STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213A_CDPH (3/12)

☒ Check here if additional pages are added: 1 Page(s)

Agreement Number	Amendment Number
10-95290	A02
Registration Number:	

1. This Agreement is entered into between the State Agency and Contractor named below:
   State Agency's Name (Also known as CDPH or the State)
   California Department of Public Health
   Contractor's Name (Also referred to as Contractor)
   County of Santa Barbara
2. The term of this Agreement is: July 1, 2010 through June 30, 2013
3. The maximum amount of this Agreement after this amendment is: $ 1,101,788 One Million, One Hundred One Thousand, Seven Hundred Eighty Eight Dollars.
4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   I. **Amendment effective date:** July 1, 2011

   II. **Purpose of amendment:**
   This amendment increases the funding level for Surveillance and Care/MAI Programs in year 3 of the contract term due to the revised state allocation formula; replaces Care/MAI Scope of Work in its entirety; and adds Prevention Program funding and Scope of Work for year 2 and 3 of the contract term.

   III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)*
County of Santa Barbara

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Takashi Wada, MD, MPH, Public Health Director/Health Officer

Address
c/o Daniel Reid, Assistant Deputy Director, Santa Barbara Public Health Dept.
345 Camino del Remedio, Bldg. 4 Room 331, Santa Barbara, CA 93110

STATE OF CALIFORNIA

Agency Name
California Department of Public Health

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Angela Salas, Chief, Contracts Management Unit

Address
1501 Capitol Avenue, Suite 71.5178, MS 1802, P.O. Box 997377,
Sacramento, CA 95899-7377

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☒ Exempt per:
Budget Act of 2011, Chapter 33

IV. Paragraph 3 (maximum amount payable) on the face of the original STD 213 is increased by $126,356 and is amended to read: ~~$975,432 (Nine Hundred Seventy Five Thousand, Four Hundred Thirty Two Dollars.)~~ **1,101,788 (One Million, One Hundred One Thousand, Seven Hundred Eighty Eight Dollars.)**

V. Exhibit A, Scope of Work, Provision 4 is amended to update a Project Representative and is to read as follows:

California Department of Public Health
Office of AIDS
Fiscal Management Section
Attention: ~~Carrie Talbot~~ **Peter Domich**
Mail Station Code 7700
1616 Capitol Avenue, Suite 616
P.O. Box 997426
Sacramento, CA 95899-7426

Telephone: (916) ~~449-5932~~ **449-5917**
Fax: (916) 449-5909
E-mail: ~~Carrie.Talbot@cdph.ca.gov~~
Peter.domich@cdph.ca.gov

VI. Exhibit A, Scope of Work, Provision 5, Services to be Performed, adds paragraph C, and is to read as follows:

C. HIV Prevention Program

The HIV Prevention Program works with local health jurisdictions and community-based organizations, providing technical and capacity building assistance, to develop and implement focused HIV prevention interventions to reduce the transmission of HIV; to test high-risk clients for HIV detection; to change individual knowledge and attitudes about HIV and risk behaviors; to promote the development of risk-reduction skills; and to change community norms related to unsafe sexual and drug-taking behaviors.

VII. Provision 4 (Amounts Payable) of Exhibit B – Budget Detail and Payment Provisions is amended to read as follows:

1. Amounts Payable

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

1) $353,962 for the budget period of 07/01/10 through 06/30/11.
2) ~~$310,735~~ **360,219** for the budget period of 07/01/11 through 06/30/12.
3) ~~$310,735~~ **387,607** for the budget period of 07/01/12 through 06/30/13.

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.

VIII. Provision 1 (Additional Incorporated Exhibits) of Exhibit E – Additional Provisions is amended to read as follows:

1. Additional Incorporated Exhibits

The following documents and any subsequent updates are not attached, but are incorporated herein and made a part hereof by this reference. These documents may be updated periodically by CDPH, as required by program directives. CDPH shall provide the Contractor with copies of said documents and any periodic updates thereto, under separate cover. CDPH will maintain on file, all documents referenced herein and any subsequent updates.

1) HIV/AIDS Surveillance Program MOU
2) HIV Care Program MOU
3) HIV Prevention Program MOU

IX. All other terms and conditions shall remain the same.

Exhibit A, A02
HIV Care Program and Minority AIDS Initiative
Scope of Work, Year 3

I. Introduction

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 maximum the number of people with HIV infection who access appropriate care, treatment, support, and prevention services. The services required by the HIV Care Program (HCP) and Minority AIDS Initiative (MAI) Scopes of Work (SOWs) in this Memorandum of Understanding are consistent with, and are designed to support, these goals.

2. Service Overview

CDPH/OA utilizes federal Health Resources Services Administration (HRSA) funds to provide support for HIV/AIDS services in local areas. Federal HRSA funds include Part B and Minority AIDS Initiative funding. HIV care services are funded using a Single Allocation Model to consolidate HRSA program funds into a single contract in each local health jurisdiction or service area.

Through this single contract, the Contractor agrees to administer (A) **HCP** and, if applicable, (B) **MAI Outreach and Treatment Education Services**.

A. The Contractor agrees to administer HCP and to ensure the provision of the HIV care 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 parts of the client services are subcontracted to other client service providers, all services provided by the subcontracted agency will be in accordance with HCP.

B. If funded, the Contractor agrees to administer the MAI outreach and treatment education services focused on providing access to, and engagement in, medical care for HIV-positive persons of color, including access to AIDS Drug Assistance Program (ADAP), Medi-Cal, or other appropriate program

II. HIV Care Program

1. HCP Services

The HIV medical and support care services must be provided under specific HRSA-defined service categories. For a listing of HRSA service category definitions, and the specific services included in each category, please refer to the HRSA website at www.hab.hrsa.gov. Additional information can be found in the *HCP and Budget Guidelines.*

CDPH/OA will not require local utilization of HRSA's "75 percent (Core services) / 25 percent (Support services)" requirement for prioritization of services.

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HCP is a two-tiered approach to service prioritization and delivery and utilizes the HRSA-defined service categories, both the Core and Support service categories.

HCP prioritizes service provisions as follows:

Tier One: *Outpatient/Ambulatory Medical Care,* as defined by HRSA. Services include, but are not limited to, primary medical care, laboratory testing, medical history taking, health screening, and prescribing and managing medications. Contractors must ensure that Tier One medical services are provided for all population groups in their geographic region via all HIV/AIDS or other funding sources before allocating HCP funds to Tier Two services.

Tier Two: HRSA-defined Core and Support service categories that (1) assist with access to Tier One care, (2) support maintenance in Tier One care, and (3) reduce the risk of treatment failure and/or HIV transmission. HCP funds may be allocated for any Tier Two service only after Contractors have ensured and documented that Tier One services are adequately provided in their geographic region via all HIV/AIDS or other funding sources.

The following HRSA service categories are included in Tier Two of HCP:

- *Mental Health Services*
- *Medical Case Management Svcs (includes Treatment Adherence)*
- *Case Management (Non-Medical)*
- *Oral Health Care*
- *AIDS Pharmaceutical Assistance*
- *Substance Abuse Services - Outpatient and Residential*
- *Health Education/Risk Reduction*
- *Home Health Care*
- *Hospice Services*
- *Outreach Services*
- *Emergency Financial Assistance*
- *Food Bank/Home-Delivered Meals*
- *Housing Services*
- *Legal Services*
- *Treatment Adherence Counseling*
- *Health Insurance Premium and Cost Sharing Assistance*
- *Home- and Community-Based Health Services*
- *Linguistic Services*
- *Medical Transportation Services*
- *Psychosocial Support Services*
- *Medical Nutrition Therapy*
- *Early Intervention Services*
- *Referral for Health Care/Supportive Services*
- *Rehabilitation Services*
- *Respite Care*
- *Child Care Services*

A. The Contractor shall:

1. Provide comprehensive, ongoing medical services to individuals with HIV/AIDS. Services must be based on HRSA Core Services which include the HRSA service category, *Outpatient/Ambulatory Medical Care* or, if these services are not funded by HCP under Tier One, the Contractor must demonstrate and document the availability of primary medical care for HIV-infected persons within each population group in the service area.

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2. Provide Tier Two services as necessary, and as funds permit, to ensure access to care, maintenance in care, and reduce the risk of treatment failure or HIV transmission.

3. Develop and implement a comprehensive system of care and support services that actively engages individuals who know their HIV status but are not accessing services, that reaches out to people who are HIV positive but unaware of their HIV status, and that is coordinated and integrated with other service delivery systems as appropriate.

4. Advisory and/or focus groups will meet at least **annually** to provide input to the Contractor on issues such as needs assessment, service delivery plans, and comprehensive planning. The Contractor shall maintain minutes and/or documentation of the advisory or focus group meetings.

   The advisory and/or focus group, should be made up of representatives from state, federal, and local programs that provide health services and education and prevention services; non-profit and for-profit community-based agencies; staff from other key points of entry into medical care, who either provide services to individuals with HIV/AIDS, or who may have contact with HIV positive individuals who are not in care or not aware of their HIV status; individuals with HIV, and their advocates, etc. The advisory group provides information to the Contractor regarding health services delivery and the needs of individuals with HIV/AIDS living within the community.

5. Ensure the protection of the client's privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their Protected Health Information (PHI) in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F. R. s 164.524).

6. Ensure that any subcontracted agencies have the organizational and administrative capabilities to support the program services and activities. The Contractor is responsible for quality assurance and utilization review activities for subcontracted HIV care services.

7. Ensure that any subcontracted agencies have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

8. Develop and maintain working relationships, and coordinate an integrated system of service delivery, with entities who provide key points of entry into medical care, including but not limited to emergency rooms,

substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, California Department of Corrections and Rehabilitation, Transitional Case Management Program (TCMP) for incarcerated populations, sexually transmitted disease (STD) clinics, HIV counseling and testing sites, mental health programs, homeless shelters, health care points of entry specified by the State, federally qualified health centers, migrant health centers, community health centers, health services for the homeless, family planning grantees, comprehensive hemophilia diagnostic and treatment centers, and non-profit and for profit private entities that provide comprehensive primary care services to populations at risk for HIV. The coordinated, integrated system of care must be informed by HIV epidemiological data and other data sources and should include leveraged resources. The Contractor shall keep documentation of these working relationships.

9. Ensure case management services that link available community support services to appropriate specialized medical services shall be provided for individuals residing in rural areas as appropriate.

10. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease. Facilities must also be accessible for hearing-, vision-, and mobility-impaired persons in accordance with the federal Americans with Disabilities Act (ADA).

11. Provide targeted prevention coordinated with all state and federal programs to low-income individuals with HIV disease and to inform such individuals of the services available under Ryan White Part B.

12. To the maximum extent practical, ensure that HIV-related health care and support services delivered pursuant to a program established with assistance provided under Ryan White Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease.

13. Ensure services provided to women, infants, children, and youth are tracked and reported (see Data Collection, subheading F).

14. Ensure that services provided under this contract are in accordance with the program policy guidance issued by Division of Service Systems (DSS), HIV/AIDS Bureau (HAB) (see www.hab.hrsa.gov), CDPH/OA's *HCP and Budget Guidelines.*

15. Ensure the Ryan White HIV/AIDS Program funds do not comprise the majority of any subcontracted agency's total budget. Ryan White HIV/AIDS Program funds are intended to provide additional funding to

those areas negatively affected by HIV disease and cannot be used to supplant local HIV-related budgets.

16. Ensure clients are eligible for Ryan White services in accordance with the program policy guidance issued by DSS, HAB (see www.hab.hrsa.gov). Screening and reassessment of client eligibility must be completed and documented every 6 months to determine continued eligibility for Ryan White services.

    Ensure that eligibility policies do not deem a Veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits. Ensure policies and procedures classifying veterans receiving VA health benefits as uninsured, thus exempting these Veterans from the "Payer of Last Resort" requirement per Veterans Policy 07-07, Policy 04-01, and Parham Letter 08/04 (see www.hab.hrsa.gov).

17. Ensure no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with contract conditions and audit requirements;

    b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

18. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontracted agencies' non-direct service (administrative) functions without prior written consent from OA.

19. Conduct assessment of HIV/AIDS service needs for the geographic service area at least once every three years. Review and update the assessment annually, if needed. Ensure that no more than five percent (5%) of the allocation is utilized to plan, conduct, and evaluate the needs assessment process. Needs assessment activities may not be billed to CDPH/OA more than once during a three year contract period.

20. Ensure that client service providers who provide Medi-Cal reimbursable services are certified as providers for purposes of Medi-Cal billing (see

www.medi-cal.ca.gov) and have the ability to bill other third-party payers for covered services.

21. Ensure that funds are payer of last resort by ensuring client service providers bill all other third-party payers, including Medi-Cal, before invoicing HCP.

22. Funded service providers should integrate, and work collaboratively, with other such services and coordinate with other available programs (including Medicaid), to ensure continuity of care and prevention of services of individuals with HIV is enhanced.

23. Ensure documentation of written referral relationships with entities considered key points of access to healthcare systems for the purpose of facilitating early intervention services for individuals diagnosed as being HIV positive.

    a. Work with consortia, service providers, and individuals with HIV/AIDS to identify key points of entry.
    b. Monitor the use of referral and linkage agreements by funded service providers.

24. Ensure funds are not used on prohibited activities (see www.hrsa.hab.gov) and CDPH/OA's HCP and Budget Guidelines.

25. Prohibit employees from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

    a. Documentation is required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

26. Ensure funds are not utilized to make payments for any item or service to the extent payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

27. Ensure funds are not used to:

    a. Make cash payment to intended recipients of services;

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b. Develop, promote, or advertise about HIV services that target the general public.

c. Generate broad scope awareness activities about HIV services that target the general public.

d. Pay costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act.

e. Pay for any item or service that can reasonably be expected to be paid under any State Compensation Program, insurance policy, or any Federal or State Health Benefits Program (except for programs related to Indian Health Service);

f. Pay for any item or service that can be paid by an entity providing health services on a prepaid basis;

g. For the development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity;

h. Purchase or improve (other than minor remodeling) any building or other facility; or

i. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov).

28. Ensure all approved subcontracted agency invoices are paid within 45 days of receipt.

29. Ensure no funds are carried over into subsequent contract years.

30. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's *HCP and Budget Guidelines,* CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

31. Administer Ryan White Part B funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

32. Annually evaluate the cost-effectiveness of the mechanisms used to deliver comprehensive care.

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33. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor must clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

34. Ensure Management Memoranda responses are accurate, complete and received on or before the required response date.

35. Ensure compliance with the following requirements regarding imposition of charges for services, for those providers who charge for services:

    a. In the case of individuals with an income less than or equal to one hundred percent (100%) of federal poverty guidelines (FPG) (see www.aspe.hhs.gov/poverty), the provider will not impose charges on any such individual for the provision of services under the contract;

    b. In the case of individuals with an income greater than one hundred percent (100%) of the FPG, the provider:

        i. Will impose charges on each such individual for the provision of such services and
        ii. Will impose charges according to a schedule of charges that is made available to the public;

    c. In the case of individuals with an income between the FPG in Columns A and B (see table below), the provider will not, for any calendar year, impose charges exceeding the percentage in Column C of the client's annual gross income:

Column A: Client's income is greater than	Column B: Client's income does not exceed	Column C: Charges are not to exceed
100% of FPG	200% of FPG	5% of the client's annual gross income
200% of FPG	300% of FPG	7% of the client's annual gross income
300% of FPG	--	10% of the client's annual gross income

36. Cooperate with any Federal investigation regarding the Ryan White program funds.

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37. Participate in any state-mandated meetings, trainings, WebEx conferences, Webinars, teleconferences, and/or other conferences to be determined.

38. Take steps to ensure people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the Office of Civil Rights (OCR) website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html

39. Ensure compliance contract Anti-Kickback Statute conditions (42 USC 1320a 7b(b). Processes and standards must be in place to avoid fraud, waste, and abuse (mismanagement) of Ryan White funds.

40. Ensure Ryan White Part B funding is only used to supplement and not supplant existing federal, state, or local funding for HIV testing, Health Insurance Premiums and cost sharing.

B. Monitoring Activities

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Partner Services (PS)

The Contractor shall ensure that client service providers:

1. Inform clients of the availability of PS. Client service providers may either offer PS directly through their agency or by referral to their designated local health programs.

2. Maintain documentation when PS is offered and the outcome (i.e., the number of partners to be notified by the client and/or by the health jurisdiction). Client service providers using ARIES should document these encounters on the Basic Medical screen. Client service providers not using ARIES should document these encounters in the client medical records.

D. Reporting Requirements

HCP Contractors are required to submit quarterly financial and narrative reports to OA. Financial Reports are to be submitted with the monthly / quarterly invoices. The HCP Quarterly Narrative Reports are due to OA according to the following schedule:

Reporting Period	Due dates
July 1 – September 30	November 15
October 1 – December 31	February 15
January 1 – March 31	May 15
April 1 – June 30	August 15

1. The quarterly HCP Financial Report tracks expenditures for the Contractor and any subcontracted agency for the quarter reported. The quarterly Financial Reports shall include the administrative costs of the Contractor and each subcontracted agency, amount of funds obligated to each subcontracted agency, total expended quarterly by each subcontracted agency, percentage expended for the quarter, and total number of unduplicated clients for the quarter reported.

2. The quarterly HCP Narrative Report is an opportunity for the Contractor to describe their HCP programs, services provided, progress and accomplishments, and to identify any technical assistance needs. The quarterly Narrative Reports shall include, for the quarter reported only, descriptions of the programs, services funded with HCP funds, any general accomplishments within the programs, issues or concerns with the programs and services funded in your county, and any technical assistance and/or training needs of the contractor and/or subcontracted agency.

   Contractors may access the HCP Financial and Narrative Report formats at:
   http://www.cdph.ca.gov/programs/aids/Pages/OAContractFY1112.aspx

E. Data Collection

The Contractor shall ensure that client service providers:

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1. Collect the HCP minimum data set. The HCP minimum dataset includes data elements required by (a) HRSA to complete the Ryan White Program Service Report (RSR), selected HAB Quality Management (QM) indicators, and the Women, Infants, Children, and Youth Report, and (b) CDPH/OA for its development of estimates and reports (i.e., estimate of unmet need for HIV medical care, statewide epidemiologic profile, Statewide Coordinated Statement of Need) and to conduct program activities.

2. Directly enter data into ARIES within two weeks from a client's date of service. Client service providers may import data into ARIES from other data collection systems only if they obtain prior written approval from CDPH/OA; said providers may not use CDPH/OA funds to develop or maintain their import systems.

3. Electronically submit the RSR through HAB's RSR Web Application System. The RSR is comprised of two reports: (1) the Provider Report and (2) the Client Report which contains an XML file with their client-level data. Client service providers must submit their completed RSR to the RSR Web Application System by February 15 each year. The RSR reporting period is January 1 through December 31 of the previous year. Client service providers must check the RSR Web Application System until notified that their RSR has been successfully submitted to HRSA. Client service providers may be contacted by CDPH/OA to resolve any data quality problems (e.g., missing data) with their RSRs.

4 Comply with the policies and procedures outlined in ARIES Policy Notices issued by the CDPH/OA (see www.projectaries.org).

F. Client Service Provider/Subcontracted Agency Reporting Requirements

Comply with the State's timeline to submit to the State a list identifying the names and budget overview of all service provision and subcontracted agencies and total funds available to each Client Service Provider. OA's HIV Care Section will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website. Please click on the link to access the current forms at http://www.cdph.ca.gov/programs/aids/Pages/OAContractFY1112.aspx

G. Quality Management Program

The Contractor shall:

1. Ensure all client service providers have a QM program in place. The QM program should fit within the framework of the client service providers' other programmatic quality assurance and quality improvement activities. Client service providers may use an existing QM program (e.g., Joint Commission on Accreditation of Healthcare Organizations, Medicaid) or develop their own program. Service providers may add additional program specific or other HAB indicators to their QM plan. The HAB QM Technical Assistance Manual can be accessed at ftp://ftp.hrsa.gov/hab/QM2003.pdf. HAB's performance measures Web page also contains a wealth of information, including more detailed descriptions of its performance measures and frequently asked questions (http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html).

2. Incorporate selected indicators from Groups 1 and 2 of HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents (also known as HAB QM indicators) into QM programs as CDPH/OA implements selected HAB QM indicators as part of its QM and monitoring program. Specific indicators will be identified and released by OA Management Memorandum. Contractors and subcontracted agencies can monitor their progress in meeting HAB QM indicators for Groups 1 and 2 by using the Compliance Reports in ARIES as appropriate.

3. Please refer to management memorandum 11-01 at *http://www.cdph.ca.gov/programs/aids/Pages/tOAHCPMAIsp.aspx* for more information.

H. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security Requirements exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.

III. Minority AIDS Initiative (MAI)

1. MAI Services

Minority AIDS Initiative (MAI) services must be targeted to HIV infected persons of color and must be planned and delivered in coordination with local HIV prevention outreach services to avoid duplication of effort. The goal of MAI is to increase access to, and engagement in, HIV/AIDS medical care for HIV-positive persons of color. This is achieved by providing outreach and treatment education services to HIV-infected persons of color who have never been in care, or who have been lost to care. For additional MAI information, please refer to the *MAI Budget Guidance.*

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In accordance with HRSA guidance, OA has defined two MAI service categories, (1) outreach and (2) treatment education. Outreach and treatment education are the only allowable service categories for MAI funding. These service categories are designed to meet the needs of persons of color in order to ensure that minority clients can access, engage in, and remain in care; receive help in adhering to treatment; and be provided with education and support that will enable them to become active participants in their own health care and improve their overall quality of life. MAI outreach and treatment education services are defined as follows:

Outreach – Those activities typically performed by an outreach worker that results in: (1) Identifying HIV-infected persons of color who know their status but have never been in care or who have been lost to HIV medical care; (2) Removing barriers that have prevented access to HIV medical care, and (3) Establishing engagement in HIV medical care. Outreach services should be conducted at times and in places where there is a high probability that persons of color with HIV infection will be reached.

MAI outreach services do not include routine HIV counseling and testing or HIV prevention education. These services may be provided on a case-by-case basis for a specific MAI client only when the service is necessary to remove a barrier to care for that client.

Treatment Education - The provision of health education, treatment adherence and risk reduction information to HIV-infected persons of color who know their HIV status but are not accessing medical care or to HIV-infected persons of color who are lost to care. Information includes educating clients living with HIV about how to communicate with medical providers, the importance of treatment adherence, how to manage medication side effects, how to understand their laboratory results, how to improve their health status, how to reduce HIV transmission, and identify medical and psychosocial support services and counseling that are available locally.

For designated county local health jurisdictions receiving additional HRSA funding specifically for MAI outreach and treatment education services to communities of color, the following services and standards must be adhered to:

1. The Contractor may provide direct client MAI services exclusively OR may subcontract all or part of the MAI outreach services. The Contractor must ensure if all or part of the MAI client services are subcontracted to other service providers, all services provided by the subcontractor will be in accordance with the MAI funding and reporting requirements.

2. The Contractor may employ MAI outreach staff or support other activities to identify HIV-infected persons of color who are out-of-care or lost-to-care and gradually engage them in appropriate HIV care and treatment services. Target populations are those out-of-care, HIV-infected persons of color who have been unable or unwilling to access services for HIV, despite an awareness of their positive serostatus. As a member of the HIV care program team, the outreach

staff person will take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in HIV care services. The Contractor must meet specific parameters to support the needs of this project. The parameters include the Contractor's ability to do the following:

a. It is strongly recommended that MAI outreach staff be culturally and linguistically competent "street-level" workers who reflect the communities they serve. Highly recommended is experience in two or three of the following areas: street-based outreach, HIV counseling and testing, health education or HIV case management.

b. MAI outreach staff are to take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in care and treatment services. This individual links and supports the client in accessing suitable HIV care and treatment services.

c. In lieu of outreach positions, MAI funds can also support outreach/treatment education activities or interventions for HIV-infected persons of color, as determined at the local level and approved by OA.

d. Commit to submitting data in an accurate and timely fashion, including committing to full participation in any evaluation or research component.

e. Be able to commit the MAI outreach worker to participate in ongoing staff trainings including but not limited to, attendance at various state-mandated meetings, trainings, Webex/teleconferences or conferences as required.

A. The Contractor shall:

1. Provide services that identify and engage HIV-infected persons of color who know their HIV status but are not accessing medical care, to reach out to persons of color who are HIV-infected but unaware of their HIV status, and/or to locate and reestablish access for HIV-infected persons of color who have been lost to care.

2. Work with existing community resources and entities that serve as key points of entry into medical care, including but not limited to emergency rooms, substance abuse treatment programs, TCMP for those individuals released from state correctional institutions, detoxification centers, adult and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, homeless shelters, Federal Qualified Health Centers, etc. to coordinate and integrate HIV care service delivery.

3. Ensure MAI outreach and treatment education services are planned and delivered in coordination with local HIV prevention outreach programs and other HIV services providers to avoid duplication of effort.

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4. Ensure services are responsive to the needs of the clients in the service area, are sensitive to linguistic, ethnic, and cultural differences of the population(s) being served, and that services are linguistically and culturally appropriate. Services may not be denied due to immigration status, place of residence within California, current or prior health condition, or inability to pay.

5. Ensure MAI planning efforts are coordinated with all other local funding streams for HIV/AIDS to ensure that Ryan White HIV/AIDS program funds are the payer of last resort, maximize education and outreach efforts to link individuals to ADAP and other appropriate program, and reduce any duplication.

6. Ensure client eligibility and service provision under this contract are in accordance with the CDPH/OA's *MAI Policy Guidance.*

7. Ensure MAI clients have access to, and are enrolled in, ADAP, Medi-Cal, or other appropriate program(s) providing HIV medications.

8. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease.

9. Ensure the protection of the client's privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their PHI in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F.R. s 164.524).

10. Ensure any subcontractors have the organizational and administrative capabilities to support the program services and activities. The Contractor is responsible for quality assurance and utilization review activities for subcontracted MAI services.

11. Ensure any subcontractors have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

12. Ensure no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine

programmatic and financial reports, and compliance with contract conditions and audit requirements;

b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

13. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontractors' non-direct service (administrative) functions.

14. Ensure that funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

15. Funded service providers should integrate, and work collaboratively, with other such services and coordinate with other available programs (including Medicaid), to ensure continuity of care and prevention of services of individuals with HIV is enhanced.

16. Ensure funds are not used on prohibited activities (see www.hab.hrsa.gov) and CDPH/OA's HCP and Budget Guidelines.

17. Prohibit employees from soliciting or receiving payment in-kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

    a. Documentation is required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

18. Ensure funds are not used to:

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a. Purchase or improve any building or other facility, with the exception of minor repairs or remodeling approved in writing by the State;

b. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov); or

c. Make cash payment to intended recipients of services.

d. Develop, promote, or advertise about HIV services that target the general public.

e. Generate broad scope awareness activities about HIV services that target the general public.

f. Pay costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act.

g. Pay for any item or service that can reasonably be expected to be paid under any State Compensation program, insurance policy, or any Federal or State Health Benefits Program (except for programs related to Indian Health Service);

h. Pay for any item or service that can paid by an entity that provides health services on a prepaid basis;

i. For the development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity;

19. Ensure all approved subcontractor invoices are paid by the Contractor within 45 days of receipt.

20. Ensure funds are not carried over into subsequent contract years.

21. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's *MAI Budget Guidance,* CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

22. Cooperate with any Federal investigation regarding the Ryan White program funds.

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23. Participate in any state-mandated meetings, trainings, WebEx conferences, teleconferences, and/or other conferences to be determined.

24. Administer MAI funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

25. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor shall clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

26. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the OCR website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

27. Ensure compliance contract Anti-Kickback Statute conditions (42 USC 1320a 7b(b). Processes and standards must be in place to avoid fraud, waste, and abuse (mismanagement) of Ryan White funds.

28. Ensure Ryan White Part B MAI funding is only used to supplement and not supplant existing federal, state, or local funding for HIV testing, Health Insurance Premiums and cost sharing.

B. Monitoring Activities

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

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3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Reporting Requirements

Each MAI contractor is required to submit an MAI Quarterly Narrative Status Report. The MAI Quarterly Narrative Status reports are due to OA according to the following schedule:

REPORTING PERIODS	DUE DATES
July 1 – September 30, 2011	November 15
October 1 – December 31, 2011	February 15
January 1 – March 31, 2012	May 15
April 1 – June 30, 2012	August 15

The quarterly MAI Narrative Status Report is an opportunity for the Contractor to provide program accomplishments, successful outreach and/or treatment education strategies, challenges and lessons learned, problems or issues, and requests for training and technical assistance, in addition to reporting numbers of clients served and the types of services provided.

Contractors may access the Narrative Report format at: http://www.cdph.ca.gov/programs/aids. Each MAI contractor, on an annual or as needed basis, must comply with the State's timeline to submit to the State a list identifying the names and budget overview of all service providers and subcontracted agencies and total funds for service provision that are available to each. OA MAI will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website.

D. Data Collection

1. Until MAI reporting is incorporated into the State's ARIES data reporting system, Contractors receiving MAI funds for outreach and treatment education services must track and report activities manually. Both forms, *MAI Demographic Reporting Form* and *MAI Client Contact Reporting Form*, are to be submitted to OA on a monthly basis either via fax or email. These forms may be accessed via OA's website.

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2. Ensure compliance with all CDPH/OA Policy Letters, Management Memoranda, ARIES Policy Notices, and other policies and procedures issued by CDPH/OA.

E. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.

Memorandum of Understanding (MOU)
Amendment 2
HIV Care Program and Minority AIDS Initiative

This agreement was entered into on July 1, 2010 between the California Department of Public Health/Office of AIDS and the County of Santa Barbara.

1. Provision 2 (MAXIMUM AMOUNT PAYABLE) is amended to read as follows:

   The maximum amount payable by the STATE to the CONTRACTOR under this MOU shall not exceed the following:

   A. $310,356 for the budget period of July 1, 2010 to June 30, 2011.
   B. $270,007 for the budget period of July 1, 2011 to June 30, 2012.
   C. ~~$270,007~~ **234,908** for the budget period of July 1, 2012 to June 30, 2013.
   D. ~~$850,370~~ **815,271** for the entire MOU term.

2. Provision 3 (MOU EXHIBITS) is amended to add Exhibit A, A02 entitled "Scope of Work, Year 3" consisting of 20 pages, replacing Exhibit A-5 entitled "Scope of Work, Year 3" in its entirety. All further references to Exhibit A-5 in the body of this agreement or any attachments thereto shall be deemed to read Exhibit A, A02 entitled "Scope of Work Year 3".

   Provision 3 (MOU EXHIBITS) is further amended to add Exhibit B-3 A02 entitled "Budget Year 3" consisting of one page, replacing Exhibit B-3 A1 in its entirety. All further references to Exhibit B-3 A1 in the body of this agreement or any attachments thereto shall be deemed to read Exhibit B-3 A02.

3. The effective date of this amendment shall be July 1, 2012.

4. All other terms and conditions shall remain the same.

Exhibit B-3
BUDGET - Year 3
HIV Care Program and Minority AIDS Initiative
July 1, 2012 through June 30, 2013

	HCP Budget	MAI Budget	Total MOU Budget
A. PERSONNEL	$36,066	$0	$36,066
B. OPERATING EXPENSES	$4,466	$0	$4,466
C. CAPITAL EXPENDITURES	$0	$0	$0
D. OTHER COSTS	$188,966	$0	$188,966
E. INDIRECT COSTS (Up to 15% of Personnel)	$5,410	$0	$5,410
TOTAL BUDGET	**$234,908**	**$0**	**$234,908**

Exhibit A
Scope of Work
HIV Prevention Program
January 1, 2011 – June 30, 2013

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. The services required by the HIV Prevention Program Scope of Work (SOW) in this Memorandum of Understanding (MOU) 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 are 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 at high risk for HIV in the service area.

The Local Health Jurisdiction (LHJ) will identify one HPP Coordinator who will attend the Office of AIDS (OA), HIV Prevention Branch required meetings when convened.

3. Services to be Performed

Allowable interventions include:

Section 1: HIV Testing (with/without counseling) Services
Section 2: Hepatitis C (HCV) Testing
Section 3: Prevention with Positives (PwP) in Care and non-Care settings
Section 4: Centers for Disease Control and Prevention (CDC)-Diffusion of Effective Behavioral Interventions (DEBI) Project and non-DEBI Interventions
Section 5: Syringe Services Programs (SSPs), where locally authorized
Section 6: Partner Services (PS)

Program Requirements:

LHJs receiving OA prevention funding will be required to certify in the first progress report (with or without providing documentation) that they spend prevention allocation dollars on prevention interventions focused on African Americans in proportion greater or equal to two times the proportion of living African American male HIV/AIDS cases in their jurisdiction. LHJs may request a waiver from OA. The waiver request should be no more than two pages and must include a narrative that addresses the means by which the LHJ plans to programmatically fulfill the intent of this requirement, including the data used to support this funding decision. Waiver requests must be submitted to Sandy Simms, Chief, Program Operations Section, at Sandy.Simms@cdph.ca.gov.

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SECTION 1: HIV Testing (with/without counseling) Services

The Contractor shall administer HIV testing by providing anonymous and/or confidential (with or without counseling) HIV testing services to Californians with perceived risk for HIV. Both anonymous and confidential HIV testing services may (or may not) provide client-focused prevention counseling and assessment of client needs regarding HIV transmission, personal risk behaviors, risk-reduction planning, and referral to other services.

At a minimum, individuals seeking testing services shall be informed about the validity and accuracy of the antibody test before consent to test is performed. Furthermore, all individuals who are tested at CDPH/OA-funded sites shall be given the results of this test in person. Risk information collected during the client assessment and the counseling session (if applicable) will be used as a basis for data collection and program development.

As in the past, CDPH/OA encourages LHJs to continue providing testing services to populations at highest risk for HIV infection. LHJs should continue to prioritize testing in clinics/venues where high-risk clients access services. If the program is offering counseling, high-risk clients should be offered a minimum of a 20 minute counseling session. High-risk negatives should receive appropriate referrals to other prevention services, multi-session groups and other appropriate social and support services. HIV positive individuals should receive referral to HIV care and treatment, Partner Services and other psych-social referrals.

When a client has an HIV positive test result then the client should be given as much time as needed for the results disclosure session. A Counselor Information Form (CIF) needs to be completed for both HIV negative individuals and HIV positive individuals.

A. Client Services to be performed

1. Contractor shall provide testing services to clients in accordance with this agreement and as defined in the HIV Testing Guidelines and OraQuick Rapid HIV Testing Guidelines.

2. Client records relating to any program activity or services executed under this agreement containing personally identifying information which was developed or acquired by the Contractor shall be confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian conservator.

3. Agencies must comply with all applicable Federal and State laws.

4. Contractor shall obtain informed consent from clients served under this contract to verify consent given by the client. Informed consent is required by statute. Written consent is required for testing in non-healthcare settings; oral consent is required for ATS; and oral consent is allowed for testing in medical settings. All individuals tested with OA funds in non-healthcare settings shall be given the results of their test in person.

5. Contractor shall provide HIV test result disclosure in person.

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6. Testing sites shall provide laboratory testing services from a CDPH/OA approved laboratory or via Clinical Laboratory Improvement Amendments (CLIA)-waived rapid testing in accordance with all laws, regulations and guidelines. The testing process shall consist of a Food and Drug Administration (FDA) approved screening procedure (e.g., enzyme-linked immunosorbent assay [ELISA], OraQuick Advance). Initially reactive and indeterminate ELISA results shall be repeated according to established testing protocols. Repeatedly reactive ELISA, preliminary positive OraQuick or indeterminate results are to be confirmed by an FDA approved HIV antibody supplemental test (e.g., Immunofluorescent Assay or Western Blot.)

7. LHJs that have operational blood and plasma facilities, such as blood banks, shall ensure continued reasonable access to anonymous HIV testing through Alternative Test Sites (ATS). HIV testing services shall be free of charge at an ATS. Voluntary, non-coercive anonymous donations may be accepted. Other than at an ATS, testing may be conducted on an anonymous or confidential basis and co-payments of up to $15.00 and/or donations may be accepted. Funds collected must remain in the HIV testing program.

8. The contractor shall ensure that all HIV counseling interventions are provided by staff who have successfully completed the OA HIV counselor training according to current OA HIV Counselor Training Program Guidelines.

9. HIV Counseling & Testing information such as Client Assessment Questionnaires, CIFs, invoices, et cetera must be retained by the Contractor for three years in addition to the current year.

10. The test site must submit a comprehensive, written protocol that provides for annual review of counselor performance with appropriate standards, client surveys, outreach needs, accessibility of clinic location(s), return rates for disclosure sessions, and the availability of and referral to HIV prevention services for HIV positive and high-risk HIV negative clients.

11. The test site shall maintain signed statements of confidentiality for employees and volunteers who have access to client files of individuals.

B. Program Description and Other Requirements

The Contractor shall provide required program descriptions in a manner specified by CDPH/OA. The contractor will develop a comprehensive, written protocol for the provision of the following testing services. Where multiple testing sites exist within one jurisdiction, the written protocol must address operational differences that may occur from site to site (e.g., HIV clinic, sexually transmitted disease clinic, or off-site testing clinics, et cetera).

1. If the contractor is providing rapid HIV testing services, a written Quality Assurance Plan and site-specific testing protocols will be developed and maintained.

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

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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 five business days of each client encounter.
    c. Completing and closing each client record within three months of the initial client encounter.

SECTION 2: HCV Testing

The Contractor can integrate HIV and HCV testing services to increase the number of injection drug users (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.

SECTION 3: PwP in Care and non-Care settings

CDC-DEBI and non-DEBI intervention services may be provided to clients in care and non-care settings. PwP encompasses interventions that assess risk for HIV transmission, support behavioral change, and assist HIV infected clients in developing risk reduction plans. PwP can be implemented as an individual intervention or can focus on couples, group, or community-based approaches. Interventions delivered in clinic settings can be reinforced by incorporating complementary interventions in community or home settings. The emphasis in recent years on PwP in both care and non-care settings has resulted in the availability of tested, science-based interventions with demonstrated evidence of effectiveness in reducing HIV transmission risk.

SECTION 4: CDC-DEBI and non-DEBI Behavioral Interventions

A. Client Services to be performed

1. Contractor shall provide Health Education/Risk Reduction (HE/RR) services to clients in accordance with this agreement and as defined in the HIV Prevention Branch 2009 Program Guidance.

2. HE/RR activities may include:

    a. Targeted prevention activities (TPA) for high-risk HIV negative and HIV positive persons.
    b. Individual level interventions (ILI).
    c. Group level interventions (GLI).
    d. Comprehensive Risk Counseling and Services (CRCS) for individuals with multiple health needs.
    e. Health Communication/Public Information (HC/PI) programs for at-risk behavioral risk groups (BRGs). HC/PI activities must be pre-approved by OA.

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3. All selected activities will be targeted to the LHJs high-risk BRGs most likely to become infected with or transmit HIV disease. Recent epidemiological data, needs assessments, gap analyses, community input and/or other relevant information will be used in selecting BRGs.

B. Program Description and Other Requirements

1. CDPH/OA's LEO process monitoring system will be set up for all selected activities, including entering BRGs, anticipated numbers to be reached, and estimated dollar amounts dedicated to each BRG within each activity.

2. Activities will be documented by:
   a. Completing the appropriate CDPH/OA LEO data forms.
   b. Entering data into the LEO system within 5 business days of each client encounter.

SECTION 5: Syringe Services Programs (SSPs) where locally authorized

SSPs are defined by the CDC as including: 1) Syringe Exchange Programs (SEPs); 2) sharps disposal for IDUs; and 3) support for nonprescription sale of syringes (NPSS) in pharmacies. OA also includes a fourth component: policy work related to access to sterile syringes. SSPs are allowable using CDC PS 10-1001 funding which ended in December 31, 2011. For January through June 2012, LHJs can only use Low Cost Extension funding which is an extension of PS10-1001.

SECTION 6: Partner Services

1. CDPH/OA places a high value on increasing access to PS for individuals diagnosed with HIV infection, and their sexual and needle-sharing partners. LHJs receiving a PS allocation must use those funds specifically for PS. Testing staff will refer clients diagnosed with HIV infection to Disease Intervention Specialists (DIS)/PS staff. Some testing and other prevention services staff may also be cross-trained in PS activities, in which case PS activities may be done on-site by these trained staff members.

2. Data Collection/Data Entry: A referral to PS is to be documented on both the CIF and the HE/RR forms and the data entered into LEO. In the circumstance where testing staff have training and expertise to provide PS offer and elicitation, then the PS activities (including the type of disclosure [i.e., self-disclosure, dual disclosure, or anonymous third-party disclosure] and number of sex and needle-sharing partners to be notified will be documented on the CIF/HE/RR form). The CIF and HE/RR form data will be entered into LEO. Partner information elicited for dual and third-party notification will be documented on a Partner Information Form (PIF) and the data entered into LEO. PIFs must be entered within one business day of the original client encounter.

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4. Services to be Performed (July 1, 2012 - June 30, 2013)

The goals of the new Centers for Disease Control and Prevention (CDC) grant PS12-1201 will be achieved by enhancing public health departments' capacities to increase HIV testing, refer, and link HIV positive people to medical care and PS, and increase program monitoring and accountability. OA has developed a two-tiered system which prioritizes among the CDC "Required" and "Recommended" activities.

A. <u>All LHJs funded under OA's Prevention Grant to LHJs must:</u>

1. Provide targeted HIV testing.
2. Provide Linkage to Care (LTC) services.
3. Provide PS.
4. Meet monitoring and evaluation requirements set by OA.
5. Offer HIV testing through an alternative test site (ATS).
6. Assign a staff member to attend to healthcare reform (HCR) issues.
7. Meet the subsidiary requirements that support HIV testing, PS and LTC services. In response to the CDC Prevention Grant PS12-1201, OA has designated that these core services be delivered together.

Funded LHJs may select to implement one or more activities from the Tier I set of activities. If an LHJ intends to implement any Tier II activities, all Tier I activities must be implemented first. Activities can be implemented with OA funding or from other funding sources. An exception is made for Hepatitis C testing. While this is a Tier II activity, it may be implemented even if not all Tier I activities are implemented. The following is a descriptive list of Tier I activities:

B. Tier I Activities Include:

1. HIV Testing in Non-Healthcare Settings:

a. LHJs must continue to adhere to the requirements outlined in Number II, Section 1.
b. LHJs shall administer HIV testing by providing anonymous and/or confidential HIV testing services (with or without counseling) to individuals at risk for HIV. Testing services may include: assessment of client needs regarding HIV transmission; client-focused prevention counseling, where appropriate; risk-reduction planning; and referral to other services. LHJs funded for testing in non-healthcare 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.
c. LHJs are required to have an ATS. The number of hours and location(s) dedicated to anonymous testing are not specified and can be determined by assessing local needs. ATS testing must still remain free and anonymous.
d. Funded agencies must ensure all HIV counseling interventions are provided by staff members who have successfully completed the three-day Basic Counselor Skills Training (BCST). In addition, test kit operators are required to complete an annual competency assessment test to maintain their certification for testing client samples.

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e. OA will continue to provide OraSure sample collection devices, OraQuick Advance Rapid HIV Test kits and external controls to all funded LHJs. OA determined an allotment for each LHJ based on the HIV prevalence formula used for base funding. If the LHJ's test kit needs exceed the allotment, base funding may be used to purchase test kits directly from OraSure Technologies, Inc. OA will conduct a mid-year assessment of test kit usage and examine the need for adjustment to allotments.
f. LHJs are required to enter data into LEO. Compliance with standards and requirements are monitored using the data entered into the LEO system.
g. TA contacts with providers occur routinely, prompted either by requests from the provider or by data submitted that requires follow-up. In-person site visits occur as either a routine part of program monitoring or in order to provide more intensive TA.
h. LHJs must increase the number of newly identified HIV positive tests annually by at least ten percent.

2. **HIV Testing in Healthcare Settings:**
   a. LHJs must continue to adhere to the requirements outlined in Number II, Section 1.
   b. LHJs should work with local healthcare settings (HCS) 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 healthcare settings.
   c. All LHJs will be required to survey the larger HCS in their jurisdictions to determine to what extent the HCS are providing any HIV testing in their settings and what their capacity for routine, opt-out HIV testing is. The survey questions will be available in the beginning of the FY and the LHJs answers should be included in the semi-annual progress report due February 15, 2013.
   d. Funding for routine, opt-out HIV testing cannot be used to pay for HIV testing staff.
   e. This funding can only pay for HIV testing (i.e., test kits and other testing costs) in so far as a patient has no other payer for healthcare services (i.e., payer of last resort).

3. **LTC:**
   a. LTC is considered an OA priority activity for all funded HIV testing sites in both medical and nonmedical settings. LTC is considered to be achieved when a newly diagnosed HIV positive person is seen by a healthcare provider (e.g., physician, physician assistant, nurse practitioner) to receive medical care for his or her HIV infection.
   b. HIV testing coordinators will be required to establish a system that refers individuals with preliminary and confirmed HIV positive test results to a medical provider for follow-up. In designing this system, coordinators should include identification of HIV care providers, referrals to medical care, and verification of linkage to first appointment.
   c. LHJs will be required to use the OA LEO system or AIDS Regional Information and Evaluation System (ARIES) to document and record LTC activities.
   d. The objective for LHJs to achieve is to link a minimum of 80 percent of newly-identified HIV positive people into medical care within 90 days of receipt of their HIV antibody test results.

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4. **Retention and Re-engagement in Care:**
   a. LHJs that fund or provide Retention and Re-Engagement in Care will be required to develop a comprehensive plan to identify out-of-treatment HIV positive individuals, and engage and retain HIV positive people in treatment.
   b. The LHJ is responsible for determining the most effective approaches for achieving active collaboration between local prevention and care providers with the goal of achieving LTC and continued engagement in care for HIV positive individuals. In order to decrease duplication of effort and ensure maximum impact of LTC interventions, LHJs that fund or provide Retention and Re-Engagement in Care services will demonstrate active collaboration and coordination with care sites.
   c. OA's LEO system or ARIES should be utilized to document and record Retention and Re-Engagement in Care activities.

5. **PS:**
   a. All LHJs that receive OA Prevention Funds are required to provide PS.
   b. At a minimum, LHJs should: 1) 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; 2) assess PS activities and outcomes; and 3) implement provider outreach programs to enhance PS with key community providers. Every LHJ should maintain a staff member to coordinate the PS activities of that jurisdiction. If an LHJ has the infrastructure to only provide an offer of PS, collaboration with a Disease Intervention Specialist (DIS) from the STD Control Branch must be established and maintained for comprehensive PS activities.
   c. 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.
   d. All LHJs should develop 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.
   e. Local programs should track the number, type, and outcomes of PS activities provided by entering data into LEO and frequently reviewing this data.

6. **HIV positive Risk Assessment, Linkage to Services and Behavioral Interventions in Healthcare Settings:**
   a. The goal of HIV positive Risk Assessment, Linkage to Services and Behavioral Interventions in Healthcare Settings (HCS) 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 to community-based Prevention with Positive (PwP) interventions.
   b. LHJs which elect to fund or conduct HIV positive Risk Assessment, Linkage to Services and Behavioral Interventions in HCS will select at least one Ryan White-funded clinic or HIV care provider who can initiate behavioral risk screening within their medical setting.
   c. Selected interventions must be evidence-based and designed for people living with HIV. LHJs may also choose interventions that target services to both people living with HIV

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and their partners. In that case, evidence-based interventions designed for serodiscordant relationships should be used.

d. If a medical setting chooses to refer clients at risk of transmitting HIV to community-based interventions, those interventions must also be evidence-based and designed to target people living with HIV or serodiscordant relationships. If other evidence-based interventions are adapted to the population, documentation of the adaptation should be submitted to OA for approval.
e. All staff members who facilitate the evidence-based interventions must have completed training in the intervention. Supervisors must monitor and ensure that all staff administer the intervention with fidelity and follow the curriculum and intervention activities as defined by the intervention. Documentation of each intervention session must be maintained to describe session activities and compliance with intervention requirements.
f. OA's LEO system or ARIES should be used to document and record client assessments. Behavioral interventions will be recorded and monitored using the LEO system. All evaluation required by evidence-based interventions must be completed and maintained.

7. HIV Treatment Adherence:

a. OA will fund LHJs' efforts to support the appropriate and consistent use of antiretroviral (ARV) medicines to maximize their benefits in sustaining health and suppressing viral load, and to ensure that treatment adherence interventions are available in every LHJ and accessible to all patients living with HIV having difficultly taking ARVs as prescribed.
b. LHJs that elect to fund or provide HIV Medication Treatment Adherence are responsible for determining the most effective approaches to designing a program. The activity should include collaboration with healthcare providers, medical case managers, and others working with people living with HIV/AIDS to:
   - Regularly screen HIV-infected individuals to determine whether they are on ARV therapy.
   - Routinely assess treatment adherence and monitor viral suppression of those on ARV therapy to identify individuals who would benefit from treatment adherence interventions.
   - Develop 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.
c. 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.
d. OA requires LHJs to use ARIES or LEO to track service utilization by clients referred to treatment adherence interventions.

8. Syringe Services Program (SSP):

SSPs are defined by the CDC as including: 1) syringe exchange programs (SEPs); 2) sharps disposal for IDUs; and 3) support for nonprescription sale of syringes (NPSS) in pharmacies. OA also includes a fourth component: policy work related to access to sterile syringes. SSPs constitute an allowable service category for FY 2010 and FY 2011. However, due to changes in federal law the CDC has notified its funded partners that its

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funds may not be used to support syringe exchange for Federal FY 2012. LHJs may use FY 2012 federal funds to support NPSS, syringe disposal and policy work related to access to sterile syringes. OA will allow LHJs to fund syringe exchange if and when federal policy changes. At that time additional guidance will be issued and TA provided to LHJs.

9. **Integrated HIV, Hepatitis, TB and STD Screening for HIV positive Persons:**
   a. 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 can be offered 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.
      - 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.
   b. OA funding cannot be used to pay for clinical laboratory tests, except as noted for HIV testing and Hepatitis screening.
   c. LHJ will be required to report on their activities supporting the integration of this screening and monitoring in their bi-annual and annual progress reports.

10. **Condom Distribution:**
   a. Using OA epidemiologic data in collaboration with LHJs local knowledge and resources, the LHJ will identify venues in their jurisdiction that serve the targeted population in communities where HIV/AIDS is most prevalent.
   b. LHJs will be required to contact and recruit 10 eligible venues into the condom distribution program for FY 2012-2013.
   c. 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.
   d. Once the LHJ has identified a venue, the LHJ must fill out the *Participating Venue Information* (PVI) form for each participating venue. There is no limit to how many eligible venues each LHJ can have participating in the program. Should an LHJ recruit more venues throughout the year, a PVI form for each new venue will need to be received by OA before the venue is allowed to order condoms.
   e. 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 festivals, health fairs, concerts, et cetera, unless the events themselves specifically target OA's priority populations.
   f. LHJs should include information about their condom distribution plans in their bi-annual and annual progress reports.

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11. Healthcare Reform:

a. Each funded LHJ is required to dedicate a proportion of a specific full-time equivalent (FTE) position to Healthcare Reform (HCR) planning activities. Duties for each local HCR staff

b. person and the percentage of time spent will be determined by each LHJ and will vary depending on local policies and resources.
c. The HCR staff position may or may not be from within the LHJ's HIV/AIDS program; however, if it is not, a strong partnership should be maintained between the HCR staff and the local HIV/AIDS program.
d. LHJs should include information about their HCR-related activities in their bi-annual and annual progress reports to OA.

If a LHJ intends on conducting Tier II activities, they will be required to document that all Tier I activities are being conducted by OA or other funding sources. If a LHJ does not intend on implementing Tier II activities, they will at least be required to implement the HIV Testing, LTC and PS from Tier I. If selected, Tier II activities must be provided to the highest risk populations as reflected in local surveillance data and OA priority populations.

C. Tier II activities include:

1. Hepatitis C Testing:

a. 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 choose this activity prior to completion of all Tier I activities.
b. OA funds may be used for HCV laboratory tests, HCV rapid tests, and Home Access kits.
c. HIV counselors must be certified prior to administering the new HCV rapid test.
d. As of January 1, 2012, 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 hepatitis C 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. Training for the rapid CLIA-waived HCV and combination rapid HIV/HCV tests will be available in the beginning of FY 12-13.
e. HCV test information should be collected on the CIF and entered into LEO.

2. Behavioral Interventions for High-Risk Negative People:

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

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b. 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.
c. All OA-funded behavioral interventions should be recorded in LEO.

3. **Social Marketing, Media and Mobilization:**
   a. According to the CDC, Social Marketing is the application of commercial technologies to the planning and implementation of prevention programs. Social marketing for HIV prevention aims to bring about behavior change that improves health by promoting specific HIV prevention messages.
   b. OA has chosen health messages for social marketing activities, media, and mobilization activities which include the following:
      - Benefits of early detection of HIV infection.
      - Need for routine and regular HIV healthcare.
      - 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.
      - Emerging messages from CDC or OA.
   c. Messaging should address one or more of the health messages above and be targeted to HIV positive people, or priority populations as defined by OA.
   d. 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 both the health messages to promote 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. A summary of the LHJ's search for pre-existing material and justification for creating any new material must be submitted prior to commencing any social marketing, media or mobilization activities. Due to limited resources, campaigns should already be developed and demonstrated effective.
   e. Progress on activities will be clearly documented in bi-annual and annual progress reports submitted to OA, as well as entered into the LEO system.

4. **Pre-Exposure Prophylaxis (PrEP) Planning and/or Delivery:**
   a. PrEP is a bio-medical prevention strategy which involves the administration of HIV ARV medications to HIV negative people before exposure to HIV in order to reduce their chances of becoming infected. Since results from recent trials have demonstrated the efficacy of PrEP in MSM, the CDC has identified PrEP as a recommended HIV prevention intervention for MSM at high risk for HIV acquisition. OA has included PrEP Planning as an approved Tier II activity.

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b. OA funds may be used for the following PrEP activities:
   - Assessing LHJ capacity.
   - Planning, educational, and promotional materials.
   - Personnel.
   - Required client activities. Appropriate client activities include: assessing for high-risk, assessing for adherence, risk reduction, and medication adherence counseling and referrals to relevant services.

c. OA funds may not be used for medical care, STD testing, hepatitis B testing and vaccination, blood work, or for the purchase of ARV medications.

d. LHJs should develop protocols for monitoring the HIV status, STD incidence, medication adherence, and risk behaviors of each PrEP client every two to three months. Clients who report multiple risk behaviors and/or inconsistent medication adherence should be monitored and supported more closely. Guidelines should also be established to address serious adherence issues or high rates of seroconversion among participants. LHJs should include information about formative work in the bi-annual and annual progress reports to OA.

5. Reporting Requirements

A. Progress Reports

Progress Reports will be required on a semi-annual basis to be submitted to the LHJ assigned Prevention Operations Advisor via email. The first progress report will cover the first six months of the contract from January 1, 2012 to June 30, 2012. This report will be due on August 15, 2012. The second semi-annual report will cover the second six months of the contract from July 1, 2012 to December 31, 2012 and will be due February 15, 2013. The final report must address the period of January 1, 2013 through June 30, 2013 and FY 2012-2013 comprehensive activities. The final and comprehensive year-end report will be due August 15, 2013.

The progress reports should address all applicable services performed in Tier I and/or Tier II activities that the LHJ and subcontracted agencies have implemented including HIV Testing (with/without counseling), LTC, Retention and Re-engagement in Care, PS, Risk Assessment, linkages to services and behavioral interventions for people living with HIV/AIDS, HIV Treatment Adherence, Syringe Exchange Program, condom distribution, Healthcare Reform, Hepatitis C Testing, Behavioral Interventions for High-Risk Negative People, Social Marketing, Media and Mobilization, and Pre-Exposure Prophylaxis (PrEP) Planning and/or Delivery. Additionally, for the period covering January 1, 2012 to June 30, 2012, LHJs must address local changes to the African American requirement as appropriate.

Please limit your reports to 5 - 15 pages, including attachments.

Exhibit A
Scope of Work
HIV Prevention Program
January 1, 2011 – June 30, 2013

The progress report should address, but is not limited to the following categories:

1. **Administrative Issues:**
   a. Successes – Examples include, but are not limited to the following:
      - Staffing (e.g., vacancies and/or staff accomplishments).
      - Training/Capacity Building (e.g., attended and/or provided).
      - Collaborative Activities (e.g., with subcontracted agencies and/or other service providers).
   b. Challenges and Barriers – Examples include, but are not limited to the following:
      - Staffing (e.g., gaps and/or turnover).
      - Training/Capacity Building (e.g., capacity limited, training unavailable, and/or training needs unfulfilled).
      - Collaborative Efforts (e.g., unsuccessful efforts with subcontracted agencies and/or other service providers).

   c. Strategies to Overcome Challenges and Barriers – Example include, but are not limited to the following:
      - Describe the LHJs plan to resolve administrative challenges and/or barriers.
      - Identify alternatives that the LHJ developed to address administrative challenges and/or barriers.
      - Identify resources that the LHJ used to address administrative challenges and/or barriers.

2. **Programmatic Issues:**
   a. Successes – Examples include, but are not limited to the following:
      - Describe progress your LHJ is making toward providing services to your proposed target populations.
      - Describe progress your LHJ is making toward reaching the number of clients that you proposed to reach.
      - Describe progress your LHJ is making toward providing services to high-risk populations.

   b. Challenges and Barriers – Examples include, but are not limited to the following:
      - Describe any issues that are preventing your LHJ from providing services to your proposed target populations.
      - Describe any issues that are preventing your LHJ from providing services to the number of clients that you proposed to reach.
      - Describe any issues that are preventing your LHJ from reaching high-risk populations.

   c. Strategies to Overcome Challenges and Barriers – Example include, but are not limited to:
      - Describe the LHJs plan to resolve programmatic challenges and/or barriers.
      - Identify alternatives that the LHJ developed to meet program goals.
      - Identify resources that the LHJ used to address programmatic challenges and/or barriers.

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3. **Administrative and Programmatic Changes – Examples include, but are not limited to the following:**
   a. Reorganization.
   b. New Subcontracted Agencies.
   c. New or Discontinued Program Activities.

4. **Technical Assistance Needs/Capacity Building Needs – Examples include, but are not limited to the following:**
   a. LEO.
   b. Administrative.
   c. Programmatic.

5. **Evaluation Efforts – Examples include, but are not limited to the following:**
   a. From the routine reports available in LEO, please provide a summary of your progress for targeting high-risk individuals, completing interventions, and ensuring that those that test HIV positive receive their test results and are referred to PS and medical care.
   b. Is the LHJ focusing on Outcome Measures?
      - If so, please describe.

      - If not, what would you consider as an Outcome Measure that your LHJ can focus on over the fiscal year (e.g., increase the number of HIV positive individuals reached, increase condom usage, and/or increase the number of high-risk clients served/decrease the number of low-risk clients served)?

Memorandum of Understanding (MOU)
HIV Prevention Program

1. MOU TERM

The term of this MOU shall be from July 1, 2011 through June 30, 2013.

2. MAXIMUM AMOUNT PAYABLE

The maximum amount payable by the STATE to the CONTRACTOR under this MOU shall not exceed the following:

A. Year 1: $49,484 for the budget period of July 1, 2011 to June 30, 2012.
B. Year 2: $113,967 for the budget period of July 1, 2012 to June 30, 2013.
C. Total: $163,451 for the entire MOU term.

3. MOU EXHIBITS

The following attached exhibits are incorporated herein, and made a part hereof by this reference:

A. Exhibit A entitled "Scope of Work," consisting of fifteen pages.
B. Exhibit B-1 entitled "Budget Year 1", consisting of one page.
C. Exhibit B-2 entitled "Budget Year 2", consisting of one page.
D. Exhibit C entitled "Invoice Form," consisting of one page.

4. PROJECT REPRESENTATIVES

The project representatives during the term of this MOU will be:

Department of Public Health	**County of Santa Barbara**
Cheryl Renee Austin Prevention Operations Advisor Prevention Operations Section Office of AIDS MS 7700 P.O. Box 997426 Sacramento, CA 95899-7426 Telephone: (916) 449-5810 Fax: (916) 449-5800 E-Mail: Cheryl.Austin@cdph.ca.gov	Susie Herrera Health Educator Santa Barbara County Public Health Department 2115 S. Centerpointe Parkway Santa Maria, CA 93455 Telephone: (805) 346-8276 Fax: (805) 346-7332 E-Mail: susie.herrera@sbcphd.org

Exhibit B-1, A02
BUDGET - Year 1
HIV PREVENTION PROGRAM
July 1, 2011 to June 30, 2012

A. PERSONNEL	$8,195
B. OPERATING EXPENSES	$59
C. CAPITAL EXPENDITURES	$0
D. OTHER COSTS	$40,000
E. INDIRECT COSTS	$1,230
TOTALS	**$49,484**

Exhibit B-2, A02
BUDGET - Year 2
HIV PREVENTION PROGRAM
July 1, 2012 to June 30, 2013

A. PERSONNEL	$15,189
B. OPERATING EXPENSES	$500
C. CAPITAL EXPENDITURES	$0
D. OTHER COSTS	$96,000
E. INDIRECT COSTS	$2,278
TOTALS	**$113,967**

County of Santa Barbara
10-95290 A02

As per State contract requirements, please print Invoice on letterhead

Exhibit C
Invoice Form

HIV PREVENTION PROGRAM INVOICE

OA Date Stamp

Contractor Name

Mailing Address ***This address must match payment remittance address***

(city, state and zip code)

Contract Number

Period of Service (month / year)

Expense Category		Amounts
A. Personnel		$ -
Prevention	$ -	
Partner Services	$ -	
B. Operating Expenses		$ -
Prevention	$ -	
Partner Services	$ -	
C. Capital Expenses		$ -
Prevention	$ -	
Partner Services	$ -	
D. Subcontracts (Goal II, 6 & 7)		$ -
Prevention	$ -	
Partner Services	$ -	
E. Indirect Costs (up to 15%)		$ -
Prevention	$ -	
Partner Services	$ -	
TOTAL INVOICE		$ -
Prevention	$ -	
Partner Services	$ -	

I hereby certify that the amount claimed is accurate and a true representation of the amount owed.

Authorized Signature

Date

Print name of authorized signature

Title

California Dept. of Public Health
Office of AIDS
MS 7700, P. O. Box 997426
Sacramento, CA 95899-7426

(previous formats are obsolete)

Memorandum of Understanding (MOU)
Amendment 2
HIV/AIDS Surveillance Program

This agreement was entered into on July 1, 2010 between the California Department of Public Health/Office of AIDS and the County of Santa Barbara.

1. Provision 2 (MAXIMUM AMOUNT PAYABLE) is amended to read as follows:

   The maximum amount payable by the STATE to the CONTRACTOR under this MOU shall not exceed the following:

   A. $43,606 for the budget period of July 1, 2010 to June 30, 2011.
   B. $40,728 for the budget period of July 1, 2011 to June 30, 2012.
   C. ~~$40,728~~ **38,732** for the budget period of July 1, 2012 to June 30, 2013.
   D. ~~$125,062~~ **123,066** for the entire MOU term.

2. Provision 3 (MOU EXHIBITS) is amended to add **Exhibit A-2, entitled "Scope of Work" Year 2 consisting of 6 pages; Exhibit A-3, entitled "Scope of Work" Year 3 consisting of 6 pages**. All further references to Exhibit A, entitled "Scope of Work" in the body of this agreement or any attachments thereto shall be deemed to read Exhibit A-1, entitled "Scope of Work" Year 1; Exhibit A-2, entitled "Scope of Work" Year 2; and Exhibit A-3, entitled "Scope of Work" Year 3.

3. The effective date of this amendment shall be July 1, 2012.

4. All other terms and conditions shall remain the same.

Exhibit B-3
HIV/AIDS Surveillance Program
Year 3
July 1, 2012 to June 30, 2013

	Original Budget	This Amendment	Amended Total
A. PERSONNEL	$32,158	**($1,487)**	**$30,671**
B. OPERATING EXPENSES	$3,746	**($286)**	**$3,460**
C. CAPITAL EXPENDITURES	$0	$0	$0
D. OTHER COSTS	$0	$0	$0
E. INDIRECT COSTS (Up to 15% of Personnel)	$4,824	**($223)**	**$4,601**
TOTAL BUDGET	**$40,728**	**($1,996)**	**$38,732**