

Grantees shall geocode addresses and link surveillance data to Census or other data with information on social determinants of health, and spatially display data and assess social determinants of health to identify communities that are disproportionately affected by HIV and related diseases and conditions in order to help eliminate health disparities. Grantee activities are to be in accordance with the *Technical Guidance for HIV Surveillance Programs – Policies and Procedures for Geocoding and Linking Activities with HIV Data* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx ; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information). Note: Please contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 if assistance is needed in developing health equity and health disparity related activities and associated evaluation criteria.

Recipient (Grantee) Activities for Optional Activity (1) Conduct HIV Molecular Surveillance are as follows:

1. Grantee shall review existing state laws and regulations regarding the reporting of HIV test results to the health department. If HIV nucleotide sequence data are not specifically referenced on the list of reportable HIV laboratory test results, consult the state office of legal counsel to determine whether current laws and regulations can be interpreted for this purpose, e.g., if the language states reporting of "all tests indicative of HIV infection and care," can reporting HIV nucleotide sequence data be required?

2. Grantee shall identify public, commercial, and private laboratories that perform HIV genotype testing and determine the capacity of their genotype testing Systems to generate and export HIV nucleotide sequence data in standard text-based file formats.
3. Grantee shall develop, in collaboration with laboratories, procedures for extracting HIV nucleotide sequence data, usually stored as FASTA files, from the genotype testing systems and linking the sequence data to standard patient demographic information and associated data, e.g., specimen collection date. Additional linking procedures may be necessary if specimens collected for HIV genotype testing are sent to a reference laboratory.
4. Grantee shall develop standard procedures for receiving HIV nucleotide sequence data files from laboratories through mechanisms such as the electronic laboratory reporting (ELR)—consider grouping fields for HIV nucleotide sequences with HIV serology, HIV RNA quantitative viral load (VL), and CD4 lymphocyte count (CD4) data for reporting purposes—National Electronic Disease Surveillance System (NEDSS) program, and direct transmission using the Secure File Transfer Protocol (SFTP). If these data transfer mechanisms cannot be developed, other methods of HIV nucleotide sequence data transfer from the laboratory to the health department include using CDs, DVDs, or FIPS 140-2 compliant flash drives or external hard drives, provided that the data are encrypted to advanced encryption standards (AES) and comply with state and local security requirements.
5. Grantee shall develop procedures for processing and managing the HIV nucleotide sequence data received using the Rhapsody software, available through the NEDSS program, or another data translation tool to parse and import the data submitted from laboratories into the local MHS database.
6. Develop internal processes for validating the usefulness of HIV nucleotide sequences collected, including comparing the length of sequences received to expected lengths, assessing sequences for embedded non-sequence characters, and ensuring that sequence segments can be concatenated properly.
7. Grantee shall link validated HIV nucleotide sequence data with case surveillance information. Develop processes for merging the sequence data with demographic

and clinical data from eHARS using the SAS software. The resulting MHS dataset should include unique record ID, STATENO, patient information, laboratory CLIA number, accession number, unique specimen ID, Logical Observation Identifiers Names and Codes (LOINC), specimen collection date, facility information, provider information, HIV nucleotide sequence(s), and other variables. Unmatched sequences should be investigated.

8. Grantee shall collect antiretroviral use history among newly diagnosed HIV-infected persons through the HIV Testing and Antiretroviral Use History section of the CDC Adult HIV Confidential Case Report Form or from other sources, e.g., medical and pharmacy records, AIDS Drug Assistance Program (ADAP) documents, and National HIV Monitoring and Evaluation Program (NHM&E) forms. Enter antiretroviral use history data in eHARS under the Testing and Treatment History (TTH) document.
9. Grantee shall determine the completeness and quality of the collected MHS data, i.e., HIV nucleotide sequence data merged with eHARS data, by reviewing them for the inclusion of required data elements, e.g., demographic and clinical variables that are key elements for HIV case surveillance.
10. Grantee shall generate monthly MHS datasets and transmit them to CDC before the 15th day of the next month through a CDC-approved designated method for transmitting data. Data transmitted to the CDC must not include personal identifiers and must be encrypted and password-protected as specified in *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm) All MHS areas must have encryption software and a CDC-approved designated method for transmitting data.
11. Grantee shall apply outcome standards described in the Introduction to Policies and Procedures, Data Quality, and Reporting chapters of Technical Guidance for HIV Surveillance Programs, Vol. I: Policies and Procedures to meet the surveillance standards for case ascertainment, data quality, timeliness, and completeness, assessed at 12 months after the end of the diagnosis year: (1) ≥50% of newly diagnosed HIV

cases reported to the national HIV surveillance system for a calendar year should have HIV nucleotide sequences from specimens obtained within 3 months of HIV diagnosis and (2) ≥85% of newly diagnosed HIV cases with HIV nucleotide sequences reported to the national HIV surveillance system should have HIV treatment data.

12. Grantee shall conduct local data analyses and disseminate reports. Semi-annually or as appropriate, CDC will provide local datasets and accompanying SAS programs for local analyses. Alternatively, MHS areas can process their own HIV nucleotide sequence data, apply surveillance HIV mutation lists, and develop programs to analyze the local data.
13. Grantee shall review existing state and local policies on maintaining patient confidentiality and assure that activities associated with MHS comply with the requirements specified in *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm) and staff responsible for the management of HIV nucleotide sequence data and MHS data have been trained in the security and confidentiality procedures for HIV surveillance. Designate an Overall Responsible Party (ORP) and submit a signed statement that certifies compliance with the security and confidentiality requirements.
14. Grantee shall attend CDC-sponsored conferences and workshops in accordance with the cooperative agreement.

Recipient (Grantee) Activities for Optional Activity (2) Perinatal HIV Exposure Surveillance are as follows:

Implement and conduct surveillance activities for perinatal HIV exposure by performing the following activities:

1. Grantee shall establish active and passive reporting systems with laboratories, pediatric clinics, and HIV clinics to receive testing results on HIV-exposed infants, including all positive and negative HIV virologic tests (DNA PCRs and RNA assays).
2. Grantee shall regularly contact delivery hospitals and clinics to identify potential/

suspect perinatal HIV exposure cases, as consistent with local/state reporting laws.

3. Grantee shall conduct medical record review of mother-infant pairs and longitudinal follow-up of all HIV exposed children to ascertain knowledge of maternal HIV infection status before birth, infant's HIV diagnosis; infant's AIDS diagnosis; infant's vital status; the use of maternal and neonatal zidovudine (ZDV) and other antiretroviral medications, and efficacy of these medications in preventing HIV transmission.
4. Grantee shall conduct medical record review to evaluate recommendations for opportunistic infection prophylaxis and initiation of HIV evaluation and treatment in children.
5. Grantee shall assess potential adverse outcomes of antiretroviral exposure among infected and uninfected children in the short term (e.g., birth defects, ascertained through record reviews and registry matches) and in the long term (e.g., by matching to tumor registries).
6. Grantee shall match HIV registries to birth registries (e.g., establish programs matching HIV cases in women of childbearing age with the birth registry database), to ensure complete ascertainment of HIV-exposed infants.
7. If an HIV-infected woman gave birth to an HIV-exposed infant who was not reported, the case should be sent to appropriate surveillance staff for follow-up. Establishing routine reporting of HIV-infected pregnant women to surveillance programs is recommended. Routinely enter estimated delivery dates of expectant mothers in local data fields; data are to be reviewed monthly and distributed to staff for follow-up; any HIV test results (positive, negative, indeterminate) are to be tracked.
8. Grantee shall conduct activities to improve the quality, efficiency, and productivity of perinatal HIV exposure surveillance. All grantees should perform focused analyses or develop activities that explore methods to improve data quality and reporting efficiency and maximize the performance of the system. For example, grantees should conduct activities to improve provider exposure reporting on the Perinatal Case Report Form (PCRF). This includes educating providers on their reporting responsibilities, establishing on-going communication with all reporting sites and providing them feedback, conducting routine visits to reporting sources,

and establishing awareness of and support for perinatal surveillance activities. In particular, special efforts shall be made to inform providers of their importance in promptly notifying the health department of perinatal HIV exposure cases in accordance with their state reporting laws.

9. Grantee shall routinely evaluate their perinatal HIV surveillance program and perinatal HIV exposure reporting according to completeness and timeliness standards provided by CDC that have been developed as part of the Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures document (contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information) and according to the perinatal outcome standards to be specified by CDC. At least once a year, all recipients shall re-abstract demographic, risk, laboratory, and clinical data from a representative sample of records to assess the quality and validity of information collected. Evaluation plans should include routine analysis of perinatal exposure data to discover possible sources of under-reporting and delays in reporting, monitor data quality, and assess completeness of reporting by methods developed by CDC or by comparing surveillance registries with alternate databases that are not routinely used for case finding (e.g., Medicaid databases, tumor registries, etc.). Grantees should send regular updates on their evaluation activities according to the evaluation standards developed by CDC.
10. Grantee shall analyze and disseminate perinatal HIV surveillance data and promote their use for prevention and health services planning and evaluation. At least annually, all grantees should disseminate reports of aggregate perinatal HIV surveillance data to key prevention and health services stakeholders and partners. These activities should include: providing perinatal HIV exposure data and ongoing epidemiologic assistance to HIV planning groups to monitor the impact of implementation of efforts in the elimination of perinatal HIV infections; disseminating perinatal exposure data through publications and presentations; participating in planning and implementation meetings; conducting perinatal analyses to monitor trends, assess need for health-care resources, and project the future impact of the disease; and providing feedback to exposure reporting sources on ways in which perinatal HIV exposure data have been used to promote public health.

11. Grantees shall ensure that the security and confidentiality procedures of the program are consistent with the requirements delineated in the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm)

    An Overall Responsible Party (ORP) must be designated and a signed statement provided to certify compliance with the security and confidentiality requirements. The ORP accepts overall responsibility for implementing and enforcing the security standards and may be liable for breaches of confidentiality. The ORP should be a high-ranking public official (e.g., division director or department chief) who has the authority to make decisions about surveillance operations that may affect programs outside the HIV surveillance unit.

    The certification statement designating the ORP should include the following:

12. Grantee shall ensure a statement acknowledging that all program requirements included in the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs have been implemented unless otherwise justified.
13. Grantee shall ensure a statement that the program requirements apply to all local/state/territorial staff and contractors funded through the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
14. Grantee shall ensure a statement that the program requirements apply at all sites where the HIV Reporting System or other HIV surveillance database is maintained.
    - Name and address of organization
    - Phone number
    - Name of the designated ORP
    - Title of ORP
    - Signature of ORP
    - Date

    This information should be included with the application and clearly referenced in the table of contents. This certification statement should be submitted annually and any

changes in this designation should be communicated in writing to the respective program consultant. HIV surveillance funds may be restricted unless the ORP designation has been submitted and is on file for FY 2013 and subsequent budget periods in the HIV Incidence and Case Surveillance Branch, CDC.

15. Grantee shall attend CDC-sponsored conferences and workshops consistent with recipient activities in accordance with their cooperative agreement.

Recipient (Grantee) Activities for Optional Activity (3) Geocoding and Data Linkage are as follows:

Implement and conduct surveillance activities for Geocoding and Census Data Linkage HIV by performing the following activities:

1. Grantee shall collect HIV surveillance information according to routine surveillance procedures. Required data elements include local street address, city, and state of residence at diagnosis for each newly diagnosed HIV case.
2. Grantee must have a Memorandum of Agreement (MOA) for the 5-year funding period in place between the jurisdiction and CDC before submitting data to CDC. Data cannot be submitted to CDC without this signed agreement.
3. Grantee must geocode residence at HIV disease diagnosis information for cases diagnosed for the respective year to the census tract level.
4. Grantees may elect to annually geocode current residence for analyses of people living with HIV infection in the jurisdiction.
5. Grantee shall provide updated information for residence at HIV disease diagnosis and/or current residence that are not accurate, missing or not complete.
6. Grantees are required to have up-to-date death matches on all cases.
7. Grantees shall apply geocoding standards provided by CDC, including the collection of variables derived from the geocoding process, such as the type of address geocoded and a variable describing the geographic level at HIV disease diagnosis and/or current address of the geocoded data. If additional steps are taken to verify addresses, this will be indicated in the dataset (variables to be determined).
8. Grantees shall link geocoded addresses with the social determinants of health (SDH)

variables from the American Community Survey (ACS) census dataset provided by CDC using Federal Information Processing Standards (FIPS) codes.

9. Grantees shall update data elements in eHARS with the most up-to-date and complete information for residence at HIV disease diagnosis and current residence (i.e., should be populated in real-time or through routine uploads).
    - eHARS variables should be exported to create a separate analysis dataset. Demographic variables exported to the analysis dataset will include, but are not limited to: race/ethnicity, sex, transmission category, date of HIV disease diagnosis, state of residence at HIV disease diagnosis (and/or current residence), age, country of origin, and the FIPS codes (state, county, and city).
    - Cleaned data should be entered back into eHARS either manually or through the All Document Import functions. During the cooperative agreement time period, if the eHARS system allows this capability, census tract data would be entered into eHARS.
10. Grantees shall ensure that the security and confidentiality procedures of the program are consistent with the requirements delineated in the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm).
11. Grantees shall submit geocoded census tract information with routine eHARS data submissions to CDC, or as specified by project officer. Street address should not be transmitted to CDC.
    - If a jurisdiction's policies or laws prevent the sharing of census tract data with CDC, grantees should submit to CDC line-listed ACS/SDH variables and eHARS variables Stateno and Reporting State on a monthly/quarterly basis (or as specified by Project Officer).

    *Please note: Because the use of data in this form is very limited, data that share the same unique ACS/SDH identifiers will be combined and assigned a dummy census tract variable in order to identify a numerator and a denominator (i.e., number of cases and the population size per census tract) for calculating rates.

- Data sent to CDC should be formatted as a cumulative SAS dataset (.sas7bdat). Grantees will provide SDH data according to mutually agreed upon procedures.
- Provide process measures at the end of each fiscal year funding period to CDC on geocodable addresses in order to know the reported universe. If address data are modified after data are sent to CDC, the next data transfer will contain the corrected data. Procedures will be agreed upon by the project areas and the CDC.
- Transmit data to CDC over the Secure Data Network (SDN). Data should be transmitted to CDC with no personal identifiers (e.g., name, address, social security number, phone number) and should be encrypted in accordance with current SDN procedures for HIV Surveillance data.
- Data sent to CDC will not be integrated into the National HIV surveillance datasets but will be stored on a secure server with restricted access, in accordance with the CDC Assurance of Confidentiality for HIV/AIDS Surveillance Data. However, if the eHARS system is upgraded to allow for this integration during the cooperative agreement time period, census tract data would be entered into eHARS. Grantees, however, will still be expected to maintain an external, local storage data system for this activity.

12. Grantee shall use geocoded data to create a thematic map (e.g., choropleth map, dot density map, or graduated symbol map) to be included in Epi Profile to illustrate the distribution of diagnoses of HIV infection.
    - Grantees should also use geocoded data to produce maps showing the relationship between residence at diagnosis and/or current address and testing initiatives (e.g., overlay map with local testing sites) and should work with HIV prevention groups to provide a written summary that recommend geographic areas within the jurisdiction where testing efforts should be targeted.
    - All maps should be reviewed carefully to ensure the locations of individuals have not been disclosed.

Details may be found in Technical Guidance for HIV Surveillance Programs — Geocoding and Linking HIV Data

<u>GIS: Geocoding and data linkage</u>

*Jurisdictions have been placed in Tiers based on persons living with HIV infection through the end of 2009.

Tier 1 = <1,000 persons living with HIV yearend 2009: 8 areas - Alaska, Idaho, Montana, North Dakota, South Dakota, U.S. Virgin Islands, Vermont, Wyoming.

Tier 2 = 1,000-3,999 persons living with HIV year-end 2009: 12 areas - Delaware, Hawaii, Iowa, Kansas, Maine, Nebraska, New Hampshire, New Mexico, Rhode Island, Utah, and West Virginia.

Tier 3 = 4,000-19,999 persons living with HIV year-end 2009: 28 areas - Alabama, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Virginia, Washington, Wisconsin, Houston, and San Francisco.

Tier 4 = ≥20,000 persons living with HIV year-end 2009: 11 areas - California, Florida, Georgia, Maryland, New Jersey, New York, North Carolina, Texas, Chicago, Los Angeles, New York City, and Philadelphia.

***NOTE:** For some optional activities under Component A, local laws or regulations may be required.

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities

- Provide documentation of technical guidance and standards for surveillance

- Provide technical assistance and programmatic guidance using program monitoring techniques such as site visits, routine conference calls, and feedback on progress report submissions.
- Ensure that program specific policies and procedures are in compliance with the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: *http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm*).
- Review written program operational policies and procedures for compliance with the *Technical Guidance for HIV Surveillance Programs*.
- Support and provide opportunities for training in surveillance methods, program planning and management, and relevant scientific information.
- Host conferences and facilitate routine communications regarding the conduct of surveillance program activities.
- Provide criteria for the surveillance case definition of HIV infection.
- Provide standardized data collection forms.
- Provide access to the National Death Index and the Social Security Death Master files.
- Coordinate the Routine Interstate De-Duplication Review (RIDR) processes.
- Provide technical assistance on data management and analytic procedures to ensure data integrity and accuracy. Provide guidance to obtain equipment with the necessary technologic capabilities to process and transfer data and provide software for collecting, transferring and evaluating HIV surveillance data, as well as technical assistance to maintain and use it, or standards for data collection and reporting to the national system.
- Facilitate the transfer and utilization of information and technology among all states and jurisdictions.
- Assist grantees in using HIV surveillance data for public health policy formulation; allocation of resources for HIV surveillance, prevention, and care; and to evaluate public health recommendations.
- Promote and facilitate integration of HIV surveillance activities with other CDC programs and related programs at other federal agencies.

- Provide technical assistance in information technology to assure adherence to appropriate security and confidentiality procedures in electronic transfer of HIV data.
- Conduct annual evaluations on process and outcome standards and provide feedback to Grantees according to the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures*.
- Maintain a secure and confidential national HIV surveillance database.
- Disseminate national surveillance data for public health uses through reports, slide sets, web-based applications, and presentations.
- Maintain current data release agreements with grantees.

II. AWARD INFORMATION

Component A – Case Surveillance

Type of Award: Cooperative Agreement.

CDC substantial involvement in this program appears in the Activities Section above.

Award Mechanism: U62; Prevention/Surveillance Activities/Studies of AIDS

Fiscal Year Funds: 2013

Approximate Current Fiscal Year Funding: $53,000,000

Approximate Total Project Period Funding: $265,000,000 (This amount is an estimate, and is subject to availability of funds and includes direct and/or indirect costs.

Approximate Number of Awards: 59

Approximate Average Award: $800,000 (This amount is for the first 12-month budget period, and includes both direct and indirect costs.)

Floor of Individual Award Range: None

Ceiling of Individual Award Range: $4,000,000 (This ceiling is for the first 12-month budget period and includes the total cost including direct and indirect costs.

A**nticipated Award Date:** January 1, 2013

Budget Period Length: 12 months

Project Period Length: 5 years

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress/performance by

the grantee (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.
Please see attached estimated funding ranges for Component A: Case Surveillance

Based on HIV prevalence, prior performance and ability to fill critical positions, certain applicants will be required to accept direct assistance DA in the form of personnel in lieu of financial assistance to ensure full implementation of HIV Surveillance Programs.

Please review CDC's policy on direct financial assistance to Grant and Cooperative Agreement Recipients (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

Award Information for Optional Activities:

Each optional activity must be reflected on the applicant's form SF424A. In addition, a separate detailed budget and budget narrative are required for each optional activity. Please note: Optional Activities will be awarded based on structured review and evaluation, and are contingent upon the availability of funds as follows:

(1) HIV Molecular Surveillance
Estimated total: $2.4 Million
Average award: $40,000
Range: $20,000-$80,000

(2) Perinatal HIV Exposure Surveillance
Estimated total: $2.4 Million
Average award: $70,000
Range: approximately $30,000-$120,000

(3) Geocoding and Data Linkage

Estimated total: $2.0 Million

Average award: $35,000

Range is based on tiers: $10,000- 60,000

Tier 1 = <1,000 persons living with HIV yearend 2009: 8 areas - Alaska, Idaho, Montana, North Dakota, South Dakota, U.S. Virgin Islands, Vermont, Wyoming.

Estimated Funding Range: $10,000 - $15,000

Tier 2 = 1,000-3,999 persons living with HIV year-end 2009: 12 areas - Delaware, Hawaii, Iowa, Kansas, Maine, Nebraska, New Hampshire, New Mexico, Rhode Island, Utah, and West Virginia.

Estimated Funding Range: $25,000 - $35,000

Tier 3 = 4,000-19,999 persons living with HIV year-end 2009: 28 areas - Alabama, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Virginia, Washington, Wisconsin, Houston, and San Francisco.

Estimated Funding Range: $30,000 - $35,000

Tier 4 = ≥20,000 persons living with HIV year-end 2009: 11 areas - California, Florida, Georgia, Maryland, New Jersey, New York, North Carolina, Texas, Chicago, Los Angeles, New York City, and Philadelphia.

Estimated Funding Range: $50,000-$60,000

**NOTE: Under Component A- Case Surveillance: In order to be funded for the Perinatal HIV Exposure Surveillance optional activity, jurisdictions must have the necessary statutes and regulations in place.*

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

III. ELIGIBILITY INFORMATION – Case Surveillance: Component A

Eligible Applicants

Eligible applicants that can apply for this funding opportunity are listed below:

- Eligibility for this program is limited to State health departments, the six independently funded local health departments (Chicago, Houston, Los Angeles, New York City, the City of Philadelphia and San Francisco),the District of Columbia, and the territorial health departments (Commonwealth of Puerto Rico, the U.S. Virgin Islands) or their Bona Fide Agents. Competition is limited to the above listed organizations because they are the only sources authorized by local reporting laws, rules, or regulations to collect and report cases of HIV/AIDS surveillance data in their respective jurisdictions, the entire United States, Puerto Rico and the U.S. Virgin Islands.
- All eligible applicants for Component A - HIV case surveillance activities will be funded. Funding will include activities that expand the uses and improve the quality of HIV surveillance data to more effectively guide public health policy and provide relevant information necessary to direct and evaluate prevention and care activities.
- Jurisdictions with eligible state and local (independently funded city or county) health departments must discuss how the state and local area will collaborate during the project period to ensure full implementation of HIV Surveillance activities within the jurisdictions (state and local areas). The jurisdictions should document any agreements reached in a letter of agreement (LOA), which must be submitted by both parties as part of their application. An independently funded city or county may opt not to apply; if this occurs, their funding allocation will

then be available to the state to provide services for that independently funded area. At a minimum, the LOA must include the following:

- Name and address of entity providing HIV Surveillance activities
- Funding source (i.e. CDC-RFA-PS13-1302)
- Scope of work (activities) to be provided (i.e., a statement of the funding requested by each eligible entity, the assignment of responsibility for geographic areas and general HIV Surveillance activities which will be covered)
- Date agreement will be in effect
- Signature of authorized representatives and dates. See the letter of agreement template provided in attachments.

An sample LOA is attached as Appendix B in this announcement.

Competition is limited to grantees currently funded under FOA PS08-802 to ensure that the HIV surveillance system covers the entire United States and its territories. The eligible health departments have jurisdiction over promulgating laws and legislations over specific states and metropolitan areas. Only entities that are legislatively charged to administer and enforce state laws, rules, or regulations pertaining to collecting, protecting, and maintaining HIV surveillance data are eligible to apply under this announcement.

All State and local health departments were eligible to conduct core surveillance activities under FOA PS08-802 (FY2008-FY 2012).

In summary, the criterion for selection of the identified eligible applicants for this award is as follows: They have the authority to promulgate rules, regulations and laws to conduct HIV surveillance activities in their jurisdictions.

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state

or local government as documentation of the status is required. Attach with "Other Attachment Forms" when submitting via www.grants.gov.

Required Registrations

Registering the applicant organization through www.Grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the "Get Registered" screen of www.Grants.gov. Please visit www.Grants.gov at least 30 days prior to submitting an application to become familiar with the registration and submission processes. The "one-time" registration process will take three to five days to complete. However, the Grants.gov registration process also requires that an applicant register its organization with the Central Contractor Registry (CCR) and DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) which will require up to at least 4 weeks to complete registration in its entirety. The CCR registration can require an additional two weeks to complete. Applicants are required to maintain a current registration in CCR. CCR registration must be renewed annually.

Central Contractor Registration and Universal Identifier Requirements

All applicant organizations **must obtain** a DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for Federal grants or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An Authorized Organization Representative (AOR) should be consulted to determine the appropriate number. If the organization does not have a DUNS number, an AOR should complete the **US D&B D-U-N-S Number Request Form** or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. A DUNS number will be provided immediately by telephone at no charge. Note this is an organizational number. Individual Program Directors/Principal Investigators do not need to register for a DUNS number.

Additionally, all applicant organizations must register in the Central Contractor Registry (CCR) and maintain the registration with current information at all times during which it has an application under consideration for funding by CDC and, if an award is made,

until a final financial report is submitted or the final payment is received, whichever is later. CCR is the primary registrant database for the Federal government and is the repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the CCR internet site at www.ccr.gov.

If an award is granted, the grantee organization must notify potential sub-recipients that no organization may receive a sub-award under the grant unless the organization has provided its DUNS number to the grantee organization.

Cost Sharing or Matching

Cost sharing or matching funds are not required for this program.

Other

If a funding amount greater than the ceiling of the award range is requested, the application will be considered.

Special Requirements:

Attendance at CDC-Sponsored Conferences and Workshops

Participation in CDC sponsored grantee meetings and the National HIV Surveillance Workshop is mandatory. All grantees are required to attend and are to include budget allocations consistent with this requirement. These allocations will be reviewed and approved annually as a part of the award continuation process. Failure to attend the mandated meetings and workshops (regardless of state financial or administrative crisis) shall be cause for a determination for reduction in travel funding.

Security and Confidentiality Procedures

Applicants must ensure that the security and confidentiality procedures of the program are consistent with the requirements delineated in the *Data Security and Confidentiality*

Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs:Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action (available at:. http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm) Guidelines include the physical security of hard copies and electronic files containing confidential surveillance information; and any laws, rules, regulations, or health department policies that require or permit the release of patient identifying information collected under the HIV surveillance system to entities outside of the public health department and measures the health department has taken to ensure that the confidentiality of individuals reported to the surveillance system is protected from further or unlawful disclosure. As part of the application, the applicant must submit a signed copy of the form designating the overall responsible party (ORP) and attesting that all Program Requirements as stipulated in the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* have been attained.

National HIV Surveillance System (NHSS) Software Requirement

The National HIV Surveillance System uses the eHARS software system to collect, store, manage, and process HIV surveillance data. This software system is essential to ensuring standard and comparable data across jurisdictions, performing calculations to create variables for analyzing national data, using jurisdictional data to measure program performance outcomes, and distributing legislatively mandated formula funding to jurisdictions for major HIV federal programs.

Grantees must ensure that all laboratory data including CD 4 and Viral load are uploaded into eHARS and transmitted to CDC.

Grantees must transmit data to CDC on a monthly basis.

Grantees must ensure that all CDC provided eHARS software releases and upgrades are installed within 90 days of release.

Note: CDC approved encryption software should be purchased using funds from this cooperative agreement. Additionally, eHARS (software and hardware equipment) may be purchased using funds from this cooperative agreement.

Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting a grant, loan, or an award.

Maintenance of Effort

Maintenance of Effort is not required for this program

II. FUNDING OPPORTUNITY DESCRIPTION FOR COMPONENT B (Incidence Surveillance)

Statutory Authority

This program is authorized under Sections 317(k) (2) and 318(c) of the Public Health Service Act [42 U.S.C. Sections 247b (k) (2) and 247c(c)], as amended.

Background

A primary goal of the National HIV/AIDS Strategy for the United States (http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf) is reducing new HIV infections. Monitoring the outcomes for the Strategy depends on HIV incidence surveillance and, according to the Strategy,

> "the quality of information that we have to understand the epidemic we face and how it is changing depends on having an effective HIV

surveillance system. The National HIV Surveillance System is the primary source of data used to monitor the epidemic in the United States. HIV surveillance data are used extensively to target and evaluate HIV prevention and care programs. Therefore, completeness and timeliness of the data are critical. Surveillance of HIV disease necessitates a complex system of reporting from providers, laboratories, and State and local health departments to coordinate accurate, complete and timely reporting."

Supporting existing surveillance methods to identify populations at greatest risk that need to be targeted for HIV prevention services is central to the National HIV/AIDS Strategy for the United States. This program also supports efforts to improve the health of populations disproportionately affected by HIV, viral hepatitis, STDs and TB by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity consistent with the NCHHSTP's white paper "Establishing a Holistic Framework to Reduce inequities in HIV, Viral Hepatitis, STD, and Tuberculosis in the United States."

Purpose

The purpose of HIV incidence surveillance is to provide reliable and scientifically valid estimates of the number of newly acquired HIV infections at the local, state, and national level. The primary purpose of providing cooperative agreement funds for HIV incidence surveillance is to assist state and local health departments to conduct the following activities:

1. Plan and carry-out surveillance activities to obtain supplementary case information on testing and treatment history and recency of infection.
2. Monitor HIV incidence by calculating annual population-based estimates of new HIV infections among adults and adolescents.
3. Describe demographic and behavioral characteristics of newly HIV infected populations and subgroups.
4. Identify emerging epidemics and monitor trends in transmission.

5. Disseminate HIV incidence surveillance data to assist targeting of prevention resources and interventions to areas and populations most heavily affected and to evaluate programs designed to prevent the transmission of HIV.
6. Evaluate the performance of HIV incidence surveillance using process and outcome standards described in the document *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures.*

Program Implementation – Incidence Surveillance: Component B

Recipient (Grantee) Activities

1. Collaborate with CDC, laboratories, providers and affected communities to further develop and ensure the capacity to conduct population-based HIV incidence surveillance.
2. Conduct HIV incidence surveillance activities in accordance with the policies and procedures described in the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).
3. Obtain HIV testing and treatment history information on all individuals newly diagnosed with HIV infection reported to HIV surveillance as described in the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information) to allow HIV incidence estimation.
4. In a manner consistent with CDC's guidance, collect results from tests for recent HIV infection (e.g., Serologic Testing Algorithm for Recent HIV Seroconversion [STARHS], or other methods as they become available) necessary for the statistical estimation of HIV incidence. Currently results are obtained through required submission of remnant samples from HIV diagnostic tests for testing at a CDC

funded laboratory. Therefore, for all newly diagnosed HIV infections reported to HIV surveillance, funded health departments are required to:

a) Collaborate with public and private HIV testing laboratories (within and outside the state) to secure remnant specimens from the original diagnostic HIV test or other HIV related test conducted within 3 months of the initial diagnosis.

b) Coordinate with public and private HIV testing laboratories (within and outside the state) to arrange transport of remnant specimens to the designated laboratory for recency testing as described in the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx ; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

c) On a monthly basis, at a minimum, among cases of HIV disease newly reported to the state or local surveillance system, identify which diagnostic specimens represent diagnoses of HIV infection not known to have progressed to AIDS and inform the appropriate laboratory of the need for shipping and/or testing using an approved test of recency.

d) As future tests of recent HIV infection become available, programs must adapt to CDC guidance for the collection of results from these tests.

e) All remnant specimens sent to the CDC funded laboratory should be made available to CDC for additional testing upon request. All remnant specimens should be made available to CDC for additional testing.

5. Integrate HIV incidence surveillance activities with case surveillance and other program activities (e.g., data collection, data management, data quality, data de duplication, dissemination, etc.) to build a seamless surveillance system and maximize efficient use of resources.
6. Collect all CD4 and viral load test results, as applicable by local laws and regulations, and enter all test results into the surveillance software (eHARS) for routine reporting to CDC.
7. Submit data monthly or as specified by the CDC using eHARS software or according to data submission standards established by CDC.

8. Conduct systematic evaluations of HIV incidence surveillance using outcome and process standards contained in the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information) and use evaluation results for program improvement.
9. Calculate and disseminate annual population-based estimates of HIV incidence and promote the use of HIV incidence data for prevention and health services planning.
10. As needed, collaborate with CDC to revise program design, implementation, and evaluation.
11. Attend CDC-sponsored mandated conferences and workshops consistent with the funded activities. Budget allocations consistent with this requirement will be reviewed and approved annually as a part of the award continuation process. Failure to attend the mandated conferences and workshops (regardless of state financial or administrative crisis) may result in reduction in travel funds.
12. Ensure that the security and confidentiality procedures of the program are consistent with the requirements delineated in the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

CDC activities

- Provide technical assistance and guidance for the collection of HIV testing and treatment history information and results of tests of recency for all newly diagnosed HIV cases in a consistent and uniform manner across incidence surveillance areas.

- Provide guidance for the efficient transport and processing of diagnostic specimens of persons newly diagnosed with HIV infection as described in the *Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures* available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx.

- Provide guidance that includes current scientific and technical information required to obtain, transport, and/or process specimens according to existing standards of safety to obtain reliable results for incidence estimation.

- Host conferences and facilitate routine communications regarding the conduct of surveillance program activities.

- Provide training and technical assistance for data analysis and dissemination of area specific population-based incidence estimates.

- Provide technical assistance for the evaluation of the overall effectiveness of the program and the use of evaluation results for program improvement.

- Maintain a secure and confidential national data system for HIV incidence surveillance and estimation.

- Coordinate the interaction between areas funded to conduct HIV incidence surveillance and the designated testing laboratory as appropriate.

- Provide technical assistance on data management and analytic procedures to ensure data integrity and accuracy. Provide guidance to obtain equipment with the necessary technologic capabilities to process and transfer data and provide software for collecting, transferring and evaluating HIV surveillance data, as well as technical assistance to maintain and use it, or standards for data collection and reporting to the national system.

SECTION II. AWARD INFORMATION

Component B – Incidence Surveillance

Type of Award: Cooperative Agreement.

CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U62

Fiscal Year Funds: 2013

Approximate Current Fiscal Year Funding: $ 7,000,000

Approximate Total Project Period Funding: $ 35,000,000 (This amount is an estimate, is subject to availability of funds, and includes Direct and Indirect costs.)

Approximate Number of Awards: 25

Approximate Average Award: $ 280,000 (This amount is for the first 12-month budget period, and includes direct and indirect costs.)

Floor of Individual Award Range: None

Ceiling of Individual Award Range: $450,000 (This ceiling is for the first 12-month budget period and includes Total Cost.)

Anticipated Award Date: January 1, 2013

Budget Period Length: 12 months

Project Period Length: 5 years

HIV Incidence Surveillance

*Jurisdictions have been placed in Tiers based on reported HIV diagnosis through the end of 2009

Tier 1 = Diagnosed cases between 300-999 year end 2009: 14 areas – Alabama, Arizona, Connecticut, Colorado, Dist. Of Columbia, Indiana, Massachusetts, Michigan, Mississippi, Philadelphia, San Francisco, South Carolina, Virginia, Washington. Amount available is $245,865.

Tier 2 = Diagnosed cases between 1000-1499 yearend 2009: 5 areas – Chicago, Houston, Louisiana, New Jersey, New York. Amount available is $279,165..

Tier 3 = Diagnosed cases between 1500-2999 yearend 2009: 3 areas – California, Los Angeles, North Carolina. Amount available is $334,665.

Tier 4 = Diagnosed cases > 3,000 yearend 2009: 3 areas – Florida, New York City, Texas. Amount available is $379,065.

Throughout the project period, CDC's commitment to the continuation of awards will be conditional on the availability of funds, evidence of satisfactory progress/performance by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

SECTION III. ELIGIBILITY INFORMATION – Incidence Surveillance: Component B

ELIGIBLE APPLICANTS

Eligibility for HIV Incidence Surveillance funds is limited to the 25 State and local jurisdictions currently funded under FOA PS08-802 as follows: Alabama, Arizona, California, Chicago, Colorado, Connecticut, District of Columbia, Florida, Houston, Indiana, Los Angeles, Louisiana, Massachusetts, Michigan, Mississippi, New Jersey, New York City, New York, North Carolina, Philadelphia, San Francisco, South Carolina, Texas, Virginia, and Washington.

Competition is limited to the above listed organizations because they possess a mature HIV reporting system. In order to guarantee execution of this complex project, ensure continuity of the national HIV incidence estimate and provide estimates that possess adequate statistical precision, eligible sites must have been previously funded for HIV Incidence Surveillance under FOA 08-802 and demonstrated the capacity to collect HIV testing and treatment information and recency results.

Competition is limited to grantees currently funded under FOA PS08-802 to ensure that the HIV surveillance system covers the entire United States and its territories. The eligible health departments have jurisdiction over promulgating laws and legislations over specific states and metropolitan areas. Only entities that are legislatively charged to administer and enforce state laws, rules, or regulations pertaining to collecting, protecting, and maintaining HIV surveillance data are eligible to apply under this announcement. Additionally, for HIV Incidence Surveillance eligibility is limited to areas that have reported at last 300 annual newly diagnosed cases of HIV infection (not AIDS) in 2010. This is needed to be able to produce sufficiently precise state and national estimates with ability to stratify by subgroups, and the purpose of calculating a multi-year national incidence estimate consistency of jurisdictions across years is essential.

Adding or removing a currently funded jurisdiction would impact the amount of data available for the national estimate because the minimum criteria of 15% of cases with a STARHS result must be met for all years of the estimate.

All State and local health departments were eligible to conduct core surveillance activities under FOA PS08-802 (FY2008-FY 2012).

In summary, the criterion for selection of the identified eligible applicants for this award is as follows: They have the authority to promulgate rules, regulations and laws to conduct HIV surveillance activities in their jurisdictions.

Special Requirements:

Attendance at CDC-Sponsored Conferences and Workshops

All grantees are required to attend CDC-sponsored mandated meetings, conferences, and workshops (for example, the Incidence Coordinator's Consultation). Budget allocations consistent with this requirement will be reviewed and approved annually as a part of the award continuation process. Failure to attend the mandated conferences and workshops (regardless of state financial or administrative crisis) shall be cause for a determination for reduction in travel funding.

Security and Confidentiality Procedures

Applicants must ensure that the security and confidentiality procedures of the program are consistent with the requirements delineated in the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs:Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* (available at: http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm

Guidelines include the physical security of hard copies and electronic files containing confidential surveillance information; and any laws, rules, regulations, or health department policies that require or permit the release of patient identifying information collected under the HIV surveillance system to entities outside of the public health department and measures the health department has taken to ensure that the confidentiality of individuals reported to the surveillance system is protected from further or unlawful disclosure. As part of the application, the applicant must submit a signed copy of the form designating the overall responsible party (ORP) and attesting that all Program Requirements as stipulated in the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action* have been attained.

IV. APPLICATION AND SUBMISION INFORMATION - Components A and B

Submission Dates and Times

This announcement is the definitive guide on LOI and application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

Application Deadline Date: August 1, PUBLICATION ON GRANTS.GOV, 11:59 pm U.S. Eastern Standard Time.

Applicants must download the SF424 application package associated with this funding opportunity from Grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 email:pgotim@cdc.gov Monday-Friday 7:00am – 4:30pm U.S. Eastern Standard Time for further instruction. CDC Telecommunications for the hearing impaired or disabled is available at: TTY 1-888-232-6348.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of all Federal Holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. The Grants.gov Support Center can be reached at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Content and Form of Application Submission

All applicants are required to sign and submit CDC Assurances and Certifications that can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm

Print, scan and upload as an additional attachment into the application package.

A letter of intent is not applicable to this funding opportunity announcement.

A Project Abstract must be completed in the Grants.gov application forms. The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information.

A **Project Narrative** must be submitted with the application forms. The project narrative must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format:

- Maximum total number of pages: 35 (this does not include optional activities under component A).
  Maximum number of pages for Component A: 20
  Maximum number of pages for Component B: 15
  If the narrative exceeds the page limit in either component, only the first pages which are within the page limit will be reviewed.
- Maximum number for pages for each optional activity: 5 (e.g. if the applicant applies for all three optional activities, the maximum number of pages will be 15)
  Maximum number of pages for Molecular HIV Surveillance: 5
  Maximum number of pages for Perinatal HIV exposure Surveillance: 5
  Maximum number of pages for Geocoding and Census Data Linkage: 5
  If the narrative exceeds the page limit in an optional activity, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, Times New Roman
- Double spaced
- Page margin size: One inch
- Number all narrative pages consecutively; not to exceed the maximum number of pages in each component.

A Project Narrative for Component A (HIV Case Surveillance) must be submitted with the application forms. The project narrative must be uploaded in a PDF file format when submitting via Grants.gov. The project narrative should describe the objectives and methods you plan to conduct over the entire five year project period to implement the following activities (please address each item in the order listed):

Instructions for writing Program Objectives:
Outcome evaluation objectives should be specific, measurable, action-oriented/ achievable, realistic, and time-phased (SMART objectives). Programs should conduct systematic evaluations of HIV surveillance data and program processes and identifying resources and staff for evaluation, defining evaluation processes, and identifying emerging challenges, and solutions. Process standards, what a program must, should, or may do to achieve the minimum level of data quality required are to be used to assess data quality assurance while outcome standards are used to evaluate system performance using measurable objectives. Process and outcome standard results should be used to facilitate monitoring of system performance and identification of areas that need increased support. These include standards for death ascertainment, intrastate and interstate de-duplication, completeness and timeliness, risk factor ascertainment, CD4 reporting, and data dissemination.

1. **Identify and report persons with HIV**

   At a minimum, all grantees shall identify and report persons with HIV (i.e. soliciting case reports in a timely manner directly from potential reporting sources) in appropriate in-patient and out-patient facilities serving HIV-infected persons and in laboratories, where feasible and permitted by law, and shall conduct a systematic review of death certificates. Other required components of active surveillance programs include educating providers on their reporting responsibilities, establishing on-going communication with all reporting sites and providing them feedback, conducting routine visits to reporting sources, and establishing awareness of and support for surveillance activities. The minimum information required to report a case of HIV infection (all stages) to CDC's eHARS is the alpha-numeric (soundex)

code of the patient's name (patient and physician names should not be submitted to CDC); state-assigned patient identifier number; HIV diagnosis information, including date(s) of diagnosis; and the patient's date of birth, race/ethnicity, and sex.

* Additional information important to ascertain if available is the initial CD4 count and/or viral load test results. In an effort to better characterize the extent of disease at diagnosis, and the impact of targeted testing efforts on identifying persons early in the course of their infections, information on CD4 count at initial diagnosis should be collected. This information should be submitted to CDC as part of the case record. Information on the mode of HIV exposure is also essential in order to monitor epidemic trends and target prevention interventions. Therefore, timely follow-up to complete risk history shall be conducted.

2. **Conduct Death Ascertainment**

   Link all cases of HIV infection not yet known to be dead with state death certificate records by looking at all death records for the year, including those with no mention of HIV, as well as those that mention HIV infection as a cause of death. Other linkages to find deaths include linkages to the Social Security Death Master File and the National Death Index.

3. **Conduct intrastate de-duplication of HIV cases**

   The surveillance program should conduct duplicate review procedure at least monthly. The surveillance program should perform exact and ‘fuzzy matching’ using tools provided by data management. Exact variable match for determining that a duplicate case is the same person uses first name, last name, middle name, Soundex, date of birth, sex, full Social Security number, and death date.

4. **Participate in Routine Interstate Duplicate Review (RIDR) of HIV cases**

   Recipients should routinely interact with other reporting areas using the Routine Interstate Duplication Removal (RIDR) procedures to ensure that reciprocal

notification of newly identified HIV cases, perinatal exposure cases, and deaths from HIV infection is executed. Routine engagement in this activity will improve the efficiency in reporting to CDC and minimize the number of duplicate case reports in the national data system. It should be carried out by appropriately trained and authorized surveillance staff, in a confidential manner consistent with local security, confidentiality and reporting policies and procedures.

5. Conduct risk factor ascertainment

Grantees should regularly review medical records to ensure more complete case finding and better ascertainment of risk factor information. Information on the HIV behavioral risk factors is also essential in order to monitor epidemic trends and target prevention interventions. Therefore, timely follow-up to complete risk factor history shall be conducted. Funding limitations may preclude complete investigations of all cases, but at a minimum, jurisdictions are expected to follow-up a representative sample of reported cases to ascertain HIV risk factors according to a protocol developed by CDC and the recipient.

6. Collect HIV Laboratory Reports

a. Diagnostic and clinical monitoring reports

Electronic submission of clinical and laboratory reports is becoming increasingly common and can improve the accuracy and efficiency of data collection, entry, and processing. Areas should develop policies and technical information systems that facilitate electronic reporting of HIV surveillance data from health care providers and public and private laboratories to health departments. The electronic transmission of HIV-related laboratory test results such as HIV diagnostic tests, CD4 and VL results, and HIV viral genetic sequences enhances the completeness, timeliness, efficiency and accuracy of reporting to surveillance programs. Building electronic laboratory reporting (ELR) capacity will shift the burden of entering and processing paper-based laboratory reports to more of a focus on formatting, data cleaning, conducting quality assurance procedures, and importing electronic data. Surveillance programs shall work towards

implementing ELR and/or increasing electronic reporting of HIV laboratory data from private and public laboratories to state and local health departments. Surveillance programs should work towards ensuring that state policy is supportive of the reporting of HIV-related laboratory results, including all CD4 and VL (absolute value and undetectable) results.

b. Although many laboratories have been reporting data electronically, many programs still need a clear plan of implementing or maintaining ELR including:
    - Receipt of electronic data in multiple formats
    - Data cleaning
    - Quality assurance procedures
    - Formatting and uploading of all labs into enhanced HIV/AIDS Reporting System (eHARS) and transmitting monthly to CDC.
    - Periodic reporting back to laboratories

7. Investigate Cases of Public Health Importance (COPHI)

Recipients shall develop procedures for promptly notifying CDC of unusual occurrences of HIV transmission and for using CDC-developed protocols and criteria to conduct epidemiologic and laboratory investigations of cases that may have rare or previously unidentified modes of HIV transmission, unusual clinical manifestations, or unusual laboratory test results. These include transfusion and transplant-related cases, cases of HIV transmitted in health care or other occupational settings, cases of HIV-2 infection, cases transmitted through female-to-female sexual contact, cases with potentially unusual HIV strain variants, and cases with clinical evidence of HIV infection but negative HIV test results.

8. Conduct evaluation of the HIV Surveillance System

Recipients shall continue to assess the quality of their HIV surveillance system and the data generated from this set of activities. Evaluation activities should include critical reviews of surveillance methods and redirection of resources to those case-finding methods that are the most accurate and productive. Using the process and outcome standards provided in the Technical Guidance for HIV Surveillance Programs,

assessments should include routine analysis of surveillance data to discover possible sources of under reporting, delays in reporting, and monitoring data quality.

9. **Conduct analysis of HIV surveillance data and disseminate findings**

   All recipients should routinely disseminate reports of aggregate surveillance data for monitoring the HIV burden and education of the public and reporting sources and should promote uses of HIV surveillance data for prevention and health services planning and evaluation. These activities should include: providing HIV surveillance data and ongoing epidemiologic assistance to HIV planning groups; disseminating surveillance data through publications and presentations; participating in planning and implementation meetings; conducting analyses to monitor trends, assess need for health-care resources, and project the future impact of the disease; and providing feedback to reporting sources on ways in which the surveillance data have been used to promote public health.

10. **Report data to CDC**

    Recipients should ensure that data collection forms and electronic data formats used to submit case reports from laboratories, clinical records, and patient interviews contain the required data elements.

11. **Integrate program activities to enhance efficiency and improve outcomes**

    Describe how HIV case surveillance is working with other HIV funded programs, as well as STD, TB, and Hepatitis programs to integrate activities to ensure program and service collaboration.

12. **Attend CDC-sponsored conferences and workshops**

    Failure to comply with the requirements of FOA PS13-1302 could result in a determination of non-compliance with the terms and conditions of the Notice of Grant Award. Failure to comply with the requirements of FOA PS13-1302 could result in

enforcement actions such as withholding of funds, suspension, termination, disallowance of costs, and debarments, etc. as stated in 45 CFR 92.

13. Adhere to Security and Confidentiality procedures

All programs should have Standard Operating Procedures (SOPs) for security and confidentiality, and data release processes on file. This document should be readily available for review upon request from CDC.

14. Conduct Molecular HIV Surveillance (Optional)

Recipients shall collect, from all persons diagnosed with HIV infection, HIV nucleotide sequences generated from HIV genotype antiretroviral drug resistance tests. For newly diagnosed persons, Grantees shall also collect dates of their antiretroviral drug use (starting and ending dates, if any) and shall report these data using the testing and treatment history [TTH] document in eHARS in accordance with the Technical Guidance for HIV Surveillance Programs – Draft Policies and Procedures for Molecular HIV Surveillance and the Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures for TTH collection (both documents are available at https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

15. Conduct Perinatal HIV Exposure Surveillance (Optional)

Where laws and regulations allow for collection of perinatal HIV exposure surveillance, Recipients shall identify and collect data on infants exposed to HIV positive mothers in accordance with the Technical Guidance for HIV Surveillance Programs Volume I: Policies and Procedures, Pediatric HIV Surveillance, Volume 1, Section 11 (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

16. Conduct Geocoding and Data Linkage (Optional)

Recipients shall geocode addresses and link surveillance data to Census or other data with information on social determinants of health, and spatially display data and assess social determinants of health to identify communities that are disproportionately affected by HIV and related diseases and conditions in order to help eliminate health disparities. Grantee activities are to be in accordance with the Technical Guidance for HIV Surveillance Programs – Policies and Procedures for Geocoding and Linking Activities with HIV Data (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information). Note: Please contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 if assistance is needed in developing health equity and health disparity related activities and associated evaluation criteria.

17. Key Staff

Please identify each key staff member (using an asterisk by their name) in this section and the budget justification. A key staff member is defined as any jurisdiction employee designated as the Principal Investigator (PI) or HIV Surveillance Program Coordinator regardless of their CDC supported level of effort. Additionally, any staff member who occupies a position such as epidemiologist, data manager, laboratory reporting coordinator, or program component coordinator (molecular surveillance, perinatal exposure, or incidence surveillance) who are to be funded at the 50% level of effort (or higher) on the award. Also, discuss any hiring restrictions that may prevent the hiring of staff (hiring freeze, budget cuts, new hire justifications, etc.).

18. Budget

The budget and budget justification for Component A are to be included as separate attachments and will not to be counted in the narrative page limit.

a. Submit a single budget and justification for HIV Case Surveillance Recipient Activities.
b. In the staff Component please consider the recommended staff for HIV Case Surveillance (see Technical Guidance for HIV Surveillance Programs, Vol. I:

Policies and Procedure, available at: http://team.cdc.gov; contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information) and assure at least one staff member with HIV incidence surveillance duties has expertise in SAS.

c. In the travel Component, include a total for local travel and a total for out-of-state travel.

The following information is required for all proposed contracts: name of contractor, period of performance, method of selection (e.g., competitive or sole source), description of activities, justification for subcontracting, and itemized budget. Following receipt of a current year (CY 2013) award, CDC may request additional activity – or project-specific budgetary information.

Additional information may be included in the application appendices. This additional information includes:

1. Curricula Vitae (Key Staff)
2. Organizational charts
3. Letters of support, including letters from jurisdiction-specific public health laboratories
4. Applicable state regulations relating to the HIV surveillance program (e.g., laboratory and reporting)

No more than 10 attachments should be uploaded per application.

Additional requirements for additional documentation with the application are listed in Section VI. Award Administration Information, subsection entitled “Administrative and National Policy Requirements.”

Additional information submitted via Grants.gov should be uploaded in a PDF file format, and should be named: “Other Attachments Forms” (i.e., *Curriculum vitae*, Letters of Support, Indirect Cost Rate Agreement, etc.).

A project narrative for Component B (HIV Incidence Surveillance) must be submitted with the application forms. The Component B narrative should describe the methods and activities to be conducted over the entire five year project period and must include the following items in the order listed:

1. **Describe the characteristics of the HIV reporting system** including regulations (include CD4 and VL reporting regulations), major sources of reports and facilities of diagnoses, percentage of cases with laboratory reports, including test type, percentage of laboratory tests reported electronically, percentage of cases initiated by a laboratory report and percentage of cases with last documented negative HIV test including test type, and potential collection of HIV nucleotide sequences. This description must also verify that diagnosed HIV infections are reported in a timely manner (see standards for timeliness of reporting in Technical Guidance for HIV Surveillance Programs). If cases are not reported in a timely manner, please explain.

2. **Describe evaluation results for CDC performance standards** for completeness of HIV Testing and Treatment History and completeness of test for recency, and data quality as described in the HIV incidence surveillance section of the *Technical Guidance for HIV Surveillance Programs, Vol. I: Policies and Procedure* (available at: https://partner.cdc.gov/sites/NCHHSTP/HICSB/default.aspx contact the HIV Incidence and Case Surveillance Branch at 404-639-2050 for access information).

3. **Provide a plan and a timeline** for meeting each HIV incidence surveillance outcome standard. Programs should develop objectives that are specific, measurable, action-oriented, achievable, realistic, and time-phased (SMART objectives) and can be expected to lead to programmatic success. Objectives should be related to both the processes of HIV incidence surveillance (i.e., what a program must, should, or may do to achieve the minimum level of data quality required) and the expected outcomes of HIV incidence surveillance (i.e., the level of achievement as it relates to the outcome standards for HIV incidence surveillance). Programs must conduct systematic evaluations of the processes and outcomes of HIV incidence surveillance

to determine success in meeting the outcome standards as listed in the Technical Guidance and to identify challenges that must be addressed.

Programs should include objectives related to:

- Integration of HIV incidence surveillance with core HIV surveillance
- Collection of Testing and Treatment History Data
- Collection of recency result
- Reporting of data to CDC
- Data quality (including completeness of edit check resolution)
- Data analysis
- Dissemination of data.

4. **Describe any laws or regulations that support HIV incidence surveillance activities** (e.g., collection of testing and treatment history information, reporting of recency results, obtaining specimens for recency testing, shipping diagnostic specimens to the recency testing laboratory).

5. **Describe the process for obtaining HIV testing and treatment information from persons newly diagnosed with HIV.** Please specify how many (number and percentage) publicly funded sites are collecting HIV testing and treatment information and what percentage of new diagnoses this represents. Please specify how many (number and percentage) private providers are collecting HIV testing and treatment information and what percentage of new diagnoses this represents.

6. **Describe how the applicant has been able to, and will continue to obtain recency results:**
    a. Describe how the surveillance system has been able to, and will continue to coordinate with laboratory partners, including public health laboratories and commercial laboratories responsible for HIV testing of individuals tested in the jurisdiction, to obtain remnant specimens from the original diagnostic HIV test or HIV related tests for recency testing. Please specify how many

(number and percentage) of the laboratories are sending specimens to the recency testing laboratory for HIV incidence surveillance and what percentage of new HIV diagnoses this represents.

b. Describe how applicant has been able to and will continue to collaborate with CDC to ensure appropriate and efficient preparation and transport of specimens from the laboratory of diagnosis (public health laboratory or commercial laboratory) to the recency testing laboratory.

c. Describe the use of HIV incidence surveillance data for estimation of HIV incidence and the impact of the estimates on policy making and prevention planning.

7. Key Staff

Please identify each key staff member (using an asterisk by their name) in this section and budget justification. A key staff member is defined as a HIV Incidence Surveillance jurisdiction employee designated as Incidence Surveillance Coordinator, data manager, etc. If there are vacancies for HIV Incidence Surveillance provide copies of job announcements and descriptions. If there are vacancies, are there any hiring restrictions that would that would prevent the hiring of staff? If yes, please explain (hiring freeze, budget cuts, new hire justifications, etc.).

8. Describe how HIV incidence surveillance has been integrated with HIV case surveillance (e.g., staffing, modification of case report form, modification of reporting requirements). If the two systems have not been integrated, please describe the plan for integration.

9. Budget

Submit a single budget and justification for HIV Incidence Surveillance Recipient Activities.

a. In the Staff Component please consider the recommended staff for HIV Incidence Surveillance (see Technical Guidance for HIV Surveillance Programs, Vol. I: Policies and Procedure, available at: http://team.cdc.gov; contact the HIV

Incidence and Case Surveillance Branch at 404-639-2050 for access information) and assure at least one staff member with HIV incidence surveillance duties has expertise in SAS.

b. In the Travel Component, include a total for local travel and a total for out-of-state travel.
c. The following information is required for all proposed contracts: name of contractor; period of performance; method of selection (e.g., competitive or sole source); description of activities; justification for subcontracting; and itemized budget. Following receipt of a current year (CY 2013) award, CDC may request additional activity - or project-specific - budgetary information.

Additional information may be included in the application appendices. This additional information includes:

1. Curricula Vitae (Key Staff)
2. Organizational charts
3. Letters of support, including letters from jurisdiction-specific public health laboratories
4. Applicable state regulations relating to the HIV surveillance program (e.g., laboratory and reporting)

No more than 10 attachments should be uploaded per application.

Additional requirements for additional documentation with the application are listed in Section VI. Award Administration Information; subsection entitled "Administrative and National Policy Requirements."

Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Grantees may not use funds for research.
- Grantees may not use funds for clinical care.

- Grantees may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Grantees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- The direct and primary grantee in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.
- Projects that involve the collection of information from 10 or more individuals and are funded by a grant/cooperative agreement will be subject to review and approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Additional Submission Requirements

Electronic Submission

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.Grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC, Procurement and Grant Office, Technical Information Management Section (PGO TIMS) staff at (770) 488-2700, Email: pgotim@cdc.gov, Monday-Friday 7:30 a.m.-4:30 p.m. for further instruction.

Note: Application submission is not concluded until successful completion of the validation process. After submission of the application package, applicants will receive a "submission receipt" email generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject the submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of the application package is complete and no submission errors exists.

To guarantee compliance with the application deadline published in the Funding Opportunity Announcement, applicants are also strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.

In the event that a "validation" email is not received within two (2) business days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track the application or refer to the Application User Guide, Version 3.0 page 57.

Applications must be submitted electronically at www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully made available to CDC for processing from Grants.gov on the deadline date. The application package can be downloaded from www.Grants.gov. Applicants can complete the application package off-line, and then upload and submit the application via the Grants.gov Web site. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (http://www.grants.gov), are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when Grants.gov receives the application. The tracking number serves to document submission and initiate the electronic validation process before the application is made available to CDC for processing.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of all Federal Holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service

is received any time it's needed. The Grants.gov Support Center can be reached at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Organizations that encounter technical difficulties in using www.Grants.gov to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to the GMO/GMS [See Section VII "Agency Contacts"], for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevented electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to the GMO/GMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

Intergovernmental Review

Executive Order 12372 does apply to this program. Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (E.O.) 12372. The order sets up a system for State and local governmental review of proposed Federal assistance applications. Applicants should contact their State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each State affected. Click on the following link to get the current SPOC list http://www.whitehouse.gov/omb/grants/spoc.html.

V. Application Review Information

Eligible applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of FOA PS13-1302. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures of effectiveness must be objective, quantitative and measure the intended outcome of the proposed program. The measures of effectiveness must be included in the application and will be an element of the evaluation of the submitted application.

Note: Please contact NCHHSTP/Office of Health Equity if assistance is needed in developing measures of effectiveness related to health equity/health disparities and associated evaluation criteria.

Criteria

Eligible applications will be evaluated against the following criteria:

Applications are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. These measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement for Component A (Case Surveillance) and Component B (Incidence Surveillance). All measures must be objective, quantitative, and must measure intended outcomes. The measures of effectiveness must be submitted with the application and will be evaluated against the specific requirements listed under each grantee activity as a part of a structural review conducted by the HIV Case Surveillance Branch. For Component A (Case Surveillance), see Grantee Activities parts 1- 16 and for those eligible for Component B (Incidence Surveillance) see Grantee Activities parts 1-12.

Awards will be based on base amount and HIV prevalence. See attached document "Estimated Award Ranges for Component A."

Budget (SF 424A) and Budget Narrative (Reviewed, but not scored). Although the budget is not scored applicants should consider the following in development of their budget. Is the itemized budget for conducting the project, and justification reasonable and consistent with stated objectives and planned program activities?

If the applicant requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov.

The applicant can obtain guidance for completing a detailed justified budget on the CDC website, at the following Internet address: http://www.cdc.gov/od/pgo/funding/budgetguide.htm.

Review and Selection Process

Review

All eligible applications will be initially reviewed for completeness by the Procurement and Grants Office (PGO) staff. In addition, eligible applications will be jointly reviewed for responsiveness by National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention and Control (NCHHSTP) and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified that the application did not meet eligibility and/or published submission requirements.

Applications will be structurally reviewed based on how well the applicant describes how they will conduct recipient activities and meet the process and outcome standards including fully implementing lab reporting for HIV Surveillance.

Selection

All eligible applicants for components A and B will be considered based on responsiveness to the announcement. All applicants will be funded based on the attached document "Estimated Award Ranges for Component A."

Funding for Component A – Case Surveillance will be calculated based on an estimated base amount of $120,000 plus 2009 HIV prevalence disease data. Decreases have been capped at 10%. If an area is scheduled to have a reduction of 5% or less, it will occur in year 1 (FY 2013). If an area will have a reduction of more than 5% to 10%, it will occur over a two year period (2013 and 2014).

In addition, the following factors may affect the funding decision:
HIV case morbidity; number of persons living with HIV; maintaining geographic diversity; and the number of optional activities applied for and approved.

VI. Award Administration Information

Award Notices

Successful applicants (grantees) will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the program director. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

Any application awarded in response to this FOA will be subject to the DUNS, CCR Registration and Transparency Act requirements.

Unsuccessful applicants will receive notification of the results of the application review by mail.

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. The following additional requirements apply to this project:

- AR-4 HIV/AIDS Confidentiality Provisions
- AR-5 HIV Program Review Panel Requirements
- AR-7 Executive Order 12372
- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2020
- AR-12 Lobbying Restrictions
- AR-13 Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14 Accounting System Requirements
- AR-21 Small, Minority, and Women-Owned Business
- AR-23 States and Faith-Based Organizations
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing Text Messaging While Driving, October 1, 2009
- AR-30 Information Letter 10-006. – Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-32 Executive Order 131410: Promoting Quality and Efficient Health Care in Federal Government

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: http://www.access.gpo.gov/nara/cfr/cfr-table-search.html.

Reporting

Federal Funding Accountability And Transparency Act Of 2006 (FFATA): Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended

(FFATA), requires full disclosure of all entities and organizations receiving Federal funds including grants, contracts, loans and other assistance and payments through a single publicly accessible Web site, www.USASpending.gov. The Web site includes information on each Federal financial assistance award and contract over $25,000, including such information as:

1. The name of the entity receiving the award
2. The amount of the award
3. Information on the award including transaction type, funding agency, etc.
4. The location of the entity receiving the award
5. A unique identifier of the entity receiving the award; and
6. Names and compensation of highly-compensated officers (as applicable)

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by recipients: 1) information on executive compensation when not already reported through the Central Contractor Registry; and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the Federal Funding Accountability and Transparency Act of 2006, please review the following website: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf .

Each funded applicant must provide CDC with an annual Interim Progress Report submitted via www.grants.gov:

1. The interim progress report is due no less than 90 days before the end of the budget period. The Interim Progress Report will serve as the non-competing continuation application, and must contain the following elements:
    a. Standard Form ("SF") 424S Form.
    b. SF-424A Budget Information-Non-Construction Programs.

c. Budget Narrative.
d. Indirect Cost Rate Agreement.
e. Project Narrative.

Additionally, funded applicants must provide CDC with an original, plus two hard copies of the following reports:

2. Annual progress report, due 90 days after the end of the budget period.
3. Financial Status Report* (SF 269) Due no more than 90 days after the end of the budget period.
4. Final performance and Financial Status Reports*, no more than 90 days after the end of the project period.

*Disclaimer: As of February 1, 2011, current Financial Status Report (FSR) requirements will be obsolete. Existing practices will be updated to reflect changes for implementation of the new Federal Financial Reporting (FFR) requirements.

Note: All jurisdictions funded to perform recipient (grantee) activities will be evaluated on performance. The first annual progress report (APR) will be due to PGO 90 days after the budget period and each year thereafter (i.e. 3/31/14). Based on the review of the APR, the grantee will be notified if a corrective action(s) is required due to grantee not conducting recipient activities or not meeting process or outcome standards. The grantee will have an opportunity in the IPR for year 2 (out years) to document plan of action to improve performance of HIV Surveillance activities. In subsequent budget periods, funding is contingent on performance.

These reports must be submitted to the attention of the Grants Management Specialist listed in the Section VII below entitled “Agency Contacts”.

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

Pamela Gruduah, Deputy Branch Chief,
HIV Incidence and Case Surveillance Branch ((HICSB)
Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Road NE, Mail Stop E-47
Atlanta, GA 30333
Telephone: (404) 639-8459
Email: PYB1@cdc.gov

For **financial, grants management, or budget assistance**, contact:

Merlin Williams, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-15
Atlanta, GA 30341
Telephone: 770-488-2851
E-mail: mqw6@cdc.gov

For assistance with **submission difficulties,** contact:

Grants.gov Contact Center Phone: 1-800-518-4726.
Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays

For **submission** questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
Email: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at:

TTY 1-888-232-6348

VIII. Other Information

For additional information on reporting requirements, visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Other CDC funding opportunity announcements can be found at www.grants.gov.

[APPENDIX A]

PS 13-1302 Estimated Award Ranges for Component A: Case Surveillance*

Jurisdiction	Year 1 (2013) Lower Range	Year 1 (2013) Upper Range	Year 2 (2014) Lower Range	Year 2 (2014) Upper Range
Alaska	$143,197	$158,271	$143,714	$158,842
Alabama	$626,931	$692,923	$635,998	$702,946
Arkansas	$333,766	$368,900	$337,652	$373,194
Arizona	$686,778	$759,070	$686,778	$759,070
California	$2,569,649	$2,840,139	$2,613,060	$2,888,118
Colorado	$636,288	$703,266	$636,288	$703,266
Connecticut	$610,172	$674,400	$618,943	$684,095
District of Columbia	$1,182,018	$1,306,440	$1,119,807	$1,237,681
Delaware	$256,570	$283,578	$259,091	$286,363
Florida	$4,608,033	$5,093,089	$4,687,477	$5,180,895
Georgia	$1,771,531	$1,958,007	$1,800,831	$1,990,393
Hawaii	$221,201	$244,485	$223,096	$246,580
Iowa	$205,871	$227,541	$195,036	$215,566
Idaho	$150,699	$166,562	$151,347	$167,279
Illinois	$646,539	$714,595	$655,952	$725,000
Indiana	$578,602	$639,508	$548,149	$605,849
Kansas	$238,007	$263,061	$240,200	$265,484
Kentucky	$355,701	$393,143	$359,973	$397,865
Louisiana	$918,386	$1,015,058	$932,606	$1,030,775
Massachusetts	$841,380	$929,946	$854,238	$944,158
Maryland	$1,523,801	$1,684,201	$1,548,722	$1,711,746
Maine	$165,084	$182,462	$165,987	$183,459
Michigan	$889,824	$983,490	$842,992	$931,728
Minnesota	$415,711	$459,470	$421,044	$465,364
Missouri	$642,424	$710,048	$642,424	$710,048
Mississippi	$501,879	$554,709	$508,735	$562,287
Montana	$131,329	$145,153	$131,635	$145,491

Jurisdiction	Year 1 (2013) Lower Range	Year 1 (2013) Upper Range	Year 2 (2014) Lower Range	Year 2 (2014) Upper Range
North Carolina	$1,250,054	$1,381,638	$1,270,137	$1,403,835
North Dakota	$122,451	$135,341	$122,600	$135,506
Nebraska	$192,620	$212,896	$194,010	$214,432
New Hampshire	$165,654	$183,092	$166,567	$184,101
New Jersey	$2,591,809	$2,864,631	$2,455,398	$2,713,860
New Mexico	$257,212	$284,286	$243,674	$269,324
Nevada	$440,418	$486,778	$440,418	$486,778
New York	$1,660,303	$1,835,071	$1,572,918	$1,738,488
Ohio	$908,843	$1,004,511	$922,895	$1,020,041
Oklahoma	$371,864	$411,008	$352,292	$389,376
Oregon	$362,650	$400,824	$357,992	$395,676
Pennsylvania	$804,254	$888,912	$816,456	$902,398
Rhode Island	$203,238	$224,632	$203,238	$224,632
Puerto Rico	$989,601	$1,093,769	$1,005,079	$1,110,877
South Carolina	$777,240	$859,054	$788,965	$872,013
South Dakota	$134,225	$148,353	$134,583	$148,749
Tennessee	$844,798	$933,724	$857,717	$948,003
Texas	$2,179,587	$2,409,017	$2,216,101	$2,449,375
Utah	$224,239	$247,843	$226,188	$249,998
Virginia	$1,059,865	$1,171,429	$1,076,586	$1,189,910
Virgin Islands	$141,204	$156,068	$141,685	$156,599
Vermont	$133,086	$147,095	$133,423	$147,467
Washington	$991,704	$1,096,094	$939,509	$1,038,405
Wisconsin	$361,557	$399,615	$354,272	$391,564
West Virginia	$209,498	$231,550	$198,472	$219,364
Wyoming	$124,113	$137,177	$124,291	$137,375

Jurisdiction	Year 1 (2013) Lower Range	Year 1 (2013) Upper Range	Year 2 (2014) Lower Range	Year 2 (2014) Upper Range
Chicago	$1,108,053	$1,224,691	$1,125,626	$1,244,112
Houston	$1,053,841	$1,164,771	$1,037,208	$1,146,388
Los Angeles	$2,015,272	$2,227,406	$2,048,882	$2,264,554
New York City	$4,828,512	$5,336,776	$4,911,852	$5,428,890
Philadelphia	$926,220	$1,023,716	$940,578	$1,039,586
San Francisco	$1,064,648	$1,176,716	$1,008,614	$1,114,784

*1. These amounts are estimates based on current resources and are subject to change depending on availability of funds.

*2. Awards for FY 2015 - FY 2017 will be based on FY 2014 awards.

[APPENDIX B] **SAMPLE**

Letter of Agreement

Between state health department and local (independently funded city or county) health department

Date:

To:

Name of organization providing HIV Surveillance Activities:

Name of organization agreeing to the provision of HIV Surveillance Activities:

Address:

Funding source: CDC-PS13-1302

Point of contact (POC) at organization providing HIV Surveillance Activities:

POC at organization agreeing to the provision of HIV Surveillance Activities:

Dear Mr(s) (name):

This agreement is made between (name of agency) and (name of other agency) on (state date) in (state name). In the first paragraph of the letter of agreement, clearly mention the full names of the both parties and also the date and place where this agreement is being prepared. Keep it brief and formal.

The agreement should include the following provisions and indicate where the respective parties will perform their respective tasks. The second paragraph should consist of the various statements to which both parties must agree and these statements also serve as the purpose of the agreement (e.g. geographic areas and general HIV Surveillance activities which will be covered). The financial details must be clearly mentioned as these can be final and binding. Finally, include the agreement period (e.g. January 2013-December 2017).

If both parties agree to the terms, then sign and date this letter and send a copy to CDC.

Agreed and accepted

Signature: Date:
Title:

Signature: Date:
Title:

Place: