GRANT CONTRACT

(cost reimbursement grant contract with an individual, business, non-profit, or governmental entity of another state or country)

Begin Date	End Date	Agency Tracking #	Edison ID
April 1, 2026	March 31, 2027	-	

Grantee Legal Entity Name	Edison Vendor ID

Subrecipient or Recipient	Assistance Listing Number
☒ Subrecipient ☐ Recipient	Grantee's fiscal year end

Service Caption (one line only)

Ryan White Part B Core Medical, Support Services and Minority Aids Initiative (MAI)

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Grant Contract Amount
TOTAL:					

Grantee Selection Process Summary

☒ Competitive Selection	Request for Grant Proposal (RFGP) #34349-53026 will be completed.
☐ Non-competitive Selection	

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

CPO USE - GR

Speed Chart (optional)	Account Code (optional)
HL00000744	71304000

GRANT CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF HEALTH
AND
GRANTEE NAME

This Grant Contract, by and between the State of Tennessee, Department of Health, hereinafter referred to as the "State" and Contractor Legal Entity Name, hereinafter referred to as the "Grantee," is for the provision of Ryan White Part B Core Medical, Support Services and Minority Aids Initiative (MAI), as further defined in the "SCOPE OF SERVICES."

The Grantee is a/an Individual, For-Profit Corporation, Non-Profit Corporation, Special Purpose Corporation Or Association, Partnership, Joint Venture, Or Limited Liability Company.
Grantee Place of Incorporation or Organization: Location
Grantee Edison Vendor ID # Number

A. SCOPE OF SERVICES AND DELIVERABLES:

A.1. The Grantee shall provide all services and deliverables ("Scope") as required, described, and detailed in this Grant Contract.

A.2. Service Definitions.

a. **Minority AIDS Initiative (MAI)** – addresses the HIV/AIDS care needs of African American and other disproportionately impacted communities.

b. **Early Intervention Services** - include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

c. **Eligible Enrollee** - means an individual who meets the Ryan White Part B program requirements for enrollment.

d. **Home and Community-Based Health Services** – are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider.

e. **Hospice Services** - are end-of-life care services provided to clients in the terminal stage of an HIV-related illness.

f. **Medical Case Management** - is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

g. **Medical Nutrition Therapy** – the goal of Medical Nutrition Therapy is to correct and prevent malnutrition in people living with HIV and reduce the risk of other diseases/comorbidities.

h. **Outpatient/Ambulatory Health Services** - are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical

setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight.

i. **Food Bank/Home Delivered** Meals - refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

j. **Non-Medical Case Management Services (NMCM)** -provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service includes several methods of communication including face-to-face, phone contact, and other forms of communication deemed appropriate by the Ryan White HIV/AIDS Program Part B (RWHAPPB).

k. **Medical Transportation** - is the provision of nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.

l. **Respite Care** - is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

m. **Quality Improvement Reporting**. - In order to ensure quality Services are provided under this Agreement, a Quality Improvement Project Report is required. This is a completed QI project report form which includes the following elements: problem definition, project measures, project goals, root cause analysis, implementation plan, observations, results, and follow-up actions.

n. **Ryan White Services Report ("RSR")** -In order to qualify to provide Services under this Agreement, the Grantee must use CAREWare Database. This is a free, scalable software for managing and monitoring HIV clinical and supportive care which quickly produces a completed Ryan White HIV/AIDS Services Report (RSR). If the Grantee is unable to use the CAREWare Database, see A.6.a. for alternative reporting.

A.3. Service Goals. To provide HIV-related core medical and support services for all eligible enrollees of the TN Ryan White Part B program.

A.4. Service Recipients. Service recipients are defined as all eligible enrollees of the TN Ryan White Part B program.

A.5. Service Description**.**

a. **Minority AIDS Initiative (MAI)** - the program established by Congress under each of the Ryan White Part A, B, C, and D programs, which addresses the HIV/AIDS care needs of African Americans and other disproportionately impacted communities.

b. **Early Intervention Services** must include the following four (4) components:

(1) Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services, if found to be HIV-infected.

i. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts; and
ii. HIV testing paid for by Early Intervention Services cannot supplant testing efforts paid for by other sources.

(2) Referral services to improve HIV care and treatment services at key points of entry;
(3) Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care; and
(4) Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

c. **Home and Community-Based Health Services** are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

(1) Appropriate mental health, developmental, and rehabilitation services;
(2) Day treatment or other partial hospitalization services;
(3) Durable medical equipment; and
(4) Home health aide services and personal care services in the home

Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

d. **Hospice Services** are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

(1) Mental health counseling;
(2) Nursing care;
(3) Palliative therapeutics;
(4) Physician services; and
(5) Room and board.

Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

e. **Medical Case Management** is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

(1) Initial assessment of service needs;
(2) Development of a comprehensive, individualized care plan;
(3) Timely and coordinated access to medically appropriate levels of health and support services and continuity of care;
(4) Continuous client monitoring to assess the efficacy of the care plan;
(5) Re-evaluation of the care plan at least every 6 months with adaptations as necessary;
(6) Ongoing assessment of the client's and other key family members' needs and personal support systems;
(7) Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and
(8) Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance marketplaces/exchanges).

f. ***Medical Nutrition Therapy*** includes:

(1) Nutrition assessment and screening;
(2) Dietary/nutritional evaluation;
(3) Food per medical provider's recommendation; and
(4) Nutrition education and/or counseling.

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services. All services performed must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietician or licensed nutrition professional.

g. ***Outpatient/Ambulatory Health Services*** are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight.

(1) Allowable activities include:

i. Medical history taking;
ii. Physical examination;
iii. Diagnostic testing, laboratory testing;
iv. Treatment and management of physical and behavioral health conditions;
v. Behavioral risk assessment, subsequent counseling, and referral;
vi. Preventive care and screening;
vii. Pediatric development assessment;
viii. Prescription, and management of medication therapy;
ix. Treatment adherence;
x. Education and counseling on health and prevention issues; and
xi. Referral to and provision of specialty care related to HIV diagnosis.

h. ***Food Bank/Home Delivered Meals*** refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

(1) Personal hygiene products

(2) Household cleaning supplies

(3) Water filtration/purification systems in communities where issues of water safety exist.

Unallowable costs include household appliances, pet foods, and other non-essential products.

i. **Non-Medical Case Management Services** (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service includes several methods of communication including face-to-face, phone contact, and other forms of communication deemed appropriate by the Ryan White HIV/AIDS Program Part B (RWHAPPB).

(1) Key activities include:

i. Initial assessment of service needs;
ii. Development of a comprehensive, individualized care plan;
ii. Continuous client monitoring to assess the efficacy of the care plan;
iii. Re-evaluation of the care plan at least every 6 months with adaptations as necessary; and
iv. Ongoing assessment of the client's and other key family members' needs and personal support systems.

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management Services have as their objective improving health care outcomes.

j. **Medical Transportation** is the provision of nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.

Unallowable costs include:

- Direct cash payments or cash reimbursement to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle
- Any other costs associated with a privately owned vehicle such as lease, loan payments, insurance, license, or registration fees.

k. **Respite Care** is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

Recreational and social activities are not allowable program activities as a part of the Part B funding.

l. **Quality Improvement Reporting**. In order to ensure quality Services are provided under this Agreement, a Quality Improvement Project Report is required. This is a completed QI project report form which includes the following elements: problem definition, project measures, project goals, root cause analysis, implementation plan, observations, results, and follow-up actions.

m. **Ryan White Services Report ("RSR")**. In order to qualify to provide Services under this Agreement, the Grantee must use CAREWare Database. This is a free, scalable software for managing and monitoring HIV clinical and supportive care which quickly produces a completed Ryan White HIV/AIDS Services Report (RSR). If the Grantee is unable to use the CAREWare Database, see A.6.a. for alternative reporting.

The Grantee agrees to provide core medical and support services as appropriate for people living with HIV according to federal and state rules and regulations and the TDH Ryan White Part B 2024 Universal Standards of Care attached and incorporated as Attachment 7. Updates to this document will be provided to the Grantee at the annual meetings as described in A.5.d. below. The Grantee shall use the grant funds to implement and coordinate activities related to HIV/AIDS treatment, and services as follows:

a. The Grantee shall provide, per the MAI, Outreach Services, as appropriate, to targeted minority populations and other disproportionately impacted communities consisting of the following functions:

(1) Locate minority individuals within the service area, as identified in the Annual Estimates, who have fallen out of care or have not received a Ryan White Service in the past thirty (30) days and refer them to a Medical Case Manager from the State-maintained list of MCMs who will assist them in returning to medical care and enrollment into the AIDS Drug Assistance Program (ADAP).

(2) Locate newly diagnosed minority individuals who have failed to access care and assist them in beginning their care program.

b. The Grantee shall provide, per the MAI, Educational Services, as appropriate, to targeted minority populations, consisting of the following functions:

(1) Educate minority populations using state-provided materials about the importance of HIV treatment and the availability of RWHAP services.

(2) Educate minority individuals about the RWHAP and assist as necessary with enrollment in the program, scheduling appointments, etc.

(3) Utilize language interpretation/translation services, if necessary, coupled with culturally specific educational materials and/or programs, seminars, and/or discussions to increase minority participation in medical services for people living with HIV/AIDS.

c. In accordance with the National Monitoring Standards for Ryan White B Grantees: Fiscal - Part B (located at https://hab.hrsa.gov/sites/default/files/hab/Global/fiscalmonitoringpartb.pdf and https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/about-program/rwhap-nms-part-b.pdf),comprehensive monitoring site visits will be conducted at least annually. As part of

the fiscal assessment requirements, program income and time and effort analyses will be verified as part of the monitoring site visit process.

d. Clients are empowered to seek Case Management services wherever most convenient for them. No agency providing Ryan White Part B funded services may require any client to transfer medical care from an existing site to a new site as a pre-condition for receiving any/all Case Management services from any client's agency of choice.

e. All service categories an agency is funded for through Ryan White Part B must be reported to the Part B Program, regardless of the actual payor (e.g., Medicare, Medicaid, Private insurance, RW Part A, etc.) of the service. This aligns with the HRSA-required Eligible Services reporting, which states that service data should be reported on all Ryan White Part B clients who received at least one service for which the provider received RWHAP funding or at least one service that was funded through RWHAP-related funding (i.e., program income or pharmaceutical rebates).

For agencies funded for Outpatient/Ambulatory Health Services (OAHS) Through Ryan White Part B, the agency is required to report ALL HIV-related outpatient services provided by the agency to Ryan White Part B clients, regardless of the payor of those services. Therefore, even if the service was ultimately paid for by private insurance, Medicare, Medicaid, or another Ryan White Program Part, the services should be reported in CAREWare. If the agency is only funded for Part B OAHS, those services should be reported on a Part B contract in CAREWare. However, if the agency is also funded for Part A OAHS, the service should be documented on the Part A contract if the client resides in a Part A county, or on a Part B contract if the client resides in a non-Part A Tennessee county. For agencies that also receive Part C and/or Part D OAHS, the agency's internal eligibility guidelines should be used to determine which contract to document clients' services on.

For agencies funded for any other non-OAHS service category through Ryan White Part B. The agency is required to report ALL core medical and/or support services provided by the agency to Ryan White Part B clients, regardless of the payor. If the agency is only funded for a particular service category through Part B, then those services should be reported on a Part B contract. However, if the agency is also funded for that service category through Part A, the service should be documented on the Part A contract if the client resides in a Part A county, or on a Part B contract if the client resides in a non-Part A Tennessee county. For agencies that also receive funding for a service category through Part C and/or Part D, the agency's internal eligibility guidelines should be used to determine which contract to document clients' services on.

For agencies funding services through Ryan White program income or pharmaceutical rebates, the agency is required to report those services provided by the agency to Ryan White Part B clients.

A.6. Reporting Requirements.

a. The Grantee shall utilize the Tennessee State Server CAREWare database (preferred) or shall submit a Quarterly Export Data File. All Grantees must utilize CAREWare software or an authorized CAREWare interface by no later than April 01, 2026. Failure to do so will result in quarterly administrative findings requiring the Grantee to submit a Corrective Action Plan within 30 days. The quarterly export shall be submitted no later than the fifteenth (15th) day of the month following the end of each calendar year quarter. Data

submitted after the 15th of the month due will result in an administrative finding requiring the Grantee to submit a Corrective Action Plan within 30 days.

b. The Grantee agrees to gather all the data elements required to complete the Ryan White Services Report (RSR) and shall be in the format described by the Health Resources and Services Administration Guidelines. A copy has been provided to the Grantee and is posted on the website and includes:www.ryanwhite.hrsa.gov and includes:

(1) the Grantee Report, which collects information about the services the provider was funded to provide;
(2) the Service Provider Report which captures services actually delivered on a contract-by-contract basis under each Ryan White HIV/AIDS Program Part; and
(3) the Client Report which captures the services received by each individual client.

The RSR shall be submitted electronically through the HRSA Electronic Handbook. (https://hab.hrsa.gov/program-grants-management/ryan-white-hivaids-program-services-report-rsr). The submission will be for the complete calendar year (January – December) and the due date is determined annually by HRSA and is typically the first week of March of each following calendar year.

c. The Grantee shall complete and submit (to the State contacts listed in D.8.) the Program Income Report (Attachment 8) quarterly. Program income is income earned as a result of the Federal award during the period of performance. Program Income includes but is not limited to 340B income, insurance collections, etc. as it relates to income generated from the RWPB program. Effective April 01, 2023, Grantees are required to report all 340B program income received as the result of an insurance premium paid by the Ryan White Part B program, regardless of the origination of the Grantee's 340 pharmacy approval. Failure to do so will result in quarterly administrative findings requiring the Grantee to submit a Corrective Action Plan within 30 days. Policy Clarification 15-03 states that Ryan White programs must monitor and track program income earned by subrecipients. The Program Income report is due to the RWPB Program no later than the fifteenth (15th) day of the month following the end of each calendar year quarter. See 340B Definition at A.11.a.

d. The Grantee shall complete and submit a monthly and annual Multi Budget Supplemental Form (Attachment 9). The Multi Budget Supplemental Form will list the expenditures in each priority area for services provided during the month. The monthly report is to be submitted with the INVOICE FOR REIMBURSEMENT and is due to the State within thirty (30) days after the end of the calendar month in which the subject costs were incurred or services were rendered by the Grantee. The annual report is to be submitted to the State contacts listed in D.8. no later than April 15th of each year that the Grant Contract is effective. Failure to do so will result in quarterly administrative findings requiring the Grantee to submit a Corrective Action Plan within 30 days.

e. The Grantee shall complete and submit a Quarterly RWPB MAI Service Utilization Report in REDCap. The Quarterly RWPB MAI Service Utilization Report will list the progress made toward the projections of the Annual Estimates by submitting subservice-level data on the number of clients served, as well as any changes, challenges, or successes. The MAI Utilization Report will be used to identify the number of days between the client's initial referral and actual linkage to ADAP. Increments of 30, 60, 90, 120 or > days will be used to identify the timeframe. The quarterly report is due to the State Minority AIDS Initiative Program Director no later than the fifteenth (15th) day of the month following the end of each quarter (July 15, October 15, January 15, and April 15).

f. Grantees must enter clinical measures into CAREWare in a timely, complete, and accurate manner. Failure to do so may result in administrative findings during audits. Repeated findings in these areas could lead to a reduction in funding

A.7. Upon approval of this Grant Contract, the State will provide via email to the Grantee an invoice template in Excel format, herein is provided an example, that meets the requirements of Sections C.3. – C.5. Likewise, we will email a copy of Policy 007 and the Policy 007 Report template for the purposes of complying with Section C.9. The Grantee is required to use this template to create all invoice and Policy 007 report submissions. If the Grantee has not received the invoice and Policy 007 report templates within thirty (30) days of the contract approval, please contact RW.Invoices@tn.gov.

A.8. Mandatory Disclosures. Consistent with 45 CFR 75.113, applicants and non-federal entities must disclose, in a timely manner, in writing to the HHS awarding agency, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

Department of Health and Human Services
Health Resources and Services Administration
Office of Federal Assistance Management
Division of Grants Management Operations
5600 Fishers Lane, Mailstop 10SWH-03
Rockville, MD 20879

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

Fax: (202) 205-0604 (Include: “mandatory Grant Disclosures” in subject line) or Email: 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 parts 180 & 376 and 31 U.S.C. 3321). The recipient must include this mandatory disclosure requirement in all sub-awards and contracts under this award.

A.9. Federal Government Audit. If the recipient is audited by HRSA and a repayment of federal funds is required based on the activities of the subrecipient, the subrecipient shall repay the State of Tennessee for the repayments and penalties. The subrecipient is responsible for all Ryan White Part B Program rules and requirements as outlined in the Public Health Service Act- Title XXVI, Policy Clarification #16-02, and Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) National Monitoring Standards for Ryan White Part B Grantees: Program – Part B.

A.10. Grantee 340B Pharmacy.

a. A “340B Pharmacy” is a federally established drug price control program that permits qualifying providers, generally hospitals, specialty clinics and their associated outpatient

facilities serving uninsured and low-income patients in rural communities, to purchase outpatient drugs from manufacturers at discounted prices. See §340B(a)(4) of the Public Health Services Act, 42 USC 256b.

b. As a subrecipient of the federal grant funding herein, as indicated on the FAIW Attachment, the Grantee may potentially obtain status for operating a pharmacy under Section 340(B)(a)(4) of the Public Health Service Act (340B Pharmacy Status). If the Grantee obtains 340B Pharmacy Status based upon the subgrantee status resulting from this Grant Contract, the Grantee understands that all income of the 340B Pharmacy is program income of this grant award. See: PCN 15-03; link below. The purpose of this grant is to supplement, not duplicate, 340B program income. Receipt of program income earned in one grant budget year, but received in a later year, may be utilized by the Grantee in the year received. See pcn-15-03-program-income.pdf (hrsa.gov). Program income that is reasonably determinable shall appear on the grant budget herein as a grantee program income contribution. Furthermore, such income shall be reported quarterly, pursuant to Grant Contract Section A.6.d above.

A.11. Incorporation of Additional Documents. Each of the following documents is included as a part of this Grant Contract by reference or attachment. In the event of a discrepancy or ambiguity regarding the Grantee's duties, responsibilities, and performance hereunder, these items shall govern in order of precedence below.

a. this Grant Contract document with any attachments or exhibits (excluding the items listed at subsections b. and c., below);
b. the State grant proposal solicitation as may be amended, if any;
c. the Grantee's proposal (Attachment 1) incorporated if applicable, to elaborate supplementary scope of services specifications.

A.12. Incorporation of Federal Award Identification Worksheets. The federal award identification worksheets, which appear as Attachment 2, are incorporated in this Grant Contract.

A.13. In the event that the Grantee is subject to an audit in accordance with Section D.19. hereunder, the Grantee shall log in to their account on the Edison Supplier Portal to complete the Information for Audit Purposes (IAP) and End of Fiscal Year (EOFY) eForms.

A.14. No funds awarded under this Grant Contract shall be used for lobbying federal, state, or local officials.

B. TERM OF GRANT CONTRACT:

B.1. This Grant Contract shall be effective on April 1, 2026 ("Effective Date") and extend for a period of twelve (12) months after the Effective Date ("Term"). The State shall have no obligation for goods or services provided by the Grantee prior to the Effective Date.

B.2. Renewal Options. This Grant Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to four (4) renewal options under the same terms and conditions for a period not to exceed twelve (12) months each by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of sixty (60) months.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Grant Contract exceed Written Dollar Amount ($Number) ("Maximum Liability"). The Grant Budget, attached and

incorporated hereto as Attachment 3, shall constitute the maximum amount due the Grantee under this Grant Contract. The Grant Budget line-items include, but are not limited to, all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Grantee.

C.2. Compensation Firm. The Maximum Liability of the State is not subject to escalation for any reason unless amended. The Grant Budget amounts are firm for the Term and are not subject to escalation for any reason unless amended, except as provided in Section C.6.

C.3. Payment Methodology. The Grantee shall be reimbursed for actual, reasonable, and necessary costs based upon the Grant Budget, not to exceed the Maximum Liability established in Section C.1. Upon progress toward the completion of the Scope, as described in Section A of this Grant Contract, the Grantee shall submit invoices (Attachment 4) prior to any reimbursement of allowable costs.

C.4. Travel Compensation. Reimbursement to the Grantee for travel, meals, or lodging shall be subject to amounts and limitations specified in the "State Comprehensive Travel Regulations," as they are amended from time to time, and shall be contingent upon and limited by the Grant Budget funding for said reimbursement.

C.5. Invoice Requirements. The Grantee shall invoice the State no more often than monthly, with all necessary supporting documentation, and present such to:

RW.Invoices@tn.gov

a. Each invoice shall clearly and accurately detail all of the following required information (calculations must be extended and totaled correctly).

(1) Invoice/Reference Number (assigned by the Grantee).
(2) Invoice Date.
(3) Invoice Period (to which the reimbursement request is applicable).
(4) Grant Contract Number (assigned by the State).
(5) Grantor: Department of Health, CEDEP Division.
(6) Grantor Number (assigned by the Grantee to the above-referenced Grantor).
(7) Grantee Name.
(8) Grantee Tennessee Edison Registration ID Number Referenced in Preamble of this Grant Contract.
(9) Grantee Remittance Address.
(10) Grantee Contact for Invoice Questions (name, phone, or fax).
(11) Itemization of Reimbursement Requested for the Invoice Period— it must detail, at minimum, all of the following:

i. The amount requested by Grant Budget line-item (including any travel expenditure reimbursement requested and for which documentation and receipts, as required by "State Comprehensive Travel Regulations," are attached to the invoice).
ii. The amount reimbursed by Grant Budget line-item to date.
iii. The total amount reimbursed under the Grant Contract to date.
iv. The total amount requested (all line-items) for the Invoice Period.

b. The Grantee understands and agrees to all of the following.

(1) An invoice under this Grant Contract shall include only reimbursement requests for actual, reasonable, and necessary expenditures required in the delivery of service described by this Grant Contract and shall be subject to the Grant Budget

and any other provision of this Grant Contract relating to allowable reimbursements.

(2) An invoice under this Grant Contract shall not include any reimbursement request for future expenditures.

(3) An invoice under this Grant Contract shall initiate the timeframe for reimbursement only when the State is in receipt of the invoice, and the invoice meets the minimum requirements of this section C.5.

(4) An invoice under this Grant Contract shall be presented to the State within thirty (30) days after the end of the calendar month in which the subject costs were incurred or services were rendered by the Grantee. An invoice submitted more than thirty (30) days after such date will NOT be paid. The State will not deem such Grantee costs to be allowable and reimbursable by the State unless, at the sole discretion of the State, the failure to submit a timely invoice is warranted. The Grantee shall submit a special, written request for reimbursement with any such untimely invoice. The request must detail the reason the invoice is untimely as well as the Grantee's plan for submitting future invoices as required, and it must be signed by a Grantee agent that would be authorized to sign this Grant Contract.

C.6. Budget Line-items. Expenditures, reimbursements, and payments under this Grant Contract shall adhere to the Grant Budget. The Grantee may vary from a Grant Budget line-item amount by up to twenty percent (20%) of the line-item amount, provided that any increase is off-set by an equal reduction of other line-item amount(s) such that the net result of variances shall not increase the total Grant Contract amount detailed by the Grant Budget. Any increase in the Grant Budget, grand total amounts shall require an amendment of this Grant Contract.

C.7. Disbursement Reconciliation and Close Out. The Grantee shall submit a grant disbursement reconciliation report within thirty (30) days following the end of the quarter and a final invoice and final grant disbursement reconciliation report within forty-five (45) days of the Grant Contract end date, in form and substance acceptable to the State (Attachment 5).

a. If total disbursements by the State pursuant to this Grant Contract exceed the amounts permitted by Section C of this Grant Contract, the Grantee shall refund the difference to the State. The Grantee shall submit said refund with the final grant disbursement reconciliation report.

b. The State shall not be responsible for the payment of any invoice submitted to the state after the grant disbursement reconciliation report. The State will not deem any Grantee costs submitted for reimbursement after the grant disbursement reconciliation report to be allowable and reimbursable by the State, and such invoices will NOT be paid.

c. The Grantee's failure to provide a final grant disbursement reconciliation report to the state as required shall result in the Grantee being deemed ineligible for reimbursement under this Grant Contract, and the Grantee shall be required to refund any and all payments by the state pursuant to this Grant Contract.

d. The Grantee must close out its accounting records at the end of the contract period in such a way that reimbursable expenditures and revenue collections are NOT carried forward.

C.8. Indirect Cost. Should the Grantee request reimbursement for indirect costs, the Grantee must submit to the State a copy of the indirect cost rate approved by the cognizant federal agency or the cognizant state agency, as applicable. The Grantee will be reimbursed for indirect costs in accordance with the approved indirect cost rate and amounts and limitations specified in the attached Grant Budget. Once the Grantee makes an election and treats a given cost as direct or indirect, it must apply that treatment consistently and may not change during the Term. Any

changes in the approved indirect cost rate must have prior approval of the cognizant federal agency or the cognizant state agency, as applicable. If the indirect cost rate is provisional during the Term, once the rate becomes final, the Grantee agrees to remit any overpayment of funds to the State, and subject to the availability of funds the State agrees to remit any underpayment to the Grantee.

C.9. Cost Allocation. If any part of the costs to be reimbursed under this Grant Contract are joint costs involving allocation to more than one program or activity, such costs shall be allocated and reported in accordance with the provisions of Central Procurement Office Policy 2013-007 or any amendments or revisions made to this policy statement during the Term.

C.10. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any reimbursement, invoice, or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount as an allowable cost.

C.11. Non-allowable Costs. Any amounts payable to the Grantee shall be subject to reduction for amounts included in any invoice or payment that are determined by the State, on the basis of audits or monitoring conducted in accordance with the terms of this Grant Contract, to constitute non-allowable costs.

C.12. State's Right to Set Off. The State reserves the right to deduct from amounts that are or shall become due and payable to the Grantee under this Grant Contract or any other contract between the Grantee and the State of Tennessee under which the Grantee has a right to receive payment from the State.

C.13. Prerequisite Documentation. The Grantee shall not invoice the State under this Grant Contract until the State has received the following, properly completed documentation.

a. The Grantee shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the Grantee acknowledges and agrees that, once this form is received by the State, all payments to the Grantee under this or any other grant contract will be made by automated clearing house ("ACH").

b. The Grantee shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Grantee's Federal Employer Identification Number or Social Security Number referenced in the Grantee's Edison registration information.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Grant Contract until it is signed by the parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Grant Contract, the officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.2. Modification and Amendment. This Grant Contract may be modified only by a written amendment signed by all parties and approved by the officials who approved the Grant Contract and, depending upon the specifics of the Grant Contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.3. Termination for Convenience. The State may terminate this Grant Contract without cause for any reason. A termination for convenience shall not be a breach of this Grant Contract by the State. The State shall give the Grantee at least thirty (30) days written notice before the effective termination date. The Grantee shall be entitled to compensation for authorized expenditures and satisfactory services completed as of the termination date, but in no event shall the State be liable to the Grantee for compensation for any service that has not been rendered. The final decision as to the amount for which the State is liable shall be determined by the State. The Grantee shall not have any right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount for the State's exercise of its right to terminate for convenience.

D.4. Termination for Cause. If the Grantee fails to properly perform its obligations under this Grant Contract in a timely or proper manner, or if the Grantee violates any terms of this Grant Contract ("Breach Condition"), the State shall have the right to immediately terminate the Grant Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Grantee shall not be relieved of liability to the State for damages sustained by virtue of any Breach Condition and the State may seek other remedies allowed at law or in equity for breach of this Grant Contract.

D.5. Subcontracting. The Grantee shall not assign this Grant Contract or enter into a subcontract for any of the services performed under this Grant Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this Grant Contract pertaining to "Conflicts of Interest," "Lobbying," "Nondiscrimination," "Public Accountability," "Public Notice," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Grantee shall remain responsible for all work performed.

D.6. Conflicts of Interest. The Grantee warrants that no part of the total Grant Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Grantee in connection with any work contemplated or performed relative to this Grant Contract.

The Grantee acknowledges, understands, and agrees that this Grant Contract shall be null and void if the Grantee is, or within the past six months has been, an employee of the State of Tennessee or if the Grantee is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, an employee of the State of Tennessee.

D.7. Lobbying. The Grantee certifies, to the best of its knowledge and belief, that:

a. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, grant, loan, or cooperative agreement, the Grantee shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

c. The Grantee shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352.

D.8. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Grant Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by email or facsimile transmission with recipient confirmation. All communications, regardless of method of transmission, shall be addressed to the respective party as set out below:

The State:

Phadre Johnson, Director, Ryan White Part B
Communicable and Environmental Diseases and Emergency Preparedness (CEDEP) Division
6th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, Tennessee 37243
Email Address: Phadre.Johnson@tn.gov
Telephone #: (615) 532-6509

With a Copy To:
Daniel Gawlak, Contract Analyst
Andrew Johnson Tower, 6th Floor
710 James Robertson Parkway
Nashville, TN 37243

The Grantee:

Grantee Contact Name & Title
Grantee Name
Address
Email Address
Telephone # Number
FAX # Number

A change to the above contact information requires written notice to the person designated by the other party to receive notice.

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

D.9. Subject to Funds Availability. This Grant Contract is subject to the appropriation and availability of State or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate or suspend this Grant Contract upon written notice to the Grantee. The State's right to terminate or suspend this Grant Contract due to lack of funds is not a breach of this Grant Contract by the State. Upon receipt of the written notice, the Grantee shall cease all work associated with the Grant Contract. Should such an event occur, the Grantee shall be entitled to compensation for all satisfactory and authorized services completed as of the termination or suspension date but shall not be entitled to compensation for any services performed subsequent to termination date or during a period of suspension. Upon

such termination or suspension, the Grantee shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.10. Nondiscrimination. The Grantee agrees that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Grant Contract or in the employment practices of the Grantee on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Grantee shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.11. HIPAA Compliance. As applicable, the State and the Grantee shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Grant Contract.

a. The Grantee warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable requirements in the course of this Grant Contract.

b. The Grantee warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of this Grant Contract so that both parties will be in compliance with the Privacy Rules.

c. The State and the Grantee will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and the Grantee in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Grant Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.

d. The Grantee will indemnify the State and hold it harmless for any violation by the Grantee or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

D.12. Public Accountability. If the Grantee is subject to Tenn. Code Ann. § 8-4-401 *et seq*., or if this Grant Contract involves the provision of services to citizens by the Grantee on behalf of the State, the Grantee agrees to establish a system through which recipients of services may present grievances about the operation of the service program. The Grantee shall also display in a prominent place, located near the passageway through which the public enters in order to receive Grant supported services, a sign at least eleven inches (11") in height and seventeen inches (17") in width stating:

NOTICE: THIS AGENCY IS A RECIPIENT OF TAXPAYER FUNDING. IF YOU OBSERVE AN AGENCY DIRECTOR OR EMPLOYEE ENGAGING IN ANY ACTIVITY WHICH YOU CONSIDER TO BE ILLEGAL, IMPROPER, OR WASTEFUL, PLEASE CALL THE STATE COMPTROLLER'S TOLL-FREE HOTLINE: 1-800-232-5454.

The sign shall be on the form prescribed by the Comptroller of the Treasury. The Grantor State Agency shall obtain copies of the sign from the Comptroller of the Treasury, and upon request from the Grantee, provide Grantee with any necessary signs.

D.13. Public Notice. All notices, informational pamphlets, press releases, research reports, signs, and similar public notices prepared and released by the Grantee in relation to this Grant Contract shall include the statement, "This project is funded under a Grant Contract with the State of Tennessee." All notices by the Grantee in relation to this Grant Contract shall be approved by the State.

D.14. Licensure. The Grantee and its employees and all sub-grantees shall be licensed pursuant to all applicable federal, state, and local laws, ordinances, rules, and regulations and shall upon request provide proof of all licenses.

D.15. Records. The Grantee and any approved subcontractor shall maintain documentation for all charges under this Grant Contract. The books, records, and documents of the Grantee and any approved subcontractor, insofar as they relate to work performed or money received under this Grant Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the Grantor State Agency, the Comptroller of the Treasury, or their duly appointed representatives.

The records shall be maintained in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification, Public Company Accounting Oversight Board (PCAOB) Accounting Standards Codification, or Governmental Accounting Standards Board (GASB) Accounting Standards Codification, as applicable, and any related AICPA Industry Audit and Accounting guides.

In addition, documentation of grant applications, budgets, reports, awards, and expenditures will be maintained in accordance with U.S. Office of Management and Budget's *Uniform Administrative Requirements, Audit Requirements, and Cost Principles for Federal Awards*.

The Grantee shall also comply with any recordkeeping and reporting requirements prescribed by the Tennessee Comptroller of the Treasury.

The Grantee shall establish a system of internal controls that utilize the COSO Internal Control - Integrated Framework model as the basic foundation for the internal control system. The Grantee shall incorporate any additional Comptroller of the Treasury directives into its internal control system.

Any other required records or reports which are not contemplated in the above standards shall follow the format designated by the head of the Grantor State Agency, the Central Procurement Office, or the Commissioner of Finance and Administration of the State of Tennessee.

D.16. Monitoring. The Grantee's activities conducted and records maintained pursuant to this Grant Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.17. Progress Reports. The Grantee shall submit brief, periodic, progress reports to the State as requested.

D.18. Annual and Final Reports. The Grantee shall submit, within three (3) months of the conclusion of each year of the Term, an annual report. For grant contracts with a term of less than one (1) year, the Grantee shall submit a final report within three (3) months of the conclusion of the Term. For grant contracts with multiyear terms, the final report will take the place of the annual report for the final year of the Term. The Grantee shall submit annual and final reports to the Grantor State Agency. At minimum, annual and final reports shall include: (a) the Grantee's name; (b) the

Grant Contract's Edison identification number, Term, and total amount; (c) a narrative section that describes the program's goals, outcomes, successes and setbacks, whether the Grantee used benchmarks or indicators to determine progress, and whether any proposed activities were not completed; and (d) other relevant details requested by the Grantor State Agency. Annual and final report documents to be completed by the Grantee shall appear on the Grantor State Agency's website or as Attachment 6 to the Grant Contract.

D.19. Audit Report. For purposes of this Section, pass-through entity means a non-federal entity that provides a subaward to a subrecipient to carry out part of a federal program.

The Grantee shall provide audited financial statements to the Tennessee Comptroller of the Treasury ("Comptroller") if during the Grantee's fiscal year, the Grantee: (1) expends seven hundred fifty thousand dollars ($750,000) or more in direct and indirect federal financial assistance and the State is a pass-through entity; (2) expends seven hundred fifty thousand dollars ($750,000) or more in state funds from the State; or (3) expends seven hundred fifty thousand dollars ($750,000) or more in federal financial assistance and state funds from the State, and the State is a pass-through entity. For Grantee fiscal years beginning on or after October 1, 2024, an audit threshold of one million dollars ($1,000,000) shall apply.

At least ninety (90) days before the end of its fiscal year, the Grantee shall complete the Information for Audit Purposes ("IAP") form online (accessible through the Edison Supplier Portal) to notify the State whether or not Grantee is subject to an audit. The Grantee should submit only one, completed form online during the Grantee's fiscal year. Immediately after the fiscal year has ended, the Grantee shall fill out the End of Fiscal Year ("EOFY") form (accessible through the Edison Supplier portal). If the Grantee is subject to an audit, Grantee shall obtain the Comptroller's approval before engaging a licensed, independent public accountant to perform the audit. The Grantee may contact the Comptroller for assistance identifying auditors.

The audit contract between the Grantee and the Auditor shall be on a contract form prescribed by the Comptroller. The Grantee shall be responsible for payment of fees for an audit prepared by a licensed, independent public accountant. Payment of the audit fees by the Grantee shall be subject to the provision relating to such fees contained within this Grant Contract. The Grantee shall be responsible for reimbursing the Comptroller for any costs of an audit prepared by the Comptroller.

All audits shall be performed in accordance with the Comptroller's requirements, as posted on its web site. When a federal single audit is required, the audit shall be performed in accordance with U.S. Office of Management and Budget's *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*.

A copy of the audit report shall be provided to the Comptroller by the licensed, independent public accountant. Audit reports shall be made available to the public. The Grantee shall also submit a copy of the audit report to the State contact listed in D.8.

D.20. Procurement. If other terms of this Grant Contract allow reimbursement for the cost of goods, materials, supplies, equipment, or contracted services, such procurement shall be made on a competitive basis, including the use of competitive bidding procedures, where practical. The Grantee shall maintain documentation for the basis of each procurement for which reimbursement is paid pursuant to this Grant Contract. In each instance where it is determined that use of a competitive procurement method is not practical, supporting documentation shall include a written justification for the decision and for use of a non-competitive procurement. If the Grantee is a subrecipient, the Grantee shall comply with 2 C.F.R. §§ 200.317—200.327 when procuring property and services under a federal award.

The Grantee shall obtain prior approval from the State before purchasing any equipment under this Grant Contract.

For purposes of this Grant Contract, the term "equipment" shall include any article of nonexpendable, tangible, personal property having a useful life of more than one year and an acquisition cost which equals or exceeds ten thousand dollars ($10,000.00).

D.21. Strict Performance. Failure by any party to this Grant Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this agreement shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Grant Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.22. Independent Contractor. The parties shall not act as employees, partners, joint venturers, or associates of one another in the performance of this Grant Contract. The parties acknowledge that they are independent contracting entities and that nothing in this Grant Contract shall be construed to create a principal/agent relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Grantee, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Grantee's employees, and to pay all applicable taxes incident to this Grant Contract.

D.23. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Grant Contract. In no event will the State be liable to the Grantee or any other party for any lost revenues, lost profits, loss of business, loss of grant funding, decrease in the value of any securities or cash position, time, money, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Grant Contract or otherwise. The State's total liability under this Grant Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability originally established in Section C.1 of this Grant Contract. This limitation of liability is cumulative and not per incident.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Grant Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Grant Contract arising from a Force Majeure Event is not a default under this Grant Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Grantee's representatives, suppliers, subcontractors, customers or business apart from this Grant Contract is not a Force Majeure Event under this Grant Contract. Grantee will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred, and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Grantee's performance longer than forty-eight (48) hours, the State may, upon notice to Grantee: (a) cease payment of the fees until Grantee resumes performance of the affected obligations; or (b) immediately terminate this Grant Contract or any purchase order, in

whole or in part, without further payment except for fees then due and payable. Grantee will not increase its charges under this Grant Contract or charge the State any fees other than those provided for in this Grant Contract as the result of a Force Majeure Event.

D.25. Tennessee Department of Revenue Registration. The Grantee shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Grant Contract.

D.26. Charges to Service Recipients Prohibited. The Grantee shall not collect any amount in the form of fees or reimbursements from the recipients of any service provided pursuant to this Grant Contract.

D.27. No Acquisition of Equipment or Motor Vehicles. This Grant Contract does not involve the acquisition and disposition of equipment or motor vehicles acquired with funds provided under this Grant Contract.

D.28. State and Federal Compliance. The Grantee shall comply with all applicable state and federal laws and regulations in the performance of this Grant Contract.

D.29. Governing Law. This Grant Contract shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflict or choice of law rules. The Grantee agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Grant Contract. The Grantee acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising there from, shall be subject to and limited to those rights and remedies, if any, available under Tenn. Code Ann. §§ 9-8-101 through 9-8-408.

D.30. Completeness. This Grant Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Grant Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.31. Severability. If any terms and conditions of this Grant Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Grant Contract are declared severable.

D.32. Headings. Section headings are for reference purposes only and shall not be construed as part of this Grant Contract.

D.33. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101, *et seq*., addressing contracting with persons as defined at Tenn. Code Ann. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Grant Contract. The Grantee certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.34. Debarment and Suspension. The Grantee certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Grant Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal

offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Grant Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Grantee shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified, or presently fall under any of the prohibitions of sections a-d.

D.35. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with the requirements of this Grant Contract and applicable state and federal law. All material, information, and data regardless of form, medium or method of communication, that the Grantee will have access to, acquire, or is provided to the Grantee by the State or acquired by the Grantee on behalf of the State shall be regarded as "Confidential Information." The State grants the Grantee a limited license to use the Confidential Information but only to perform its obligations under the Grant Contract. Nothing in this Section shall permit Grantee to disclose any Confidential Information, regardless of whether it has been disclosed or made available to the Grantee due to intentional or negligent actions or inactions of agents of the State or third parties. Confidential Information shall not be disclosed except as required under state or federal law or otherwise authorized in writing by the State. Grantee shall take all necessary steps to safeguard the confidentiality of such Confidential Information in conformance with the requirements of this Grant Contract and with applicable state and federal law.

As long as the Grantee maintains State Confidential Information, the obligations set forth in this Section shall survive the termination of this Grant Contract.

D.36. State Sponsored Insurance Plan Enrollment. The Grantee warrants that it will not enroll or permit its employees, officials, or employees of contractors to enroll or participate in a state sponsored health insurance plan through their employment, official, or contractual relationship with Grantee unless Grantee first demonstrates to the satisfaction of the Department of Finance and Administration that it and any contract entity satisfies the definition of a governmental or quasigovernmental entity as defined by federal law applicable to ERISA.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Grant Contract, the special terms and conditions shall be subordinate to the Grant Contract's other terms and conditions.

E.2. Printing Authorization. The Grantee agrees that no publication coming within the jurisdiction of Tenn. Code Ann.§§ 12-7-101, *et seq*., shall be printed pursuant to this Grant Contract unless a printing authorization number has been obtained and affixed as required by Tenn. Code Ann. § 12-7-103(d).

E.3. Prohibited Advertising. The Grantee shall not refer to this Grant Contract or the Grantee's relationship with the State under this Grant Contract in commercial advertising in such a manner

as to state or imply that the Grantee or the Grantee's goods or services are endorsed. The obligations set forth in this Section shall survive the termination of this Grant Contract.

E.4. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the "Children's Act for Clean Indoor Air of 1995," Tenn. Code Ann. §§ 39-17-1601 through 1606, the Grantee shall prohibit smoking of tobacco products within any indoor premises in which services are provided to individuals under the age of eighteen (18) years. The Grantee shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Grant Contract.

E. 5. Grantee Participation. Grantee Participation amount(s) detailed in the Grant Budget are intended as a goal for the total project, and the amount of actual Grantee Participation expenditures will not impact the maximum amounts reimbursable to the Grantee as detailed by the Grant Budget column, "Grant Contract."

E.6. Personally Identifiable Information. While performing its obligations under this Grant Contract, Grantee may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Grant Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Grantee agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Grantee shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Grantee and in accordance with this Grant Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Grantee shall immediately notify State: (1) of any disclosure or use of any PII by Grantee or any of its employees, agents and representatives in breach of this Grant Contract; and (2) of any disclosure of any PII to Grantee or its employees, agents and representatives where the purpose of such disclosure is not known to Grantee or its employees, agents and representatives. The State reserves the right to review Grantee's policies and procedures used to maintain the security and confidentiality of PII and Grantee shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify or ensure that Grantee is in full compliance with its obligations under this Grant Contract in relation to PII. Upon termination or expiration of the Grant Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Grantee shall immediately return to the State any and all PII which it has received under this Grant Contract and shall destroy all records of such PII.

The Grantee shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Grantee ("Unauthorized Disclosure") that come to the Grantee's attention. Any such report shall be made by the Grantee within twenty-four (24) hours after the Unauthorized Disclosure has come to the attention of the Grantee. Grantee shall take all necessary measures to halt any further Unauthorized Disclosures. The Grantee, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Grantee shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Grant Contract or otherwise available at law. The obligations set forth in this Section shall survive the termination of this Grant Contract.

E.7. Federal Funding Accountability and Transparency Act (FFATA). This Grant requires the Grantee to provide supplies or services that are funded in whole or in part by federal funds that are subject to FFATA. The Grantee is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Grantee provides information to the State as required.

The Grantee shall comply with the following:

a. Reporting of Total Compensation of the Grantee's Executives.

(1) The Grantee shall report the names and total compensation of each of its five most highly compensated executives for the Grantee's preceding completed fiscal year, if in the Grantee's preceding fiscal year it received:

i. 80 percent or more of the Grantee's annual gross revenues from federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 C.F.R. § 170.320 (and sub awards); and
ii. $25,000,000 or more in annual gross revenues from federal procurement contracts (and subcontracts), and federal financial assistance subject to the Transparency Act (and sub awards); and
iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. § 78m(a), 78o(d)) or § 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.).

As defined in 2 C.F.R. § 170.315, "Executive" means officers, managing partners, or any other employees in management positions.

(2) Total compensation means the cash and noncash dollar value earned by the executive during the Grantee's preceding fiscal year and includes the following (for more information see 17 § C.F.R. 229.402(c)(2)):

i. Salary and bonus.
ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
v. Above-market earnings on deferred compensation which is not tax qualified.
vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

b. The Grantee must report executive total compensation described above to the State by the end of the month during which this Grant Contract is established.

c. If this Grant is amended to extend the Term, the Grantee must submit an executive total compensation report to the State by the end of the month in which the amendment to this Grant becomes effective.

d. The Grantee will obtain a Unique Entity Identifier (SAM)and maintain its number for the term of this Grant. More information about obtaining a Unique Entity Identifier Number can be found at: https://www.gsa.gov

The Grantee's failure to comply with the above requirements is a material breach of this Grant for which the State may terminate this Grant Contract for cause. The State will not be obligated to pay any outstanding invoice received from the Grantee unless and until the Grantee is in full compliance with the above requirements.

E.8. Equal Opportunity. As a condition for receipt of grant funds, the Grantee agrees to comply with 41 C.F. R. § 60-1.4 as that section is amended from time to time during the term.

E.9. Clean Air Act and Federal Water Pollution Control Act. As a condition for receipt of funds, the Grantee agrees to comply with the Clean Air Act, 42 U.S.C. § 7401 *et seq*. and the Federal Water Pollution Control Act, 33 U.S.C § 1251 *et seq*., as those sections are amended from time to time during the term. Violations must be reported to the HRSA and the Region 4 Office of the Environmental Protection Agency.

E.10. Healthy Eating Requirements. Grant recipients who purchase or serve snacks or meals in conjunction with their performance under this Grant Contract shall provide only healthy foods. No high sugar beverage shall be served at any time. Fruits and vegetables shall be given preference in menu selections.

E. 11. Assistance Listing Number. When applicable, the Grantee shall inform its licensed independent public accountant of the federal regulations that require compliance with the performance of an audit. This information shall consist of the following Assistance Listing Numbers: 93.917.

E. 12. Security Audit. The State may conduct audits of Grantee's compliance with the State's Enterprise Information Security Policy ("The Policy") or under this Grant Contract, including those obligations imposed by Federal or State law, regulation or policy. The Policy, as may be periodically revised, can be located at the following link: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology-solutions/sts-security-policies.html. The State's right to conduct security audits is independent of any other audit or monitoring required by this Grant Contract. The timing and frequency of such audits shall be at the State's discretion and may, but not necessarily shall, be in response to a security incident.

a. A security audit may include the following: (i) review of access logs, screen shots and other paper or electronic documentation relating to Grantee's compliance with the Policy. This may include review of documentation relevant to subcontractors or suppliers of security equipment and services used with respect to State data; (ii) physical inspection of controls such as door locks, file storage, communications systems, and employee identification procedures; and (iii) interviews of responsible technical and management personnel regarding security procedures.

b. Grantee shall provide reports or additional information upon request of the state and access by the State or the State's designated staff to Grantee's facilities and/or any location involved with providing services to the State or involved with processing or storing State data, and Grantee shall cooperate with State staff and audit requests submitted under this Section. Any confidential information of either party accessed or

disclosed during the course of the security audit shall be treated as set forth under this Grant Contract or federal or state law or regulations. Each party shall bear its own expenses incurred in the course of conducting this security audit. Grantee shall at its own expense promptly rectify any non-compliance with the Policy or other requirements identified by this security audit and provide proof to the State thereof.

E.13. Information Technology Security Requirements (State Data, Audit, and Other Requirements).

a. The Grantee shall protect State Data as follows:

(1) The Grantee shall ensure that all State Data is housed in the continental United States, inclusive of backup data. All State data must remain in the United States, regardless of whether the data is processed, stored, in-transit, or at rest. Access to State data shall be limited to US-based (onshore) resources only.

All system and application administration must be performed in the continental United States. Configuration or development of software and code is permitted outside of the United States. However, software applications designed, developed, manufactured, or supplied by persons owned or controlled by, or subject to the jurisdiction or direction of, a foreign adversary, which the U.S. Secretary of Commerce acting pursuant to 15 CFR 7 has defined to include the People's Republic of China, among others are prohibited. Any testing of code outside of the United States must use fake data. A copy of production data may not be transmitted or used outside the United States.

(2) The Grantee shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 **or** 140-3 (or current applicable version) validated encryption technologies. The State shall control all access to encryption keys. The Grantee shall provide installation and maintenance support at no cost to the State.

(3) The Grantee and any Subcontractors used by the Grantee to host State data, including data center vendors, shall be subject to an annual engagement by a licensed CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") 2 Type 2 examination. The scope of the SOC 2 Type 2 examination engagement must include the Security, Availability, Confidentiality, and Processing Integrity Trust Services Criteria. In addition, the Grantee services that are part of this Contract, including any processing or storage services, must be included in the scope of the SOC 2 Type 2 examination engagement(s).

(4) The Grantee must annually review its SOC 2 Type 2 examination reports. Within 30 days of receipt of the examination report, or upon request from the State or the Comptroller of the Treasury, the Grantee must provide the State or the Comptroller of the Treasury a non-redacted copy of the Contractor's SOC 2 Type 2 examination report(s). The Grantee must review the annual SOC 2 Type 2 examination reports for each of its Subcontractors and must also assist the State or Comptroller of the Treasury with obtaining a non-redacted copy of any SOC examination reports for each of its Subcontractors, including data centers used by the Grantee to host or process State data.

If the Contractor's SOC 2 Type 2 examination report includes a modified opinion, meaning that the opinion is qualified, adverse, or disclaimed, the Grantee must share the SOC report and the Contractor's plan to address the modified opinion

with the State or the Comptroller of the Treasury within 30 days of the Contractor's receipt of the SOC report or upon request from the State or the Comptroller of the Treasury. If any Subcontractor(s) SOC 2 Type 2 examination report includes a modified opinion, the Grantee must assist the State or Comptroller of the Treasury with obtaining the Subcontractor(s) SOC report and the Subcontractor(s) plan to address the modified opinion.

The Grantee must have a process for correcting control deficiencies that were identified in the SOC 2 Type 2 examination, including follow-up documentation providing evidence of such corrections. Within 30 days of receipt of the examination report, or upon request from the State or the Comptroller of the Treasury, the Grantee must provide the State or the Comptroller of the Treasury with a corrective action plan and evidence of correcting the control deficiencies. The Grantee must require each of its Subcontractors, including data centers used by the Grantee to host State data, to have a process for correcting control deficiencies identified in their SOC examination reports and must assist the State or Comptroller of the Treasury with obtaining a corrective action plan and obtaining evidence of correcting control deficiencies identified in Subcontractor(s) SOC reports.

No additional funding shall be allocated for these examinations as they are included in the Maximum Liability of this Contract.

(5) The Grantee must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment per the NIST 800-115 definition. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Grantee shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment. The Grantee shall provide a letter of attestation on its processing environment that penetration tests and vulnerability assessments has been performed on an annual basis and taken corrective action to evaluate and address any findings.

In the event of an unauthorized disclosure or unauthorized access to State data, the State Strategic Technology Solutions (STS) Security Incident Response Team (SIRT) must be notified and engaged by calling the State Customer Care Center (CCC) at 615-741-1001. Any such event must be reported by the Grantee within twenty-four (24) hours after the unauthorized disclosure has come to the attention of the Contractor.

(6) If a breach has been confirmed a fully un-modified third-party forensics report must be supplied to the State and through the STS SIRT. This report must include indicators of compromise (IOCs) as well as plan of actions for remediation and restoration. Grantee shall take all necessary measures to halt any further Unauthorized Disclosures.

(7) Upon State request, the Grantee shall provide a copy of all Confidential State Data it holds. The Grantee shall provide such data on media and in a format

determined by the State

(8) Upon termination of this Contract and in consultation with the State, the Grantee shall destroy, and ensure all subcontractors shall destroy, all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Grantee shall provide a written confirmation of destruction to the State within ten (10) business days after destruction.

b. Minimum Requirements

(1) The Grantee and all data centers used by the Grantee to host State data, including those of all Subcontractors, must comply with the State's Enterprise Information Security Policies as amended periodically. The State's Enterprise Information Security Policies document is found at the following URL: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology-solutions/sts-security-policies.html.

(2) The Grantee agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(3) If the Application requires middleware or database software, Grantee shall maintain middleware and database software versions that are always fully compatible with current versions of the Operating System and Application to ensure that security vulnerabilities are not introduced.

(4) In the event of drive/media failure, if the drive/media is replaced, it remains with the State and it is the State's responsibility to destroy the drive/media, or the Grantee shall provide written confirmation of the sanitization/destruction of data according to NIST 800-88.

c. Business Continuity Requirements. The Grantee shall maintain set(s) of documents, instructions, and procedures which enable the Grantee to respond to accidents, disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

(1) "Disaster Recovery Capabilities" refer to the actions the Grantee takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:

i. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident

1 hour

ii. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity:

24 hours

The Grantee and the Subcontractor(s) shall maintain a documented Disaster Recovery plan and shall share this document with the State when requested. The Grantee and the Subcontractor(s) shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use actual State Data Sets that mirror production data, and success shall be defined as the Grantee verifying that the Grantee can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Grantee shall provide written confirmation to the State after each Disaster Recovery Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements.

E.14. Comptroller Audit Requirements.

When requested by the State or the Comptroller of the Treasury, the Grantee must provide the State or the Comptroller of the Treasury with a detailed written description of the Grantee's information technology control environment, including a description of general controls and application controls. The Grantee must also assist the State or the Comptroller of the Treasury with obtaining a detailed written description of the information technology control environment for any third or fourth parties, or Subcontractors, used by the Grantee to process State data and/or provide services under this Contract.

Grantee will maintain and cause its Subcontractors to maintain a complete audit trail of all transactions and activities in connection with this Contract, including all information technology logging and scanning conducted within the Grantee's and Subcontractor's information technology control environment. Upon reasonable notice and at any reasonable time, the Grantee grants the State or the Comptroller of the Treasury with the right to audit the Grantee's information technology control environment, including general controls and application controls. The audit may include testing the general and application controls within the Grantee's information technology control environment and may also include testing general and application controls for any third or fourth parties, or Subcontractors, used by the Grantee to process State data and/or provide services under this Contract. The audit may include the Grantee's and Subcontractor's compliance with the State's Enterprise Information Security Policy and all applicable requirements, laws, regulations, or policies.

Upon reasonable notice and at any reasonable time, the Grantee and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control audits of the Grantee and all Subcontractors used by the Grantee. Grantee will provide to the State, the Comptroller of the Treasury, or their duly appointed representatives access to Grantee and Subcontractor(s) personnel for the purpose of performing the information technology control audit. The audit may include interviews with technical and management personnel, physical or virtual inspection of controls, and review of paper or electronic documentation.

The Grantee must have a process for correcting control deficiencies that were identified in the State's or Comptroller of the Treasury's information technology audit. For any audit issues identified, the Grantee and Subcontractor(s) shall submit a corrective action plan to the State or the Comptroller of the Treasury which addresses the actions taken, or to be taken, and the anticipated completion date in response to each of the audit issues and related recommendations of the State or the Comptroller of the Treasury. The corrective action plan shall be provided to the State or the Comptroller of the Treasury upon request from the State or Comptroller of the Treasury and within 30 days from the issuance of the audit report or communication of the audit issues and recommendations. Upon request from the State or Comptroller of the Treasury, the Grantee and Subcontractor(s) shall provide documentation and evidence that the audit issues were corrected.

Each party shall bear its own expenses incurred while conducting the information technology controls audit.

IN WITNESS WHEREOF,

GRANTEE LEGAL ENTITY NAME:

GRANTEE SIGNATURE	**DATE**
PRINTED NAME AND TITLE OF GRANTEE SIGNATORY (above)	

DEPARTMENT OF HEALTH:

DR. JOHN R. DUNN, INTERIM COMMISSIONER	**DATE**

GRANTEE'S PROPOSAL

ATTACHMENT 2

Federal Award Identification Worksheet

Subrecipient's name (must match name associated with its Unique Entity Identifier (SAM)	
Subrecipient's Unique Entity Identifier (SAM)	
Federal Award Identification Number (FAIN)	
Federal award date	
Subaward Period of Performance Start and End Date	
Subaward Budget Period Start and End Date	
Assistance Listing number (formerly known as the CFDA number) and Assistance Listing program title.	
Grant contract's begin date	
Grant contract's end date	
Amount of federal funds obligated by this grant contract	
Total amount of federal funds obligated to the subrecipient	
Total amount of the federal award to the pass-through entity (Grantor State Agency)	
Federal award project description (as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA)	
Name of federal awarding agency	
Name and contact information for the federal awarding official	
Name of pass-through entity	
Name and contact information for the pass-through entity awarding official	
Is the federal award for research and development?	
Indirect cost rate for the federal award (See 2 C.F.R. §200.332 for information on type of indirect cost rate)	

ATTACHMENT 3

GRANT BUDGET

Additional Identification Information As Necessary

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the period beginning DATE, and ending DATE.

	EXPENSE OBJECT LINE-ITEM CATEGORY [1]	GRANT CONTRACT	GRANTEE PARTICIPATION	TOTAL PROJECT
	Salaries [2]	0.00	0.00	0.00
	Benefits & Taxes	0.00	0.00	0.00
	Professional Fee, Grant & Award [2]	0.00	0.00	0.00
	Supplies	0.00	0.00	0.00
	Telephone	0.00	0.00	0.00
	Postage & Shipping	0.00	0.00	0.00
	Occupancy	0.00	0.00	0.00
	Equipment Rental & Maintenance	0.00	0.00	0.00
	Printing & Publications	0.00	0.00	0.00
	Travel, Conferences & Meetings [2]	0.00	0.00	0.00
	Interest [2]	0.00	0.00	0.00
	Insurance	0.00	0.00	0.00
	Specific Assistance To Individuals [2]	0.00	0.00	0.00
	Depreciation [2]	0.00	0.00	0.00
	Other Non-Personnel [2]	0.00	0.00	0.00
	Capital Purchase [2]	0.00	0.00	0.00
	Indirect Cost (% and method)	0.00	0.00	0.00
	In-Kind Expense	0.00	0.00	0.00
	GRAND TOTAL	**0.00**	**0.00**	**0.00**

[1] Each expense object line-item is defined by the *U.S. OMB's Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Subpart E Cost Principles* (posted on the Internet at: https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E) and CPO Policy 2013-007 (posted online at https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-.html).

[2] Applicable detail follows this page if line-item is funded.

ATTACHMENT 3

GRANT BUDGET LINE-ITEM DETAIL:

SALARIES	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

PROFESSIONAL FEE, GRANT & AWARD	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

TRAVEL/CONFERENCES & MEETINGS	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

INTEREST	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

SPECIFIC ASSISTANCE TO INDIVIDUALS	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

DEPRECIATION	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

OTHER NON-PERSONNEL	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

CAPITAL PURCHASE	AMOUNT
Specific, Descriptive, Detail (Repeat Row As Necessary)	Amount
ROUNDED TOTAL	Amount

TN Department of Health

Invoice Reimbursement Form

Contract #
Supplier Name
Program Name

Section 1: Contract Information (to be completed by TDH Accounts)

PO # (Req.) _____

PO Line # (Req.) _____

Receipt # (Req.) _____

Agency Invoice # _____

Edison Contract # _____

Edison Vendor # _____

Edison Address Line # _____

AP Attachment (check if yes) ☐

Section 2: Invoice Information (to be completed by Contractor/Grantee)

Contract Invoice # _____

Invoice Date _____

Service Start Date _____

Service End Date _____

Contract Start Date _____

Contract End Date _____

Contact Person Name _____

Phone # _____

Remit Payment to:

Business Name _____

Street Address _____ City _____ State _____ ZIP _____

Budget Line Items	(A) Total Contract Budget	(B) Amount Billed YTD	(C) Monthly Expenditures Due
Salaries			
Benefits			
Professional Fee/Grant/Award			
Supplies			
Telephone			
Postage and Shipping			
Occupancy			
Equipment Rental and Maintenance			
Printing and Publications			
Travel/Conferences and Meetings			
Interest			
Insurance			
Specific Assistance to Individuals			
Depreciation			
Other Non-Personnel			
Capital Purchase			
Indirect Costs			
TOTAL	$ 0.00	$ 0.00	$ 0.00

Section 3: Payment Information (to be completed by TDH Program)

Invoice Received Date _____ Invoice Received by (Name) _____

Service Type (Select One): ☐ Medical Services ☐ Non-Medical Services

Speedchart	Department ID	User Code	Project ID	Amount ($)

Total Amount: $ 0.00

Additional Signatures as Required by Program (Not required for processing and payment by F&A Accounts Payable)

_____ Program Signature 1

_____ Program Signature 2

_____ Program Signature 3

Section 4: Authorized Signatures

Contractor/Grantee Authorization

Name: _____

Date: _____

Signature: _____

TDH Program Authorization

Name: _____

Date: _____

Signature: _____

TDH Accounts Authorization

Name: _____

Date: _____

Signature: _____

Section 5: Additional Comments

Section 6: Month to Month Expense Tracking Sheet (Not Required by F&A Accounts Payable)

Budget Line Items	Budget Amt	Jul Expenses	Aug Expenses	Sep Expenses	Oct Expenses	Nov Expenses	Dec Expenses	Jan Expenses	Feb Expenses	Mar Expenses	Apr Expenses	May Expenses	Jun Expenses	YTD Totals	Balance Remaining
Salaries	$ 0.00													$ 0.00	$ 0.00
Benefits	$ 0.00													$ 0.00	$ 0.00
Fee/Grant/Award	$ 0.00													$ 0.00	$ 0.00
Supplies	$ 0.00													$ 0.00	$ 0.00
Telephone	$ 0.00													$ 0.00	$ 0.00
Postage and Shipping	$ 0.00													$ 0.00	$ 0.00
Occupancy	$ 0.00													$ 0.00	$ 0.00
Equipment Rental and Maintenance	$ 0.00													$ 0.00	$ 0.00
Printing and Publications	$ 0.00													$ 0.00	$ 0.00
Travel/Conferences and Meetings	$ 0.00													$ 0.00	$ 0.00
Interest	$ 0.00													$ 0.00	$ 0.00
Insurance	$ 0.00													$ 0.00	$ 0.00
Specific Assistance to Individuals	$ 0.00													$ 0.00	$ 0.00
Depreciation	$ 0.00													$ 0.00	$ 0.00
Other Non-Personnel	$ 0.00													$ 0.00	$ 0.00
Capital Purchase	$ 0.00													$ 0.00	$ 0.00
Indirect Costs	$ 0.00													$ 0.00	$ 0.00
Totals	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

REPORTING TEMPLATE

Introduction

Reporting Template has three parts:
•Schedule A,
•Schedule B, and
•Schedule C which are Program Expense Reports (PER), Program Revenue Reports (PRR) and Reconciliation Between Total and Reimbursable Expenses and Total Expense Summary Report.
Program Expense Reports (PER), Program Revenue Reports (PRR) and Reconciliation Between Total and Reimbursable Expenses and Total Expense Summary Report including Schedule A-1 and Schedule B-1 must be submitted in the same format/the same column heading each quarter. The final Report (definition can be found in grant contract agreement) must be approved by the contracting state agency.

Schedule Headings

At the top of each schedule, the name of the reporting contractor/grantee and the period covered by the report need to be entered. The period of the report should always be the most recent quarter ended and report programs in the same sequence as the previous quarter.

Column Headings

For each program for Schedule A and B, Contracting State Agency, Program Name, Assistance Listing Number/Program Number, Edison Contract Number, and Grant/Contract Term should be entered. These can be found in the grant contract agreement.
•The Contracting State Agency is for the state agency who awards the grant and initiates the contract agreement.
•The Program Name is the title to describe the program or the title that corresponds to the Federal Assistance Listing number.
•The Assistance Listing Number/Program Name is a number assigned to identify the Federal Assistance Listings under which the subaward was made by the contracting State agency.
•The Edison contract number is the number assigned by the contracting state agency and should include the amendment number, if any. This can be found in the grant contract agreement.
•The grant/contract term is the beginning and ending dates of the grant/contract. This can be found in the grant contract agreement.

Program Columns

Program expense columns (Quarter-To-Date and Year-To-Date) are for reporting direct program expenses. Direct program expenses that benefit more than one program (i.e., allocable-direct costs) may be allocated to the benefitted programs within the expense categories. The cognizant state agency should approve the method used for cost allocations and the contacting state agency should abide by the cost allocation approved by the cognizant state agency.
The Quarter-To-Date column can be used to capture all expenses for the specific quarter. For example, the expenses for the 2nd quarter (from 10/1/22 to 12/31/2022) can be entered in this column.
All accumulated expenses for each program can be entered in Year-To-Date column. For example, if a grantee/organization has entered the expenses for the 2nd quarter in Quarter-To-Date column, all accumulated expenses for the 1st quarter and the 2nd quarter should be entered in Year-To-Date column.

Do not send a worksheet that is linked to another file

E-mail completed files to: policy2013_007.amo.health@tn.gov

or Mailing Address:

Rushdi Eskarous
Tennessee Department of Health
Fiscal Services
6th Floor Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Telephone: 615-741-2974

QUESTIONS:

Angela Sumner: angela.sumner@tn.gov
Rushdi Eskarous: rushdi.eskarous@tn.gov

PROGRAM EXPENSE REPORT (PER) SCHEDULE A

Purpose/Scope

The Program Expense Report (PER Schedule A) contains expenses by the detailed line items and then summarizes by subtotals or total**.** This schedule can be used for any grants received from a state agency or multiple state agencies.

These expenses include direct and allocated direct program expenses in each line item. Per 2 CFR Part 200.413, direct costs are those costs that can be identified specifically with a particular final cost objective, such as a grant, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy. Per 2 CFR Part 200.405, allocable direct costs are those that benefit more than one program, but do not fall under the criteria of indirect costs.

Except for depreciation, every expense reported in Lines 1 through 21 must represent an actual cash disbursement or accrual (as defined in the Basis for Reporting Expenses/Expenditures section on page 1 of this instructions). If more than two programs (e.g., four programs), complete multiple Schedule As to report all four program expenses.

Instruction for Expenses by Object Line-Items

Line 1 Salaries and Wages

Enter the amount of compensation, fees, salaries, bonuses, severance payments, and wages paid to program directors, program managers/staffs, and employees.

References:

2 CFR Part 200.430
Form 990 Part IX line 5, 7

Line 2 Employee Benefits & Payroll Taxes

Enter (a) the grantee's/organization's contributions to pension plans and to employee benefit programs such as health, life, and disability insurance; and (b) the grantee's/organization's portion of payroll taxes such as social security, Medicare taxes, and unemployment and workers' compensation insurance.

References:

2 CFR Part 200.431
Form 990 Part IX lines 8, 9, 10

Line 3 Total Personnel Expenses

Add lines 1 Salaries and Wages and 2 Employee Benefits & Payroll Taxes.

Line 4 Professional Fees

Enter the costs/fees of professionals, consultants, and personal-service contractors who are not officers or employees of the grantee/organization. These include legal, accounting, and auditing fees.

References:

2 CFR Part 200.459
Form 990 Part IX line 11

Line 5 Supplies

Enter the grantee's/organization's expenses for office supplies, housekeeping supplies, and other supplies.

References:
2 CFR Part 200.453
Form 990 Part IX line 13

Line 6 Telecommunication

Enter the grantee's/organization's expenses for telephone, cellular phones, beepers, telegram, FAX, telephone equipment maintenance, internet, cloud servers, and other related expenses.

References:
2 CFR Part 200.471
Form 990 Part IX line 13

Line 7 Postage and Shipping

Enter the grantee's/organization's expenses for postage, messenger services, overnight delivery, outside mailing service fees, freight and trucking, and maintenance of delivery and shipping vehicles. Include vehicle insurance here or on line 14.

References:
2 CFR Part 200.474
Form 990 Part IX line 13

Line 8 Occupancy

Enter the grantee's/organization's expenses for use of office space and other facilities including rent, heat, light, power, other utilities, outside janitorial services, mortgage interest, real estate taxes, and similar expenses. Include property insurance here or on line 14.

References:
2 CFR Part 200.465
Form 990 Part IX line 16

Line 9 Equipment Rental and Maintenance

Enter the grantee's/organization's expenses for renting and maintaining computers, copiers, postage meters, other office equipment, and other equipment, except for telecommunications, truck, and automobile expenses, reportable on lines 6, 7, and 11, respectively.

References:
2 CFR Part 200.452
Form 990 Part IX line 13

Line 10 Printing and Publications

Enter the grantee's/organization's expenses for producing printed materials, purchasing books and publications, buying subscriptions to publications, publication costs for electronic and print media, and page charges for professional journal publications.

References:
- 2 CFR Part 200.461
- Form 990 Part IX line 13

Line 11 Travel

Enter the grantee's/organization's expenses for airfare, transportation, meals and lodging, subsistence, and related items incurred by employees on official business of the organization. These costs may be charged on an actual cost basis, on a per diem or mileage basis in lieu of actual costs incurred, consistent with those normally allowed in like circumstances in the organization's non-federal/state-funded activities and in accordance with organization's written travel reimbursement policies. Include gas and oil, repairs, licenses and permits, and leasing costs for company vehicles. Include travel expenses for meetings and conferences. Include vehicle insurance here or on line 14.

If an organization does not have the written travel reimbursement policies, they may use the State Travel policy which is:

F&A Policy 08 Comprehensive State Travel Regulations.

References:
- 2 CFR Part 200.475
- Form 990 Part IX line 17

Line 12 Conference and Meetings

Enter the grantee's/organization's expenses for conducting or attending meetings, conferences, seminars, retreats, and conventions including registration fees. When host of conference, include rental of facilities, speakers' fees and expenses, costs of meals and refreshment (food and beverages), and printed materials for the conference.

References:
- 2 CFR Part 200.432
- Form 990 Part IX line 19

Line 13 Interest

Enter the interest expense for the business related loans and interest costs that are related to capital leases on equipment, trucks and automobiles, and other notes and loans. Do not include mortgage interest reportable on line 8.

References:
- 2 CFR Part 200.449
- Form 990 Part IX line 20

Line 14 Insurance

Enter the grantee's/organization's expenses for liability insurance, fidelity bonds, and other insurance. Do not include employee-related insurance reportable on line 2. Do not include shipping vehicle, property, and organization vehicles for travel if reported on lines 7, 8, or 11 respectively.

References:
2 CFR Part 200.447
Form 990 Part IX line 23

Line 15 Grants and Awards

Enter the grantee's/organization's awards, grants, subsidies, and other pass-through expenditures to other organizations. Include allocations to affiliated organizations. Include in- kind grants to other organizations. Include scholarships, tuition payments, travel allowances, and equipment allowances to clients. These expenses will not include when calculating Administrative Expense in line 22.

References:
2 CFR Part 200.1
Form 990 Part IX line 1

Line 16 Specific Assistance to Individuals

Enter the grantee's/organization's direct payment for expenses of clients, patients, and individual beneficiaries. Include such expenses as medicines, medical and dental fees, children's board, food and homemaker services, clothing, transportation, insurance coverage, scholarships, fellowships, stipends, research grants, wage supplements, and similar payments.

References:
2 CFR Part 200.456
Form 990 Part IX line 2

Line 17 Depreciation

Enter the expenses the grantee's/organization's records for depreciation (the method for allocating the cost of fixed assets to periods benefitting from asset use) of equipment, buildings, leasehold improvements, and other depreciable fixed assets.

References:
2 CFR Part 200.436
Form 990 Part IX line 22

Line 18 Other Nonpersonnel Expenses

Enter the grantee's/organization's allowable expenses for Advertising, Information Technology, Bad Debts, Contingency Provisions, Fines and Penalties, Independent Research and Development, Organization Costs, Rearrangement and Alteration, Recruiting, and Taxes. Include the Organization's and Employees' Membership Dues in Associations and Professional Societies. Include other fees for the Organization's Licenses, Permits, and Registrations, etc.

NOTE: Expenses reportable on lines 1 through 17 should not be reported as an additional expense category on line 18. A description should be attached for each additional category entered on line 18. The contracting state agency may determine these requirements in the grant contract agreement.

a) Advertising:

Enter expenses paid for advertising. Include amounts for print and electronic media advertising. Also include internet site link costs, signage costs, and advertising costs for the organization's in-house fundraising campaigns.

References:
2 CFR Part 200.421
Form 990 Part IX line 12

b) Information Technology:

Enter expenses for information technology, including hardware, software, and support services such as maintenance, help desk, and other technical support services. Also include expenses for infrastructure support, such as website design and operations, virus protection and other information security programs and services to keep the organization's website operational and secured against unauthorized and unwarranted intrusions, and other information technology contractor services.

References:
2 CFR Part 200.1
Form 990 Part IX line 14

c) Bad Debts:

Enter expense amounts for losses (whether actual or estimated) arising from uncollectable accounts and other claims, related collection costs, and related legal costs.

References:
2 CFR Part 200.426
Form 990 Part IX line 24

d) Contingency Provisions:

Enter expense amounts for contributions to a contingency reserve or any similar provision made for events the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of their happening.

References:
2 CFR Part 200.433
Form 990 Part IX line 24

e) Fines and Penalties:

Enter costs of fines and penalties resulting from violations of, or failure of the organization to comply with Federal, State, and local laws and regulations except when incurred as a result of compliance with specific provisions of an award or instructions in writing from the awarding agency.

References:
2 CFR Part 200.441
Form 990 Part IX line 24

f) Independent Research and Development:

Enter the expenses of all research activities, including the training of individuals in research techniques.

References:
2 CFR Part 200.1
Form 990 Part IX line 24

g) Organization Costs:

Enter expenses such as incorporation fees, brokers' fees, fees to promoters, and organizers.

References:
2 CFR Part 200.455
Form 990 Part IX line 24

h) Rearrangement and Alteration:

Enter expenses incurred for ordinary or normal rearrangement and alteration of facilities. Include the expenses incurred in the restoration or rehabilitation of the organization's facilities.

References:
2 CFR Part 200.462
Form 990 Part IX line 24

i) Recruiting:

Enter expenses for recruiting staff and maintaining workload requirements, costs of "help wanted" advertising, operating costs of an employment office necessary to secure and maintain an adequate staff, costs of operating an aptitude and educational testing program and relocation costs incurred incident to recruitment of new employees.

References:
2 CFR Part 200.463
Form 990 Part IX line 24

j) Taxes:

Enter expenses for payment of taxes to the local government or state.

References:
2 CFR Part 200.470
Form 990 Part IX line 24

k) Organization's and Employee's Membership Dues in Associations and Professional Societies:

Enter expenses of the organization's membership or subscriptions in business, technical, and professional organizations.

References:
2 CFR Part 200.454
Form 990 Part IX line 24

Line 19 Total Nonpersonnel Expenses

Add lines 4 Professional Fees through 18 Other Non-personnel Expenses.

Line 20 Reimbursable Capital Purchases

Enter the organization's purchases of fixed assets. Include land, equipment, buildings, leasehold improvements, and other fixed assets.

References:

2 CFR Part 200.439

Form 990 Par X line 10a or Schedule D Part VI

Line 21 Total Direct Program Expenses

Add Line 3 Total Personnel Expenses, and Line 19 Total Non-personnel Expenses, and Line 20 Reimbursable Capital Purchases. These expenses are the summary of the direct and allocated direct program expenses that entered in Line 1 Salaries and Wages through Line 20 Reimbursable Capital Purchases.

Reference:

2 CFR Part 200.405 2 CFR Part 200.413

Form 990 Part IX, column B

Line 22 Administrative Expenses

The distribution will be made in accordance with an allocation plan approved by your cognizant state agency. Pass-through funds (Line 15 Grants and Awards) are not included when computing administrative expenses.

References:

2 CFR Part 200.414

Form 990 Part IX, Column C

Line 23 Total Direct Program and Administrative Expenses

Line 23 is the total of Line 21 Total Direct Program Expenses and Line 22 Administrative Expenses. Total Direct Program and Administrative Expenses (Line 23) Year To Date (if quarter end 3/31/2023) should agree with Total of YTD (Year To Date) Actual Expenditures Through 3/31/2023 (Column E) of the Invoice for Reimbursement.

Line 24 In-Kind Expenses

In-kind Expenses is for reporting the value of contributed resources (non-cash) applied to the program. Approval and reporting guidelines for in-kind contributions will be specified by those contracting state agencies who allow their use toward earning grant funds.

References:

2 CFR Part 200.434

Form 990 Part XI line 6

Line 25 Total Program Expenses

The sum of Line 23 Total Direct Program and Administrative Expenses and Line 24 In-kind Expenses goes on this line.

PROGRAM EXPENSE REPORT (PER) SCHEDULE A-Q1-Q4

Purpose/Scope

This template tracks expenses for all the quarters and summarizes in the Year-To-Date column. The Year-To-Date column can be linked to Year-To-Date column of the Schedule A.

Additionally, this schedule provides the Grant Budget Amount (from grant contract agreement) column and the Over/(Under) Budget Amount column which compares cumulative Year-To-Date expenses to Grant Budget Amount.

Instruction for Expenses by Object Line-Items

The instructions for expense line items are the same as Schedule A.

PROGRAM REVENUE REPORT AND RECONCILIATION BETWEEN TOTAL PROGRAM AND REIMBURSABLE EXPENSES SCHEDULE B

Purpose/Scope

Program Revenue Report (PRR) and Reconciliation Between Total and Reimbursable Expenses, Schedule B, are intended to capture all revenue by the detailed source and reconcile total program expenses and reimbursable expenses. Each revenue column should match up with the Edison Contract Number and the Program Name from Schedule A and align with its corresponding expense column from the Schedule A. The Reconciliation of Total Program Expenses And Reimbursable Expenses, at the bottom of Schedule B, should be completed to show how Total Program Expenses (Line 51 of Schedule B or Line 25 of Schedule A) reconciles to the amount to be reimbursed.

If multiple programs exist, additional copies of the Schedule B can be used to enter all Program Revenue and Reconciliation Between Total and Reimbursable Expenses.

Additional supplemental schedules showing the Sources of Revenue in the aggregations may be attached, if needed. The contracting state agency may provide more guidance in the grant contract agreement.

Instruction for Sources of Revenue

• Reimbursable Program Funds

Line 31 Reimbursable Federal Program Funds

Enter the portion of Total Direct Program & Administrative Expenses reported on Line 23 of the Schedule A that are reimbursable from the Federal program funds.

Reference:
Form 990 Part VIII 1e

Line 32 Reimbursable State Program Funds

Enter the portion of Total Direct Program & Administrative Expenses reported on Line 23 of the Schedule A that are reimbursable from the state program funds.

Reference:
Form 990 Part VIII 1e

Line 33 Total Reimbursable Program Funds

Add Line 31 Reimbursable Federal Program Funds and Line 32 Reimbursable State Program Funds.

• Matching Revenue Funds

Note: matching requirements can be found in the grants contact agreement for the grants received from the contracting state agency.

Line 34 Other Federal Funds

Enter the matching portion (the grantee portion) of the program costs that will be covered by other Federal fund sources.

Reference:
Form 990 Part VIII 1e

Line 35 Other State Funds

Enter the matching portion (the grantee portion) of the program costs that will be covered by other State fund source.

Reference:
Form 990 Part VIII 1e

Line 36 Other Government Funds

Enter the matching portion (the grantee portion) of the program costs that will be covered by other government fund source.

Reference:
Form 990 Part VIII 1e

Line 37 Cash Contributions (Nongovernment)

Enter the matching portion (the grantee portion) of the cash contributions that were received from corporations, foundations, trusts, and individuals, United Ways, other not-for-profit organizations, and affiliated organizations. This is only applicable when the grantee has received contributions from above donors for this program and this is included as expense line-items of the Schedule A.

References:
Form 990 Part VIII 1f

Line 38 In-Kind Contributions (Equals Schedule A. Line 24)

Enter the matching portion (the grantee portion) of the direct and administrative in-kind contributions.

Approval and guidelines for valuation and reporting of in-kind contributions will be specified by those grantor agencies who allow their use toward program purposes.

References:
Form 990 Part VIII line 1f and Part XI line 6

Line 39 Program Income

Enter the matching portion (the grantee portion) of program income. For example, income from fees for services performed.

Reference:
Form 990 Part VIII line 2a to 2f

Line 40 Other Matching Revenue

Enter the matching portion of other revenues that are not included in lines 34 through 39.
References:
Form 990 Part VIII 3 through 11e

Line 41 Total Matching Revenue Funds

Add lines 34 through 40.

Line 42 Other Program Funds

Enter any other program revenues that are funded by the contracting state agency but are not reported as matching revenue funds on Line 41 Total Matching Revenue Funds. Example of this can be in-kind expenses (Line 24 of Schedule A), if any.

References:
Form 990 Part VIII 1a through 11e

Line 43 Total Revenue

Add lines 33, 41, and 42.
References:
Form 990 Part VIII 12

Instruction for Reconciliation Between Total and Reimbursable Expenses

Line 51 Total Program Expenses

This line is brought forward from Line 25 Total Program Expenses on Schedule A.

Line 52 Other Unallowable Expenses

Enter amount for Other Unallowable Expenses here. Some program expenses may not be reimbursable under certain grants. Example of this can be the in-kind expenses which is non-cash item. This will vary according to the contracting state agency and the type of grant or contract. Consult with the contracting state agency that funds the program for additional guidelines.

Line 53 Excess Administration

This line may be used to deduct allocated Administration and General expenses (indirect costs) in excess of the allowable percentage specified in the grant contract agreement or the indirect cost rate that is approved by the cognizant State agency. This line may also be used to deduct an adjustment resulting from limitations on certain components of Administration and General expenses. Consult with the contracting state agency that funds the program for additional guidelines.

Line 54 Matching Expenses

Total program expenses should be deducted from matching (cost sharing) expenses required by the program compliance. This portion can be a specified as an amount or percentage to match the federal award. Program income (e.g., user fees or rental of real property) can be deducted from matching portion.

Line 55 Reimbursable Expense (Line 51 Less Lines 52, 53, And 54)

This should equal the amount the contracting state agency has already paid for the quarter's operations of the program. The cumulative Year-To-Date column is what the grantor has actually paid to date if the organization has submitted the invoice and reimbursed monthly.

Line 56 Total Reimbursement To Date

The Quarter-to-Date column is the total amounts received for this quarter from filing of Invoices for Reimbursement (usually monthly). The cumulative Year-to-Date column amount is the total amount received for the grant program.

Line 57 Difference (Line 55 minus Line 56)

This is the portion of Reimbursable Expenses that are not paid yet. If a grantee submits a monthly invoice for reimbursement and reimbursement has been received, this will be zero.

Line 58 Advances

Any advance payments from the contracting state agency should appear on this line. Most of time, the contracting state agency will not pay the expenses in advance.

Line 59 This Reimbursement (Line 57 minus 58)

The remainder should be the amount due under the grant contract. Request for reimbursement is made through the invoicing process and not through filing of the quarterly or annual report. Any amounts showing here needed to be included in the invoice for reimbursement.

NONGRANT EXPENSE REPORT (NER)
NONGRANT REVENUE REPORT (NRR) AND
RECONCILIATION BETWEEN TOTAL NONGRANT AND REIMBURSABLE EXPENSES
SCHEDULE A-1, SCHEDULE A-1-Q1-Q4, and SCHEDULE B-1

Purpose/Scope

These schedules may be used for the nongrants/unallowable expenses that are not reimbursed/will not be reimbursed by the contracting state agencies.

These schedules should be completed to reconcile expenses per the Total Expense Summary Report (Schedule C) to the trial balance/general ledger when the nongrants/unallowable expenses exist in the grantee's books.

Instruction for Schedules A-1, A-1-Q1-Q4, and B-1

The instruction for these schedules A-1, A-1-Q1-Q4, and B-1 are the same as the instructions for Schedule A and B except these expenses will not be reimbursed by the contracting state agency.

Heading sections may be entered as N/A if this heading is not applicable for Nongrant/Unallowable Expense or Revenue.

TOTAL EXPENSE SUMMARY REPORT
Schedule C

Purpose/Scope

The Total Expense Summary Report is intended to recap all the direct program expenses in one column, separately identify nongrant/unallowable expenses, and total administrative expenses in other columns, as well as a grand total of all the expenses of the grantee. The amounts in Grand Total Year-to-Date column should tie to the general ledger/trial balance of the grantee/organization.

Schedule C should be only one schedule regardless if there are multiple Schedule As and Bs. The grantee will complete all the schedules at one time and will submit the same schedule to the multiple contracting state agencies if the grantee has received awards from the multiple state agencies.

Instruction for Expenses by Object Line-Items

The object line-items are the same as Schedule A. See each line-item instruction in Schedule A.

Instruction for Columns

Total Direct Program Expenses Column

This column is the summary of all the individual programs' cumulative year to date expenses as identified separately under the respective program names in Schedule A.

Total Nongrant/Unallowable Expenses Column

The nongrant/unallowable expense column includes the following expenses:

I. The cumulative year-to-date expenses for all other programs that are not funded by the contracting state agency/agencies.

II. The cumulative year-to-date expenses for fund-raising activities, if any.

III. Other cumulative year-to-date expenses that are not allowable for reimbursement according to the terms of the grants or the Federal guidance.

Total Administrative Expenses Column

The administrative expenses column is for categorizing the cumulative year-to-date administrative expenses into the Expense by Object. Total Direct Program Expenses (line 21) of this column is the sum of all the line 21s. Line 22 of this column will make line 21 amount to be a credit amount so that Total Direct and Administrative Expenses is showing zero since these expenses are already claimed in columns Total Direct Program Expenses Year-To-Date and Total Nongrant/Unallowable Expenses Year-To-Date.

Grand Total Column

The Grand Total column contains all the cumulative year-to-date expenses for the entire reporting organization. The Grant Total Year-to-Date expenses must be traceable to the reporting organization's general ledger or trial balance.

STATE OF TENNESSEE
PROGRAM EXPENSE REPORT

Schedule A | **Page # of # Pages:**

Contractor/Grantee Name: | **Report Period:**

Contracting State Agency:		
Program Name:	A	B
Assistance Listing Number/Program Number:		
Edison Contract Number:		
Grant/Contract Term:		

Line Item #	Expense By Object	Quarter To Date	Year To Date	Quarter To Date	Year To Date
1	Salaries and Wages		0.00		0.00
2	Employee Benefits & Payroll Taxes		0.00		0.00
3	**Total Personnel Expenses**	0.00	0.00	0.00	0.00
4	Professional Fees		0.00		0.00
5	Supplies		0.00		0.00
6	Telecommunication		0.00		0.00
7	Postage and Shipping		0.00		0.00
8	Occupancy		0.00		0.00
9	Equipment Rental and Maintenance		0.00		0.00
10	Printing and Publications		0.00		0.00
11	Travel		0.00		0.00
12	Conferences and Meetings		0.00		0.00
13	Interest		0.00		0.00
14	Insurance		0.00		0.00
15	Grants and Awards		0.00		0.00
16	Specific Assistance to Individuals		0.00		0.00
17	Depreciation		0.00		0.00
18	Other Non-personnel Expenses: (list details in a-d)				
	a		0.00		0.00
	b		0.00		0.00
	c		0.00		0.00
	d		0.00		0.00
19	**Total Non-personnel Expenses**	0.00	0.00	0.00	0.00
20	Reimbursable Capital Purchases		0.00		0.00
21	**Total Direct Program Expenses**	0.00	0.00	0.00	0.00
22	Administrative Expenses		0.00		0.00
23	**Total Direct and Administrative Expenses**	0.00	0.00	0.00	0.00
24	In-Kind Expenses		0.00		0.00
25	**Total Program Expenses**	0.00	0.00	0.00	0.00

STATE OF TENNESSEE
PROGRAM EXPENSE REPORT

Schedule A-Q1-Q4 | **Page # of # Pages:**

Contractor/Grantee Name: | **Report Period:**

Contracting State Agency:
Program Name: A
Assistance Listing Number/Program Number:
Edison Contract Number:
Grant/Contract Term:

Line Item #	Expense By Object	1 Quarter	2 Quarter	3 Quarter	4 Quarter	Year To Date	Grant Budget Amount (From Contract Agreement)	Over/(Under) Budget Amount
1	Salaries and Wages					0.00		0.00
2	Employee Benefits & Payroll Taxes					0.00		0.00
3	**Total Personnel Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	Professional Fees					0.00		0.00
5	Supplies					0.00		0.00
6	Telecommunication					0.00		0.00
7	Postage and Shipping					0.00		0.00
8	Occupancy					0.00		0.00
9	Equipment Rental and Maintenance					0.00		0.00
10	Printing and Publications					0.00		0.00
11	Travel					0.00		0.00
12	Conferences and Meetings					0.00		0.00
13	Interest					0.00		0.00
14	Insurance					0.00		0.00
15	Grants and Awards					0.00		0.00
16	Specific Assistance to Individuals					0.00		0.00
17	Depreciation					0.00		0.00
18	Other Non-personnel Expenses: (list details in a-d)							0
	a					0.00		0.00
	b					0.00		0.00
	c					0.00		0.00
	d					0.00		0.00
19	**Total Non-personnel Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
20	Reimbursable Capital Purchases					0.00		0.00
21	**Total Direct Program Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
22	Administrative Expenses					0.00		0.00
23	**Total Direct and Administrative Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
24	In-Kind Expenses					0.00		0.00
25	**Total Program Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STATE OF TENNESSEE
NONGRANT/UNALLOWABLE EXPENSE REPORT

Schedule A-1 **Page # of # Pages:**

Contractor/Grantee Name: **Report Period:**

Contracting State Agency:		
Program Name:	A	B
Assistance Listing Number/Program Number:		
Edison Contract Number:		
Grant/Contract Term:		

Line Item #	Expense By Object	Quarter To Date	Year To Date	Quarter To Date	Year To Date
1	Salaries and Wages		0.00		0.00
2	Employee Benefits & Payroll Taxes		0.00		0.00
3	**Total Personnel Expenses**	0.00	0.00	0.00	0.00
4	Professional Fees		0.00		0.00
5	Supplies		0.00		0.00
6	Telecommunication		0.00		0.00
7	Postage and Shipping		0.00		0.00
8	Occupancy		0.00		0.00
9	Equipment Rental and Maintenance		0.00		0.00
10	Printing and Publications		0.00		0.00
11	Travel		0.00		0.00
12	Conferences and Meetings		0.00		0.00
13	Interest		0.00		0.00
14	Insurance		0.00		0.00
15	Grants and Awards		0.00		0.00
16	Specific Assistance to Individuals		0.00		0.00
17	Depreciation		0.00		0.00
18	Other Non-personnel Expenses: (list details in a-d)				
	a		0.00		0.00
	b		0.00		0.00
	c		0.00		0.00
	d		0.00		0.00
19	**Total Non-personnel Expenses**	0.00	0.00	0.00	0.00
20	Reimbursable Capital Purchases		0.00		0.00
21	**Total Direct Nongrant Expenses**	0.00	0.00	0.00	0.00
22	Administrative Expenses		0.00		0.00
23	**Total Direct Nongrant and Administrative Expenses**	0.00	0.00	0.00	0.00
24	In-Kind Expenses		0.00		0.00
25	**Total Nongrant Expenses**	0.00	0.00	0.00	0.00

STATE OF TENNESSEE
NONGRANT/UNALLOWABLE EXPENSE REPORT

Schedule A-1-Q1-Q4 **Page # of # Pages:**

Contractor/Grantee Name: **Report Period:**

Contracting State Agency:
Program Name: A
Assistance Listing Number/Program Number:
Edison Contract Number:
Grant/Contract Term:

Line Item #	Expense By Object	1 Quarter	2 Quarter	3 Quarter	4 Quarter	Year To Date	Grant Budget Amount (From Contract Agreement)	Over/(Under) Budget Amount
1	Salaries and Wages					0.00		0.00
2	Employee Benefits & Payroll Taxes					0.00		0.00
3	**Total Personnel Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	Professional Fees					0.00		0.00
5	Supplies					0.00		0.00
6	Telecommunication					0.00		0.00
7	Postage and Shipping					0.00		0.00
8	Occupancy					0.00		0.00
9	Equipment Rental and Maintenance					0.00		0.00
10	Printing and Publications					0.00		0.00
11	Travel					0.00		0.00
12	Conferences and Meetings					0.00		0.00
13	Interest					0.00		0.00
14	Insurance					0.00		0.00
15	Grants and Awards					0.00		0.00
16	Specific Assistance to Individuals					0.00		0.00
17	Depreciation					0.00		0.00
18	Other Non-personnel Expenses: (list details in a-d)							0.00
	a					0.00		0.00
	b					0.00		0.00
	c					0.00		0.00
	d					0.00		0.00
19	**Total Non-personnel Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
20	Reimbursable Capital Purchases					0.00		0.00
21	**Total Direct Nongrant Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
22	Administrative Expenses					0.00		0.00
23	**Total Direct Nongrant and Administrative Exp**	0.00	0.00	0.00	0.00	0.00	0.00	0.00
24	In-Kind Expenses					0.00		0.00
25	**Total Nongrant Expenses**	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STATE OF TENNESSEE
PROGRAM REVENUE REPORT AND
RECONCILIATION BETWEEN TOTAL PROGRAM AND REIMBURSABLE EXPENSES

Schedule B **Page # of # Pages:**

Contractor/Grantee Name: **Report Period:**

Contracting State Agency:		
Program Name:	A	B
Assistance Listing Number/Program Number:		
Edison Contract Number:		
Grant/Contract Term:		

Line Item #	Sources Of Revenue	Quarter To Date	Year To Date	Quarter To Date	Year To Date
	Reimbursable Program Funds:				
31	Reimbursable Federal Program Funds (Line 23)				
32	Reimbursable State Program Funds (Line 23)				
33	**Total Reimbursable Program Funds (equals line 55)**	0.00	0.00	0.00	0.00
	Matching Revenue Funds:				
34	Other Federal Funds				
35	Other State Funds				
36	Other Government Funds				
37	Cash Contributions (non-government)				
38	In-Kind Contributions (equals line 24)	0.00	0.00	0.00	0.00
39	Program Income				
40	Other Matching Revenue				
41	**Total Matching Revenue Funds (lines 34 - 40)**	0.00	0.00	0.00	0.00
42	Other Program Funds				
43	**Total Revenue (lines 33, 41, & 42)**	0.00	0.00	0.00	0.00
	Reconciliation Between Total and Reimbursable Expenses				
51	Total Program Expenses (line 25)	0.00	0.00	0.00	0.00
52	Subtract Other Unallowable Expenses (contractual)				
53	Subtract Excess Administration Expenses (contractual)				
54	Subtract Matching Expenses (equals line 41)	0.00	0.00	0.00	0.00
55	Reimbursable Expenses (line 51 minus lines 52,53,54)	0.00	0.00	0.00	0.00
56	Total Reimbursement To Date				
57	Difference (line 55 minus line 56)	0.00	0.00	0.00	0.00
58	Advances				
59	This reimbursement (line 57 minus line 58)	0.00	0.00	0.00	0.00

STATE OF TENNESSEE
NONGRANT/UNALLOWABLE REVENUE REPORT AND
RECONCILIATION BETWEEN TOTAL AND REIMBURSABLE EXPENSES

Schedule B-1 **Page # of # Pages:**

Contractor/Grantee Name: **Report Period:**

	A	B
Contracting State Agency:		
Program Name:		
Assistance Listing Number/Program Number:		
Edison Contract Number:		
Grant/Contract Term:		

Line Item #	Sources Of Revenue	A Quarter To Date	A Year To Date	B Quarter To Date	B Year To Date
	Reimbursable Nongrant Funds:				
31	Reimbursable Federal Program Funds (Line 23)				
32	Reimbursable State Program Funds (Line 23)				
33	**Total Reimbursable Nongrant Funds (equals line 55)**	0.00	0.00	0.00	0.00
	Matching Revenue Funds:				
34	Other Federal Funds				
35	Other State Funds				
36	Other Government Funds				
37	Cash Contributions (non-government)				
38	In-Kind Contributions (equals line 24)	0.00	0.00	0.00	0.00
39	Program Income				
40	Other Matching Revenue				
41	**Total Matching Revenue Funds (lines 34 - 40)**	0.00	0.00	0.00	0.00
42	Other Program Funds				
43	**Total Revenue (lines 33, 41, & 42)**	0.00	0.00	0.00	0.00
	Reconciliation Between Total and Reimbursable Expenses				
51	Total Nongrant Expenses (line 25)	0.00	0.00	0.00	0.00
52	Subtract Other Unallowable Expenses (contractual)				
53	Subtract Excess Administration Expenses (contractual)				
54	Subtract Matching Expenses (equals line 41)	0.00	0.00	0.00	0.00
55	Reimbursable Expenses (line 51 minus lines 52,53,54)	0.00	0.00	0.00	0.00
56	Total Reimbursement To Date				
57	Difference (line 55 minus line 56)	0.00	0.00	0.00	0.00
58	Advances				
59	This reimbursement (line 57 minus line 58)	0.00	0.00	0.00	0.00

STATE OF TENNESSEE
TOTAL EXPENSE SUMMARY REPORT

Schedule C

Page # of # Pages:

Contractor/Grantee Name:

Report Period:

Line Item #	Expense By Object	Total Direct Program Expenses Year To Date	Total Nongrant/Unallowable Expenses Year To Date	Total Administrative Expenses Year To Date	Grand Total Year To Date
1	Salaries and Wages	0.00			0.00
2	Employee Benefits & Payroll Taxes	0.00			0.00
3	**Total Personnel Expenses**	0.00	0.00	0.00	0.00
4	Professional Fees	0.00			0.00
5	Supplies	0.00			0.00
6	Telecommunication	0.00			0.00
7	Postage and Shipping	0.00			0.00
8	Occupancy	0.00			0.00
9	Equipment Rental and Maintenance	0.00			0.00
10	Printing and Publications	0.00			0.00
11	Travel	0.00			0.00
12	Conferences and Meetings	0.00			0.00
13	Interest	0.00			0.00
14	Insurance	0.00			0.00
15	Grants and Awards	0.00			0.00
16	Specific Assistance to Individuals	0.00			0.00
17	Depreciation	0.00			0.00
18	Other Non-personnel Expenses: (list details in a-d)				
	a	0.00			0.00
	b	0.00			0.00
	c	0.00			0.00
	d	0.00			0.00
19	**Total Non-personnel Expenses**	0.00	0.00	0.00	0.00
20	Reimbursable Capital Purchases	0.00			0.00
21	**Total Direct Program Expenses**	0.00	0.00	0.00	0.00
22	Administrative Expenses	0.00			0.00
23	**Total Direct and Administrative Expenses**	0.00	0.00	0.00	0.00
24	In-Kind Expenses	0.00			0.00
25	**Total Expenses**	0.00	0.00	0.00	0.00

Annual (Final) Report*

1. **Grantee Name: Organization Name**
2. **Grant Contract Edison Number: XXXXX**
3. **Grant Term: April 2026 – March 2027**
4. **Grant Amount: $XXXXXX.00**
5. **Agency Services Overview – The agency provides a range of essential services to support our community. Below is a summary of each service offered, including the number of clients served, the total service units provided, and the corresponding financial investment:**
   - **[Service Name}**
     - **Clients served: [Number]**
     - **Service Units Provided: [Number]**
     - **Total Dollar Amount: $[Amount]**
   - **[Service Name}**
     - **Clients served: [Number]**
     - **Service Units Provided: [Number]**
     - **Total Dollar Amount: $[Amount]**
   - This data highlights our commitment to delivering impactful services while maintaining financial accountability.
6. **Narrative Performance Details:** *(Description of program goals, outcomes, successes and setbacks, benchmarks or indicators used to determine progress, any activities that were not completed)*

Program Goals

Outcomes

- Linkage to care
- Retention
  -
- Viral Suppression
  -
- Gaps in Care
  -
- Visit Frequency
  -

Successes and Setbacks

Organization Name had a successful year, which was highlighted by our ability to provide new opportunities for patients to initiate care and remain in care. This was achieved through increased communication enhancements, such as texting clients about appointments, sending automatic calendar reminders about appointments, and towards the end of the year utilizing telehealth services. Our care services better utilized technology, as we understand more of our clients do have mobile phones and are more engaged with their peers via their use of the mobile phones for all communication (via telephone, email, social medial, text, etc). By utilizing this technology we have created greater ability to remain connected to patients regarding reminders for appointments, and being able to meet with clients wherever they are located. Throughout the course of the grant year, leaders of our program made

commitments to seek and develop ways to maximize resources for the purpose of enhancing patient care. This led the agency to commit to developing telehealth through technology enhancements and declaring the Population Health Practice Administrator as the Telehealth Champion. As COVID 19 became a primary motivator, the agency was able to rapidly expand our telehealth services in order to ensure clients remain in care, and have ready access to providers and case managers, even if it was not possible for the client to visit our offices. Essentially, via telehealth and improved utilization of technology, Organization Name, has created more access and support in real time for our clients. In turn, this has expanded trusting relationships between providers and clients, and led to improved interest in receiving care for our clients, including adherence to ART and medical services; and for the providers to better understand barriers and issues for clients that prevent access to care.

Organization Name did not meet our program goal for "Gaps in Care", as we missed our target by 10 percent. This was likely due to the following:

1. Change in staff at the end of 2019, led to the need for new staff to be trained and catch-up on various client issues;
2. Once COVID-19 cases/infections increased, our office and health services closed for part of March, this led to some clients not having access to Care (in-person) in March.
3. Although Organization Name is experiencing increases in viral suppression and retention in-care among all clients, there are still a number of clients that are hard-to-reach, uninterested in care, and/or have significant barriers to seeking care. Our organization will have to think more creatively on how to expand outreach to these clients, and working to meet their needs at a specific/detailed level. Until this is achieved, it will be difficult to further reduce Gaps in Care.

Benchmarks or Indicators Used to Determine Progress
Ryan White and HRSA performance metrics were used for indication of progress made toward outcomes

Activities not Completed
-

Submit one copy to:

RW Fiscal: RW.Invoices@tn.gov
RW Program Director: phadre.johnson@tn.gov
RW Program Assistant Director: maria.sutton@tn.gov
TN Finance & Administration: fa.audit@tn.gov

ATTACHMENT 7

Ryan White Part B Program

Standards of Care

Ryan White Part B Program
Andrew Johnson Tower, 4th Floor
710 James Robertson Parkway
Nashville, TN 37243

TN Department of Health

REVISIONS

This document may be revised or updated periodically. The table below will show the history of such revisions. Prior versions of this document are not to be used. All revisions are conducted by the Standards of Care Committee and approved by the Ryan White Part B Director.

Revised Section	Revision Description	Released	Page
Non-Medical Case Manager Section	Changed the Staff Requirement, see Case Manager Manual	1-Jan-22	Page 48
Medical Transportation	Added Rideshare as a Resource	1-Jan-22	Page 41
Emergency Financial Assistance (EFA)	- Added Gas/Propane to the List of Authorized Utilities; - Removed the 21 Weeks of Support Limitation per year for EFA support.	1-Jan-22	Page 23
Notes	Added Note 7 – Clarifying that Ryan White Part B (RWPB) is the payor of last resort	1-Jan-22	Page 70
Outpatient/Ambulatory Care	- Updated Hepatitis B testing guidelines; - Removed the "Toxoplasmosis serology test" as a required test during Intake and screening. - Added Covid-19 screening and vaccination	1-Jan 22	Page 54
Oral Health Care	New Program Guidance	1-Jan-22	Page 51

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Universal Standards of Care

These standards are to be used as minimum requirements for all subcontractors of the Ryan White Part B. The Ryan White Part B Grantee and/or staff of the Lead Agency will review agency documentation to ensure that these standards are being met.

HIV/AIDS Bureau, Division of metropolitan HIV/AIDS Programs & Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal Program Requirements can be found at the below link: *https://hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf*

Section 1: General
1. Every client is treated with respect, dignity, and compassion. 2. Promote client autonomy and informed participation in care. 3. Subcontractors/providers demonstrate a willingness to provide services to all affected communities. 4. Subcontractors/providers demonstrate cultural sensitivity, must have a written plan for providing language translation services, and assistance for clients who are visually or hearing impaired, when necessary. 5. Subcontractors/Providers coordinate services with collateral care providers to ensure efficient service delivery and optimal client services and avoid duplication of services, as appropriate. 6. Involve the client's caregivers, as appropriate and with client consent, in supporting client's optimal well-being. 7. Within existing resources, ensure that services are available and accessible to all individuals in need of and eligible for services. 8. Provider is licensed and accredited by appropriate local, state and/or federal agencies if applicable. 9. Offer services in a safe, timely, reliable, and cost-efficient manner. 10. Maintain a file documenting activity for the promotion of HIV services to low-income individuals.
Section 2: Confidentiality

1. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable local, state and federal law.
2. Subcontractor/provider has in place a policy addressing client confidentiality. Clients are informed of this policy and confirm their understanding of the policy.
3. Subcontractor/provider will have a system of safeguarding client information (written, verbal, electronic).
4. The provider shall have an "Authorization for the Release of Confidential Information" form, signed by the client prior to the release of any information about the client, as required by state and federal laws including but not limited to the Health Insurance Portability and Accountability Act.

*The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule addresses the use and disclosure of individuals' health information - called "protected health information" by organizations subject to the Privacy Rule – called "covered entities." The rule also ensures that individuals understand and control how their health information is used. *

Section 3: Client Rights and Responsibilities

1. The subcontractor/provider shall inform all clients of their rights, obligations, and realistic expectations of service.
2. No client shall be discriminated against with regard to race, color, religion, age, gender, gender identity, marital status, political affiliation, national origin, sexual orientation, or disability.
3. The subcontractor/provider shall have a formal complaint procedure. Clients are informed of this policy and confirm their understanding of the policy. The policy must be posted in a public area.
4. The subcontractor/provider has written policy and procedures to ensure that any incidents of abuse, neglect, or exploitation of clients by a subcontractor/provider are reported to the proper authorities.
5. Each agency will have a policy that protects the rights and outlines the responsibilities of the clients and the agency.
6. All clients have the right to be treated respectfully by staff, and the client's decisions and needs should drive services.

7. Agencies must develop a written Client Rights and Responsibilities Statement that is reviewed with each client, signed by the client, maintained in the client's record and a copy provided to the client during the intake or assessment process annually.
8. The Client Rights and Responsibilities should be posted in an area accessible to the public.

Section 4: Client Input

1. A client survey must be conducted on a yearly basis, including a measure of satisfaction.
2. An ongoing mechanism for client input must be maintained (e.g., suggestion box).
3. Subcontractors/providers must ensure input from consumers (and, as appropriate, caregivers) in service design and delivery through a mechanism chosen by the agency.
4. There must be evidence that the results of customer input, if applicable, has been incorporated into the subcontractor/provider's plans and objectives.
5. The subcontractor/agency will have a procedure for internal review and evaluation of Continuous Quality Improvement processes.

Section 5: Client Education

The subcontractor/provider shall have an agency plan for each funded service for conducting client education, including:

1. Education on HIV disease
   Ryan White Services
2. HIV transmission and Prevention Services
3. The role and importance of HIV and primary medical care (including assessment of whether the person has seen their HIV medical doctor according to the latest guidelines established by the Public Health Service and/or Health Resources & Services Administration/HIV/AIDS Bureau (HRSA/HAB))
4. Medications (including assessment of medication adherence) and oral health
5. Ensure all providers are educated regarding RW, Prevention, and PrEP services.

Section 6: Culturally Appropriate Services

1. Provider services should allow access to care (services, information, materials) in a manner that factors in the language needs, health literacy, culture and diversity of the populations served
2. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
4. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
5. Approved language line or certified/trained staff personnel must provide language assistance
6. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. *

** Standards are from National Standards for Culturally and Linguistically Appropriate Services (CLAS)*

Section 7: Eligibility

Ryan White Part B Eligibility

1. Providers must document that clients receiving services are eligible for Ryan White Part B:
   - Have a diagnosis of HIV/AIDS
   - Have a household income, which does not exceed the percentage of the Federal Poverty Level as determined by the Ryan White Part B program
   - Is a resident of Tennessee
2. There must be documentation that clients have been properly screened for other service resources as appropriate to verify that Ryan White is payer of last resort, e.g., 3rd Party Insurance, Food Stamps, etc.
3. There must be a written policy to ensure veterans receiving Veterans Administration (VA) health benefits are classified as uninsured exempting them from the payer of last resort requirement. This includes being eligible for prescription drugs.
4. Documentation of Ryan White eligibility complies with TDH requirements

and must be updated every six months.

5. When presenting for services, client will be informed of the eligibility requirements for services, either in writing or verbally, in a manner that he or she is able to understand.
6. Services are made available to any individual who meets program eligibility requirements subject to the availability of funding. Clients cannot be denied services due to pre-existing conditions.
7. If applicable, reason for program ineligibility must be documented in the client's record.
8. Service providers/agencies must have written eligibility policy/standards, consistent with the eligibility requirements of the funding source(s) in the service area.
9. Affected individuals (people not identified with HIV) may be eligible for services in limited situations, but these services for affected individuals must always benefit people living with HIV. Services may be provided to individuals affected with HIV only in the circumstances described below.
    - The service has as its primary purpose enabling the affected individual to participate in the care of someone with HIV or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for someone who is living with HIV.
    - The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care.
    - The service promotes family stability for coping with the unique challenges posed by HIV.
    - Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member.
10. Where applicable, additional eligibility for each specific service must be complied with beyond Universal Standards.

Note: In instances where the person served is a person affected by HIV, such as caregivers, partners, family and friends, verification of HIV status of the infected person is required when available.

Section 8: Intake and Screening

1. Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.
2. Additional Ryan White Part B Elements required:
   - Date of intake
   - Ryan White demographic and statistical information as defined by the Part B Program
   - HIV /AIDS diagnosis and if appropriate, other medical diagnosis
   - Insurance Information
   - Method of payment for services
   - Client or guardian signature of authorization*

Section 9: Assessment

After each client is determined eligible for the service, individual client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

- Identifying client's goals, strengths, and challenges
- Psychosocial
- Medical History/Physical Health
- Financial Resources
- Services Needs
- Religious
- Educational
- Social functioning

Section 10: Plan of Care

1. A written Plan of Care must be developed prior to service delivery and with the participation and agreement of the client or guardian. The purpose of the plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and attainable.
   - Basing plan of care on meaningful assessments and shall have specific, attainable, measurable objectives.

2. Additional elements required:
   - Where applicable, document coordination and follow up of medical treatment.
   - A client may disagree with the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons, and client signature.

Section 11: Monitoring

1. Monitoring is an ongoing process related to the assessment and planning sections above. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.
2. Additional Part B elements required:
   - The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided
   - Monitored information must be documented to aid in the client re-assessment (If applicable, provide the rationale(s) for client non-compliance in the plan.)

Section 12: Re-Assessment

Re-assessment is an on-going process that may occur throughout the process of receiving services. Every six months, the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for services and review/update of the plan of care. The purpose of the re-assessment is to address the issues noted during the monitoring phase.

Section 13: Discharge (Termination of services)

1. The objective of discharge is to ensure a smooth and systematic transition for:
   - a client no longer needing services
   - a client assessed as ineligible for the service
   - to assist provider agencies to monitor caseloads more easily.

The process includes a discharge or case closure summary in the client's record. The discharge/case closure documentation will include a reason for discharge and a transition plan to other services or other provider services is applicable. Discharge may be initiated by the client or service staff.

2. Essential elements include:
   - Conditions which result in a client's discharge/termination from services may include:
     - Attainment of goals.
     - Non-compliance with stipulations of written plan.

- Change in status which results in program ineligibility.
- Client desire to terminate services.
- If a client's actions put agency personnel or others at risk.

- Client has the right to an appeal process when services are terminated as per the agency's written Grievance Policy.
- Client must be provided information regarding transfer to an outside agency.

Section 14: Record Keeping (Documentation)

1. Providers must collect client level data per HRSA Ryan White Services Report (RSR) reporting requirements.
2. Client records must be maintained in an orderly manner. The purpose of this requirement is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.
   - Documentation shall be recorded on paper or electronically
   - Documentation shall be prepared, completed, secured, maintained, and disclosed in accordance with regulatory, legislative, statutory, and organizational requirements.
   - **In accordance with TDH policy, records should be kept for five years or in accordance with agency policy if it is longer than five years.**

Section 15: Client Complaint & Grievance

1. The subcontractor/provider must have a formal complaint and grievance procedure. Clients are informed of policy and procedures during initial intake, reviewed periodically as needed, and shall confirm their understanding of the policy.
2. The grievance procedure must include:
   - Staff responsible
   - Required documentation
   - Review process
   - Time frames
   - Maintenance of confidentiality
   - Process for advising consumer and staff of outcome
   - Appeals process
3. Provider complaint and grievance policy must be posted in publicly accessible areas.

Section 16: Staff Requirements

1. Staff receives annual training and is knowledgeable regarding HIV/AIDS and the affected community, see **Case Management Manual** for list of trainings.
2. Staff members have a clear understanding of their job description and responsibilities.
3. The staff shall be appropriately certified or licensed as required by the state or local government for the provision of services and shall abide by ethical standards as outlined by their respective professional associations.
4. There are written personnel and agency policies, including a formal complaint procedure for staff.
5. A job performance evaluation is conducted annually for each Ryan White Part B funded position.
6. Agency must document that staff have required education and experience to perform their respective job duties.

Section 17: Referral

1. Subcontractors/providers demonstrate comprehensive knowledge of the community resource network of related health and social services organizations to ensure referrals to a wide-base of HIV-related services.
2. A current list of provider agencies that provide services by referral is maintained and updated.
3. Subcontractors/providers make appropriate referrals to collateral services when clients have additional service needs beyond the scope of Part B services.
4. Provision of all Ryan White Part B funded services and referrals are documented.
5. A client must be informed of service provider options and given an opportunity to choose providers within funded providers.

Section 18: Operations and Facilities

1. Subcontractor/provider demonstrates compliance with physical and programmatic accessibility requirements designated by the Americans with Disabilities Act (ADA).
2. Facility meets the applicable Occupational Safety and Health Administration (OSHA) requirements.
3. Service delivery hours should accommodate target populations and the facility must be accessible by public transportation or provide for transportation assistance and have procedures in place for after hours and/or emergencies.

4. The facility must develop written client material that describes available services and eligibility requirements.
5. The subcontractor/provider shall maintain a safe environment for provision of services. This shall include adopting a written policy about the agency's right to refuse services to clients who:
   - Threaten physical abuse to staff or other clients
   - Are being verbally or physically abusive of /to staff or other clients
   - Engage in sexual harassment of staff or other clients
   - Possess illegal substances or weapons while accessing services

Section 19: Quality Management

Providers must develop a quality management/improvement plan in accordance with Part B requirements, including a procedure for internal review and evaluation.

STANDARDS OF CARE

Overview:
The Standards of Care are developed by the Standards of Care (SOC) Committee which is comprised of members from each* Part B regional consortia/planning group area. These standards are to be used as minimum requirements for all subcontractors of the Ryan White Part B Program. The Ryan White Part B Grantee and/or staff of the Lead Agency monitor agencies to ensure that these standards are being met.

Purpose of SOC:
To set minimum standards for provision of care for persons receiving Ryan White services. These standards are set as the key activities for each service that when followed, provide quality services. Quality services support a person's ability to engage and adhere to HIV medical treatment protocols and address social barriers that impede a person's ability to adhere to care.

Standards beyond the minimal are critical to excellent care and are contained in professional standards of care, generally accepted principles of health care provision, research-based practices of care, etc. It is expected that Ryan White Part B providers are familiar with these standards and incorporate them into their practice.

***Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds Policy Clarification Notice #16-02 (Revised December 2016)**
https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Relationship to Monitoring and Technical Assistance:
Providers will be monitored for compliance with these standards. A "monitoring tool" will be used by the Grantee and/or Lead Agency to carry out the monitoring; this tool will reflect the elements of these Standards of Care. After monitoring is completed, if significant non-compliance with standards OR professional standards of care are noted, the provider will be offered training and/or technical assistance and complete a corrective action plan.

*Note on Units of Service: Units of service are set by the Grantee office, not the Standards of Care. *

***HIV/AIDS Bureau, Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part B Grantees: Program – Part B**
https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf

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AIDS Drug Assistance Program (ADAP)

HRSA Definition: The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide Food and Drug Administration (FDA) -approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. ADAP recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate. Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge/Termination: N/A
Documentation: Universal Standards apply. ***Additionally:*** Medication formulary must include pharmaceutical agents from all the classes approved in HHS Clinical Practice Guidelines for use of Antiretroviral Agents in HIV-1 infected adults and adolescents and meets the minimum requirements from all approved classes of medications according to HHS treatment guidelines.
Staff Requirements: Universal Standards apply.

Early Intervention Services (EIS)

HRSA Definition: Early intervention services (EIS) includes counseling individuals with respect to HIV/AIDS; referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. HIV education, including risk prevention and adherence counseling are a part of every patient encounter. EIS:

1. Assists clients with linkage to and follow-up on participation in out-patient HIV medical care (primary focus); In order to address barriers to care, assists clients in linkage to and follow up on participation in other Ryan White core medical services (e.g., oral health, home health, hospice, ADAP, other prescription assistance, insurance assistance, mental health, substance abuse, medical case management and nutritional counseling), other Ryan White support services; and other non-Ryan White community services;
2. Develops formal relationships with "Points of Entry" and informal relationships with other community "contacts" who are engaged in the provision of HIV testing. Points of Entry are those entities that have identified at least three (3) HIV+ cases in the last year and entities with a significant number of persons who have dropped out of HIV medical care as determined by the Part B Grantee.
3. Emphasizes patient "engagement" in HIV medical care, with a focus on reducing barriers to engaging in care and service. EIS is a transition service that connects persons to Medical Case Management services. EIS is located in HIV medical settings or in community settings where formal linkages with these HIV medical settings exist. Treatment engagement includes but is not limited to the following activities:
    - Determines current status of linkage to medical care in general and HIV medical care, including determining readiness for engaging in care;
    - Teach and support self-management and health literacy;
    - Educate and/or reinforce the importance of consistently maintaining HIV medical care; and
    - Education with regard to HIV prevention, transmission, safer sex, risk factors and risk behavior management.

Part B requirement: EIS services must include the following four components:

1. Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV- infected recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
   HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
2. Referral services to improve HIV care and treatment services at key points of entry.
3. Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care.
4. Outreach Services and Health Education/Risk Reduction related to HIV Diagnosis
5. At this time testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures) is not covered under EIS as the State has adequate testing resources.

STANDARD
Eligibility: Universal Standards apply. Additionally: 1. Must follow TDH requirements regarding Ryan White service eligibility process. 2. The agency must check the TDH Eligibility Database to ensure that the client does not currently have an existing Ryan White CM or MCM (Ryan White requires one primary case manager per client.) 3. EIS services are specifically designed to be provided to: • HIV+ persons who have been "lost to care" (out of HIV outpatient medical care for one year or greater); or • HIV+ persons who have been out of HIV medical care for at least six (6) months with documented clinical risk factors of high viral load, low T-cell count, acute opportunistic infection, co-morbidity of acute/chronic illness that impact HIV health or persistent psychosocial circumstances; or

• Person Living with HIV/AIDS (PLWHA) who are in medical care, but have identified issues that adversely impact retention in care; or • HIV+ women who are pregnant; or • HIV+ persons or are currently scheduled to be released from incarceration and will be released within 180 days and have documented significant clinical issues that negatively impact ability to engage in HIV medical care: or • HIV+ persons who are newly diagnosed
Intake and Universal Standards apply.
Assessment: Universal Standards apply. ***Additionally:*** In each area there is focus on identifying the specific barriers the client/patient has or may experience in accessing medical care, remaining in care and/or adhering to medical treatments.
Plan of Care: Universal Standards apply. ***Additionally:*** A written plan of care must be developed with the participation and agreement of the client or guardian.
Monitoring: Universal Standards apply. ***Additionally:*** The needs and status of the client will be reassessed every 6 months in a face-to-face encounter. A phone call follow up is required at least quarterly.
Reassessment: Universal Standards apply. ***Additionally:*** Each client must be reassessed every 6 months minimally or as the need arises.
Discharge/Termination: Universal Standards apply.
Documentation: Universal Standards apply. ***Additionally:*** Category under which client qualifies for EIS (e.g., lost to care) must be documented. Documentation is required for: 1. Referrals for health care and supportive services; 2. Referrals from key points of entry;

3. Linkage to care;
4. Training sessions to help clients understand and navigate HIV system of care.

Staff Requirements: Universal Standards apply.

Additionally:

1. Minimum Education/Experience requirements:
   All EIS Specialists hired by subcontractor/provider agencies that are funded in whole or part to provide EIS services with Ryan White Part B funds must possess at a minimum a high school (HS) diploma or General Education Diploma (GED).
2. Supervision:
   - Supervision of EIS Services must be provided by an MSW to ensure that both medical and psychosocial clinical processes are appropriately addressed.
   - MSW Supervisor - Supervisor will demonstrate efforts to ensure quality management of care through consultation and/or training of staff. Supervision will address issues of client care (e.g., boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g., record keeping. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.
3. Training: EIS specialists and their supervisors must have opportunities to participate in relevant annual training for at least five hours per year.

**In some case a waiver may be obtained, please see Notes at the end of this document.*

Additional Requirements:

1. Establish Memoranda of Understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive.
2. Document provision of all four required EIS service components, with Part B or other funding.
3. Document the number of referrals for health care and supportive services.
4. Document referrals from key points of entry to EIS programs.
5. Document training and education sessions designed to help individuals navigate and understand the HIV system of care.

6. Establish linkage agreements with testing sites where Part B is not funding testing but is funding referral and access to care, education, and system navigation services.
7. Obtain written approval from the grantee to provide EIS services in points of entry not included in original scope of work.
8. Health education and literacy training is provided that enables clients to navigate the HIV system.
9. EIS is provided at or in coordination with documented key points of entry.
10. EIS services are coordinated with HIV prevention efforts and programs.

Emergency Financial Assistance (EFA)

HRSA Definition: Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Part B requirement: This service includes the provision of short-term emergency financial assistance to clients with HIV/AIDS for utilities (gas, electricity, water and sewer, Gas/Propane Tank). Short term emergency financial assistance is defined as necessary for the client to a) gain or maintain access to medical care, adherence to medical care/treatments and/or wellness and b) address financial need that arises from high and/or unexpected medical costs.

STANDARD
Eligibility: Universal Standards apply. Additionally: 1. The client's name must be on the bill and/or account. 2. Total amount of assistance for any one client will be based on clinical need, financial status, and eligibility for other public benefit programs and is limited to a $500 dollar amount cap.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge/Termination: N/A
Documentation: Universal Standards apply. ***Additionally:*** A record of services documenting service recipients' eligibility and need for EFA, specific utility paid for and cost must be maintained.
Staff Requirements: Universal Standards apply.
Additional Requirements:

1. The payment must be made directly to vendors based on need and actual bill.
2. Demonstrate coordination with other area emergency financial assistance resources to avoid duplication of services.
3. Direct cash payments to clients are prohibited and the client's name must be on the bill and/or account. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

Food Bank/Home Delivered Meals

HRSA Definition: Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following: personal hygiene products, household cleaning supplies, and water filtration/purification systems in communities where issues of water safety exist.

Part B requirement: Food Bank/Home Delivered Meals is to provide the nutrition and personal hygiene items to enhance a person's health status. Services fund the provision of:

- **Food Bank**. A food bank is a central distribution center within an agency's catchment area or home delivery providing groceries for indigent clients with HIV/AIDS and their families.
- **Food Vouchers**. This service provides certificates or cards, which may be exchanged for food a cooperating supermarket, or meals at clinics or social service agencies.
- **Home Delivered Meals**. This service provides nutritionally balanced home delivered meals for clients with HIV/AIDS who are indigent, disabled, or homebound, and/or who cannot shop for or prepare (or have others to shop and prepare) their own food. This includes the provision of frozen and hot meals.
- **Non-Food Products**. This service provides reimbursement for the cost of non-food products, such as personal hygiene products, to be provided to eligible individuals through food and commodity distribution programs. Ryan White Part B funds may not be used for household appliances, household products, car care products, pet foods or products, or baby care items (e.g., diapers, formula, layette items, etc.), or for the purchase of clothing. Personal care kits must be provided from the agency's central distribution center.

STANDARD
Eligibility: Universal Standards apply.

Additionally: 1. Providers must document that those clients receiving services have been properly screened and/or referred for other community resources as appropriate by the primary case manager.
Intake and Screening: Universal Standards apply. ***Additionally:*** Completed by Case Managers
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply. ***Additionally:*** A record of services provided documenting service recipients; eligibility and need for food and specific service and amount provided must be maintained.
Staff Requirements: Universal Standards apply.
Additional Requirements: 1. Direct cash payments to clients are prohibited. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable. 2. Facilitate or arrange at least quarterly nutrition education for recipients to increase nutrition/food management and preparation skills. 3. **Food Bank:** The provision of this service will be limited to $30 worth of groceries per week. Households with more than one client with HIV/AIDS will be entitled to $30 per adult member with HIV/AIDS. Families with minors (under the age of 18) will be entitled to provisions based on family size. Providers must specify criteria processes and procedures utilized to determine allotment provided for dependents, which should take into account factors such as age, special nutritional needs, etc. Providers must

demonstrate their capacity to provide foods suited to special client needs.

4. **Food Vouchers:** Provision of food vouchers for any one client is limited to $30 per week, $100 per month, and $500 per year. Clients with HIV/AIDS with dependent children (under 18 years of age) are eligible for an additional $25 per month in food vouchers for each dependent child, up to an additional $500 per year for a household/family with dependent children.
5. Providers must ensure vouchers are utilized for appropriate purchases and cannot be used for tobacco and/or alcohol products.

6. **Home Delivered Meals:** Providers must demonstrate their capacity to provide nutritious food suited to special client needs. Providers will be required to demonstrate that they will adhere to generally accepted nutritional standards for provision of meals to persons with HIV/AIDS. Providers responsible for the preparation of meals will be required to adhere to state and/or local health department regulations for the preparation of food.
7. **Non-Food Products:** The provision of this service will be limited to $20 per kit twice a year per client. Clients with dependent children (under 18 years of age) are eligible for an additional $15 in kit items.
8. Provider must maintain compliance with all federal, state, and local laws regarding provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certification. (HAB 2013)
9. Any purchase of water filtration system(s) must be pre-approved by the Lead Agency and TDH and provide written justification for need.
10. Funds may not be used to purchase clothing.

Health Insurance Premium & Cost-Sharing Assistance

HRSA Definition: Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part B recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part B recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services.
- RWHAP Part B recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV. Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients.
- Paying cost-sharing on behalf of the client.

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply.

Additionally:

1. Documentation of an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles to lower the costs of having the client in the ADAP program.
2. Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications.
3. Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection.
4. Assurance that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by Ryan White.
5. Ryan White Part B cannot pay for emergency room and inpatient copays and deductibles.

Staff Requirements: Universal Standards apply.

Housing

HRSA Definition: Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services. Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation. Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Part B requirement: Services provided must comply with Ryan White Housing Assistance Program

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. The necessity of housing services for the purposes of gaining or maintain access to HIV medical care and treatment must be documented in writing by a case manager/care manager/medical care manager. 2. A person must be ineligible for or have exhausted Housing Opportunities for People with AIDS (HOPWA) funds in order to be eligible for this service. 3. Unless approved by a supervisor and the Plan of Care documents activities to make housing cost meet the following standard (e.g., new employment, move to more affordable housing), a person's monthly rent must be less than 50% of their gross family/individual income in order to be eligible for this service. If housing costs are more than 50% of their gross income, client must provide documentation of what their income is used to pay.

4. A person must have the legal right to reside in the housing unit 5. Housing environment must be in compliance with all applicable local and state housing codes and must meet HUD's habitability standards (24 CFR 574.310(b)(2)).
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply. ***Additionally:*** The assessment must include: 1. Emergency rental assistance needs; 2. Evaluation and documentation of the client's contribution, financial and otherwise, toward addressing and solving his/her housing problems; 3. Other factors that may qualify or disqualify the client from certain types of housing programs and services.
Plan of Care: Universal Standards apply. ***Additionally:*** Must include a housing component, that includes: 1. a strategy to ensure progress towards long-term stable housing and moving from assistance to self-sufficiency, including a strategy for identifying a funding source for long term housing. 2. ensures that consumers are receiving assistance to help develop skills that will enable them to attain and maintain permanent housing (e.g., budget management); 3. identifies strategies to avoid a housing emergency or crisis from developing in the future.
Monitoring: Universal Standards apply.
Reassessment: Universal Standards apply.
Discharge: Universal Standards apply.
Documentation: Universal Standards apply. ***Additionally:*** 1. Documentation of current rent and lease agreement. 2. A record of services provided documenting service recipients, eligibility, amount, and duration of payment must be maintained. 3. Documentation of client's utilization of Ryan White funding (Part A & B) for housing services must be maintained in order to comply with HRSA's recommendation regarding the limit of twenty-four (24) months

cumulative lifetime period of eligibility. Therefore, providers must comply with the requirements specified by the funding source.

Staff Requirements: Must comply with staff requirements specified in Part B Case Management/ Medical Case Management Standards of Care. Staff must also possess knowledge of local, state, and federal housing programs and how to access these programs.

Additional Requirements:

1. Must demonstrate coordination with other area emergency financial assistance and housing provider programs in order to avoid duplication of services.
2. Must ensure that case managers maintain current information about other housing resources in the area including but not limited to HOPWA housing.
3. Must ensure that staff is knowledgeable about the role of housing and case management interventions in improving HIV health care outcomes.
4. Direct cash payments to clients or family members are prohibited and funds cannot be used for mortgage payments. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
5. No person can receive more than a lifetime twenty-four (24) cumulative months of housing service from Ryan White funds.

Linguistic Services

HRSA Definition: Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

Part B requirement: Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

STANDARD
Eligibility: Universal Standards apply
Intake and Screening: Universal Standards apply
Assessment: Universal Standards apply
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply. ***Additionally:*** 1. A record of services provided documenting Linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of Ryan White-eligible services in both group and individual settings. 2. Document the provision of linguistic services, including: • Number and types of providers requesting and receiving services. • Number of assignments. • Languages involved and types of services provided – oral interpretation or written translation. Whether interpretation is for an individual client or a group.
Staff Requirements: Universal Standards apply.

Additionally: Services are provided by appropriately trained and qualified individuals holding appropriate State or local certification.

Medical Case Management (MCM)

HRSA Definition: Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized Plan of Care
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the Plan of Care
- Re-evaluation of the Plan of Care at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
  In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Part B requirement: All MCM positions must follow and use the TDH CM Manual and the TDH Eligibility Database

STANDARD
Eligibility: Universal Standards apply. ***Additionally:***

1. Must follow TDH requirements regarding Ryan White Part B service eligibility process. See TDH CM manual, Section 1, for more details.
2. The agency must check the TDH Eligibility Database to ensure that the client does not currently have an existing Ryan White CM or MCM (Ryan White requires one case manager per client.)

Intake and Screening: Universal Standards apply.

Additionally:

1. Client must participate in initial intake and screening procedures.
2. See TDH CM Manual, Section 1, for more details.

Assessment: Universal Standards apply.

Additionally:
In each area, the Case Manager is focused to identifying the specific barriers the client has or may experience in accessing medical care, remaining in care and/or adhering to medical treatments.

Plan of Care: Universal Standards apply.

Monitoring: Universal Standards apply.

Additionally: The needs and status of the client receiving Case Management will be reassessed every 6 months.

Reassessment: Universal Standards apply.

Discharge/Termination: Universal Standards apply.

Additionally: See the TDH CM Manual for more specific information.

Documentation: Universal Standards apply.

Additionally:

1. There must be documentation that all the following activities are being carried out for all clients:
   - Initial assessment of service needs.
   - Development of a comprehensive, individualized plan of care.
   - Coordination of services required to implement the plan.
   - Continuous client monitoring to assess the efficacy of the plan.
   - Periodic re-evaluation and adaptation of the plan at least every 6 months, during the enrollment of the client.

2. Client records must include:
   - Types of services provided.
   - Types of encounters/communication.
   - Duration and frequency of the encounters.
3. Documentation in client records of services provided, such as:
   - Client-centered services that link clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible.
   - Coordination and follow up of medical treatments.
   - Ongoing assessment of client's and other key family members' needs and personal support systems.
   - Treatment adherence counseling.
   - Client-specific advocacy.

See the TDH CM Manual (Core duties) for additional information.

Staff Requirements: Universal Standards apply.

Additionally: TDH CM Manual outlines education and experience guidelines for the position of Medical Case Management. These are minimum standards, each agency contracted to provide HIV/AIDS Medical Case Management Services has the authority to adopt the minimum standards or develop more stringent standards.

See TDH CM Manual for specific minimum educational/experience requirements for MCM positions.

1. Minimum educational/experience requirements: See TDH CM Manual
2. Supervision: See TDH CM Manual
3. Training: See TDH CM Manual

**In some cases, a waiver may be obtained, please see the TDH CM Manual for more details.*

Medical Nutrition Therapy

HRSA Definition: Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation*
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Part B requirement: TDH funds cannot be used for nutritional supplements such as vitamins or weight loss. Supplemental meals such as Boost and Ensure are allowed. Medical Nutrition Therapy (MNT) is defined as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a Registered Dietitian or nutritional professional. ** MNT is a specific application of the Nutrition Care Process (developed by the American Dietetic Association, currently known as Academy of Nutrition and Dietetics***) in clinical settings that are focused on the management of diseases. MNT involves in-depth and individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease. All services performed under this service category must be pursuant to a medical provider's referral and based on a nutrition plan developed by the registered dietitian or other licensed nutrition professional.

** TDH funds cannot be used for nutritional supplements*
***Medicare MNT legislation, 2000.*
**** Academy of Nutrition and Dietetics, eatright.org*

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply. ***Additionally:*** Clients will have a comprehensive assessment by a qualified licensed/registered dietician upon agency referral**.** Clients will have a

comprehensive assessment by a qualified licensed/registered dietician that is to be completed within the first 2-3 primary care visits with the primary care provider. The initial assessment shall include, but is not limited to:

1. Chief complaint.
2. Past medical and surgical history with detailed HIV/AIDS history.
3. Family and social history including substance abuse and mental health history.
4. Weight status (changes and comparisons to national standards).
5. Food and drug allergies.
6. Food restrictions, including religious-based.
7. Diet history and current nutritional status, including current intake.
8. Nutrition-related knowledge and practices.
9. Nutritional concerns.
10. Current medications and relevant laboratory data.

Plan of Care: Universal standards apply.

Additionally:

1. Staff must follow guidelines in the Nutrition Care Process.
2. Referrals to Nutritional Services should be provided as appropriate for both acute problems and for health maintenance.
3. Consults should be scheduled the same day as referral, if possible.
4. Providers of MNT shall, in conjunction with the client, develop a nutritional plan with goals and intervention strategies to determine progress made in desired outcomes or nutrition care that will be reviewed and updated as conditions warrant (at a minimum of every six months). The nutritional plan must include:
   - Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food
   - Date service is to be initiated
   - Planned number and frequency of sessions
   - The signature of the Registered Dietitian who developed the plan

Monitoring: As conditions warrant (at a minimum of every six months).

Reassessment: Universal standards apply.

Discharge/Termination: Universal Standards apply.

Documentation: Universal Standards apply.

Additionally:

1. If food is provided, the chart must say where food is provided to a client under this service category
2. Client file is maintained that includes a physician's recommendation and a nutritional plan
3. Nutritional supplements and food provided, quantity, and dates
4. The signature of each registered dietitian who rendered service, the date of service
5. Date of reassessment
6. Termination date of medical nutrition therapy
7. Any recommendations for follow up.

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff must adhere to DHHS and education guidelines provided by the Academy of Nutrition and Dietetics
2. Staff must be trained and knowledgeable about primary care, HIV/AIDS disease and treatment, available resources that promote the continuity of care, and multi-disciplinary medical care practices.
3. Staff must be licensed/certified to practice within their concentrated area consistent with city, county, state and federal laws and the Accreditation Council for Education in Nutrition and Dietetics (ACEND) and must maintain the required supervision, training and continuing education as required.

Additional Requirements: Agencies providing Medical Nutritional Therapy will have written guidelines to generate automatic referrals for this service in addition to direct consults from medical providers.

Medical Transportation

HRSA Definition: Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Part B requirement: TDH funds cannot be used for the purchasing or leasing of vehicles.

STANDARD
Eligibility: Universal Standards apply. **Additionally:** 1. Transportation passes (public transportation passes). This service provides reduced fare transportation passes to eligible clients with HIV/AIDS and their caregivers attending Ryan white core medical service and support appointments. This includes single or multiple use passes up to 31 days. • Clients receiving five or more Ryan White funded services a month may be eligible to receive a monthly bus pass. • Clients receiving less than five Ryan White funded services a month may be able to receive one-day bus passes. 2. Agency based transportation (van, transporter, etc.). This service provides free transportation to and from core medical and support services for eligible clients with HIV/AIDS and their caregivers, in vehicles 1) operated directly by the service provider or 2) through a subcontract with a provider of transportation services. 3. Mileage reimbursement (private transportation, staff transportation, voucher, etc.). This service provides reimbursement for the cost of mileage for eligible clients with HIV/AIDS and their caregivers, appropriate staff persons, and volunteer drivers assisting clients attending core medical service appointments. Gas vouchers to participating gas stations are an acceptable form of mileage reimbursement. 4. Rideshare reimbursement (voucher, invoice, etc.). This service provides reimbursement for the cost of each qualifying rideshare ride for eligible Ryan White Part B clients with HIV/AIDS and their caregiver's and/or dependent attending Ryan White core medical services. Sub-recipient will use the approved

Contracted vendor for the Rideshare program. Payments may not be made to individual clients. ● Rideshare will be based on medical need. ● Requests will be made by Ryan White Provider's staff. ● Minors need to be accompanied by an agency escort or parent/guardian. 5. Taxicab reimbursement: To qualify for reimbursement for taxicab transportation, the client must: ● Have a medical urgency or severely inclement weather which prohibits the use of other transportation sources and/or; ● No available public transportation or other resources. When clients qualify for other funding sources for transportation, they will not be eligible for Ryan White Part B funding for this service.
Intake and Screening: N/A
Assessment: N/A
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply. ***Additionally:*** 1. A record of services provided documenting service recipients, eligibility, method and cost of service and amount must be maintained. 2. Documentation must contain the level of services/number of trips provided, the reason for each trip and its relation to accessing health and support services, trip origin and destination, client eligibility, the cost per trip and the method used to meet the transportation need.
Staff Requirements: Universal Standards apply. ***Additionally:*** 1. Agency must ensure that any staff hired as drivers are subject to at a minimum mandatory pre-employment as well as random and post-accident drug screenings to be conducted by a certified, approved laboratory facility. 2. Use of volunteer drivers appropriately addresses insurance and other liability issues.

Additional Requirements:

1. No cash payments are provided to clients. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
2. **All:** Demonstrate coordination with other area transportation agencies and services, TennCare Special Transportation, and other existing transportation programs to avoid duplication of services.
3. **Agency Based:** Provided in combination with core services to clients of Ryan White Part B funded programs. They must be in compliance with all state regulations regarding transportation including driver's license; appropriate insurance and other liability issues; and/or any applicable state regulations. It can be used to provide free transportation to and from core medical service and support services for eligible clients with HIV/AIDS in vehicles a) directly operated by the service provider or b) through a subcontract with a provider of transportation services. Any agency providing direct transportation has written procedures developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service and will be in-serviced annually. The agency will maintain a copy of each in-service and sign-in roster with names both printed and signed and maintained in each driver's personnel file. Any agency providing direct transportation ensures that children under 16 are not transported without an adult escort. State law regarding height and weight mandates for car seats and/or booster seats for children must be observed. Necessity of a car seat or booster seat should be documented on the Transportation Log by staff when an appointment is scheduled by a client. Agency must ensure the safety of any vehicles used to transport clients for services. There must be safety standards in place that at a minimum ensure the vehicles are in good repair and equipped for adverse weather conditions.
4. **Mileage Reimbursement**: Mileage will be reimbursed at no more than the current Tennessee Department of Health rate. Provider agencies may state

their own rate as long as Ryan White funded reimbursement does not exceed the current TDH rate.

5. **Transportation passes**: provides public transportation passes to eligible clients with HIV/AIDS attending core medical and support service appointments.
    - Clients receiving five or more Ryan White funded services a month may be eligible to receive a monthly bus pass.
    - Clients receiving less than five Ryan White funded services a month may be able to receive one-day bus passes.

Mental Health Services

HRSA Definition: Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Note: Mental Health Services are only available to HIV infected clients

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. Individuals served must have a documented mental health diagnosis/diagnostic feature. 2. Upon initial contact with client, agency will assess client for emergent/urgent or routine mental health needs. 3. Provider confirms client eligibility for services. The process to determine client eligibility must be completed in a timely manner not to extend beyond 30 days or contingent among crisis level.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: Universal Standards apply. ***Additionally:*** 1. The plan must be reflective of mental health diagnosis/diagnostic feature and severity of mental health symptoms and as needed and serves as a vehicle for linking clients to other needed mental health services. 2. The plan must document treatment modality, recommended number of sessions and include recommendations for follow-up.

Monitoring: Universal Standards apply.

Reassessment: Universal Standards apply.

Discharge: Universal Standards apply.

Documentation: Universal Standards apply.

Additionally:

1. For group sessions: A log documenting service recipients served, begin and end date of session(s), session topics, number, and length of session(s).
2. The client file must contain a detailed treatment plan for each eligible client that includes:
   - The diagnosed mental illness or condition
   - The treatment modality (group or individual)
   - Start date for mental health services
   - Recommended number of sessions
   - Date for reassessment
   - Projected treatment end date
   - Any recommendations for follow up
   - The signature of the mental health professional rendering service
   - Documentation of service provided to ensure that services provided are allowable under Ryan White guidelines and contract requirements and are consistent with the treatment plan

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff Requirements:
   - Include all required elements from state licensure rules (e.g., 0940-05-14).
   - Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics, and implications, including cognitive impairment and generally accepted treatment modalities and practices.
   - Services must be provided by a mental health professional licensed or authorized within the State to provide such services, typically including licensed providers.
2. Supervision:

- Supervision of mental health services must be provided to ensure that both medical and psychosocial clinical processes are appropriately addressed.
- Supervision must be provided by qualified licensed professionals in effort to ensure quality medical management of care through consultation and/or training of staff.
- Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.

3. Training:
   - Staff and their supervisors must have opportunities to participate in relevant annual training for at least five hours per year.

Additional Requirements:

1. Must provide access to mechanisms for urgent and/or emergency care when needed, such as in the case of a suicidal client.
2. Providers must maintain formal and informal collaboration/linkages with mental health and substance abuse service organizations within Part B coverage area.

Agency must detail how Crisis/Emergency guidelines are disseminated to clients.

**In some cases, a waiver may be obtained, see Notes at the end of this document*

Non-Medical Case Management Services

HRSA Definition: Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized Plan of Care
- Continuous client monitoring to assess the efficacy of the Plan of Care
- Re-evaluation of the Plan of Care at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Part B requirement: Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** 1. Must follow TDH requirements regarding Ryan White service eligibility process. 2. The agency must check the TDH Eligibility Database to ensure that the client does not currently have an existing Ryan White CM or MCM (Ryan White requires one case manager per client.)
Intake and Screening: Universal Standards apply.

Assessment: Universal Standards apply.

Plan of Care: Universal Standards apply.

Monitoring: Universal Standards apply.

Reassessment: Universal Standards apply.

Additionally: Each client must be reassessed every 6 months minimally or as the need arises.

Discharge/Termination: Universal Standards apply.

Documentation: Universal Standards apply.

Staff Requirements: Universal Standards apply.

Additionally:

1. Minimum educational/experience requirements for case management positions: All case managers hired by subcontractor/provider agencies that are funded in whole or in part to provide case management services through Ryan White Part B funds, must possess one of the following:
   - High School (HS) diploma or General Education Development (GED) and one year of experience working with persons living with HIV and/or health care training (for example, Certified Medical Assistant or Medical Clerk).
2. Supervision: Supervision of Case Management Services must be provided by an MSW to ensure that both medical and psychosocial clinical processes are appropriately addressed.
   - MSW Supervisor - Supervisor will demonstrate efforts to ensure quality management of care through consultation and/or training of staff. Supervision will address issues of client care (e.g., boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g., record keeping).
   - Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.
3. Training: See TDH CM Manual.

**In some case, a waiver may be obtained, please see Notes at the end of this document.*

Additional Requirements:

1. Agency must provide assurances that any transitional case management for incarcerated persons meets contract requirements.

Oral Health Care

HRSA Definition: Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Part B requirement: Cosmetic dentistry for cosmetic purposes is prohibited.

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** The following criteria must be met for a client to be eligible for Oral Health services under Ryan White Part B - 1. Case Manager determines eligibility based upon requirements specified in the oral health guidelines. Case Manager explores available resources, (e.g., insurance) before completing an application for services under Ryan White, Part B.
Intake and Screening: Completed by Case Managers.
Assessment: Universal Standards Apply. ***Additionally:*** <u>Examples of Routine Care:</u> 1. Dental assessment and cleaning should occur in conjunction with each other and on the same day. 2. A comprehensive oral assessment is conducted prior to treatment and is ongoing if necessary and should include: • Comprehensive health history; • Client's knowledge, ability, and performance history for routine personal oral hygiene; • Hard and soft tissue examination; • Documentation of patients presenting complaints; • Charting of cavities; • Applicable X-rays of the teeth; • Periodontal screening (evaluation of gums, gingival health); • Intra-oral exam, including evaluation for HIV-associated lesions;

- Pain assessment; and
- Written diagnoses, where applicable.

Routine Care

After initial assessment, the oral health care provider may suggest oral health treatment options based upon summary of benefits. The plan may address cavities, missing teeth, periodontal condition, extractions and replacement teeth, and oral hygiene instructions. The oral health provider should include referral to primary care facility or physician for medical care, as needed.

Emergency Care is not covered under the Ryan White Part B Oral Health Guidelines.

Additional Resources for Oral Healthcare:

- **https://www.tnoralhealth.org/s/Safety-Net-Clinic-Directory_Statewide-101320-xzpt.pdf**
- **https://www.tn.gov/health/health-program-areas/oralhealth/dental-care-for-tennesseans.html**
- **http://www.tnpca.org/**

Monitoring includes eligibility and services rendered.

Discharge: Services are terminated based upon disenrollment from the Ryan White Part B Program, or if the client ends services, or if the client does not comply with service procedures.

Documentation:

1. Application must be submitted in REDCap during open enrollment by case managers.

Staff Requirement:

1. Dental provider must maintain an undisciplined license to practice in the State of Tennessee and current registration.
2. Dental providers shall adhere to the standards of care as specified in the Tennessee Dental Practices Act.

Additional Requirements:

1. Client must receive dental services from an in-network dental provider and only those services in the summary of benefits.
2. Individuals participating in the program are capped at a limit per grant year set by the TDH.

3. The case manager will ensure that the client is familiar with the Oral Health Guidelines and expenditure limitations. All costs in excess of the established expenditure limitations are the sole responsibility of the client. 4. All providers have and maintain a valid Tennessee dental license and are not under restriction. 5. Clinical decisions are informed /supported by the American Dental Association Dental Practice Parameters. (HAB 2013)
Refer to Oral Health Guidelines for further instruction.

Outpatient/Ambulatory Health Services

HRSA Definition: Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Part B requirement:

1. Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.
2. Outpatient care includes referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services).

STANDARD
Eligibility: Universal Standards apply.
Intake and Screening: Universal Standards apply.

Additionally:

1. Clients in need of routine medical care will be scheduled to be seen for an initial appointment within 30 calendar days from the eligibility verification date.
2. Clients will receive standardized comprehensive psychosocial and environmental assessment during a face-to-face contact from an appropriate program staff immediately following eligibility determination. Refer to Medical Case Management standards for more detailed information.
3. If Medical Case Management is not available at the medical provider's site, the medical provider will refer the client to medical case management within two business days.

Assessment: Universal Standards apply.

Additionally:

- Clients will have a comprehensive initial intake and assessment which will be completed within the first two primary care visits scheduled with the primary care provider. The initial assessment shall include, but is not limited to the following:
- Chief complaint
- Past medical and surgical history with detailed HIV/AIDS history
- Family and social history including substance abuse and mental health histories
- Allergies to medications
- Current and past medications, specifically HIV therapies
- Current nutrition including supplements
- Any present illnesses or concerns
- Screening for diseases associated with risk factors (Hepatitis A, Hepatitis B, Hepatitis C, and Sexually Transmitted Infections)
- Client's initial assessments will include a comprehensive physical examination in accordance with the most current published the Department of Health and Human Services' Guidelines for Use of Antiretroviral Agents in HIV infected Adults and Adolescents (DHHS Guidelines). The physical evaluation shall include, but is not limited to the following:
- Vital signs

- Systems inspection, inclusive of dermatological examination
- Neurological examination
- Genital, oral, and rectal exams as appropriate (This may be deferred but should generally be done by the second medical visit.)
- Breast examination
- Appropriate baseline testing including laboratory and radiology values, will be performed within the first two primary care visit scheduled with the primary care provider. Tests shall be inclusive of but not limited to the following:
- Complete Blood Count (CBC) with platelets
- Syphilis screening
- Chemistry profile, including serum transaminases and lipid profile
- Urinalysis
- Screening for chlamydia, gonorrhea, and trichomoniasis for clients who are sexually active, as per DHHS STD guidelines
- Glucose-6-phosphate dehydrogenase screening in appropriate racial or ethnic groups (unless previously tested)
- CD4+ lymphocyte count
- Viral load measurement
- For patients with pretreatment HIV RNA >1,000 copies/mL – genotypic resistance testing prior to initiation of therapy; if therapy is to be deferred, resistance testing may still be considered
- Cervical cytology screening for women and adolescent females, if appropriate. Liquid based cytology is the preferred approach for HPV testing.
- Routine assessments for opportunistic infections
- Assessment for Hepatitis B infection or immunity with HBsAg, anti-HBs and anti-HBc

Hepatitis B testing should be performed 1–2 months after administration of the final dose of the vaccine series using a method that allows determination of a protective concentration of anti-HBs (≥10 mIU/mL).

- Persons found to have anti-HBs concentrations of ≥10 mIU/mL after the primary vaccine series are considered to be immune.
- Immunocompromised persons might need annual testing to assess anti-HBs concentrations (See Revaccination).

- Persons found to have anti-HBs concentrations of <10 mIU/mL after the primary vaccine series should be revaccinated. Administration of all doses in the second series, on an appropriate schedule, followed by anti-HBs testing 1–2 months after the final dose,
- Persons who do not have a protective concentration of anti-HBs after revaccination should be tested for HBsAg.

4. Immunization status of the client will be reviewed during the initial assessment. Vaccines appropriate to clients' current immunization and health status should be offered according to protocol.
    - All patients should be assessed for Covid-19 vaccination status during each medical visit.
    - Covid-19 vaccine should be offered if patient has not been vaccinated.
5. Referrals to specialists (e.g., dentists, ophthalmologists, nutritionist, etc.) should be provided as appropriate.

Plan of Care:

1. Providers shall, in conjunction with the client, develop a comprehensive multi-disciplinary plan of care that will be reviewed and updated as conditions warrant or at minimum of every six months.
2. Providers shall develop and initiate a client treatment adherence plan that is consistent with DHHS Guidelines for clients who are being treated with an antiretroviral (ARV) medication regimen. The plan shall be reviewed and updated as conditions warrant.
3. Providers shall conduct an adherence evaluation related to medication regimen and appointment schedules at least annually.
4. Agency staff shall act as a liaison between the client and other service providers to support coordination and deliver of high-quality care.
5. Agencies will have a referral process for care of HIV related problems outside of their direct service area.

Monitoring: N/A

Reassessment: N/A

Discharge/Termination: N/A

Documentation: Universal Standards apply.

Additionally:

1. Completed according to generally accepted medical practice standards and state requirements.
2. Contain an up to date "Problems List" separate from progress notes which clearly prioritizes problems for primary care management.
3. Contact information for ancillary continuing health care (e.g., mental health provider, OB/GYN or other continuing specialty services.
4. Client records must include:
   - Dates and frequency of services provided.
   - Documentation that services provided are for the treatment of HIV related infection.
   - Signature of licensed provider of services.
5. Documentation that tests are:
   - Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider.
   - Consistent with medical and laboratory standards approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory Improvement Amendments (CLIA) Program.

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff adheres to generally accepted medical practice standards and state requirements.
2. Agency staff is trained and knowledgeable about primary care, HIV/AIDS disease and treatment and available resources that promote the continuity of client care. Additional resources would include National HIV curriculum and the IDSA primary care guidelines for HIV.
3. Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van.

Additional Requirements:

1. Providers are required to use the latest version federally approved medical practice guidelines for HIV/AIDS https://clinicalinfo.hiv.gov/en/guidelines.
2. Clients will be assessed for educational, nutritional, and psychosocial needs. Appropriate referrals will be made.
3. Agency staff will inform clients of their responsibility for scheduling appointments, being on time, and calling the provider to cancel or reschedule if an appointment cannot be kept.
4. Provider will screen sexually active clients for sexually transmitted diseases annually. Clients at high risk shall be screened at least every six months. If a client has been screened at another facility, the client's primary medical care chart shall contain copies of the appropriate documentation.
5. Providers shall assess risk behaviors and offer or refer clients as needed for lifestyle education and counseling services regarding such areas as exercise, smoking cessation, risk reduction and safer sex practices.
6. Providers shall offer clients not currently on antiretroviral (ARV) therapies, who qualify for ARV treatment by DHHS guidelines, education and counseling on the risks and benefits of antiretroviral therapy at least twice a year.
7. Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects
8. Providers must demonstrate strong linkages with funded providers, including Medical Care Management and Early Intervention Service providers. This must be in the form of a written Memorandum of Understanding. MOUs must contain at least the following:
    - Description of how Outpatient Provider and Medical Case Management & EIS providers share information on:
        - Patient scheduled appointments and missed appointments, labs, medications, medical records, and insurance status.
        - Arising issues that can impact patient health status or ability to adhere to medical treatment.
9. Providers must make labs and other medical information available upon request to requesting agency as soon as possible or within at least 3 – 5 business days.

Outreach Services

HRSA Definition: Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services

Part B requirement: Outreach must be 1) targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, 2) targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior, 3) conducted at times and in places where there is a high probability that individuals with HIV infection will be reached and 4) designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness.

Note: Funds may not be used to pay for HIV counseling or testing.

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** Individuals identified through epidemiologic data and/or appear in the targeted population that either need testing services or referral to HIV services.
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge/Termination: N/A

Documentation: Universal Standards apply.

Additionally: Programs must document

1. Program design and implementation
2. Target areas and populations
3. Outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care
4. Data showing that all Request for Proposal (RFP) and contract requirements are being met with regard to program design, targeting, activities, and use of funds

Staff Requirements: Universal Standards apply.

Additionally:

1. Staff are required to have a minimum of a High School Diploma or GED; although, a bachelor's level degree in Social Work or a health-related field and a minimum of 1 year of experience is preferred.
2. Staff is trained and knowledgeable about HIV/AIDS, the affected communities, and available resources. Training specific to outreach activities should include (but not limited to) the following:
   - HIV/AIDS Counseling (and testing when applicable),
   - Referral to medical care
   - Personal safety
   - Adherence counseling
   - Non-violent crisis intervention
   - Cultural diversity
   - Psychosocial issues specific to HIV/AIDS.

Additional Requirements:

1. Programs must develop outreach safety protocols.
2. Programs must document that outreach services:
   - Are planned and delivered in coordination with local HIV prevention outreach programs and avoid duplication of effort.
   - Target populations known to be at disproportionate risk for HIV infection.
   - Target communities whose residents have disproportionate risk or establishments frequented by individuals exhibiting high-risk behaviors.

• Are designed so that activities and results can be quantified for program reporting and evaluation of effectiveness.

Psychosocial Support Services

HRSA Definition: Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support (RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

Part B requirement:

- Part B has decided not to fund child abuse and neglect counseling.

STANDARD
Eligibility: Universal Standards apply.

Intake and Screening: Universal Standards apply.
Assessment: Completed by Case Manager
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply.
Staff Requirements: **Support Activities**: Must have a high school diploma or GED equivalent. And at least one of the following: 1. One or more year(s) full time relevant experience in health or human services field. 2. Life experiences with HIV/AIDS and/or affected. 3. One of more year(s) documented addiction recovery. *Note: Persons with these qualifications may conduct support activities and HIV support group with appropriate supervision.* **Peer Support**: 1. Must be PLWHA; 2. Possess a high school diploma or GED equivalent; and 3. Professional or volunteer experience related to human services, preferably in an HIV/AIDS service organization. *Note: Persons with these qualifications may conduct support activities and HIV support group with appropriate supervision.* **Pastoral Care**: 1. Must have attained a bachelor's degree in religion or theology or a Master of Divinity degree from an accredited institution and/or have experience as a minister, preacher, pastor, priest, rabbi, or other spiritual leader 2. Must be ordained or otherwise designated in conformity with the customs of a church, temple or other religious group or organization. Such customs must provide for such ordination or designation by a considered, deliberate, and responsible act

3. One or more year(s) experience in delivering Pastoral Care services

Note: Persons with these qualifications may conduct support activities, HIV support group and bereavement counseling.

Bereavement Support:

1. Must have attained a bachelor's degree in social work, counseling, psychology, pastoral care, or specialized training or experience in bereavement theory or counseling
2. One or more year(s) in providing bereavement support counseling.

Note: Persons with these qualifications may conduct support activities and HIV support group with appropriate supervision.

*In some cases, a waiver may be obtained, please see Notes at the end of this document. **

Supervision:

Agencies are required to have implemented a supervisory process that addresses the relevant skill level and/or needs of the staff providing services.

Peer supportive services:

Supervision of peers must be conducted by an individual with experience in human services field to provide 1) frequent and consistent opportunities to receive encouragement, 2) individualized support, 3) coaching on how to perform a helping role and 4) guidance on how to address personal challenges.

Note: Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.

Training:

1. Individuals who hold certification and/or licensure as a part of their job duties must maintain that in good standing with the respective governance bodies.

2. Agencies providing Psychosocial Support Services must document efforts to assist staff and supervisory staff in securing on-going education and training to better perform their respective job duties.
3. Psychosocial Support Services staff and their supervisors must have opportunities to participate in relevant training for at least five (5) hours per year.

Referral for Health Care and Support Services

HRSA Definition: Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Part B requirement: Referral for health care and support services is only to be used where these services are not provided as a part of Ambulatory/Outpatient Medical Care or Case Management.

STANDARD
Eligibility: Universal Standards apply. Additionally: The agency has procedures in place for documentation and screening of all referrals.
Intake and Screening: Universal Standards apply.
Assessment: N/A
Plan of Care: N/A
Monitoring: N/A
Reassessment: N/A
Discharge: N/A
Documentation: Universal Standards apply. ***Additionally:*** 1. A log documenting service recipient screened, completed applications, and referrals made. 2. There must be documentation of the number and type of referrals that are made.

3. The agency must maintain documentation demonstrating that services and circumstances of referral services meet contract requirements.
Staff Requirements: Universal Standards apply. ***Additionally:*** Staff must have a High School Diploma or GED.

Substance Abuse Outpatient Care

HRSA Definition: Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include screening, assessment, diagnosis, and/or treatment of substance use disorder, including:

- Pretreatment/Recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Outpatient drug-free treatment and counseling
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Part B requirement: N/A

STANDARD
Eligibility: Universal Standards apply. ***Additionally:*** Individual provided treatment must have a substance use diagnosis (can be provided with documentation or assessment of a current or previous substance use diagnosis).
Intake and Screening: Universal Standards apply.
Assessment: Universal Standards apply.
Plan of Care: Universal Standards apply. ***Additionally:*** 1. The plan must be reflective of current or previous substance abuse diagnosis and severity of need and as needed and serves as a vehicle for linking clients to other needed substance abuse services. 2. The plan must document treatment modality, recommended number of sessions and include recommendations for follow-up.
Monitoring: Universal Standards apply.
Reassessment: Universal Standards apply.
Discharge: Universal Standards apply.
Documentation: Universal Standards apply.

Additionally:

1. For group sessions: A log documenting service recipients served, begin and end date of session(s), session topics, number, and length of session(s).

Staff Requirements: Universal Standards apply.

Additionally: Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics, and implications as well as substance abuse, including cognitive impairment and generally accepted treatment modalities and practices.

Supervision:

1. Must be provided to ensure that both medical and psychosocial clinical processes are appropriately addressed.
2. Must be provided by qualified licensed professionals in effort to ensure quality medical management of care through consultation and/or training of staff.
3. Must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.

Supervision can be provided by LADAC -Licensed Alcohol and Drug Abuse Counselor, LPC-LMHC- Licensed Professional Counselor or Licensed Mental Health Counselor, LCSW – Licensed Clinical Social Worker. Training: Staff and their supervisors must have opportunities to participate in relevant annual training for at least five (5) hours per year.

Additional Requirements:

Providers must maintain formal and informal collaboration/linkages with mental health and substance abuse service organizations within the Part B County coverage.

In some cases, a waiver may be obtained, see Notes at the end of this document

Notes:

Note 1: *Requirements for clinical supervision may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Grantee or the Lead Agency who will in turn seek approval of the modification/waiver from the Tennessee Department of Health. Along with the waiver, the following documentation must be included to merit the modification/waiver:*

1) *relevant reasons and justification for such action*
2) *specific information as to why the person providing clinical supervision has sufficient:*
   - education (e.g., Master's Degree in a Health or Human Services field),
   - certification,
   - licensure, and
   - clinical experience.

Note 2: *In such cases where a medical case manager was employed prior to the implementation of the Standard and does not meet the given qualifications, the aforementioned modification/waiver provision. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to ensure that the medical case manager receives appropriate additional education (degree), training and/or supervision to ensure quality provision of care.*

Note 3: *Peers who do not meet the educational requirements and require a waiver may be medical case managers/EIS specialists if they meet the above requirements and they are an employee.*

Note 4: *Experience requirement may be waived. The agency seeking a waiver must request such in writing to the Grantee or Lead Agency who will in turn seek approval of the waiver from the Tennessee Department of Health. Documentation of the request for waiver must include relevant reasons and justification for such action and specific information why the person to be hired has sufficient education, certification, licensure and/or experience to merit the/waiver. In addition to a written statement of relevant education/experience, the agency seeking waiver must present a written plan to ensure that the staff person receives appropriate additional education (degree), training and/or supervision to ensure quality provision of care.*

Note 5: *Educational and experience requirements for psychosocial support may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Lead Agency who will in turn seek approval of the modification/waiver from the Tennessee Department of Health. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to be hired as psychosocial support staff has sufficient education, certification, licensure and/or experience to merit the modification/waiver. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to ensure that the psychosocial support staff receives appropriate additional education (degree), training and/or supervision to ensure quality provision of care.*

Note 6: *In such cases where a psychosocial support was employed prior to the implementation of the Standard and does not meet the given qualifications, there is need to use the aforementioned modification/waiver provision. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to ensure that the staff person receives appropriate additional education (degree), training and/or supervision to ensure quality provision of care.*

Note 7: *The Ryan White Part B Program is the payer of last resort. This is interpreted as "funds received will not be 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" by another payment source. (PHSA; Sections 2605(a) (6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (I)).*

Emergency Protocol

In the event of a statewide emergency, natural disaster, or pandemic, please refer to your agency's emergency procedures.

Ryan White HIV Program Income Reporting

Description:	Per HIV/AIDS Bureau Policy Clarification 15-03, program income is defined as, "gross income earned by the non-Federal entity that is directly generated by a supported activity or earned as a result of the Federal award during the period of performance except as HIV/AIDS Bureau Policy 15-03 provided on 45 CFR § 75.307(f)." Policy Clarification 15-03 also states that Ryan White programs must monitor and track program income earned by subrecipients. Please feel free to refer to Policy Clarication 15-03 at: https://hab.hrsa.gov/sites/default/files/hab/Global/pcn_15-03_program_income.pdf

Directions:	Please complete the table below with regards to the program income earned by your organization during the quarter. Please disaggregate and list the amount of program income earned, and provide a quick description of the program income. Do not submit one aggregated amount per quarter. Please feel free to add more lines for your quarterly reporting as needed.

Deadline for Submission	Quarter 1 (April-June)- **July 15** Quarter 2 (July-Sept)- **Oct. 15** Quarter 3 (Oct-Dec)- **Jan. 15** Quarter 4 (Jan-March)- **Apr 15**

Agency Name	
Contact Name	
Grant Year	

Reporting Period	**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**	
Program Income	**Amount**	**Description of Program Income (i.e. 340b, income gained from Ryan White affiliated activites, etc)**	**Amount**	**Description of Program Income (i.e. 340b, income gained from Ryan White affiliated activites, etc)**	**Amount**	**Description of Program Income (i.e. 340b, income gained from Ryan White affiliated activites, etc)**	**Amount**	**Description of Program Income (i.e. 340b, income gained from Ryan White affiliated activites, etc)**
	$0.00		$0.00		$0.00		$0.00	
	$0.00		$0.00		$0.00		$0.00	
	$0.00		$0.00		$0.00		$0.00	
	$0.00		$0.00		$0.00		$0.00	
	$0.00		$0.00		$0.00		$0.00	
Totals	**$0.00**		**$0.00**		**$0.00**		**$0.00**	

LEGEND
Contract Grant Award
Exceeds Budget
Balance Remaining in Grant

Multi-Budget Supplemental Sheet
Ryan White Part B Program
April 2026 - March 2027 Monthly for Core Medical Services

Contract Name:
Contract #:

	OAMC	MCM	MH	EIS	MNT	SAOut	NMCM	EFA	FB/HDM	H	MedT	PSY	REF	ADAP	Monthly Expense (actual)	YTD Spent	Grant Budget Amount	Remaining in Grant	Comments
Line Item															Sum of Columns B through N	Sum of Actual Monthy Spend for Current and Past Months	Budget Amount Awarded in Contract	Grant Budget Amount - YTD Actual Spend	
Salaries															$0.00	$0.00		$0.00	
Benefits															$0.00	$0.00		$0.00	
Professional Fee/Grant & Award															$0.00	$0.00		$0.00	
Supplies															$0.00	$0.00		$0.00	
Telephone															$0.00	$0.00		$0.00	
Postage & Shipping															$0.00	$0.00		$0.00	
Occupancy															$0.00	$0.00		$0.00	
Equipment Rental & Maintenance															$0.00	$0.00		$0.00	
Printing & Publications															$0.00	$0.00		$0.00	
Travel/Conferences & Meetings															$0.00	$0.00		$0.00	
Interest															$0.00	$0.00		$0.00	
Insurance															$0.00	$0.00		$0.00	
Specific Assistance to Individuals															$0.00	$0.00		$0.00	
Depreciation															$0.00	$0.00		$0.00	
Other Non Personnel															$0.00	$0.00		$0.00	
Captial Purchase															$0.00	$0.00		$0.00	
Indirect Cost															$0.00	$0.00		$0.00	
Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	***$0.00***	$ -	$ -	$0.00	
Revenue																			
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

Key

OAMC - Outpatient Ambulatory	**SAOut - Substance Abuse Outpatient**	**MedT - Medical Transportation**
MCM - Medical Case Management	**CM (non) - Case Management (non-medic**	**PSY - Psychological Support**
MH - Mental Health	**EFA - Emergency Financial Assistance**	**REF - Referral**
EIS - Early Intervention Services	**FB/HDM - Food Bank/Home Delivered Meals**	**ADAP - AIDS Drug Assistance Program**
MNT - Medical Nutrition Therapy	**H - Housing**	

Attachment 9

Multi-Budget Supplemental Sheet
Ryan White Part B Program
April 2026 - March 2027 Monthly for Core Medical Services

Contract Name:
Contract #:

	OAMC	MCM	MH	EIS	MNT	SAOut	NMCM	EFA	FB/HDM	H	MedT	PSY	REF	ADAP	Total	Comments
Line Item																
Salaries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Professional Fee/Grant & Award	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Postage & Shipping	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Equipment Rental & Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Printing & Publications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Travel/Conferences & Meetings	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Interest	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Specific Assistance to Individuals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Other Non Personnel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Captial Purchase	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Indirect Cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Subtotal	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	$ -	
Revenue																
Total	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	

Key

OAMC - Outpatient Ambulatory	**SAOut - Substance Abuse Outpatient**	**MedT - Medical Transportation**
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