Billing Code: 4166-14

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Indian Health Service**

**Funding Opportunity for Ending the HIV/HCV/Syphilis Epidemics in Indian Country II (ETHIC II): A Syndemic Elimination Program for American Indian and Alaska Native Tribes and Urban Indian Communities**

Announcement Type: New.

Funding Announcement Number: HHS-2024-IHS-ETHIC-0001.

Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.899.

Key Dates

Application Deadline Date: July 31, 2024.

Earliest Anticipated Start Date: September 1, 2024.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for the second round of cooperative agreements for the Ending the Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Syphilis Epidemics (known as "the Syndemic") in Indian Country (ETHIC II) program. This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the Indian Health Care Improvement Act, 25 U.S.C. 1621q, 1660e. The Assistance Listings section of SAM.gov (https://sam.gov/content/home) describes this program under 93.899.

## Background

### Ending the HIV Epidemic in the U.S.

In February 2019, the White House announced a new initiative, Ending the HIV Epidemic in the U.S. (EHE). This 10-year initiative beginning with fiscal year (FY) 2020, seeks to achieve the critical goal of reducing new HIV infections in the United States (U.S.) to less than 3,000 per year by 2030. The first phase of the initiative focuses on 48 counties, Washington, DC; San Juan, Puerto Rico; and seven states with a substantial rural HIV burden. By focusing on these geographic focus areas, the U.S. Department of Health and Human Services (HHS) plans to reduce new HIV infections by 75 percent within five years and 90 percent by 2030. To reach those goals, EHE focuses on four key strategies that together can end the HIV epidemic in the U.S.: (1) Diagnose, (2) Treat, (3) Prevent, and (4) Respond. In this cooperative agreement, the IHS directs applicants to implement measurable, outcome-based activities specific to those four pillars. The outcomes-based approach in health and social services is a practice that places the individual at the center of their care and supports plans to achieve the best possible outcome.

### Impact of the Syndemic on American Indian & Alaska Native People

#### HIV

New HIV diagnoses among American Indian and Alaska Native (AI/AN) populations increased by 15.5 percent from 2017 to 2021, (https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-34/content/tables.html). At the same time, diagnoses of HIV infection attributed to injection drug use was highest for both males and females. Mortality data found that AI/AN individuals have significantly

higher death rates from HIV/AIDS than Whites, which could be attributable to later diagnosis, deficiency of linkage to care, difficulty accessing care, challenges to treatment adherence, or other factors or a combination of factors (Death Rates From Human Immunodeficiency Virus and Tuberculosis Among American Indians/Alaska Natives in the United States, 1990–2009 | AJPH | Vol. 104 Issue S3 (aphapublications.org)).

Hepatitis C

HCV is a common co-morbidity for blood borne HIV infections. In 2009, approximately 21 percent of HIV-infected adults who were tested for past or present HCV infection tested positive, although co-infection prevalence varies substantially according to HIV-infected risk group (e.g., men who have sex with men (MSM), high-risk heterosexuals, and persons who inject drugs).[1], [2], [3] Data have shown that HCV disproportionately affects AI/AN people, with HCV-related mortality more than double the national rate (https://aspe.hhs.gov/system/files/pdf/260026/HepC.pdf).[4] In a recent IHS survey, almost 50 percent of the AI/AN individuals diagnosed with HCV were born after 1965 and were younger than the targeted birth cohort for HCV screening campaigns (1945-1965, 'Baby Boomers').

Untreated HCV can lead to a myriad of extrahepatic manifestations and cirrhosis with complications such as portal hypertension, end-stage liver disease, and hepatocellular carcinoma (HCC). Early diagnosis and treatment of HCV infection prevent the

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[1] Garg S, Brooks J, Luo Q, Skarbinski J. Prevalence of and Factors Associated with Hepatitis C Virus (HCV) Testing and Infection Among HIV-infected Adults Receiving Medical Care in the U.S. Infectious Disease Society of America (IDSA). Philadelphia, PA, 2014.

[2] Yehia BR, Herati RS, Fleishman JA, Gallant JE, Agwu AL, Berry SA, et al. Hepatitis C virus testing in adults living with HIV: A need for improved screening efforts. PLoS ONE 2014;9(7):e102766. *https://pubmed.ncbi.nlm.nih.gov/25032989/.*

[3] Spradling PR, Richardson JT, Buchacz K. Trends in hepatitis C virus infection among patients in the HIV Outpatient Study, 1996–2007. J Acquir Immune Defic Syndr 2010;53:388–396.

development of extrahepatic manifestations and progressive liver disease, including cirrhosis. Recently developed treatments for HCV are more accessible and highly effective at greatly reducing HCV- and HCC-related mortality. Treatment for HCV can be highly successful at the primary care level with appropriate planning and support.

## Syphilis

Recent data show that the rate of syphilis remains elevated in Indian Country. According to 2021 data from the Centers for Disease Control and Prevention (CDC), 176,713 cases of syphilis (all stages and congenital) were reported. The highest rate of primary and secondary syphilis was among AI/AN people at 46.7 percent (1,146 cases), marking an increase of 74 percent over the rate of 26.8 percent (654 cases) in 2020. Recurrent sexually transmitted infections (STIs) can increase the likelihood of HIV transmission. Syphilis often presents as a co-morbid condition with HIV diagnosis, particularly among MSM. The AI/AN youth and AI/AN women, particularly women of reproductive age, have a disparate and increased STI burden. The increase in the rate of syphilis may be connected to the use of injection drugs and methamphetamines, all known risk factors for HIV transmission.

## Addressing the Syndemic

Confronting these intersecting epidemics requires collaboration across sectors and disciplines and using existing public health and clinical infrastructures. Lasting changes to these trends for HIV and related co-morbidities among AI/AN communities will also require innovative new approaches, incorporating existing and new data sources, all driven by community input. The IHS recommends that applicants research evidence-based approaches or identify culturally appropriate interventions as best

practices for collaborative efforts.

To guide the U.S. in achieving the various goals toward eliminating the Syndemic, the AI/AN communities and the Federal Government have developed multiple strategic plans that serve as roadmaps to ending these co-occurring epidemics. Each of these plans outlines strategies and objectives to guide our efforts. HHS recently released three national strategic plans, and the IHS expects recipients to adopt these plans as they design and carry out activities toward HIV, HCV, and STI epidemic elimination: (1) The HIV National Strategic Plan: A Roadmap to End the Epidemic in the United States (2022–2025)[5]; (2) The Viral Hepatitis National Strategic Plan for the U.S.: A Roadmap to Elimination 2021–2025[6]; and (3) the Sexually Transmitted Infections National Strategic Plan for the United States 2021-2025 (https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf).

American Indian/Alaska Native-Focus on the Syndemic

One of many strengths of Indigenous peoples is the ability to understand interdependence – with each other, the land, generations past, and those to come. This type of "big thinking" naturally lends itself to recognizing that the complex issues AI/AN people face often require solutions that are equally as nuanced. To support the development of comprehensive solutions to end the Syndemic in Indian Country, the Northwest Portland Area Indian Health Board, alongside the IHS's National HIV/HCV/STI Program, and other partners, created The Indigenous HIV/AIDS Syndemic Strategy: Weaving Together the National HIV, STI, and Viral Hepatitis Plans (or Indigi-HAS at

[5] *https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf* Accessed 1/26/2024
[6] https://www.hhs.gov/sites/default/files/Viral-Hepatitis-National-Strategic-Plan-2021-2025.pdf Accessed 1/26/2024.

https://www.indiancountryecho.org/wp-content/uploads/2022/11/Indigi-HAS_final.pdf). Weaving together the three national strategies listed above, this document contains emerging practices, existing initiatives, as well as traditional Indigenous knowledge that local decision-makers can use to develop community-tailored interventions that address the Syndemics of HIV, STIs, and viral hepatitis.

The IHS encourages applicants to review the Hepatitis C Elimination Strategy for AI/AN Communities (https://www.indiancountryecho.org/hep-c-elimination-strategy/objectives), which describes the rationale and program design and provides a tool kit for implementing an HCV micro-elimination program in an AI/AN community; Tribal or IHS clinic, hospital, or health system.

Indian Health Service Syndemic Actions

The IHS promotes robust advances and innovations in HIV, HCV, and syphilis health care and suggests using the Indigi-HAS as the framework to end the Syndemic. Therefore, to the extent possible, activities funded by the IHS focus on addressing these four goals:

1. Preventing new HIV/HCV/syphilis diagnoses;
2. Improving related health outcomes of people living with HIV, HCV, or syphilis;
3. Reducing related disparities and health inequities (i.e., substance use disorder); and
4. Achieving integrated and coordinated efforts that address the Syndemic among all partners and stakeholders.
    a. To achieve these shared goals, recipients should align their organization's efforts to ensure that people with HIV/HCV/syphilis are linked to and retained

in high-quality care and have timely access to treatment and the support needed (e.g., mental health and substance use disorders services) to achieve viral suppression or cure.

Successful applicants will address the following focus areas:

1. Non-Traditional and New Models of Diagnosis, Prevention, and Care;
2. Cross-Departmental Collaborations to Address Social Determinants of Health and enhance health equity for Prevention, Care, and Treatment for people with HIV; and
3. Using a Syndemic Approach to Address Racial and Ethnic Disparities in Diagnosis, Prevention and Care.

A 2019 CDC analysis[7] shows that the vast majority (about 80 percent) of new HIV infections in the U.S. in 2016 came from the nearly 40 percent of people who either did not know they had HIV or who received a diagnosis but were not receiving HIV care and treatment (http://www.cdc.gov/nchhstp/newsroom/2019/hiv-vital-signs.html). This highlights the need to increase the proportion of people with HIV/HCV/syphilis who are aware of their status and help them get into care and treatment. Diagnosing AI/AN people with HIV/HCV/syphilis, linking those with HIV/HCV/syphilis to primary care, and achieving viral suppression are necessary public health steps toward ending the HIV, HCV, and syphilis epidemics in Indian Country. The HIV/HCV/syphilis care continuum has five main "steps" or stages that include (1) diagnosis, (2) linkage to care, (3) retention in care, (4) adherence to therapy, and (5) viral suppression/viral clearance/cure. The care continuum depicts a series of stages in which people with HIV, HCV, or syphilis engage

in care from initial diagnosis through their successful treatment with medication. It also demonstrates the proportion of individuals living with HIV, HCV, or syphilis who are engaged at each stage. The care continuum allows recipients and planning groups to measure progress and effectively direct resources. For this funding opportunity, the IHS requires applicants to address, implement, and measure the HIV/HCV/syphilis continuum of care. For example, applicants should be prepared to collect data on the number of new diagnoses of HIV/HCV/syphilis, of positive cases linked to care, how many of those linked to care are retained in care and adhering to therapy, and the number of those achieving a viral suppression/viral clearance/cure.

For nearly four decades, the national investments in HIV have shown remarkable results in preventing new infections, improving health outcomes, and reducing deaths in hundreds of thousands of Americans. Despite this, progress has plateaued, and additional effort is needed to ensure that all affected groups benefit equally. Some groups, like AI/AN people, African American and Latino gay and bisexual men, transgender individuals, or people living in the South, have a higher burden of HIV and experience health disparities at each stage of the HIV care continuum. In addition, nationally, there is a high incidence of HIV among transgender individuals, high-risk heterosexuals, and persons who inject drugs.

The U.S. has an unprecedented opportunity to end the HIV/HCV/syphilis epidemics in America. We have access to the most powerful HIV/HCV/syphilis prevention and treatment tools in history and new technology that allows us to pinpoint where infections are spreading most rapidly. By effectively equipping all vulnerable AI/AN communities with these tools, we can end the HIV/HCV/syphilis epidemics in Indian Country. This

ETHIC II funding opportunity acts boldly on this unprecedented opportunity by providing the hardest-hit AI/AN communities with resources to implement the additional expertise, technology, and resources required to address the HIV/HCV/syphilis epidemics in their communities. The Federal EHE initiative sets 2025 and 2030 targets to achieve a reduction in the number of new HIV infections by 90 percent by 2030.

Measurements and Targets

The IHS will use the targets below as overarching guides to measure our progress toward ensuring that we reduce the impact of HIV/HCV/syphilis in Indian Country:

1. Reduce the number of new HIV infections among AI/AN people by 90 percent by 2030, from a baseline of 37,100 new infections in 2017.
2. Decrease the number of new HIV diagnoses among AI/AN people by 90 percent by 2030, from a baseline of 38,351 diagnoses in 2017.
3. Increase the percentage of AI/AN people living with HIV linked to care by 95 percent by 2030, from a baseline of 77.8 percent in 2017.
4. Increase the percentage of AI/AN people living with diagnosed HIV who are virally suppressed by 95 percent in 2030, from a baseline of 63.1 percent in 2017.
5. Increase the number of AI/AN people initiated on pre-exposure prophylaxis (PrEP) by 25 percent over the number initiated on PrEP in a baseline calendar year (baseline to be determined by the applicant).
6. Reduce the rate of congenital syphilis among AI/AN people from a 2020 baseline rate of 207.6 per 100,000 to 173.3 per 100,000 by 2025 and 93.4 per 100,000 by 2030. In collaboration with the IHS Program Officer and the IHS Syndemic Data Coordinator, grantees must develop a specific baseline and target for congenital syphilis in their

target area.

7. Reduce the rate of primary and secondary syphilis among AI/AN from a 2020 baseline rate of 26.8 per 100,000 to 26 per 100,000 by 2025 and 24 per 100,000 by 2030. In collaboration with the IHS Program Officer and the IHS Syndemic Data Coordinator, grantees must develop a specific baseline and target for primary and secondary syphilis in their service area.
8. Grant recipients should contribute to reducing the 2017 national total of an estimated 44,700 cases of acute viral hepatitis C infections by 20 percent by 2025 and 90 percent by 2030. In collaboration with the IHS Program Officer and the IHS Syndemic Data Coordinator, grantees must develop a specific baseline and target for acute HCV in their target area. (The National Viral Hepatitis Strategic Plan does not identify a specific HCV target for AI/AN people.)
9. Contribute to reducing the rate of HCV-related deaths among AI/AN people from a 2017 baseline rate of 10.24 per 100,000 by 25 percent by 2025 and 65 percent by 2030. In collaboration with the IHS Program Officer and the IHS Syndemic Data Coordinator, grantees must develop a specific baseline and target for HCV-related deaths in their service area.

Purpose

The purpose of this program is to support communities to directly increase the diagnoses, treatment, and prevention of HIV, HCV, and syphilis. Successful applicants will work toward a reduction of new HIV infections and relevant co-morbidities, specifically syphilis and HCV infections; improve HIV/HCV/syphilis-related health outcomes; and reduce HIV/HCV/syphilis-related health disparities among AI/AN people. In four

separate but related parts, this initiative aims to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV/HCV/syphilis infections among AI/AN communities in the U.S. This initiative's overarching goals are to: (1) Reduce new HIV, HCV, and syphilis infections to less than 3,000 per year by 2030; and (2) achieve a 90 percent reduction in new HCV infections and a 65 percent reduction in mortality, compared to a 2015 baseline.

## II. Award Information

Funding Instrument – Cooperative Agreement

Estimated Funds Available

The total funding identified for FY 2024 is approximately $14 million. Individual award amounts are anticipated to be between $150,000 and $2,000,000. The funding available for competing and subsequent awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. The IHS is under no obligation to make awards that are selected for funding under this announcement.

Funds are provided for the purpose described in Division H, Title II of the Consolidated Appropriations Act, 2022 (Public Law No. 117-103), as part of the Minority HIV/AIDS Fund (MHAF) program described in Assistance Listing 93.899. Grant and cooperative agreements awards made with these funds must include Assistance Listing 93.899 in the Notices of Funding Opportunity and must use Assistance Listing 93.899 on the Notices of Award to improve and ensure proper tracking of the funds.

Anticipated Number of Awards

The IHS anticipates issuing approximately 26 awards under this program announcement. The IHS will award cooperative agreements in the following three focus areas.

Applicants may apply for funding from more than one focus area listed below. Applicants may also apply for multiple subcomponents of Focus Area 3. When applying for multiple components, applicants must submit a separate work plan, logic model, and budget for each component and subcomponent. Applicants awarded for more than one focus area or more than one subcomponent of Focus Area 3 will receive the award as one cooperative agreement.

1. Focus Area One – Community-Based Programs that Use a Syndemic Approach to Address Racial and Ethnic Disparities in Diagnoses, Prevention, and Care.
    a. Pillars: Diagnose, Treat, Prevent.
    b. Average $200,000 per award with an estimated 7 awards, at $200,000 for a total of $1.4 million.
    c. Component:

        Community-level programs to increase diagnoses, treatment, and prevention of HIV/HCV/Syphilis.
2. Focus Area Two – Clinical Services.
    a. Pillars: Diagnose, Treat, and Prevent.
    b. Average $750,000 per award with an estimated 6 awards, ranging from $400,000 to $1 million maximum award for a total of $4.5 million in Focus Area Two.
    c. Component:

        Clinical Services to include: Patient Care, Clinical Navigation, Treatment, and Retention in Care.
3. Focus Area Three – Supporting Special Initiatives of Regional and National

Significance in Indian Country (SPINS).

a. Pillars: Diagnose, Treat, Prevent.
b. Awards from $360,000 – $2 million with an estimated 12 awards for a total of approximately $8 million.
c. Sub-Components include:
    i. National Patient Navigation Initiative ($360,000).
    ii. National Youth Engagement in HIV/HCV/STI Health Resources, Community Engagement and Capacity Building ($1.5 million).
    iii. National Two-Spirit/Lesbian, Gay, Bi-Sexual, Transgender, Queer (2SLGBTQ) Community Engagement, Advocacy, Capacity Development, and Formative Evaluation ($670,000).
    iv. Regional or National Tribal EpiCenters/Health Boards/Urban Indian Health Programs (7 awards at $500,000 for a total of $3.5 million) that focus on clinical capacity assessment, regional advocacy, and systems improvement for HIV/HCV/syphilis diagnoses, prevention, and treatment.
    v. National Extensions for Community Health Outcomes (ECHO) ($2 million).

Period of Performance

The period of performance is for 5 years.

Cooperative Agreement

Cooperative agreements awarded by HHS are administered under the same policies as grants. However, the funding agency, IHS, is anticipated to have substantial programmatic involvement in the project during the entire period of performance. Below

is a detailed description of the involvement level required by the IHS.

Substantial Agency Involvement Description for Cooperative Agreement

A. The IHS Office of Clinical and Preventive Services (OCPS), Division of Clinical and Community Services (DCCS) will provide ongoing consultation and technical assistance to plan, implement, and evaluate each component as described under Recipient Activities (see Section V.1.B, Application Review Information, Evaluation Criteria, Project Objective(s), Work Plan, and Approach).

B. The IHS will conduct site visits to recipient sites and/or coordinate recipient visits to IHS facilities to assess work plans and ensure data security, confirm compliance with applicable laws and regulations, assess program activities, and resolve problems as needed mutually.

C. DCCS will provide a forum for outreach and education to advance this program's goals through existing and new partnerships. The IHS will facilitate the formation of an IHS National HIV/HCV/STI Prevention workgroup from clinical, public health, advocacy, and education sectors working in HIV/HCV/STI control. The purpose of the workgroup is to align IHS efforts with the HIV/HCV/STI National Strategies.

D. DCCS will coordinate the various internal IHS and external HHS-required reporting activities and provide recipients with program-related technical assistance as appropriate to provide leadership, advocacy, and support.

## III. Eligibility Information

### 1. Eligibility

To be eligible for this funding opportunity, an applicant must be one of the following

as defined under 25 U.S.C. 1603:

- A federally recognized Indian Tribe as defined by 25 U.S.C. 1603(14). The term ‘‘Indian Tribe’’ means any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation, as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
- A Tribal organization as defined by 25 U.S.C. 1603(26). The term ‘‘Tribal organization’’ has the meaning given the term in section 4 of the Indian Self Determination and Education Assistance Act (25 U.S.C. 5304(1)): ‘‘Tribal organization’’ means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided that, in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant. Applicant shall submit letters of support and/or Tribal Resolutions from the Tribes to be served.
- An Urban Indian organization as defined by 25 U.S.C. 1603(29). The term ‘‘Urban Indian organization’’ means a nonprofit corporate body situated in an

urban center, governed by an Urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a). Applicants must provide proof of nonprofit status with the application, e.g., 501(c)(3).

The Division of Grants Management (DGM) will notify any applicants deemed ineligible.

2. Additional Information on Eligibility

The IHS does not fund concurrent projects. If an applicant is successful under this announcement, any subsequent applications in response to other ETHIC announcements from the same applicant will not be funded. Applications on behalf of individuals (including sole proprietorships) and foreign organizations are not eligible. Applications deemed ineligible will be disqualified from competitive review and funding under this funding opportunity.

Note: Please refer to Section IV.2 (Application and Submission Information/Subsection 2, Content and Form of Application Submission) for additional proof of applicant status documents required, such as Tribal Resolutions, proof of nonprofit status, etc.

3. Cost Sharing or Matching

The IHS does not require matching funds or cost-sharing for grants or cooperative agreements.

4. Other Requirements

Applications with budget requests that exceed the highest dollar amount outlined under Section II Award Information, Estimated Funds Available, or exceed the period of performance outlined under Section II Award Information, Period of Performance, are considered not responsive and will not be reviewed. The Division of Grants Management (DGM) will notify the applicant.

Additional Required Documentation

Tribal Resolution

The DGM must receive an official, signed Tribal Resolution prior to issuing a Notice of Award (NoA) to any Tribal or Tribal organization selected for funding. An applicant that is proposing a project affecting another Indian Tribe must include resolutions from all affected Tribes to be served. However, if an official signed Tribal Resolution cannot be submitted with the application prior to the application deadline date, a draft Tribal Resolution must be submitted with the application by the deadline date in order for the application to be considered complete and eligible for review. The draft Tribal Resolution is not in lieu of the required signed resolution but is acceptable until a signed resolution is received. If an application without a signed Tribal Resolution is selected for funding, the applicant will be contacted by the Grants Management Specialist (GMS) listed in this funding announcement and given 90 days to submit an official, signed Tribal Resolution to the GMS. If the signed Tribal Resolution is not received within 90 days, the award will be forfeited. Applicants organized with a governing structure other than a Tribal council must submit an equivalent document commensurate with their governing organization. Please include documentation explaining and substantiating your organization's

governing structure.

Proof of Nonprofit Status

Organizations claiming nonprofit status must submit a current copy of the 501(c)(3) Certificate with the application.

## IV. Application and Submission Information

Grants.gov uses a Workspace model for accepting applications. The Workspace consists of several online forms and three forms in which to upload documents – Project Narrative, Budget Narrative, and Other Documents. Give your files brief descriptive names. The filenames are key in finding specific documents during the merit review and in processing awards. Upload all requested and optional documents individually, rather than combining them into a single file. Creating a single file causes confusion when trying to find specific documents. This can contribute to delays in processing awards, and could lead to lower scores during the merit review.

### 1. Obtaining Application Materials

The application package and detailed instructions for this announcement are available at https://www.Grants.gov.

Please direct questions regarding the application process to DGM@ihs.gov.

### 2. Content and Form Application Submission

Mandatory documents for all applications are listed below. An application is incomplete if any of the listed mandatory documents are missing. Incomplete applications will not be reviewed.

- Application forms:
    1. SF-424, Application for Federal Assistance.

2. SF-424A, Budget Information – Non-Construction Programs.
3. SF-424B, Assurances – Non-Construction Programs.
4. Project Abstract Summary form.

- Project Narrative (not to exceed 10 pages). See Section IV.2.A, Project Narrative for instructions.
- Budget Narrative (not to exceed 5 pages). See Section IV.2.B, Budget Narrative for instructions.
- One-page Timeframe Chart.
- Biographical sketches for all Key Personnel.
- Certification Regarding Lobbying (GG-Lobbying Form).

The documents listed here may be required. Please read this list carefully.

- Tribal Resolution(s) as described in Section III, Eligibility.
- Letters of Support from organization's Board of Directors.
- 501(c)(3) Certificate.
- Disclosure of Lobbying Activities (SF-LLL), if applicant conducts reportable lobbying.
- Copy of current Negotiated Indirect Cost (IDC) rate agreement (required in order to receive IDC).
- Documentation of current Office of Management and Budget (OMB) Financial Audit (if applicable).

  Acceptable forms of documentation include:

  1. E-mail confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or

2. Face sheets from audit reports. Applicants can find these on the FAC web site at https://facdissem.census.gov/.

Additional documents can be uploaded as Other Attachments in Grants.gov. These can include:

- Work plan, logic model, and/or timeline for proposed objectives.
- Position descriptions for key staff.
- Resumes of key staff that reflect current duties.
- Consultant or contractor proposed scope of work and letter of commitment (if applicable).
- Organizational chart.
- Map of area identifying project location(s).
- Additional documents to support narrative (for example, data tables, key news articles).

Public Policy Requirements

All Federal public policies apply to IHS grants and cooperative agreements. Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by Federal law to individuals eligible for benefits and services from the IHS. See https://www.hhs.gov/grants/grants/grants-policies-regulations/index.html.

Requirements for Project and Budget Narratives

A. Project Narrative (Limit – 10 pages)

This narrative should be a separate document that is no more than 10 pages and must: 1) have consecutively numbered pages; 2) use black font 12 points or

larger (tables may be done in 10 point font); 3) be single-spaced; and 4) be formatted to fit standard letter paper (8½ x 11 inches).

Be sure to succinctly answer all questions listed under the evaluation criteria (refer to Section V.1, Evaluation Criteria) and place all responses and required information in the correct section noted below or they will not be considered or scored. If the narrative exceeds the overall page limit, the reviewers will be directed to ignore any content beyond the page limit. The 10-page limit for the project narrative does not include the work plan, standard forms, Tribal Resolutions, budget, budget justifications, narratives, and/or other items. Page limits for each section within the project narrative are guidelines, not hard limits.

There are three parts to the narrative:

Part 1 - Program Information;

Part 2 - Program Planning and Evaluation; and

Part 3 - Previous HIV/HCV/Syphilis Prevention, Care, or Treatment Work.

See below for additional details about what must be included in the narrative.

Part 1: Program Information (Limit – 3 Pages)

Section 1: Community Infrastructure

Describe the applicant's current health program activities, how long it has been operating, and what programs or services the organization provides.

Describe how the applicant has determined it has the administrative infrastructure to support the activities proposed.

Part 2: Program Planning and Evaluation (Limit – 3 Pages)

Section 1: Program Plans

Describe fully and clearly the applicant's plans to conduct activities that directly lead to increased HIV, HCV, and syphilis diagnoses, enhanced prevention, and to recruiting and retaining people in HIV, HCV, and syphilis care and treatment.

Section 2: Program Evaluation

Provide a plan on how the recipient will evaluate its activities funded through this award. As part of the evaluation plan, include evaluation questions that will form the basis of the evaluation. Recipients must identify a baseline year and provide data for that baseline year for each of its proposed activities. In its evaluation, the recipient should discuss how its activities advance the following outcomes:

1. Increasing diagnosis of HIV, HCV, and STI infections;
2. Increasing linkage to care for people who are diagnosed with an HIV, HCV, or STI infection;
3. Increasing the number of people living with HIV who achieve viral suppression;
4. Increasing the number of people living with HCV who achieve a sustained virologic response; and
5. Increasing the number of people who are living with syphilis, chlamydia or gonorrhea who have been treated and cured.

Part 3: Previous HIV/HCV/syphilis prevention, care, or treatment work and documented/measurable outcomes (Limit – 4 Pages)

Section 1: Describe your organization's significant program activities and

accomplishments over the past five years associated with HIV/HCV/syphilis prevention, care, and/or treatment to enhance quality health care services.

B. Budget Narrative (Limit – 5 Pages)

Provide a budget narrative that explains the amounts requested for each line item of the budget from the SF– 424A (Budget Information for Non-Construction Programs) for the entire project, by year. The applicant can submit with the budget narrative a more detailed spreadsheet than is provided by the SF-424A (the spreadsheet will not be considered part of the budget narrative). The budget narrative should specifically describe how each item would support the achievement of proposed objectives. Be very careful about showing how each item in the "Other" category is justified. Do NOT use the budget narrative to expand the project narrative.

3. Submission Dates and Times

Applications must be submitted through Grants.gov by 11:59 p.m. Eastern Time on the Application Deadline Date. Any application received after the application deadline will not be accepted for review. Grants.gov will notify the applicant via email if the application is rejected.

If technical challenges arise and assistance is required with the application process, contact Grants.gov Customer Support (see contact information at https://www.Grants.gov). If problems persist, contact Mr. Paul Gettys, Deputy Director, DGM, by e-mail at DGM@ihs.gov. Please be sure to contact Mr. Gettys at least 10 days prior to the application deadline. Please do not contact the DGM until

you have received a Grants.gov tracking number. In the event you are not able to obtain a tracking number, contact the DGM as soon as possible by e-mail at DGM@ihs.gov.

The IHS will not acknowledge receipt of applications.

4. Intergovernmental Review

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions

- Pre-award costs are allowable up to 90 days before the start date of the award provided the costs are otherwise allowable if awarded. Pre-award costs are incurred at the risk of the applicant.
- The available funds are inclusive of direct and indirect costs.
- Only one cooperative agreement may be awarded per applicant.

6. Electronic Submission Requirements

All applications must be submitted via Grants.gov. Please use the https://www.Grants.gov website to submit an application. Find the application by selecting the “Search Grants” link on the homepage. Follow the instructions for submitting an application under the Package tab. The IHS will not accept any applications submitted through any means outside of Grants.gov without an approved waiver.

If you cannot submit an application through Grants.gov, you must request a waiver prior to the application due date. You must submit your waiver request by e-mail to DGM@ihs.gov. Your waiver request must include clear justification for the need to

deviate from the required application submission process.

If the DGM approves your waiver request, you will receive a confirmation of approval e-mail containing submission instructions. You must include a copy of the written approval with the application submitted to the DGM. Applications that do not include a copy of the waiver approval from the DGM will not be reviewed. The Grants Management Officer of the DGM will notify the applicant via e-mail of this decision. Applications submitted under waiver must be received by the DGM no later than 5:00 p.m. Eastern Time on the Application Deadline Date. Late applications will not be accepted for processing. Applicants that do not register for both the System for Award Management (SAM) and Grants.gov and/or fail to request timely assistance with technical issues will not be considered for a waiver to submit an application via alternative method.

You may update or correct your application after you have submitted it, if you resubmit before the application deadline. Go into Grants.gov, update the Workspace (correct or complete online forms, update new documents, replace uploaded documents), and submit the application again.

The IHS policy is to accept the last submitted application as the one you want us to review. So, if you submit three applications, we will only look at the last one, based on the date and time Grants.gov received it.

Please be aware of the following:

- Please search for the application package in https://www.Grants.gov by entering the Assistance Listing (CFDA) number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.

- If you experience technical challenges while submitting your application, please contact Grants.gov Customer Support (see contact information at https://www.Grants.gov).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.
- Applicants are strongly encouraged not to wait until the deadline date to begin the application process through Grants.gov as the registration process for SAM and Grants.gov could take up to 20 working days.
- Please follow the instructions on Grants.gov to include additional documentation that may be requested by this funding announcement.
- Applicants must comply with any page limits described in this funding announcement.
- After submitting the application, the applicant will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The IHS will not notify the applicant that the application has been received.

System for Award Management (SAM)

Organizations that are not registered with the SAM must access the SAM online registration through the SAM home page at https://sam.gov. Organizations based in the U.S. will also need to provide an Employer Identification Number from the Internal Revenue Service that may take an additional 2 to 5 weeks to become active. Please see SAM.gov for details on the registration process and timeline. Registration with the SAM is free of charge but can take several weeks to process. Applicants may

register online at https://sam.gov.

Unique Entity Identifier

Your SAM.gov registration now includes a Unique Entity Identifier (UEI), generated by SAM.gov, which replaces the DUNS number obtained from Dun and Bradstreet. SAM.gov registration no longer requires a DUNS number.

Check your organization's SAM.gov registration as soon as you decide to apply for this program. If your SAM.gov registration is expired, you will not be able to submit an application. It can take several weeks to renew it or resolve any issues with your registration, so do not wait.

Check your Grants.gov registration. Registration and role assignments in Grants.gov are self-serve functions. One user for your organization will have the authority to approve role assignments, and these must be approved for active users in order to ensure someone in your organization has the necessary access to submit an application.

The Federal Funding Accountability and Transparency Act of 2006, as amended ("Transparency Act"), requires all HHS recipients to report information on sub-awards. Accordingly, all IHS recipients must notify potential first-tier sub-recipients that no entity may receive a first-tier sub-award unless the entity has provided its UEI number to the prime recipient organization. This requirement ensures the use of a universal identifier to enhance the quality of information available to the public pursuant to the Transparency Act.

Additional information on implementing the Transparency Act, including the specific requirements for SAM, are available on the DGM Grants Management, Policy Topics

web page at https://www.ihs.gov/dgm/policytopics/.

## V. Application Review Information

Possible points assigned to each section are noted in parentheses. The project narrative and budget narrative should include the proposed activities for the entire period of performance. The project narrative should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the applicant. It should be well organized, succinct, and contain all information necessary for reviewers to fully understand the project. Attachments requested in the criteria do not count toward the page limit for the narratives. Points will be assigned to each evaluation criteria adding up to a total of 100 possible points. Points are assigned as follows:

1. Evaluation Criteria

   A. Introduction and Need for Assistance (10 Points)

      Must include the applicant's background information, a description of HIV/HCV/Syphilis service, capacity, and history of support for such activities. Applicants need to include current public health activities, what program services are currently being provided, and interactions with other public health authorities in the region (state, local, or Tribal). Please describe how the applicant will use funds to make improvements in the capacity to address the IHS, Tribal, and Urban Indian health (I/T/U), local-level, and/or Area-level HIV/HCV/STI burden.

      Applicants should include data specific to the HIV/HCV/Syphilis burden in its geographic area of focus to document the need for assistance. Using the data, applicants should provide a very brief narrative on the history and trends of

HIV, HCV, and/or syphilis. Applicants may use local, state, or regional data and consult available online resources such as state health department databases, the CDC AtlasPlus database (https://www.cdc.gov/nchhstp/atlas/index.htm), America's HIV Epidemic Analysis Dashboard (AHEAD) (https://ahead.hiv.gov), the Ryan White HIV/AIDS Program Compass Das (https://data.hrsa.gov/topics/hiv-aids/compass-dashboard), among others, to identify relevant data.

B. Project Objective(s), Work Plan, and Approach (25 Points)

1. Clearly identify the operational strategies to be addressed by the applicant. The operational strategies shall include at least one of the three ETHIC II program's focus areas and address at least one of the EHE Pillars (diagnose, treat, prevent) to be completed within the program period. Applicants must outline their approach to addressing the focus areas through a logic model. The logic model must include inputs, outputs, and anticipated short- and long-term outcomes. As part of the logic model, the applicant should identify project timelines and anticipated partnerships and collaborations to execute the operational strategies. The logic model is a separate document and not counted in the project narrative's page limit.
2. Objectives. Include objectives that are Specific, Measurable, Attainable, Relevant, and Time-bound (also known as SMART) (https://www.samhsa.gov/grants/how-to-apply/writing-completing-application/goals-measurable-objectives).

   The IHS strongly encourages applicants to align their objectives with the

objectives of the following strategic plans:

a. Indigenous HIV/AIDS Syndemic Strategy: Weaving Together the National HIV, STI, and Viral Hepatitis Plans (Indigi-HAS) (https://www.indiancountryecho.org/indigenous-hiv-aids-syndemic-strategy/);

b. The National HIV/AIDS Strategic Plan (https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025/);

c. The STI National Strategic Plan (https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf); and

d. The Viral Hepatitis National Strategic Plan. (https://www.hhs.gov/sites/default/files/Viral-Hepatitis-National-Strategic-Plan-2021-2025.pdf).

3. Metrics. Applicants must identify at least one metric for each objective to measure progress toward achieving the objective. Applicants must identify a baseline year for each metric against which to measure annual progress. Where possible, the IHS encourages applicants to consider 2017 as the baseline year for HIV and HCV, and 2018 as the baseline year for syphilis.

4. Strategic Alignment. The IHS requires applicants to align their strategies with the strategies outlined in the Indigenous HIV/AIDS Syndemic Strategy: Weaving Together the National HIV, STI, and Viral Hepatitis

Plans (Indigi-HAS) (https://www.indiancountryecho.org/indigenous-hiv-aids-syndemic-strategy/).

5. Recipient Activities

   Proposals must include the following activities:

   a. Coordination Operational Strategy

      i. Recipients will send at least one representative to the annual IHS HIV/HCV/STI meeting. The budget should include travel and associated costs for participation.

      ii. Recipients will participate in the IHS National HIV/HCV/Syphilis Prevention Workgroup.

   b. Diagnosis Operational Strategy

      The recipients will collaborate with constituent communities to increase local capacity to expand the availability of HIV/HCV/STI testing in health centers, emergency departments, substance abuse prevention and treatment programs, mobile units, as well as community-based organizations and non-traditional settings such as bars, parks, corrections facilities, obstetrics, and during community festivals to diagnose all people with HIV/HCV/STIs as early as possible.

   c. Treatment Operational Strategy

      The recipients will provide support to constituent communities in the development of enhanced activities and expanded capacity to identify and better serve people who are not in HIV/HCV/STI care by working

with health care providers, Ryan White clinics and I/T/U health centers, state and local health departments, and other partners to expand capacity, strengthen systems, establish new programs and services, and forge new partnerships to tailor and implement these approaches as appropriate in their constituent communities.

d. Prevention Operational Strategy

The recipients will develop local plans with community member input to guide the scale-up of proven prevention interventions and strategies that increase the access to and availability of Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), and safe syringe programs (SSPs) – where local laws permit – in the communities where these services are needed most.

PrEP is a pill that reduces the risk of getting HIV when taken as prescribed. However, of the estimated 1 million Americans at substantial risk for HIV who could benefit from PrEP, fewer than 1 in 4 actually use it. HHS agencies will support states and local communities to implement strategies to increase access to and use of PrEP – especially among populations disproportionately affected by HIV.

C. Program Evaluation (30 Points)

1. Clearly identify plans for program evaluation to ensure that objectives of the program are met at the conclusion of the funding period.
2. Include evaluation criteria based on SMART objectives.

3. Evaluation should minimally include summaries of activities in each of the proposed key operational strategies.

D. Organizational Capabilities, Key Personnel, and Qualifications (30 Points)

1. Include an organizational capacity statement that demonstrates past experience with HIV, HCV, or syphilis diagnosis, treatment and prevention, and the ability to execute program strategies within the program period.
2. Provide a project management and staffing plan. Detail that the organization has the current staffing and expertise to address each of the program activities. If current capacity does not exist, please describe the actions that the applicant will take to fulfill this gap within a specified timeline.
3. Applicant must demonstrate previous successful experience providing HIV, HCV, or syphilis technical or programmatic support to AI/AN communities.

E. Categorical Budget and Budget Justification (5 Points)

1. Provide a detailed budget and accompanying narrative to explain the activities being considered and how they are related to proposed program objectives.

2. Review and Selection

Each application will be prescreened for eligibility and completeness as outlined in the funding announcement. The Review Committee (RC) will review applications that meet the eligibility criteria. The RC will review the applications for merit based

on the evaluation criteria. Incomplete applications and applications that are not responsive to the administrative thresholds (budget limit, period of performance limit) will not be referred to the RC and will not be funded. The DGM will notify the applicant of this determination.

Applicants must address all program requirements and provide all required documentation.

3. Notifications of Disposition

All applicants will receive an Executive Summary Statement from the IHS DCCS within 30 days of the RC's conclusion outlining their application's strengths and weaknesses. The summary statement will be sent to the Authorizing Official identified on the face page (SF–424) of the application.

A. Award Notices for Funded Applications

The NoA is the authorizing document for which funds are dispersed to the approved entities and reflects the amount of Federal funds awarded, the purpose of the award, the terms and conditions of the award, the effective date of the award, the budget period, and period of performance. Each entity approved for funding must have a user account in GrantSolutions to retrieve the NoA. Please see the Agency Contacts list in Section VII for the systems contact information.

B. Approved but Unfunded Applications

Approved applications not funded due to lack of available funds will be held for 1 year. If funding becomes available during the course of the year, the application may be reconsidered.

Note: Any correspondence, other than the official NoA executed by an IHS

grants management official announcing to the project director that an award has been made to their organization, is not an authorization to implement their program on behalf of the IHS.

## VI. Award Administration Information

### 1. Administrative Requirements

Awards issued under this announcement are subject to, and are administered in accordance with, the following regulations and policies:

A. The criteria as outlined in this program announcement.

B. Administrative Regulations for Awards:

- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards currently in effect or implemented during the period of award, other Department regulations and policies in effect at the time of award, and applicable statutory provisions. At the time of publication, this includes 45 CFR part 75, at https://www.govinfo.gov/content/pkg/CFR-2023-title45-vol1/pdf/CFR-2023-title45-vol1-part75.pdf.
- If you receive an award, HHS may terminate it if any of the conditions in 2 CFR 200.340(a)(1)-(4) are met. Please review all HHS regulatory provisions for Termination at 2 CFR 200.340, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2023-title2-vol1/pdf/CFR-2023-title2-vol1-sec200-340.pdf. No other termination conditions apply.

C. Grants Policy:

- HHS Grants Policy Statement, Revised January 2007, at https://www.hhs.gov/sites/default/files/grants/ grants/policies-regulations/hhsgps107.pdf.

D. Cost Principles:

- Uniform Administrative Requirements for HHS Awards, ‘‘Cost Principles,’’ at 45 CFR part 75 subpart E, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2023-title45-vol1/pdf/CFR-2023-title45-vol1-part75-subpartE.pdf.

E. Audit Requirements:

- Uniform Administrative Requirements for HHS Awards, “Audit Requirements,” at 45 CFR part 75 subpart F, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2023-title45-vol1/pdf/CFR-2023-title45-vol1-part75-subpartF.pdf.

F. As of August 13, 2020, 2 CFR 200 was updated to include a prohibition on certain telecommunications and video surveillance services or equipment. This prohibition is described in 2 CFR 200.216, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2023-title2-vol1/pdf/CFR-2023-title2-vol1-sec200-216.pdf. This will also be described in the terms and conditions of every IHS grant and cooperative agreement awarded on or after August 13, 2020.

2. Indirect Costs

This section applies to all recipients that request reimbursement of IDC in their application budget. In accordance with HHS Grants Policy Statement, Part II–27, the

IHS requires applicants to obtain a current IDC rate agreement and submit it to the DGM prior to the DGM issuing an award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate agreement is not on file with the DGM at the time of award, the IDC portion of the budget will be restricted. The restrictions remain in place until the current rate agreement is provided to the DGM. Please refer to 2 CFR 200.414(f) Indirect (F&A) costs, found at https://www.govinfo.gov/content/pkg/CFR-2023-title2-vol1/pdf/CFR-2023-title2-vol1-sec200-414.pdf.

Electing to charge a de minimis rate of 10 percent can be used by applicants that have received an approved negotiated indirect cost rate from HHS or another cognizant Federal agency. Applicants awaiting approval of their indirect cost proposal may request the 10 percent de minimis rate. When the applicant chooses this method, costs included in the indirect cost pool must not be charged as direct costs to the award. Available funds are inclusive of direct and appropriate indirect costs. Approved indirect funds are awarded as part of the award amount, and no additional funds will be provided.

Generally, IDC rates for IHS recipients are negotiated with the PSC Division of Cost Allocation (you can find information about them and contact information at https://www.hhs.gov/about/agencies/asa/psc/indirect-cost-negotiations/index.html) or the Department of the Interior (Interior Business Center) at https://ibc.doi.gov/ICS/indirect-cost/tribal. For questions regarding the indirect cost

policy, please write to DGM@ihs.gov.

3. Reporting Requirements

The recipient must submit required reports consistent with the applicable deadlines. Failure to submit required reports within the time allowed may result in suspension or termination of an active award, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in the imposition of special award provisions and/or the non-funding or non-award of other eligible projects or activities. This requirement applies whether the delinquency is attributable to the failure of the recipient organization or the individual responsible for preparation of the reports. Per DGM policy, all reports must be submitted electronically by attaching them as a "Grant Note" in GrantSolutions. Personnel responsible for submitting reports will be required to obtain a login and password for GrantSolutions. Please use the form under the Recipient User section of https://www.grantsolutions.gov/home/getting-started-request-a-user-account/. Download the Recipient User Account Request Form, fill it out completely, and submit it as described on the web page and in the form.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required quarterly. The progress reports are due within 30 days after the reporting period ends (specific dates will be listed in the NoA Terms and Conditions). These reports must include a brief comparison of actual accomplishments to the goals established for the period, a summary of

progress to date or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 120 days of expiration of the period of performance. Individual reporting elements will be developed by award recipients in collaboration with IHS based on the recipients' objectives and logic model.

B. Financial Reports

Federal Financial Reports are due 90 days after the end of each budget period, and a final report is due 120 days after the end of the period of performance. Recipients are responsible and accountable for reporting accurate information on all required reports: the Progress Reports and the Federal Financial Report. Failure to submit timely reports may result in adverse award actions blocking access to funds.

C. Data Collection and Reporting

The recipient must report their progress towards data points in their ETHIC II objectives and activities via a standardized form co-developed with the IHS program officer.

The recipient will report on these data points on a quarterly and annual basis. Due dates for these reports will be included in the Terms & Conditions in the NoA.

The recipient will participate in quarterly calls with the program office.

Based on the activities and measures identified by the recipient in its applications, data points may include:

a. The total number of people served;

b. The total number of HIV, HCV and STI tests performed;

c. The total number of positive or reactive test results for HIV, HCV, and STIs;

d. The total number of people linked to HIV, HCV, or STI care; and

e. The total number of people prescribed PrEP or DoxyPEP.

D. Post Conference Award Reporting

The following requirements were enacted in Section 3003 of the Consolidated Continuing Appropriations Act, 2013, Public Law No. 113-6, 127 Stat. 198, 435 (2013), and; *Office of Management and Budget Memorandum M–17–08, Amending OMB Memorandum M-12-12:* All HHS/IHS awards containing funds allocated for conferences will be required to complete a mandatory post award report for all conferences. Specifically: The total amount of funds provided in this award/cooperative agreement that were spent for "Conference X" must be reported in final detailed actual costs within 15 calendar days of the completion of the conference. Cost categories to address should be: (1) Contract/Planner, (2) Meeting Space/Venue, (3) Registration web site, (4) Audio Visual, (5) Speakers Fees, (6) Non-Federal Attendee Travel, (7) Registration Fees, and (8) Other.

E. Federal Sub-award Reporting System (FSRS)

This award may be subject to the Transparency Act sub-award and executive compensation reporting requirements of 2 CFR part 170.

The Transparency Act requires the OMB to establish a single searchable database, accessible to the public, with information on financial assistance awards made by Federal agencies. The Transparency Act also includes a requirement for recipients of Federal awards to report information about first-tier sub-awards and executive

compensation under Federal assistance awards.

The IHS has implemented a Term of Award into all IHS Standard Terms and Conditions, NoAs, and funding announcements regarding the FSRS reporting requirement. This IHS Term of Award is applicable to all IHS grant and cooperative agreements issued on or after October 1, 2010, with a $30,000 sub-award obligation threshold met for any specific reporting period.

For the full IHS award term implementing this requirement and additional award applicability information, visit the DGM Grants Management web site at https://www.ihs.gov/dgm/policytopics/.

F. Non-Discrimination Legal Requirements for Recipients of Federal Financial Assistance (FFA)

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html. Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by Federal law to individuals eligible for benefits and services from the IHS.

G. Federal Awardee Performance and Integrity Information System (FAPIIS)

The IHS is required to review and consider any information about the applicant that is in the FAPIIS at https://sam.gov/content/fapiis before making any award in excess of the simplified acquisition threshold (currently $250,000) over the period

of performance. An applicant may review and comment on any information about itself that a Federal awarding agency previously entered. The IHS will consider any comments by the applicant, in addition to other information in FAPIIS, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicants, as described in 45 CFR 75.205.

As required by 45 CFR part 75 Appendix XII of the Uniform Guidance, NFEs are required to disclose in FAPIIS any information about criminal, civil, and administrative proceedings, and/or affirm that there is no new information to provide. This applies to NFEs that receive Federal awards (currently active grants, cooperative agreements, and procurement contracts) greater than $10 million for any period of time during the period of performance of an award/project.

Mandatory Disclosure Requirements

As required by 2 CFR part 200 of the Uniform Guidance, and HHS implementing regulations at 45 CFR part 75, the IHS must require an NFE or an applicant for a Federal award to disclose, in a timely manner, in writing to the IHS or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award.

All applicants and recipients must disclose in writing, in a timely manner, to the IHS and to the HHS Office of Inspector General all information related to violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. 45 CFR 75.113.

Disclosures must be sent in writing to:

U.S. Department of Health and Human Services

Indian Health Service

Division of Grants Management

ATTN: Marsha Brookins, Director

5600 Fishers Lane, Mail Stop: 09E70

Rockville, MD 20857

(Include "Mandatory Grant Disclosures" in subject line)

Office: (301) 443-5204

Fax: (301) 594-0899

E-mail: DGM@ihs.gov

AND

U.S. Department of Health and Human Services

Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator

330 Independence Avenue, SW, Cohen Building

Room 5527

Washington, DC 20201

URL: https://oig.hhs.gov/fraud/report-fraud/

(Include "Mandatory Grant Disclosures" in subject line)

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or

E-mail: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 Remedies for noncompliance, including suspension or debarment (see

2 CFR part 180 and 2 CFR part 376).

VII. Agency Contacts

1. Questions on the program matters may be directed to:

   Rick Haverkate

   HIV/HCV/STI Branch

   5600 Fishers Lane, 08N07, MAIL STOP: 08N34-ARockville, MD 20857

   Phone: 240-678-2873

   Fax: 301-594-6213

   E-mail: Richard.Haverkate@ihs.gov

2. Questions on awards management and fiscal matters may be directed to:

   Indian Health Service, Division of Grants Management

   5600 Fishers Lane, Mail Stop: 09E70

   Rockville, MD 20857

   E-mail: DGM@ihs.gov

3. For technical assistance with Grants.gov, please contact the Grants.gov help desk at (800) 518-4726, or by e-mail at support@grants.gov.

4. For technical assistance with GrantSolutions, please contact the GrantSolutions help desk at (866) 577-0771, or by e-mail at help@grantsolutions.gov.

VIII. Other Information

The Public Health Service strongly encourages all grant, cooperative agreement, and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in

which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

**Roselyn Tso,**

*Director,*

*Indian Health Service.*

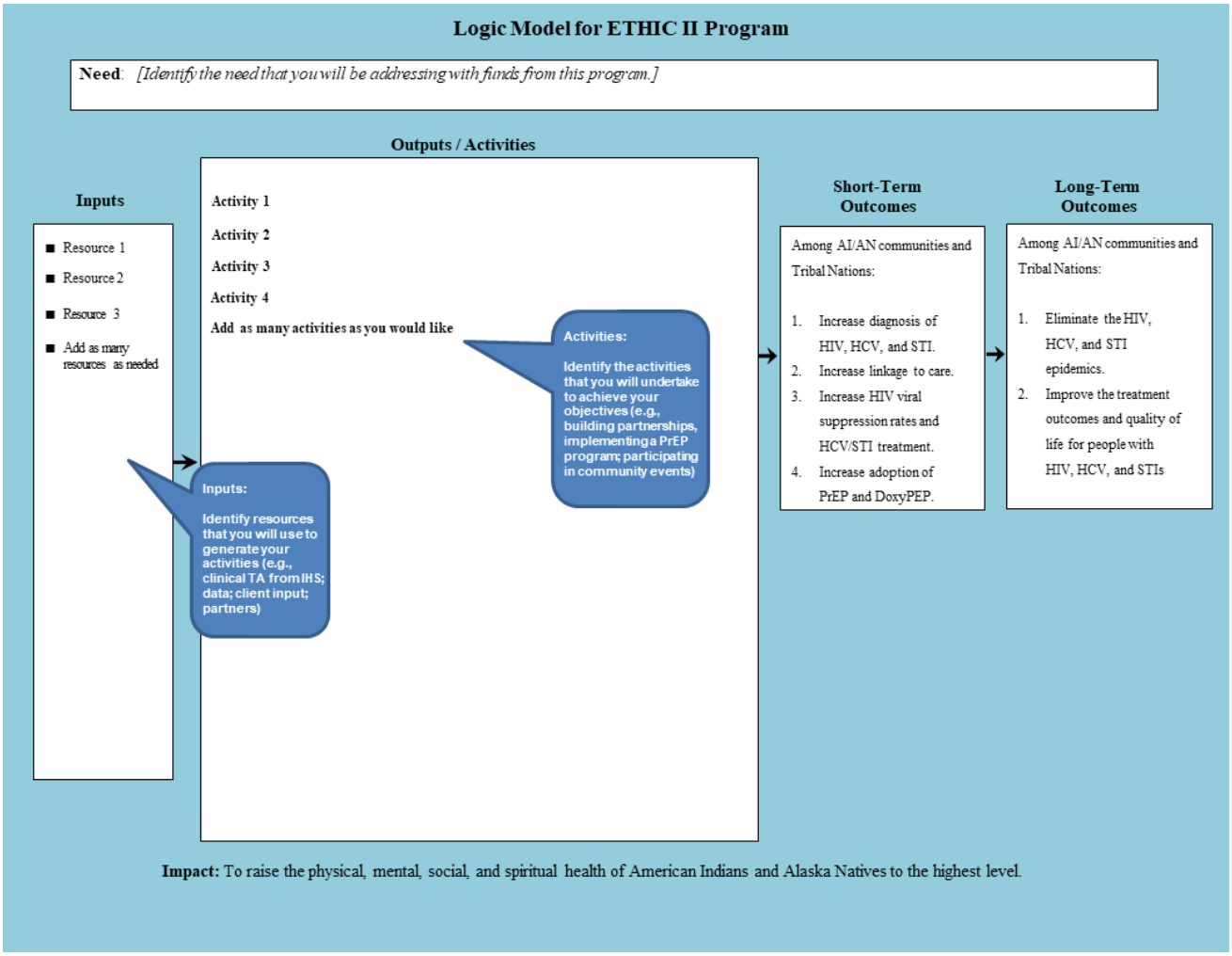


*Figure 1: Sample Logic Model*