Exhibit A - A01
HIV Prevention Program
Scope of Work

1. Mission Statement

The goals of the California Department of Public Health, Office of AIDS (CDPH/OA) are: (1) to minimize new HIV infections; ~~and,~~ (2) to maximize the number of people with HIV infection who access appropriate care, treatment, support, and prevention services**; and (3) reduce HIV/AIDS related health disparities**. The services required by the HIV Prevention Program Scope of Work (SOW) in this Cooperative Agreement Contract are consistent with, and are designed to support, these goals.

2. Service Overview

The Contractor agrees to administer the HIV Prevention Program (HPP) and to ensure the provision of HIV prevention services as described in this SOW. The Contractor may provide direct client services exclusively or subcontract all or part of the client services. The Contractor ensures that, if all or part of the client services is subcontracted to other service providers, all services provided by the subcontractor will be monitored by the Contractor in accordance with the HPP.

The Contractor will plan, develop, and ensure the delivery of prevention services to clients. Services should be designed to meet the identified needs of individuals that are HIV positive and/or at high-risk for HIV in the California Project Area (CPA).

The Local Health Jurisdiction (LHJ) will identify one HPP Coordinator who will attend the OAHIV Prevention Branch required meetings when convened.

3. Services to be Performed

Services must be consistent with the California HIV Prevention Program funded by the Centers for Disease Control and Prevention (CDC) PS12-1201 grant. In response to the National HIV/AIDS Strategy (NHAS) and CDC's PS12-1201 grant, OA aims to support the implementation of high impact prevention strategies which identify new positives, link them into ~~quality~~ HIV**/AIDS** medical care and support ~~HIV-positive individuals with preventive services~~ **and provide partner services**. OA's prevention plan also includes structural interventions, such as condom distribution, **and** health care reform planning ~~and education on nonprescription syringe sale in pharmacies,~~ which ~~are~~ **is** consistent with NHAS goals.

OA has developed the Tier I and Tier II system to help LHJs prioritize among the many evidenced-based approaches to HIV prevention currently required or recommended by the CDC. The Tier I and Tier II system is designed to provide flexibility for LHJs to make decisions that work at the local level, at the same time it prioritizes the evidence-based interventions that can best meet the goals of the NHAS.

LHJs must ensure that activities designated as Tier I are provided, using any resources available to the LHJ, before using OA prevention funding for Tier II activities (with the exception of Hepatitis C virus [HCV] testing). HCV antibody testing, while designated a Tier II activity, may be conducted by the LHJ without first ensuring that all Tier I activities are being conducted within the LHJ.

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Tier I Core Services:

All LHJs funded by OA's prevention cooperative agreement contract must meet monitoring and evaluation requirements set by OA and must provide these core services:

a. ~~Targeted HIV testing to prioritized high-risk populations~~ **Provide targeted HIV testing when positivity yield is sufficient to warrant it.**
b. Linkage-to-care (LTC) services for all newly diagnosed HIV positive individuals; and
c. Partner Services.

Other Tier I Services:

a. Routine, Opt-out HIV Testing in Healthcare Settings;
b. Retention and Re-engagement in Care;
c. HIV Medication Treatment Adherence;
d. Prevention with Positives (PWP);
e. Integrated Health Services;
f. Syringe Services Programs; and
g. Condom Distribution (Required).

Additionally LHJs must:

a. Maintain an alternative test site (ATS). ATS testing must be anonymous and provided for free;
b. Assign a staff member to attend to health care reform issues, for a proportion of time to be determined by the LHJ; and
c. Meet the subsidiary requirements that support HIV testing, PS, and LTC services.

Optional Tier II Activities:

a. HCV Testing;
b. Behavioral Interventions for Prioritized High-risk Negative People; and
c. Social Marketing, Media and Mobilization.

TIER I CORE SERVICES:

a. Targeted HIV Testing to Prioritized High-Risk Target Populations

1. LHJs shall administer HIV testing by providing anonymous and/or confidential HIV testing services (with or without counseling) to individuals at high risk for HIV. Testing services may include: assessment of client needs regarding HIV transmission; client-centered prevention counseling; risk-reduction planning; and referrals to other services. LHJs funded for testing in non-health care settings are required to: establish systems for linking newly diagnosed HIV positive or preliminarily positive clients into medical care with a verified medical visit; ensure that clients are offered PS; and establish a plan for referring clients to other prevention programs.

2. Individuals seeking testing services shall be informed about the validity and accuracy of the antibody test before consent to test is obtained. Written consent is required for testing in non-health care settings; oral consent is required for ATS testing; and oral consent is allowed

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for testing in health care settings. All individuals tested with OA funds in non-health care settings shall be given the results of their test in person.

3. Funded agencies must ensure all HIV counseling interventions are provided by staff members who have successfully completed the Basic Counselor Skills Training. In addition, test kit operators are required to complete an annual competency assessment test to maintain their certification for testing client samples.

4. All funded LHJs must ensure that all contracted testing sites maintain appropriate documentation. This includes the LHJ's written protocols for the local testing program, signed statements of confidentiality by staff, testing forms, invoices, etc. All documentation must be maintained for three years plus the current year.

5. Written quality assurance plans are required by sites conducting point-of-care rapid HIV tests waived under the federal Clinical Laboratory Improvement Act (CLIA). These plans must be submitted to OA for review by the Testing Specialist for comprehensiveness and compliance with State and Federal requirements. **Updated plans must be submitted anytime there are significant changes, such as adding HCV testing.**

6. LHJs must increase the number of newly identified HIV positive tests by at least 0.1 percent annually.

7. The contractor must maintain a referral list with contact information. The referral list must be updated annually.

b. Program Description and Other Requirements

The contractor shall set up and enter data into the CDPH/OA's Local Evaluation Online (LEO) process monitoring system for all testing and Health Education/Risk Reduction (HE/RR) activities.

1. Activities will be documented by:

   a. Completing the appropriate CDPH/OA LEO data forms;
   b. Entering initial client data into the LEO system within 5 business days of each client encounter; and
   c. Completing and closing each client record within 3 months of the initial client encounter.

c. Linkage to Care Services (LTC) for all Newly Diagnosed HIV Positive Individuals

1. All LHJs that receive OA prevention funds are required to provide LTC.

2. LTC is the process of assisting newly HIV diagnosed persons to enter into HIV medical care. LTC is a core activity required of all OA-funded HIV testing sites in both medical and non-medical settings. **Contractors may offer LTC services to other medical providers as well.**

3. LTC is considered to be achieved when a newly diagnosed HIV positive person is seen by a health care provider (e.g., physician, physician assistant, nurse practitioner) to receive medical

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care for his or her HIV infection. The standard set by Health Resources and Services Administration (HRSA) **and the indicator defined by the CDC** is that the newly HIV diagnosed individual attends an HIV medical appointment within 90 days of diagnosis.

4. Administration (HRSA) is that the newly HIV diagnosed individual attends an HIV medical appointment within 90 days of diagnosis.

5. HIV testing coordinators must establish policies and procedures describing a system for referring individuals with preliminary and confirmed HIV positive test results to a medical provider for HIV care. In designing this system, coordinators should include identification of HIV care providers, referrals to medical care, and verification of client's attendance at their first appointment.

6. A variety of different mechanisms may be used to verify, including but not limited to, verified medical visit forms, kickback cards, and/or client self-report. All verified visits must be entered on the HIV Counselor Information Form (CIF) and entered into LEO data collection system.

d. Partner Services (PS)

1. All LHJs that receive OA prevention funds are required to provide PS.

2. LHJs must offer PS to all people newly diagnosed as HIV positive, as well as, those living with HIV who have participated in recent risky behavior and may have exposed others to HIV. LHJ's should assess PS activities and outcomes, and implement provider outreach programs to enhance PS with key community providers.

3. Every LHJ must maintain a staff member to coordinate the PS activities of that LHJ. If an LHJ has the infrastructure to only provide an offer of PS, collaboration with a Disease Intervention Specialist from the State STD Control Branch must be established and maintained for comprehensive PS activities.

4. Funds allocated for PS may be used for any activities supporting PS including staff salaries and benefits, travel, training, and resources for third-party notification. PS allocations may not be used to pay for HIV testing, counseling, or other prevention activities.

5. All LHJs shall maintain a comprehensive written PS program plan that provides for routine review of PS staff performance with appropriate standards, PS protocols/quality assurance plans, and the availability of and referral to HIV testing, prevention services, STD screening, HCV testing, and HIV medical care as appropriate.

6. Local programs should track the number, type and outcomes of PS activities provided by entering data into LEO and review this data routinely.

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OTHER TIER I SERVICES:

a. HIV Testing in Healthcare Settings

1. LHJs that elect to fund HIV Testing in Healthcare Settings will work with local health care settings on ways they can implement and increase routine, opt-out HIV testing. These settings may include but are not limited to hospital emergency departments and primary care clinics in community health care settings.

2. Funding for routine, opt-out HIV testing cannot be used to pay for HIV testing staff.

3. This funding can only pay for HIV testing (i.e., test kits and other testing costs) when a patient has no other payer for health care services (OA is the payer of last resort).

4. **Documentation for routine, opt-out HIV testing includes completing a Health Care HIV Test Form for all preliminary or confirmed positive results, and entering that information in the LEO system. Required data for HIV-negative results can be retrieved from electronic medical records and submitted to OA electronically. The Prevention Research and Evaluation Section will work with any providers conducting routine, opt-out testing to develop a system to report required data.**

b. Retention and Re-engagement into Care

1. Retention and Re-engagement in Care identifies HIV positive patients vulnerable to not attending HIV medical appointments routinely, as well as, out-of-treatment HIV positive individuals, and works with the HIV positive individual to stay in or return to HIV medical care.

2. LHJ's conducting these services are responsible for determining the most effective approaches for achieving active collaboration between local prevention and care providers to provide retention and re-engagement services. In order to decrease duplication of effort and ensure maximum impact of retention and re-engagement interventions, LHJs that fund or provide Retention and Re-engagement in Care services will demonstrate active collaboration and coordination with Care sites.

3. OA's LEO or AIDS Regional Information and Evaluation System (ARIES) must be used to document and record Retention and Re-engagement in Care activities.

c. HIV Medication Treatment Adherence

1. HIV Medication Treatment Adherence services support the appropriate and consistent use of antiretroviral (ARV) medicines to maximize their benefits in sustaining health and suppressing viral load.

2. OA will fund HIV medication treatment adherence interventions to any patient(s) living with HIV having difficultly taking ARVs as prescribed.

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3. LHJs that elect to fund or provide HIV Medication Treatment Adherence should include collaboration with health care providers, medical case managers, and others working with HIV positive individuals. HIV Medication Treatment Adherence activities should include:

   - Regular screening of HIV infected individuals to determine whether they are on ARV therapy;

   - Routine assessment of treatment adherence using the adherence questions listed on the LEO HE/RR form or in ARIES, as well as monitoring of viral load suppression to identify individuals who would benefit from treatment adherence interventions; and

   - Appropriate referrals for those not on ARV therapies and for those identified as having challenges in maintaining adherence to their HIV medication requirements. This may include delivering treatment adherence interventions, consultation with health care providers or referral to HIV medication treatment adherence services.

4. OA prevention funds cannot be used to pay for medications or medical services. Purchasing supplies to assist with medication adherence is an acceptable expense when used within treatment adherence intervention programs.

5. OA requires LHJs to use LEO or ARIES to track service utilization by clients referred to treatment adherence interventions.

d. Prevention with Positives

1. The goal of Risk Assessment, Linkage to Services and Behavioral Interventions for HIV Positive Individuals (PWP Services) is to increase the number of Ryan White-funded clinics or HIV care providers providing a comprehensive risk screening program and, to the extent that resources are available, initiate behavioral, structural or biomedical interventions for HIV positive people, or develop a referral plan for community-based PWP interventions.

2. LHJs which elect to fund or conduct PWP Services will select at least one Ryan White-funded clinic or HIV care provider who can initiate behavioral risk screening within their medical setting.

3. All sites conducting PWP services will administer the LEO Group Self-Administered Questionnaire (GSAQ) and the Substance Abuse and Mental Illness Symptom Screener (SAMISS) to HIV positive individuals and enter the results in LEO and ARIES.

4. For LHJs that fund HIV behavioral interventions, selected interventions must be **CDC supported** evidence-based and designed for HIV positive people or HIV positive people and their sexual/needle sharing partners. **If other evidence-based interventions are adapted to the population, documentation of the adaptation must be submitted to OA for approval prior to implementation.**

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5. If a site choose to refer clients at risk of transmitting HIV to community-based HIV behavioral interventions, those interventions must also be **CDC supported** evidence-based and designed to target HIV positive or serodiscordant relationships. If other evidence-based interventions are adapted to the population, documentation of the adaptation should be submitted to OA for approval **prior to implementation**.

6. In addition to HIV behavioral interventions, LHJs providing PWP services must identify and refer to culturally appropriate mental health and substance use services as needed.

7. All staff members who facilitate evidence-based interventions must have completed training in the intervention. Supervisors must monitor and ensure that the intervention is administered with fidelity and follow the curriculum and intervention activities as defined by the intervention.

8. OA's LEO or ARIES should be used to document and record client assessments and referrals. HIV Behavioral Interventions will be recorded and monitored using the LEO system. ~~All evaluation required by evidence-based interventions must be completed and be maintained within LEO.~~

e. Integrated Health Services

1. Activities for integration of screening for and monitoring of Hepatitis, TB, and STDs for HIV positive individuals will be determined by each LHJ and will vary depending on the needs and opportunities within each LHJ. Activities may include, but are not limited to:

   - Providing continuing medical education highlighting the benefits of compliance with recommended clinical monitoring to increase staff integration of screening;

   - Using ARIES or electronic health records to document clinical testing of medical case management clients and Ryan White clinic patients as appropriate; and/or

   - Supporting client education that increases awareness of clinical laboratory monitoring standards and encouraging clients to talk with their health care providers about exposure or transmission risks of Hepatitis, TB, and STDs.

2. OA funding cannot be used to pay for clinical laboratory tests, except for HIV testing and Hepatitis screening.

3. LHJs are required to report on their activities in their bi-annual progress reports.

f. Syringe Services Programs

1. LHJs may use their OA HIV prevention funds to:

   - Support efforts to increase proper syringe disposal among Injection Drug Users (IDUs);

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- Support local non-prescription syringe sales in pharmacies: this may take the form of working to increase the number of pharmacies providing non-prescription syringe sales and/or encouraging IDUs to purchase sterile equipment in pharmacies which provide non-prescription syringe sales. Alternately or additionally, LHJs may provide educational literature or training about recent changes in pharmacy practice to law enforcement, pharmacy staff, IDUs and health and social service professionals who work with IDUs;

- Support policy work necessary to facilitate structural change to expand access to sterile syringes and/or improve sharps disposal among IDUs, as long as the work does not include efforts to influence state, federal or local law.

2. LHJs may not use their OA HIV prevention funds to:

   - purchase needles and syringes;
   - fund staff time used specifically to distribute needles or syringes;
   - pay for delivery modes such vehicles or rent for fixed sites used specifically for distributing needles and syringes; and/or
   - conduct any activity designed to influence legislative change at the Local, State, or Federal level.

g. Condom Distribution (Required)

1. The condom distribution program requires LHJs to use OA epidemiologic data as well as LHJs local knowledge and resources to enroll venues into the condom distribution program, where they will receive condoms and educational material to distribute to high-risk target populations in locations where HIV/AIDS is most prevalent.

2. In order for a venue to be eligible for participation in the condom distribution program, they must: 1) provide their services in a zip code that has identified HIV/AIDS cases; and 2) have a clientele (whole or partial) that is made up of the targeted population.

3. LHJs will maintain venues previously enrolled in the condom distribution program, add additional venues when possible, and replace venues if former venues stop participating in the program.

4. To enroll a new venue, the LHJ must fill out the *Participating Venue Information* (PVI) form. There is no limit to how many eligible venues each LHJ can have participating in the program.

5. Condom orders cannot be placed by an LHJ or another entity on behalf of the participating venue. Condom orders cannot be placed by an LHJ for distribution at a one-time event, such as health fairs, workshops, rallies or other presentations unless the events specifically target OA's priority populations and are part of the LHJs HE/RR prevention interventions.

6. LHJs must include information about their condom distribution plans in their bi-annual progress reports.

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TIER II SERVICES:

Please note that no more than 25% of OA funds may be used for Tier II activities.

a. Hepatitis C Testing

1. OA funding may be used to offer HCV testing to clients identified by the assessment process to be at risk for HCV. Although HCV testing is a Tier II activity, LHJs may conduct this activity without implementing all Tier I activities.

2. OA funds may be used for HCV laboratory tests, HCV rapid tests, and Home Access kits.

3. OA will provide training **to new HIV test counselors** for the rapid CLIA-waived HCV and combination rapid HIV/HCV tests. HIV counselors must be certified prior to administering the new HCV rapid test. **Supervisors who have been trained by OA will provide training to their current HIV counselors.** Additionally, **current** HIV counselors must take the University of California San Francisco, Alliance Health Project on-line HCV training.

4. Trained HIV test counselors who are authorized in California to perform rapid CLIA-waived HIV tests may also perform rapid CLIA-waived HCV and combination rapid HIV/HCV tests. HIV test counselors performing rapid CLIA-waived HCV tests or rapid combination HIV/HCV tests, including those tests administered by finger stick, will need to meet the same performance and training requirements as that for rapid CLIA-waived HIV testing.

5. HCV test information must be collected on the CIF and entered into LEO.

6. The Contractor can integrate HIV and HCV testing services to increase the number of IDUs ~~and Men who have Sex with Men (MSMs)~~ who receive HIV testing services and learn their HIV status by offering HCV screening in coordination with HIV testing. CDPH/OA will allow IDU ~~and MSM~~ clients to test only for HCV if they choose not to take an HIV test.

e. Behavioral Interventions for Prioritized High-risk Negative People

1. The priority high-risk negative populations for the California project area are:

   - MSM, including MSM/IDU with strong emphasis on African-American and Latino MSM;
   - IDUs;
   - Transgender Individuals; and
   - High-Risk Negative Individuals with Sexual and/or Injection-sharing HIV positive or MSM partners.

2. LHJs may provide high-risk HIV negative populations with evidence-based HIV behavioral interventions to reduce the rate of new HIV infection within identified high-risk target populations. Behavioral interventions may include:

   - Targeted prevention activities (TPA) for high-risk HIV-negative persons;

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- Individual level interventions (ILI); **and**
- Group level interventions (GLI); ~~and~~
- ~~Comprehensive Risk Counseling and Services (CRCS) for individuals with multiple health needs.~~

3. Intervention providers must screen potential participants prior to starting the intervention to ensure participants are part of intended target population, and divert lower risk and non-target population individuals to alternative resources. OA funds should not be used to support interventions for low-risk negatives.

4. All OA-funded behavioral interventions must be recorded in LEO.

f. Social Marketing, Media and Mobilization

1. OA has chosen the following health messages for social marketing activities, media, and mobilization activities:

   - Benefits of early detection of HIV infection;
   - Need for routine and regular HIV health care;
   - Benefits of ARV therapy for health of people living with HIV;
   - Role of suppressed viral load in reducing HIV transmission;
   - Benefits of integrated screening for HIV, TB, STDs, and Hepatitis;
   - Value of initial and ongoing PS;
   - Information about Community Viral Load; and
   - Emerging messages from CDC or OA.

2. Messaging must address one or more of the health messages above and be targeted to HIV positive people, or priority high-risk negative populations as defined by OA.

3. Due to limited resources, LHJs should choose campaigns that have already been developed and demonstrated effective. LHJs choosing to conduct social marketing, media, or mobilization activities must submit a plan to OA ***prior to starting a campaign***. The plan should include a definition of the health issue being addressed and the rationale for its selection. The plan should also describe the health messages to promote Testing, HIV Care, ARV therapy, PS, integration of STD, hepatitis, TB screening, and PS into HIV services, as well as the formative work planned to ensure community participation in the campaign development. Monitoring and evaluation activities must also be included in the plan. No LHJ's may create new material until after documentation of a search for pre-existing material and justification for developing new material is submitted to and approved by OA.

4. Progress on activities will be clearly documented in bi-annual progress reports submitted to OA, as well as entered into LEO.

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4. Reporting Requirements

A. Progress Reports

Progress Reports are required on a bi-annual basis, and must be submitted to LHJ's assigned HIV Operations Advisor via e-mail. The progress report**s** ~~for this prevention contract will~~ cover ~~the~~ six months of the contract~~,~~**.** **The first report covers the first six months of the contract term;** from ~~July~~ **January** 1, ~~2013~~ **2014** to ~~December 31, 2013~~ **June 30, 2014**. ~~The~~ **This** report ~~will be~~ **is** due on ~~February~~ **August** 15, 2014. **The second report covers July 1, 2014 through December 31, 2014 and is due on February 15, 2015. Progress reports are due August 15th and February 15th for each six month term for the duration of this agreement.**

The progress reports should address, 1) all applicable services performed in Tier I and/or Tier II, 2) required information as outlined in the **Prevention Program Guidance** ~~IPP guidance (click here for Information for Program Planning (IPP~~), and 3) relevant follow-up documentation for items identified In site visits, technical assistance and communication between OA and the LHJ.

LHJs must report on all activities that either the LHJ or subcontracted agencies have implemented.

The progress report must follow the guidance instructions that will be provided in the progress report template.

5. Project Representatives

A. The project representative during the term of this agreement will be:

California Department of Public Health **Cheryl Austin** **Telephone: (916) 449-5810** **Fax: (916) 449-5909** **Email: Cheryl.Austin@cdph.ca.gov**	**County of Santa Barbara** **Adriana Almaguer** **Telephone: (805) 346-8433** **Fax: (805) 346-7232** **Email: adriana.almaguer@sbcphd.org**

B. Direct all inquiries to:

California Department of Public Health **Office of AIDS** **Attention: Cheryl Austin** **P.O. Box 997426, MS 7700** **Sacramento, CA 95899-7426** **Telephone: (916) 449-5810** **Fax: (916) 449-5909** **Email: Cheryl.Austin@cdph.ca.gov**	**County of Santa Barbara** **Attention: Adriana Almaguer** **2115 S. Centerpointe Parkway** **Santa Maria, CA 93455** **Telephone: (805) 346-8433** **Fax: (805) 346-7232** **Email: adriana.almaguer@sbcphd.org**

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

Exhibit B – A01
Budget Detail and Payment Provisions

1. Invoicing and Payment

A. For services satisfactorily rendered, and upon receipt and approval of the invoices, the State agrees to compensate the Contractor for actual expenditures incurred in accordance with the attached budget.

B. Invoices must include the Agreement Number and Program Name and must be submitted not more frequently than monthly in arrears. Each invoice for the quarter shall be submitted for payment no more than thirty (30) calendar days following the close of each quarter, unless an alternate deadline is agreed to in writing by the program contract manager. Direct all inquiries to:

Invoice Desk
California Department of Public Health
Office of AIDS
MS 7700
1616 Capitol Avenue, Suite 616
P.O. Box 997426
Sacramento, CA 95899-7426

C. Invoices shall:

1) Submit on Contractor letterhead and signed by an authorized representative, certifying that the expenditures claimed represent actual expenses for the service performed under this contract.
2) Identify contract agreement number.
3) Identify the billing and/or performance period covered by the invoice.
4) Itemize costs for the billing period in the same or greater level of detail as indicated in this agreement. Subject to the terms of this agreement, reimbursement may only be sought for those costs and/or cost categories expressly identified as allowable in this agreement and approved by CDPH.

2. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Contractor to reflect the reduced amount.

3. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

Exhibit B – A01
Budget Detail and Payment Provisions

4. Amounts Payable

A. The amounts payable under this agreement shall not exceed:

1) $ 49,575 for the budget period of 07/01/13 through 12/31/13.
2) **$ 94,905 for the budget period of 01/01/14 through 12/31/14.**
3) **$ 94,905 for the budget period of 01/01/15 through 12/31/15.**

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

5. Timely Submission of Final Invoice

A. A final undisputed invoice shall be submitted for payment no more than sixty (60) calendar days following the expiration or termination date of this agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said invoice should be clearly marked "Final Invoice", indicating that all payment obligations of the State under this agreement have ceased and that no further payments are due or outstanding. The State may, at its discretion, choose not to honor any delinquent final invoice if the Contractor fails to obtain prior written State approval of an alternate final invoice submission deadline.

B. The Contractor is hereby advised of its obligation to submit to the state, with the final invoice, a completed copy of the **"Contractor's Release (Exhibit F)".**

6. Allowable Line Item Shifts

A. Subject to the prior review and approval of the State, line item shifts of up to fifteen percent (15%) of the annual contract total, not to exceed a maximum of one hundred thousand ($100,000) annually are allowed, so long as the annual agreement total neither increases nor decreases.

The $100,000 maximum limit shall be assessed annually and automatically adjusted by the State in accordance with cost-of-living indexes. Said adjustments shall not require a formal agreement amendment. The State shall annually inform the Contractor in writing of the adjusted maximum.

B. Line item shifts meeting this criteria shall not require a formal agreement amendment.

C. The Contractor shall adhere to State requirements regarding the process to follow in requesting approval to make line item shifts.

D. Line item shifts may be proposed/requested by either the State or the Contractor.

7. Expense Allowability / Fiscal Documentation

A. Invoices, received from the Contractor and accepted for payment by the State, shall not be deemed evidence of allowable agreement costs.

Exhibit B – A01
Budget Detail and Payment Provisions

B. Contractor shall maintain for review and audit and supply to CDPH upon request, adequate documentation of all expenses claimed pursuant to this agreement to permit a determination of expense allowability.

C. If the allowability of an expense cannot be determined by the State because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles or practices, all questionable costs may be disallowed and payment may be withheld by the State. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

8. Recovery of Overpayments

A. Contractor agrees that claims based upon the terms of this agreement or an audit finding and/or an audit finding that is appealed and upheld, will be recovered by the State by one of the following options:

1) Contractor's remittance to the State of the full amount of the audit exception within 30 days following the State's request for repayment;

2) A repayment schedule which is agreeable to both the State and the Contractor.

B. The State reserves the right to select which option, as indicated above in paragraph A, will be employed and the Contractor will be notified by the State in writing of the claim procedure to be utilized.

C. Interest on the unpaid balance of the audit finding or debt will accrue at a rate equal to the monthly average of the rate received on investments in the Pooled Money Investment Fund commencing on the date that an audit or examination finding is mailed to the Contractor, beginning 30 days after Contractor's receipt of the State's demand for repayment.

D. If the Contractor has filed a valid appeal regarding the report of audit findings, recovery of the overpayments will be deferred until a final administrative decision on the appeal has been reached. If the Contractor loses the final administrative appeal, Contractor shall repay, to the State, the over-claimed or disallowed expenses, plus accrued interest. Interest accrues from the Contractor's first receipt of State's notice requesting reimbursement of questioned audit costs or disallowed expenses.

Exhibit B - Attachment II
HIV Prevention Program
Budget (Year 2)
January 1, 2014 to December 31, 2014

A. PERSONNEL	$12,222
B. OPERATING EXPENSES	$750
C. CAPITAL EXPENDITURES	$0
D. OTHER COSTS	$80,100
E. INDIRECT COSTS (Up to 15% of Personnel)	$1,833
TOTAL BUDGET	**$94,905**

Exhibit B - Attachment III
HIV Prevention Program
Budget (Year 3)
January 1, 2015 to December 31, 2015

A. PERSONNEL	$12,222
B. OPERATING EXPENSES	$430
C. CAPITAL EXPENDITURES	$0
D. OTHER COSTS	$80,100
E. INDIRECT COSTS (Up to 17.62% of Personnel)	$2,153
TOTAL BUDGET	**$94,905**