Lead agency:

Date: Click or tap to enter a date.

Phone/email:

Regional contact:

New RWB OS funding? [ ]  Yes [ ]  No

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| **General:** Background information related to the organization seeking RWB OS funding. |

1. Briefly summarize all the services your organization currently provides and how RWB OS will be/has been incorporated.
2. Please describe all the populations your agency currently serves.
3. What data source will be used to determine target populations for RWB OS activities?
4. Does your organization currently receive non-RWB funding (e.g. CDC, Ryan White Parts A/C/D, HOPWA, donations, etc.) to provide HIV prevention and/or care services? [ ]  Yes [ ]  No
5. If yes to question #4 directly above, what services do you receive funding for and from what source?

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| **Issue:** *(New funding)* Define the concern the proposed RWB OS activities will resolve. Explain why you believe this is an issue and include data demonstrating the extent of the need in your area.  |

[Narrative Here]

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| **Successes:** *(Renewal funding)* Provide a brief narrative outlining the overall successes of RWB OS in the previous 12 months along with data demonstrating the ongoing need for RWB OS in your area. |

[Narrative Here]

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| **RWB OS-Encounters:**  |

1. Summarize your organization’s intended activities for facilitating RWB OS-Encounters.
2. What days, times, and under what circumstances will you be conducting RWB OS-Encounter activities?
3. How will you ensure the confidentiality of clients participating in RWB OS-Encounters activities?
4. Are there any state/local HIV outreach activities already occurring in the region? [ ]  Yes [ ]  No
5. If yes to question #4 directly above, what organization(s) are conducting these activities and how will coordination efforts occur with your organization?

Did you/do you intend to conduct HIV Testing as part of RWB OS-Encounters? [ ]  Yes [ ]  No

*(If yes, complete questions 6-11 below. If no, skip questions 6-11 below)*

1. Summarize your reason for providing HIV testing.
2. What days, times, and under what circumstances will you be providing HIV testing?
3. What type of test technology do you plan to use? (e.g. venipuncture, oral fluid, rapid, etc.)
4. Do you have trained staff to provide HIV testing? [ ]  Yes [ ]  No
5. Are there any existing HIV testing programs in the region/area? [ ]  Yes [ ]  No
6. If yes to question #10 directly above, what organizations are already providing HIV testing and how will coordination efforts occur with these organizations?

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| SMART Goals(Related to the RWB Outreach-Encounters funding currently being requested) | Baseline | Target |
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1. *(Renewal projects)* What were the goals/deliverables for the past 12 months related to RWB OS-Encounters?
2. *(Renewal projects)* Analyzing the previous 12 months of CAREWare data, were the goals/deliverables met? If not, why?
3. *(Renewal projects)* What adjustments will be made to ensure goals/deliverables will be met this funding cycle?
4. *(Renewal projects)* What RWB OS activities facilitating encounters occurred in the past 12 months; what were the dates, times, and nature of these activities; and how many individuals participated in each activity?

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| **RWB OS-Referrals:**   |

1. Summarize your intended referral activities when providing RWB OS.
2. What non-RWB services (e.g., HNS.) will participants be referred to once learning their status is negative?
3. How will contact information for non-RWB referrals be verified and kept current?
4. What actions will you take on behalf of clients who have a positive test result to ensure successful referral and linkage to services (e.g. ARTAS, MCM, etc.)?
5. Are there any Memorandums of Understanding (MOU), Letters of Agreement (LOA) and/or written correspondence demonstrating the partnerships and coordinationin place with key points of entry for RWB services? [ ]  Yes [ ]  No
6. If yes to question #5 directly above, with which organizations and for what services (provide a copy of applicable MOUs/LOAs)?
7. What non-RWB services (e.g., Medicaid, Medicare Part D, Pharmaceutical Manufacturer’s Patient Assistance Programs, state/local health care/supportive services, health insurance plans, etc.) will RWB eligible clients be referred to?

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| SMART Goals(Related to the RWB OS -Referrals funding currently being requested) | Baseline | Target |
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1. *(Renewal projects)* What were the goals/deliverables for the past 12 months related to RWB OS-Referrals?
2. *(Renewal projects)* Analyzing the previous 12 months of CAREWare data, were the goals/deliverables met? If not, why?
3. *(Renewal projects)* What adjustments will be made to ensure goals/deliverables will be met this funding cycle?

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| **RWB OS-Follow-up:**   |

1. Summarize your intended activities for providing follow-up related to your RWB OS activities.
2. Is there a policy in place outlining when and how often follow-up will occur as well as guidelines for termination of follow-up activities? [ ]  Yes [ ]  No *(If yes, attach the policy to your completed workplan /renewal.)*
3. What modes of communication will be used in your follow-up efforts?
4. How will you ensure the confidentiality of clients during your RWB OS-Follow-up activities?

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| SMART Goals(Related to the RWB OS-Follow-up funding currently being requested) | Baseline | Target |
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1. *(Renewal projects)* What were the goals/deliverables for the past 12 months related to RWB OS-Follow-up?
2. *(Renewal projects)* Analyzing the previous 12 months of CAREWare data, were the goals/deliverables met? If not, why?
3. *(Renewal projects)* What adjustments will be made to ensure goals/deliverables will be met this funding cycle?

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| **Requested Resources:** In the table below, provide dollar amounts needed by the region to fully implement the activities in this workplan/renewal as well as the anticipated funding source. Please include the lead agency’s RWB OS budget (i.e. Appendix C) as part of the workplan submission. |
| **Personnel/Fringe:** [ ] RWB/rebates [ ] Budget revision | $ | **Consultant Services:** [ ] RWB/rebates [ ] Budget revision | $ |
| **Subcontract Services:**[ ] Rebate [ ] Budget revision | $ | **Patient Services:** [ ] Rebate [ ] Budget revision | $ |
| **Equipment:** [ ] RWB/rebates [ ] Budget revision | $ | **Supplies:** [ ] RWB/rebates [ ] Budget revision | $ |
| **Travel:** [ ] RWB/rebates [ ] Budget revision | $ | **Other Costs:** [ ] RWB/rebates [ ] Budget revision | $ |
|  |  |  |  |
| Total additional **RWB/rebate** funds requested:Total anticipated **budget revision** necessary: | $$ |

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| **Work Statement/Implementation Plan Information:** (e.g.. How many units of a given service will be provided to how many clients) | **# Clients** **to be Served:** | **# Units to be Provided:** |
| RWB OS-Encounters |  |  |
| RWB OS-Referrals  |  |  |
| RWB OS-Follow-up |  |  |

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| APPROVAL (For DOH use only) |
| Recommendation, along with justification for the recommendation: |
| Date: | Total RWB/rebates approved: $ |
| Title: | Printed name: |
| Signature:  |

**This form, DOH ID number HD002295, is an official DOH data collection instrument.**