SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Medical Case Management
Service Goal:	Ensure that those who are unable to self-manage their care, struggling with challenging barriers to care, marginally in care, and/or experiencing poor CD4/Viral load test results receive intense care coordination assistance to support participation in HIV medical care. MCM services are best delivered when co-located in facilities that provide HIV/primary medical care.
Service Health Outcomes:	Improved retention in care (at least 1 medical visit in each 6-month period), Improved viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	535	0	8	57	**600**
Number of Visits = Regardless of number of transactions or number of units	0	0	4,240	0	32	228	**4,500**
Number of Units = Transactions or 15 min encounters	0	0	10,510	0	128	912	**11,550**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Initial assessment of the client's service needs. **Element #7:** Ongoing assessment of the client's and other key family members' needs and personal support systems; and **Element #9:** Client-specific advocacy and/or review of utilization of services. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; and Through communication via email, phone or in-person sessions, working collaboratively with client to identify need for services that would alleviate or remove barriers and support engagement in care.	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Needs Assessment results in HIV Care Connect (HCC) and dates and content of changes noted as well as record of communication dates and type. • Progress notes in HIV Care Connect (HCC).
Element #2: Development of a comprehensive Individualized Care Plan (ICP) with the client;	3,5,6	03/01/25-02/28/26	• ICP documented in HIV Care Connect (HCC). • Treatment adherence counseling documented in HIV Care Connect (HCC).

Element #5: Continuous client monitoring to assess the efficacy of the care plan. **Element #6:** Re-evaluation of the care plan at least every 6 months with adaptations as necessary. **Element #8:** Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and **Element #11:** Benefits counseling (assist with obtaining access to other public and private programs for which clients are eligible (e.g. Medi-Cal, Medicare, Covered CA, ADAP, Premium Assistance, etc.). **Activities:** In alignment with client's needs, barriers to care, eligibility, motivation and capacity, developing an ISP with goals and objectives signed by both the client and case manager to indicate commitment to implementation; Ensuring shared access to electronic health records (EHR) and electronic dental records (EDR); Reviewing health indicators to include medical visits and viral load; and Updating ICP and Care Plan as needed in collaboration with client.			• Progress notes in HIV Care Connect (HCC). • Insurance status documented in HIV Care Connect (HCC) and proof of insurance on record. • Quality Improvement Plan.
Element #3: Timely and coordinated access to medically appropriate levels of health and support services and continuity of care. **Element #4:** Coordination and follow-up of medical treatments; and **Element #12:** Provide or refer clients for advice, support, counseling on topics surrounding HIV disease, treatments, medications, treatment adherence education, caregiver bereavement support, dietary/nutrition advice and education, and terms and information needed by the client to effectively participate in his/her medical care. **Activities:** Co-locating (including shared electronic health records) with medical clinic, dental clinic, behavioral health, early intervention programs and other social services; Maintaining community referral partners; Providing referrals and advocacy for linkage to needed services; and maintaining ongoing communication with community partners and internal departments receiving referrals.	3,5,6	03/01/25-02/28/26	• Referrals and outcomes documented in Progress Notes, HIV Care Connect (HCC) and EHR. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners.
Element #10: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	3,5,6	03/01/25-02/28/26	• Case Conference Attendance Logs. • HIV Care Connect (HCC) Progress Notes.
Element #13: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results.

client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Case Management – Non-Medical
Service Goal:	Facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate).

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	1,601	0	48	76	**1,725**
Number of Visits = Regardless of number of transactions or number of units	0	0	9,708	0	104	1,188	**11000**
Number of Units = Transactions or 15 min encounters	0	0	28,983	0	396	621	**30,000**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Initial assessment of service needs; **Element #2:** Initial and ongoing assessment of acuity level; and **Element #6:** Ongoing assessment of the client's and other key family members' needs and personal support systems. **Activities:** Screening for Payer of Last Resort with support from on-site central registration; Through communication via email, phone or in-person sessions, working collaboratively with client to identify need for services and providing guidance and assistance in improving access to needed services. Referring clients to co-located (to include shared electronic health records) with medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as food, housing, transportation and psychosocial support programs; and Referring clients to needed services provided by community referral partners.	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Needs Assessment results in HIV Care Connect (HCC) and dates and content of changes noted as well as record of communication dates and type. • Progress notes in HIV Care Connect (HCC). • Referrals documented in Progress Notes, HIV Care Connect (HCC) and electronic health records (EHR). • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners

Element #3: Development of a comprehensive, individualized care plan;	3,5,6	03/01/25-02/28/26	• Care plan documented in HIV Care Connect (HCC). • Treatment adherence counseling documented in HIV Care Connect (HCC).
Element #4: Continuous client monitoring to assess the efficacy of the care plan. **Element #5:** Re-evaluation of the care plan at least every 6 months with adaptations as necessary. **Element #7:** Provide education, advice and assistance in obtaining medical, social, community, legal, financial (e.g. benefits counseling), and other services. **Element #8:** Discuss budgeting with clients to maintain access to necessary services; and **Element #10**: Benefits counseling (assist with obtaining access to other public and private programs for which clients are eligible (e.g. Medi-Cal, Medicare, Covered CA, ADAP, Premium Assistance, etc.). **Activities:** In alignment with client's needs, barriers to care, eligibility, motivation and capacity, developing an ISP with goals and objectives signed by both the client and case manager to indicate commitment to implementation; Ensuring shared access to EHR and electronic dental records (EDR); Reviewing health indicators to include medical visits and viral load; and Updating Care Plan as needed in collaboration with client.			• Benefits counseling documented in HIV Care Connect (HCC). • Progress notes in HIV Care Connect (HCC). • Insurance status documented in HIV Care Connect (HCC) and proof of insurance on record. • Quality Improvement Plan.
Element #9: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	3,5,6	03/01/25-02/28/26	• Case Conference logs. • HIV Care Connect (HCC) Progress Notes.
Element #11: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and reflecting and respecting gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Psychosocial Support Services
Service Goal:	To provide psychosocial support services to persons living with HIV/AIDS in the TGA to maintain them in the HIV system of care.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 25/26 TOTAL**
Number of Clients	0	0	72	0	5	5		**82**
Number of Visits = Regardless of number of transactions or number of units	0	0	3,744	0	260	260		**4,264**
Number of Units = Transactions or 15 min encounters	0	0	14,976	0	1,040	1,040		**17,056**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Initial individual needs assessment; **Element #2**: Individual support/counseling session; **Element #3:** Group support/counseling session. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Through one-on-one sessions, working collaboratively with the client to identify need for services that would support engagement in care and prevent falling out of care; Providing counseling regarding the emotional and psychological issues related to living with HIV and to promote problem solving, service access, and steps towards diseases self-management; Providing peer, volunteer, and staff-led groups on a regular schedule various days a week; Case Conferencing; Co-locating with case managers to support review of health indicators to include medical visits and viral load as well as reduced incidence of becoming aware but not in care (unmet need); Ensuring shared access to electronic health records (EHR); Referring clients to co-located medical clinic, dental clinic, early intervention programs and other social services such as housing, food and case management; and Referring clients to needed services provided by community referral partners.	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least every six months. • Needs Assessment in HIV Care Connect (HCC). • Service deliveries in HIV Care Connect (HCC). • Case Conference logs. • Progress Notes in HIV Care Connect (HCC). • Published group schedules. • Attendance Logs. • Documentation of topics/focus, group duration, group type (open/closed), general group goals. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners. • Quality Improvement Plan.
Element #4: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	3,5,6	03/01/25-02/28/26	• Case Conference logs. • HIV Care Connect (HCC) Progress Notes.
Element #5: Referral to mental health professional. **Activities:** Employing referral specialist to navigate insurance; Maintaining co-located substance abuse specialists, psychiatrists and therapists; and Maintaining relationship with community partners.	3,5,6	03/01/25-02/28/26	• Progress notes in EHR, HIV Care Connect (HCC) and/or paper charts. • Employment records. • MOUs/Contracts/Agreements/Letters of support from
Element #6: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC).

Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Food Services
Service Goal:	Supplement eligible HIV/AIDS consumer's financial ability to maintain continuous access to adequate caloric intake and balanced nutrition sufficient to maintain optimal health in the face of compromised health status due to HIV infection in the TGA.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	545	0	15	40	**600**
Number of Visits = Regardless of number of transactions or number of units	0	0	6,540	0	180	600	**7320**
Number of Units = Transactions or 15 min encounters	0	0	32,700	0	900	3,000	**36,600**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Food vouchers, actual food, and/or hot meals; **Element #2:** Licensure and Food Handling certification required if applicable; and **Element #3:** Align with the established IEHPC TGA RWP Standards of Care limit per client / per month. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Renewing food handling certification; Distributing food vouchers once a month on a regular basis, and as needed for emergency assistance, ensuring that every client receives an equal number of food vouchers each month; Securing vouchers from an accessible grocery store chain making every effort to purchase quantities that provide for discounts; Case Conferencing; Co-locating with case managers support review of health indicators to include medical visits and viral load; Ensuring shared access to electronic health records (EHR) and electronic dental records (EDR); Referring clients	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Current Food Handler license from the County of Riverside Department of Environmental Health. • Food voucher eligibility lists produced monthly. • Food voucher distribution receipts. • Invoices showing discount from Stater Bros. • Service deliveries in HIV Care Connect (HCC). • Case Conference logs. • Referrals documented in Progress Notes, HIV Care Connect (HCC) and EHR. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners.

medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as housing, transportation and case management; and Referring clients to needed services provided by community referral partners.			
Element #4: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Medical Transportation Services
Service Goal:	To enhance clients' access to health care or support services using multiple forms of transportation throughout the TGA.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	739	0	62	149	**950**
Number of Visits = Regardless of number of transactions or number of units	0	0	3,436	0	620	1,596	**5,652**
Number of Units = Transactions or 15 min encounters	0	0	8,868	0	744	1,428	**11,040**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Bus pass (monthly pass only when justified, otherwise day pass); **Element #2:** Gasoline vouchers; **Element #3:** Van trip; **Element #4:** Urgent taxi trip; **Element #5:** Collect and maintain data to document that funds are used only for medical appointments and to obtain support services to maintain participation in medical care (origin, destination, method, etc.); and **Element #6:** Restricted to pick-up and drop-off points within the TGA. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Educating clients on how to fill out mileage logs to document eligible mileage including purpose, starting point, destination, and signature of medical or social service provider visited; Ensuring that no cash payments are made to clients by securing gas cards from locally accessible gas station chain; Case Conferencing; Co-locating	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Mileage logs. • Invoices and check requests and cancelled checks to/from Valero. • Service deliveries in HIV Care Connect (HCC). • Case Conference logs. • Referrals documented in Progress Notes. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners. • Medical visits. • Viral loads.

with case managers to support review of health indicators to include medical visits and viral load; Ensuring shared access to electronic health records (EHR); Referring clients to co-located medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as housing, food and case management; and Referring			
Element #7: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Housing Services
Service Goal:	To provide shelter, on an emergency or temporary basis, to eligible clients throughout the TGA at risk for homelessness or with unstable housing to ensure that they have access to and/or remain in medical care.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate; Improve stable housing rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	415	0	15	25	**455**
Number of Visits = Regardless of number of transactions or number of units	0	0	4,980	0	60	300	**5,340**
Number of Units = Transactions or 15 min encounters	0	0	9,960	0	360	600	**10,920**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Housing Case Management: Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Collaborating with client to identify need for services and conducting searches on behalf of client for best match; Reviewing client's eligibility for local, state, federal and private sources of housing assistance and assist with applications or renewals for enrollment; Offering counseling, self-management strategies, training, and education that will support client's housing stability; Referring to needed services provided by community partners to	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Housing Needs Assessment results in client chart. • Housing Plan available for review including causes of housing crises and a strategy to identify, relocate and/or ensure progress towards long-term, stable housing or a strategy to identify an alternate funding source for housing assistance • Progress notes in HIV Care Connect (HCC). • Referrals documented in Progress Notes and/or HIV Care Connect (HCC). • Housing status recorded in HIV Care Connect (HCC). • Case Conference logs. • Employment records.

include, shelters, transitional housing, sober living, and group quarters that have supportive environments; Case Conferencing; Ensuring shared access to electronic health records (EHR) to monitor medical visits and viral load as well as living situation/housing status; and Referring to co-located medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as food, transportation and case management as needed.			• MOUs/Contracts/Agreements/Letters of support from partners. • Quality Improvement Plan.
Element #2: Housing Services (financial assistance): Short-term or emergency housing defined as necessary to gain or maintain access to medical care; and **Element #3:** Current local limit = 90 days per client per grant year. **Activities:** Ensuring funds are not in the form of direct cash payments to recipients or services; and Ensuring shared access to EMR to monitor medical visits and viral load as well as living situation/housing status.	3,5,6	03/01/25-02/28/26	• Service deliveries in HIV Care Connect (HCC). • Completed RW Emergency Housing Assistance/Referral Form. • Check requests and cancelled checks to/from motels, landlords, etc.
Element #4: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Emergency Financial Assistance (EFA)
Service Goal:	The overall goal of Emergency Financial Assistance is to prevent negative client outcomes as a result of emergency financial difficulties and to assist the client in securing a financially stable living situation.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert	FY 25/26 TOTAL
Number of Clients	0	0	25	0	5	5	**35**
Number of Visits = Regardless of number of transactions or number of units	0	0	25	0	5	5	**35**
Number of Units = Transactions or 15 min encounters	0	0	175	0	35	355	**565**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Direct payment to an agency. **Element #2:** Current local limit = Maximum of three months to pay their utility bills (electricity, water, gas). **Activities:** Ensuring funds are not in the form of direct cash payments to recipients or services; and Ensuring shared access to EHR to monitor medical visits and viral load as well as living situation/housing status.	3,5,6	03/01/25-02/28/26	• Service deliveries in HIV Care Connect (HCC). • Completed RW Emergency Financial Assistance Referral Form. • Check and/or utility bill requests and cancelled checks and/or utility bill from vendor.
Element #3: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies.

Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Home & Community-Based Health Services
Service Goal:	To keep consumers out of inpatient hospitals, nursing homes, and other long-term care facilities as long as possible during illness.
Service Health Outcomes:	Reduction in inpatient, nursing home, long-term care instances; Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert	FY 25/26 TOTAL
Number of Clients	0	0	13	0	5	5	**23**
Number of Visits = Regardless of number of transactions or number of units	0	0	676	0	260	260	**1,196**
Number of Units = Transactions or 15 min encounters	0	0	10,248	0	768	768	**11,784**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Development of written care plan signed by case manager and clinical health care professional responsible for client's HIV care and indicating need for this service. Care plan must also specify the types of services needed and quantity/duration. **Element #2:** Documentation signed by professional that indicates services provided: types, dates, locations. **Element #3:** Address the medical, social, mental health, and environmental needs. **Element #4:** On-going activities to promote self-reliance. **Element #5:** Assist client in becoming actively engaged in their health care. **Element #6:** Assist with referrals and linkages to needed services. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Maintaining, and	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Care plan signed by case manager and clinical health care professional responsible for client's HIV care and indicating need for this service, the types of services needed and quantity/duration. • Chart notes documenting types, dates and locations of services provided. • Needs Assessment and home care plan in HIV Care Connect (HCC) and/or paper charts. • Health indicator trends/flowsheets/reports. • Case Conference logs. • Quality Improvement Plan. • Employment records.

documenting in, paper charts and/or HIV Care Connect (HCC); Establishing initial assessment to include assessing needs and evaluating home environment; Developing home care plan to include activities to promote self-reliance and self-management; Co-locating (to include shared electronic health records) with medical clinic, dental clinic, behavioral health and social services including case management and early intervention teams; Maintaining community referral partners; Case Conferencing; Tracking of hospitalization records, medical visits, viral loads, and assessment tools/outcomes; Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.			• MOUs/Contracts/Agreements/Letters of support from partners. • Hospitalization records • Medical visits • Viral loads
Element #7: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and update as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in electronic health record (EHR) as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Oral Health Care
Service Goal:	Improve or maintain the oral health of HIV+ clients throughout the TGA to sustain proper nutrition and positive health outcomes.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate; Improve oral health.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	464	0	15	30	**509**
Number of Visits = Regardless of number of transactions or number of units	0	0	1,920	0	58	122	**2,100**
Number of Units = Transactions or 15 min encounters	0	0	9,280	0	232	488	**10,000**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Comprehensive oral exam; **Element #2:** Development/update of a treatment plan; **Element #3:** Development of oral hygiene plan; **Element #4:** Treatment visit; **Element #5:** Preventive visit; and **Element #6:** Emergency care visit. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Maintenance of, and documentation in, electronic dental record (EDR) customized to track all required data and generate reports; Conducting oral X-rays; Providing initial, follow-up and urgent care appointments; Co-locating (to include shared electronic health records) with medical and other social services including case management and early intervention teams; Case Conferencing; Tracking of medical visits, viral loads, and reduction non-	3,5,6	03/01/25-02/28/26	• Eligibility documentation completed at least yearly. • Progress notes and radiographs in EDR. • Diagnoses and procedure codes, treatment plan signed by client, oral hygiene plans, prescriptions, medical history, lab orders/results, referrals in EDR. • Past and future appointment history in EDR. • Health indicator trends/flowsheets/reports. • Case Conference logs. • Quality Improvement Plan. • Employment records.

preventative visit rate: Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.			
Element #7: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and update as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EDR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Early Intervention Services (Part A)
Service Goal:	Quickly link HIV infected individuals to testing services, core medical services, and support services necessary to support treatment adherence and maintenance in medical care. Decrease the time between acquisition of HIV and entry into care and decrease instances of out-of-care to facilitate access to medications, decrease transmission rates, and improve health outcomes.
Service Health Outcomes:	If RW-funded testing: maintain 1.1% positivity rate or higher (targeted testing); Link newly diagnosed HIV+ to medical care in 30 days or less; Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	100	0	40	49	**189**
Number of Visits = Regardless of number of transactions or number of units	0	0	1000	0	330	400	**1730**
Number of Units = Transactions or 15 min encounters	0	0	3000	0	500	550	**4050**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Identify/locate HIV+ unaware and HIV+ that have fallen out of care. **Element #4:** Coordination with local HIV prevention programs; **Element #9:** Utilize the "Bridge" model to reconnect those that have fallen out of care; and **Element #10: Establish** and maintain formal linkages with traditional (prisons, homeless shelters, treatment centers, etc.) AND non-traditional (faith-based organizations, community centers, hospitals, etc.) entry points. **Activities: Employing** educated staff who are offered training to remain informed about epidemiology and target populations trends revealing	3, 5, 6	03/01/25-02/28/26	• Resumes of staff and staff training records. • Advertising/Promotion collateral. • No-Show reports and other functions of the EHR. • Case Conference logs. • MOU/Letters of Support/Contracts/Agreements with County of Riverside and State of California. • List of active EIS partners showing mix of traditional and non-traditional sites and schedule of partner activities (e.g. hosting our team to conduct regular testing and education, coordinating services with our mobile testing van, etc.).

characteristics of high-risk individuals so that efforts to identify/locate can be focused; Conducting advertising and promotion to those groups to make them aware of services; Tracking missed appointments and other indicators of poor treatment adherence such as declining mental health in shared electronic health records (EHR) so that reports can be generated of those who have fallen out of care and case manager can be aware of those at high risk; Case Conferencing; Establishing regular contact with local HIV prevention programs to avoid duplication of services, coordinating training opportunities, linking clients to partner counseling and referral services, implementing data-to-care efforts and conducting mandated disease reporting; Training new staff and updating current staff on The Bridge and similar interventions that can be adapted to our service area; and Employing Community Partner Liaison to support EIS team and Leadership Team to maintain relationships with diverse group of both traditional and non-traditional collaborating partners who can provide access to high risk populations.			• Service deliveries in HIV Care Connect (HCC) and documentation in EIS Logs and electronic databases. • Progress notes in HIV Care Connect (HCC). • EIS Enrollment Forms and Counseling Information Forms. • EIS logs showing documentation, when available, of the profile of individuals served as evidence of targeting efforts at high-risk populations.
Element #2: Provide testing services and/or refer high-risk unaware to testing; and **Element #6:** Provide education/information regarding availability of testing and HIV care services to HIV+, those at-risk, those affected by HIV, and caregivers. Activities that are exclusively HIV prevention education are prohibited. **Activities:** Conducting HIV testing on-site, at stationary sites throughout the community, via mobile testing unit and at special events; Delivering education/ information in conjunction with testing tailored for audience age, gender, race/ ethnicity/gender/sexual orientation, risk group, immigration status, addiction history, etc.; Maintaining partnership with on-site laboratory for confirmatory testing; Hosting State of California HIV testing training program for certification of new test counselors; Recruiting and retaining volunteer test counselors; and Maintaining walk-in Sexual Health Clinic on-site at DAP.	3,5,6	03/01/25-02/28/26	• EIS logs and Counseling Information Forms. • Records showing positivity rate of 1.1% or higher for targeted testing. • EIS Schedule showing education sessions utilizing Ryan White Part A funds were accompanied by testing. • List of partners welcoming DAP to provide testing and education services to the populations they serve. • Lease with LabCorp and evidence of interface between EHR and LabCorp. • Staff training logs. • Volunteer files. • Record of testing services provided through DAP's Sexual Health Clinic.

Element #3: One-on-one, in-depth encounters. **Element #5**: Identify and problem-solve barriers to care. **Element #7:** Referrals to testing, medical care, and support services. **Element #8:** Follow-up activities to ensure linkage. **Element #11**: Utilize standardized, required documentation to record encounters, progress; and **Element #12:** Maintain up-to-date, quantifiable data to accommodate reporting and evaluation. **Activities:** Through one-on-one sessions, working collaboratively with the client to identify greatest barriers that if addressed will expedite linkage to medical care (e.g. insurance status, income, transportation, fear and concern, etc.); Case Conferencing; Co-locating medical clinic, dental clinic, behavioral health, home health programs and other social services	3,5,6	03/01/25-02/28/26	• EIS data showing rate of linkage to medical within 30 days. • Past and present medical appointment history and most recent lab results in on-site EHR and/or in HIV Care Connect (HCC). • EIS Enrollment Forms. • Needs assessments as appropriate documented in HIV Care Connect (HCC) and/or client chart. • Case Conference logs. • Referrals and outcomes recorded in HIV Care Connect (HCC). • Progress notes in HIV Care Connect (HCC) documenting encounters as well as reduced incidence of falling out of care after EIS discharge.
such as housing, food assistance and case management; Ensuring shared medical records review health indicators to include medical visits and viral load; Maintaining network of community clinic referral options to ensure client can link to care at most convenient and preferred provider; Documenting follow-up efforts such as phone calls, emails, social media connections, in-person sessions, mail or communication with collaborating partners per client consent; Adhering to using Inland Empire HIV Planning Council and local Ryan White Program published Standards of Care and EIS policies, procedures and forms; and Maintaining Ryan White Program-approved spreadsheets and support ongoing data entry in electronic databases.			• Functions of EpicCare and LEO are customized to record required data and generate reports.
Element #13: N/A			
Element #14: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enroll staff in annual C&L Competency training; Provide care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retain additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies. • Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – MAI

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	DAP Health
Grant Period:	March 1, 2025 – February 28, 2026
Service Category:	Early Intervention Services (MAI)
Service Goal:	Quickly link HIV infected individuals to testing services, core medical services, and support services necessary to support treatment adherence and maintenance in medical care. Decrease the time between acquisition of HIV and entry into care and decrease instances of out-of-care to facilitate access to medications, decrease transmission rates, and improve health outcomes.
Service Health Outcomes:	If RW-funded testing: maintain 1.1% positivity rate or higher (targeted testing); Link newly diagnosed HIV+ to medical care in 30 days or less; Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

BLACK / AFRICAN AMERICAN	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	10	0	5	5	**20**
Number of Visits = Regardless of number of transactions or number of units	0	0	100	0	20	50	**170**
Number of Units = Transactions or 15 min encounters	0	0	200	0	150	200	**550**

HISPANIC / LATINO	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	90	0	15	15	**120**
Number of Visits = Regardless of number of transactions or number of units	0	0	900	0	180	200	**1,280**
Number of Units = Transactions or 15 min encounters	0	0	1800	0	300	800	**2,900**

TOTAL MAI (sum of two tables above)	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 25/26 TOTAL**
Number of Clients	0	0	100	0	20	20	**140**

Number of Visits = Regardless of number of transactions or number of units	0	0	1,000	0	200	250		**1,450**
Number of Units = Transactions or 15 min encounters	0	0	2,000	0	450	1,000		**3,450**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Identify/locate HIV+ unaware and HIV+ that have fallen out of care. **Element #4:** Coordination with local HIV prevention programs; **Element #9:** Utilize the "Bridge" model to reconnect those that have fallen out of care; and **Element #10: Establish** and maintain formal linkages with traditional (prisons, homeless shelters, treatment centers, etc.) AND non-traditional (faith-based organizations, community centers, hospitals, etc.) entry points. **Activities:** Employing educated staff who are offered training to remain informed about epidemiology and target populations trends revealing characteristics of high-risk individuals so that efforts to identify/locate can be focused; Conducting advertising and promotion to those groups to make them aware of services; Tracking missed appointments and other indicators of poor treatment adherence such as declining mental health in shared electronic health records (EHR) so that reports can be generated of those who have fallen out of care and case manager can be aware of those at high risk; Case Conferencing; Establishing regular contact with local HIV prevention programs to avoid duplication of services, coordinating training opportunities, linking clients to partner counseling and referral services, implementing data-to-care efforts and conducting mandated disease reporting; Training new staff and updating current staff on The Bridge and similar interventions that can be adapted to our service area; and Employing Community Partner Liaison to support EIS team and Leadership Team to maintain relationships with diverse group of both traditional and non-traditional collaborating partners who can provide access to high risk populations.	3,5,6	03/01/25-02/28/26	• Resumes of staff and staff training records. • Advertising/Promotion collateral. • No-Show reports and other functions of the EHR. • Case Conference logs. • MOU/Letters of Support/Contracts/Agreements with County of Riverside and State of California. • List of active EIS partners showing mix of traditional and non-traditional sites and schedule of partner activities (e.g. hosting our team to conduct regular testing and education, coordinating services with our mobile testing van, etc.). • Service deliveries in HIV Care Connect (HCC) and documentation in EIS Logs and electronic databases. • Progress notes in HIV Care Connect (HCC). • EIS Enrollment Forms and Counseling Information Forms. • EIS logs showing documentation, when available, of the profile of individuals served as evidence of targeting efforts at high-risk populations.
Element #2: Provide testing services and/or refer high-risk unaware to testing; and **Element #6:** Provide education/information regarding availability of testing and HIV care services to HIV+, those at-risk, those affected by	3,5,6	03/01/25-02/28/26	• EIS logs and Counseling Information Forms. • Records show showing positivity rate of 1.1% or higher for targeted testing.

HIV, and caregivers. Activities that are exclusively HIV prevention education are prohibited. **Activities:** Conducting HIV testing on-site, at stationary sites throughout the community, via mobile testing unit and at special events; Delivering education/information in conjunction with testing tailored for audience age, gender, race/ethnicity/gender/sexual orientation, risk group, immigration status, addiction history, etc.; Maintaining partnership with on-site laboratory for confirmatory testing; Hosting State of California HIV testing training program for certification of new test counselors; Recruiting and retaining volunteer test counselors; and Maintaining walk-in Sexual Health Clinic on-site at DAP			• EIS Schedule showing education sessions utilizing Ryan White Part A funds were accompanied by testing. • List of partners welcoming DAP to provide testing and education services to the populations they serve. • Lease with LabCorp and evidence of interface between EHR and LabCorp. • Staff training logs. • Volunteer files. • Record of testing services provided through DAP's Sexual Health Clinic.
Element #3: One-on-one, in-depth encounters. **Element #5:** Identify and problem-solve barriers to care. **Element #7:** Referrals to testing, medical care, and support services. **Element #8:** Follow-up activities to ensure linkage. **Element #11:** Utilize standardized, required documentation to record encounters, progress; and **Element #12:** Maintain up-to-date, quantifiable data to accommodate reporting and evaluation. **Activities:** Through one-on-one sessions, working collaboratively with the client to identify greatest barriers that if addressed will expedite linkage to medical care (e.g. insurance status, income, transportation, fear and concern, etc.); Case Conferencing; Co-locating medical clinic, dental clinic, behavioral health, home health programs and other social services such as housing, food assistance and case management; Ensuring shared medical records review health indicators to include medical visits and viral load; Maintaining network of community clinic referral options to ensure client can link to care at most convenient and preferred provider; Documenting follow-up efforts such as phone calls, emails, social media connections, in-person sessions, mail or communication with collaborating partners per client consent; Adhering to using Inland Empire HIV Planning Council and local Ryan White Program published Standards of Care and EIS policies, procedures and forms; and Maintaining Ryan White Program-approved spreadsheets and support ongoing data entry in electronic databases.	3,5,6	03/01/25-02/28/26	• EIS data showing rate of linkage to medical within 30 days. • Past and present medical appointment history and most recent lab results in on-site EHR and/or in HIV Care Connect (HCC). • EIS Enrollment Forms. • Needs assessments as appropriate documented in HIV Care Connect (HCC) and/or client chart. • Case Conference logs. • Referrals and outcomes recorded in HIV Care Connect (HCC). • Progress notes in HIV Care Connect (HCC) documenting encounters as well as reduced incidence of falling out of care after EIS discharge. • Functions of EpicCare and LEO are customized to record required data and generate reports.
Element #13: Develop and implement specific, evidence-based strategies proven effective for African American and/or Hispanic populations. **Element #14:** Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enroll staff in annual C&L Competency training; Provide care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects, and respects gender and sexual diversity of community served; Recruiting, retaining and promoting	3,5,6	03/01/25-02/28/26	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies.

diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retain additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• Race, ethnicity and language proficiency recorded in HIV Care Connect (HCC). • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

DAP Health
Ryan White Part A
Line Item Budget: Medical Case Management
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Nebgen, Harlie; Case Mgmt & EIS Manager	$ 83,608	0.2	$ 16,722	$ 16,722		$ 16,722
	Welden, Zayda; Senior Director of Social Services	$ 147,361	0.1	$ 14,736	$ 14,736		$ 14,736
	Smith, Garrett, Eligibility Specialist	$ 45,198	0.2	$ 9,040	$ 9,040		$ 9,040
	Aguilera, Jazmin; Eligibility Specialist	$ 44,782	0.2	$ 8,956	$ 8,956		$ 8,956
	Castilllo, Azuel; Medical Case Manager	$ 56,763	0.2	$ 11,353	$ 11,353		$ 11,353
	Villeda, Betsy; Medical Case Manager	$ 56,763	0.2	$ 11,353	$ 11,353		$ 11,353
	Lainez, Roxane; Medical Case Manger	$ 51,438	0.2	$ 10,288	$ 10,288		$ 10,288
	Kiley, Carol; Medical Case Manager	$ 65,811	0.2	$ 13,162	$ 13,162		$ 13,162
	Flores, Monica; Medical Case Manager	$ 50,190	0.2	$ 10,038	$ 10,038		$ 10,038
	Padilla, Samantha; Medical Case Manager	$ 56,763	0.2	$ 11,353	$ 11,353		$ 11,353
	Ramirez, Gilbert; Medical Case Manager Superviso	$ 63,960	0.2	$ 12,792	$ 12,792		$ 12,792
	Segura, Salley; Medical Case Manager	$ 49,920	0.2	$ 9,984	$ 9,984		$ 9,984
	Contreras, Alejandro; Medical Case Manager	$ 50,190	0.2	$ 10,038	$ 10,038		$ 10,038
	Vacant-TBD; Medical Case Manager	$ 50,000	0.2	$ 10,000	$ 10,000		$ 10,000
	Reed, Daniel, Soc. Serv. Data Entry Assistant	$ 40,202	0.15	$ 6,030	$ 6,030		$ 6,030
	Avila, Joseph; Soc. Serv. Programs Assistant	$ 47,840	0.15	$ 7,176	$ 7,176		$ 7,176
	Personnel Subtotal			**$ 173,020**	**$ 173,020**	**$ -**	**$ 173,020**

Fringe			**Percent**	**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 46,715	$ 46,715	$ -	$ 46,715
	Fringe Subtotal		**27.0%**	**$ 46,715**	**$ 46,715**	**$ -**	**$ 46,715**

Total Personnel							**$ 219,735**

Equipment	Equipment > $5,000			**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Computer software and hardware			$ 5,000	$ 5,000		$ 5,000
	Equipment Total			**$ 5,000**	**$ 5,000**		**$ 5,000**

Supplies				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Office supplies, small tools and equipment			$ 995	$ 995		$ 995
	Supplies Total			**$ 995**	**$ 995**		**$ 995**

Direct				$ 225,730	$ 225,730		$ 225,730
Admin	Administration (limited to 10% of total service budget)					$ 22,954	$ 22,954
GRAND TOTAL				**$ 225,730**	**$ 225,730**	**$ 22,954**	**$ 248,684**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 11,550
- Total RW Funding Divided by Units to be Provided: 21.53

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Medical Case Management
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 173,020**

Nebgen, Harlie; Case Mgmt & EIS Manager - 0.20 FTE @ $83,608/year
Provides professional oversight of the delivery of MCM to ensure consistent and high quality services, client satisfaction, positive health outcomes, progress toward clinical quality improvement measures, compliance with policies and procedures, Standards of Care and National Monitoring Standards. Works with clients facing acute needs to ensure productive and beneficial Medical Case Manager assignments and facilitates re-assignments as requested. Informs clients of new and updated policies for public benefits programs.

Welden, Zayda; Director of Social Services - 0.10 FTE @ $147,361/year
Provides professional oversight of the delivery of MCM to ensure consistent and high quality services, client satisfaction, positive health outcomes, progress toward clinical quality improvement measures, compliance with policies and procedures, Standards of Care and National Monitoring Standards. Works with clients facing acute needs to ensure productive and beneficial Medical Case Manager assignments and facilitates re-assignments as requested. Informs clients of new and updated policies for public benefits programs.

Smith, Garrett, Eligibility Specialist - 0.20 FTE @ $45,198/year
Aguilera, Jazmimn; Eligibility Specialist - 0.20 FTE @ $44,782/year
Serves as the first point of contact for new clients to review, update and assist in establishing eligibility for Ryan White-funded PSS and other available state, county and local programs to assess payer of last resort, reviews income and residency eligibility and other general issues of compliance with the Standards of Care. Perform bi-annual eligibility recertifications with clients. Performs data entry related to client eligibility recertification for PSS. On behalf of client participates in case conferencing and

Castillo, Azusel; Medical Case Manager - 0.20 FTE @ $56,763/year
Villeda, Betsy; Medical Case Manager - 0.20 FTE @ $56,763/year
Lainez, Roxane; Medical Case Manger - 0.20 FTE @ $51,438/year
Kiley, Carol; Medical Case Manager - 0.20 FTE @ $65,811/year
Flores, Monica; Medical Case Manager - 0.20 FTE @ $50,190/year
Padilla, Samantha; Medical Case Manager - 0.20 FTE @ $56,763/year
Ramirez, Gilbert; Medical Case Manager Supervisor - 0.20 FTE @ $63,960/year
Segura, Salley; Medical Case Manager - 0.20 FTE @ $49,920/year
Contreras, Alejandro; Medical Case Manager - 0.20 FTE @ $50,190/year
Vacant-TBD; Medical Case Manager - 0.20 FTE @ $50,000/year

Provides intensive support and care coordination for clients requiring Medical Case Management as defined by standards of care and D.A.P. Policies and Procedures. Assess and document client's mental, social, financial and functional status, determines eligibility for services. Recommends, refers and coordinates client services including financial/budgeting counseling, public assistance, benefits specialists, insurance options, dental care, transportation, legal, mental health, health, prescriptions, etc. Coordinates medical/health services for an assigned HIV positive client population. With client, prepares a collaborative case management plan to coordinate access to medically appropriate health and support services required for continuity of care including physician care, pharmacy, mental health, psychosocial, nutrition, housing, etc. Prepares complete, accurate and timely documentation of all client interactions. Provides ongoing assessment of client needs and personal support system, updating the coordinated care plan as needed to effectively and efficiently maintain continuity of care and improve the overall health of the client. Participates in case conference meetings. Provides crisis intervention as necessary.

Reed, Daniel, Soc. Serv. Data Entry Assistant - 0.15 FTE @ $40,202/year
Answers New Client Intake line, answers questions of potential clients and family members and initiates enrollment process for new clients. Assists in chart review audit including outcomes monitoring. Participates in case conferencing and supports internal and external referrals as needed to ensure quality MCM.

Avila, Joseph; Soc. Serv. Programs Assistant - 0.15 FTE @ $47,840/year
Answers New Client Intake line, answers questions of potential clients and family members and initiates enrollment process for new clients. Assists in chart review audit including outcomes monitoring. Participates in case conferencing and supports internal and external referrals as needed to ensure quality MCM.

Fringe FICA, staff insurance, retirement, disability, work's compensation, other benefits **$ 46,715**

Equipment

Equipment > $5,000	$	5,000

Computer Software and Hardware

Medical record and health information systems computer software and hardware costs (less than $4,999 each), necessary to document treatment plans, services provided, track compliance with treatment, health outcomes, test results and other information necessary to provide medical services. Includes the annual software license renewals and maintenance contracts.Monthly cost @ ~416.66 x 12 months = $5,000.

Supplies	$	995

Office Supplies, small tools and equipment

Standard office supplies, tools and minor equipment (i.e.: paper, related copy supplies, pens, pencils, tablets, paper clips, desk/office supplies, and other miscellaneous items), calculators, printers, scanners, keyboards, mouse, etc. No item's cost exceeds $4,999. Monthly cost @ ~82.92 x 12 months = $995.

Direct Costs Total	$	225,730
Administrative Costs	$	22,954

HRSA - 2 CFR 200.414(f) ~ 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = 10% Administrative Cost.

DAP Health
Ryan White Part A
Line Item Budget: Case Management Non-Medical
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Nebgen, Harlie; Case Mgmt & EIS Manager	$ 83,608	0.25	$ 20,902	$ 20,902		$ 20,902
	Welden, Zayda; Senior Director of Social Services	$ 147,361	0.1	$ 14,736	$ 14,736		$ 14,736
	Smith, Garrett, Eligibility Specialist	$ 45,198	0.3	$ 13,559	$ 13,559		$ 13,559
	Aguilera, Jazmin; Eligibility Specialist	$ 44,782	0.3	$ 13,435	$ 13,435		$ 13,435
	Castilllo, Azuel; Medical Case Manager	$ 56,763	0.3	$ 17,029	$ 17,029		$ 17,029
	Villeda, Betsy; Medical Case Manager	$ 56,763	0.3	$ 17,029	$ 17,029		$ 17,029
	Lainez, Roxane; Medical Case Manger	$ 51,438	0.3	$ 15,431	$ 15,431		$ 15,431
	Kiley, Carol; Medical Case Manager	$ 65,811	0.3	$ 19,743	$ 19,743		$ 19,743
	Flores, Monica; Medical Case Manager	$ 50,190	0.3	$ 15,057	$ 15,057		$ 15,057
	Padilla, Samantha; Medical Case Manager	$ 56,763	0.3	$ 17,029	$ 17,029		$ 17,029
	Ramirez, Gilbert; Medical Case Manager Supervisor	$ 63,960	0.3	$ 19,188	$ 19,188		$ 19,188
	Segura, Salley; Medical Case Manager	$ 49,920	0.3	$ 14,976	$ 14,976		$ 14,976
	Contreras, Alejandro; Medical Case Manager	$ 50,190	0.3	$ 15,057	$ 15,057		$ 15,057
	Vacant-TBD; Medical Case Manager	$ 50,000	0.3	$ 15,000	$ 15,000		$ 15,000
	Reed, Daniel, Soc. Serv. Data Entry Assistant	$ 40,202	0.2	$ 8,040	$ 8,040		$ 8,040
	Avila, Joseph; Soc. Serv. Programs Assistant	$ 47,840	0.15	$ 7,176	$ 7,176		$ 7,176
	Personnel Subtotal			**$ 243,388**	**$ 243,388**	**$ -**	**$ 243,388**

Fringe			**Percent**	**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 65,715	$ 65,715	$ -	$ 65,715
	Fringe Subtotal		**27.0%**	**$ 65,715**	**$ 65,715**	**$ -**	**$ 65,715**

Total Personnel							**$ 309,103**

Equipment	Equipment > $5,000			**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Computer software and hardware			$ 18,959	$ 18,959		$ 18,959
	Equipment Total			**$ 18,959**	**$ 18,959**		**$ 18,959**

Supplies				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Office supplies, small tools and equipment			$ 5,000	$ 5,000		$ 5,000
	Supplies Total			**$ 5,000**	**$ 5,000**		**$ 5,000**

Other				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Training, conferences and educational seminars			$ 7,500	$ 7,500		$ 7,500
	Other Total			**$ 7,500**	**$ 7,500**	**$ -**	**$ 7,500**

Direct				$ 340,562	$ 340,562		$ 340,562
Admin	Administration (limited to 10% of total service budget)					$ 32,985	$ 32,985
GRAND TOTAL				**$ 340,562**	**$ 340,562**	**$ 32,985**	**$ 373,547**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

· Total Number of RW Units to be Provided for this Service Category: 30,000
· Total RW Funding Divided by Units to be Provided: 12.45

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Case Management Non-Medical
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 243,388**

Nebgen, Harlie; Case Mgmt & EIS Manager - 0.25 FTE @ $83,608/year
Provides professional oversight of the delivery of MCM to ensure consistent and high quality services, client satisfaction, positive health outcomes, progress toward clinical quality improvement measures, compliance with policies and procedures, Standards of Care and National Monitoring Standards. Works with clients facing acute needs to ensure productive and beneficial Medical Case Manager assignments and facilitates re-assignments as requested. Informs clients of new and updated policies for public benefits programs.

Welden, Zayda; Director of Social Services - 0.10 FTE @ $147,361/year
Provides professional oversight of the delivery of MCM to ensure consistent and high quality services, client satisfaction, positive health outcomes, progress toward clinical quality improvement measures, compliance with policies and procedures, Standards of Care and National Monitoring Standards. Works with clients facing acute needs to ensure productive and beneficial Medical Case Manager assignments and facilitates re-assignments as requested. Informs clients of new and updated policies for public benefits programs.

Smith, Garrett, Eligibility Specialist - 0.30 FTE @ $45,198/year
Aguilera, Jazmimn; Eligibility Specialist - 0.30 FTE @ $44,782/year
Serves as the first point of contact for new clients to review, update and assist in establishing eligibility for Ryan White-funded PSS and other available state, county and local programs to assess payer of last resort, reviews income and residency eligibility and other general issues of compliance with the Standards of Care. Perform bi-annual eligibility recertifications with clients. Performs data entry related to client eligibility recertification for PSS. On behalf of client participates in case conferencing and makes integral referrals to link clients to care and services.

Castillo, Azusel; Medical Case Manager - 0.30 FTE @ $56,763/year
Villeda, Betsy; Medical Case Manager - 0.30 FTE @ $56,763/year
Lainez, Roxane; Medical Case Manger - 0.30 FTE @ $51,438/year
Kiley, Carol; Medical Case Manager - 0.30 FTE @ $65,811/year
Flores, Monica; Medical Case Manager - 0.30 FTE @ $50,190/year
Padilla, Samantha; Medical Case Manager - 0.30 FTE @ $56,763/year
Ramirez, Gilbert; Medical Case Manager Supervisor - 0.30 FTE @ $63,960/year
Segura, Salley; Medical Case Manager - 0.30 FTE @ $49,920/year
Contreras, Alejandro; Medical Case Manager - 0.30 FTE @ $50,190/year
Vacant-TBD; Medical Case Manager - 0.30 FTE @ $50,000/year

Provides intensive support and care coordination for clients requiring Medical Case Management as defined by standards of care and D.A.P. Policies and Procedures. Assess and document client's mental, social, financial and functional status, determines eligibility for services. Recommends, refers and coordinates client services including financial/budgeting counseling, public assistance, benefits specialists, insurance options, dental care, transportation, legal, mental health, health, prescriptions, etc. Coordinates medical/health services for an assigned HIV positive client population. With client, prepares a collaborative case management plan to coordinate access to medically appropriate health and support services required for continuity of care including physician care, pharmacy, mental health, psychosocial, nutrition, housing, etc. Prepares complete, accurate and timely documentation of all client interactions. Provides ongoing assessment of client needs and personal support system, updating the coordinated care plan as needed to effectively and efficiently maintain continuity of care and improve the overall health of the client. Participates in case conference meetings. Provides crisis intervention as necessary.

Reed, Daniel, Soc. Serv. Data Entry Assistant - 0.20 FTE @ $40,202/year
Answers New Client Intake line, answers questions of potential clients and family members and initiates enrollment process for new clients. Assists in chart review audit including outcomes monitoring. Participates in case conferencing and supports internal and external referrals as needed to ensure quality CMNM.

Avila, Joseph; Soc. Serv. Programs Assistant - 0.15 FTE @ $47,840/year
Answers New Client Intake line, answers questions of potential clients and family members and initiates enrollment process for new clients. Assists in chart review audit including outcomes monitoring. Participates in case conferencing and supports internal and external referrals as needed to ensure quality CMNM.

Fringe **$ 65,715**
FICA, staff insurance, retirement, disability, work's compensation, other benefits

Equipment
Equipment > $5,000 **$ 18,959**
Computer Software and Hardware
Medical record and health information systems computer software and hardware costs (less than $4,999 each), necessary to document treatment plans, services provided, track compliance with treatment, health outcomes, test results and other information necessary to provide medical services. Includes the annual software license renewals and maintenance contracts.Monthly cost @ ~1,579.92 x 12 months = $18,959.

Supplies **$ 5,000**
Office Supplies, small tools and equipment
Standard office supplies, tools and minor equipment (i.e.: paper, related copy supplies, pens, pencils, tablets, paper clips, desk/office supplies, and other miscellaneous items), calculators, printers, scanners, keyboards, mouse, etc. No item's cost exceeds $4,999. Monthly cost @ ~$417 x 12 months = $5,000.

Other
Training/Conference/Educational Seminars **$ 7,500**
Costs associated with professional development required by contract to increase staff knowledge about and expertise to deliver services to low-income people living with HIV. Cost ~$500 per Personnel x 15 Personnel = $7,500

Direct Costs Total **$ 340,562**

Administrative Costs **$ 32,985**

HRSA - 2 CFR 200.414(f) ~ 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = 10% Administrative Cost.

DAP Health
Ryan White Part A
Line Item Budget: HCBHS
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Welden, Zayda; Director of Social Services	$ 147,361	0.10	$ 14,736	$ 14,736		$ 14,736
	Baxter, Shelly; RN Case Mgr	$ 93,777	0.14	$ 13,129	$ 13,129		$ 13,129
	Becker, JoAnn; Social Work Case Manager	$ 95,885	0.14	$ 13,424	$ 13,424		$ 13,424
	Francis, Carolyn; Program Asst-In-Home Staff Supervisor	$ 75,995	0.14	$ 10,639	$ 10,639		$ 10,639
	Nelson, Stefany; Social Work Case Manager	$ 87,305	0.14	$ 12,223	$ 12,223		$ 12,223
	Thompson, Kathleen; RN Case Mgr	$ 85,407	0.14	$ 11,957	$ 11,957		$ 11,957
	Reed, Dan; Soc. Serv. Data Entry Assistant	$ 40,202	0.10	$ 4,020	$ 4,020		$ 4,020
	Sandlin, Rebecca; Home Care Supportive Serv. Mgr.	$ 100,888	0.14	$ 14,124	$ 14,124		$ 14,124
	Jassso, Jazlyn; Home Health Aide/Homemaker	$ 50,000	0.10	$ 5,000	$ 5,000		$ 5,000
	Personnel Subtotal			**$ 99,252**	**$ 99,252**	**$ -**	**$ 99,252**

Fringe			Percent	Program Cost	Direct Costs	Admin Costs	Program Total
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 26,798	$ 26,798	$ -	$ 26,798
	Fringe Subtotal		**27.0%**	**$ 26,798**	**$ 26,798**	**$ -**	**$ 26,798**

Total Personnel							**$ 126,050**

Travel				Program Cost	Direct Costs	Admin Costs	Program Total
	Mileage			$ 2,000	$ 2,000		$ 2,000
	Travel Total			**$ 2,000**	**$ 2,000**	**$ -**	**$ 2,000**

Supplies				Program Cost	Direct Costs	Admin Costs	Program Total
	Office supplies, small tools and equipment			$ 920	$ 920		$ 920
	Computer software and hardware			$ 500	$ 500		$ 500
	Supplies Total			**$ 1,420**	**$ 1,420**		**$ 1,420**

Contractual				Program Cost	Direct Costs	Admin Costs	Program Total
	Certified Home Health Aide/Homeamker - Elder Love			$ 60,000	$ 60,000		$ 60,000
	Contractual Total			**$ 60,000**	**$ 60,000**		**$ 60,000**

Other				Program Cost	Direct Costs	Admin Costs	Program Total
	Training/Conference/Educational Seminars			$ 500	$ 500		$ 500
	Other Total			**$ 500**	**$ 500**		**$ 500**

Direct				$ 189,970	$ 189,970		$ 189,970
Admin	Administration (limited to 10% of total service budget)					$ 18,997	$ 18,997
GRAND TOTAL				**$ 189,970**	**$ 189,970**	**$ 18,997**	**$ 208,967**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 11,784
- Total RW Funding Divided by Total RW Units to be Provided: 17.73

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: HCBHS
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 99,252**

Welden, Zayda; Director of Social Services - 0.10 FTE @ $147,361/year

Works closely with HCBHS team to ensure continuity of client care, quality, HIPAA compliance/guidelines, and achievement of HRSA performance measures. Provides professional oversight and direction to HCBHS team to assure client satisfaction and positive health outcomes. Expeditiously handles patient's grievances and complaints related to HCBHS. Evaluates new potential referral services for current patients and outreach to the unaware, out of care and/or newly diagnosed.

Baxter, Shelly; RN Case Manager - 0.14 FTE @ $93,777/year
Thompson, Kathleen; RN Case Manager - 0.14 FTE @ $85,1407/year

RN CM is an advocate and care coordinator for at risk patients, including hospital discharge, non- compliance for management of chronic disease, newly diagnosed for chronic disease or cancer, frail elderly or emergency room high utilization. The RN Case Manager is responsible for making an in depth assessment of a client's needs and provides appropriate interventions that will improve the outcome, provide appropriate access to care, decrease re-hospitalization or provide other support systems for the management of the condition. Conducts a thorough needs assessment based on the risk factor or diagnosis provided at the time of referral. This may include a medical history, functional abilities and social components including family support systems, ability to function independently, ability to obtain medication and understand the prescription, language skills and medical insurance status. Coordinates care with the SW Case Manager also assigned to the client.

Becker, JoAnn; Social Work Case Manager - 0.14 FTE @ $95,885/year
Nelson, Stefany; Social Work Case Manager - 0.14 FTE @ $87,305/year

The Social Work Case Manager conducts assessments of clients and coordinates the delivery and/or referrals of social, medical, psycho social and/or in home services to persons with HIV infection who are patients of a health and/or rehabilitation facility in a manner consistent with the policies and procedures of DAP Health and related program protocols. Additionally, as a member of the Home Care Team this role will coordinate client discharge and ensure provision of services in accordance with Comprehensive Client Service Plan Also, while serving as a representative, acting as a resource/referral source for clients, making recommendations concerning their social and practical needs. Coordinates care with the Medical Case Manager RN also assigned to the client. As a member of the Home Care Team, this role will coordinate and ensure provision of services in accordance with Comprehensive Client Service Plan Also, while serving as a representative, acting as a resource/referral source for clients, making recommendations concerning their social and practical needs. Coordinates care with the Medical Case Manager RN also assigned to the client.

Francis, Carolyn; Program Assistant - In-Home Staff Supervisor - 0.14 FTE @ $75,995/year

This role provides administrative support to the Home Care Supportive Services Manager, as well as be responsible for supervising Homemakers/CHHAs/CNAs to ensure effective client care while following RW standards of Care and DAP Health guidelines and protocols. Schedule In-Home Care staff according to client's assessments and needs stablished by the Case Management team.

Reed, Daniel; Social Services Data Entry Assistant - 0.10 FTE @ $40,202/year

Answers New Client Intake line, answers questions of potential clients and family members and initiates enrollment process for new clients. Assists in chart review audit including outcomes monitoring. Participates in case conferencing and supports internal and external referrals as needed to ensure quality CMNM.

Sandlin, Rebecca; Home Care Supportive Services Manager - 0.14 FTE @ $100,888/year

Works closely with HCBHS team to ensure continuity of client care, quality, HIPAA compliance/guidelines, and achievement of HRSA performance measures. Provides professional oversight and direction to HCBHS team to assure client satisfaction and positive health outcomes. Expeditiously handles patient's grievances and complaints related to HCBHS. Evaluates new potential referral services for current patients and outreach to the unaware, out of care and/or newly diagnosed.

Jassso, Jazlyn; Home Health Aide/Homemaker - 0.10 FTE @ $50,000/year

Provides in-home care and assistance per care plan to include skilled health services and personal care services in the home. Reports on client progress and/or continued needs for in-home care to RN Case Manager and Social Worker.

Fringe **$ 26,798**

FICA, staff insurance, retirement, disability, work's compensation, other benefits

Travel **$ 2,000**

Mileage

Reimbursement for travel for the delivery or improvement of HCBHS at IRS determined mileage rates. (current IRS rate is applicable). Mileage at 0.70 x 2,857 miles = $2,000.

Supplies **$ 1,420**

Office supplies, small tools and equipment

Standard office supplies, tools and minor equipment (i.e.: paper, related copy supplies, pens, pencils, tablets, paper clips, desk/office supplies, and other miscellaneous items), calculators, printers, scanners, keyboards, mouse, etc. No item's cost exceeds $4,999. Monthly cost ~76.66 per month x 12 months = $920.

Computer software and hardware

Medical record and health information systems computer software and hardware costs (less than $4,999 each), necessary to document treatment plans, services provided, track compliance with treatment, health outcomes, test results and other information necessary to provide medical services. Includes the annual software license renewals and maintenance contracts. Monthly cost ~ 41.66 per month x 12 months = $500.

Contractual **$ 60,000**

Certified Home Health Aide/Homeamker - Elder Love

Provided by home health attendant care givers, home health homemakers and home health nursing through agency personnel. Provides in-home care and assistance per care plan to include skilled health services and personal care services in the home. Reports on client progress and/or continued needs for in-home care to RN Case Manager and Social Worker. Monthly cost ~5,000 per month x 12 months = $60,000.

Other **$ 500**

Training/Conference/Educational Seminars

Costs associated with professional development required by contract to increase staff knowledge about and expertise to deliver services to low-income people living with HIV. ~50.00 per Personnel x 10 Personnel = $500.

Direct Costs Total **$ 189,970**

Administrative Costs **$ 18,997**

HRSA - 2 CFR 200.414(f) - 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = ~10% Administrative Cost.

DAP Health
Ryan White Part A
Line Item Budget: Psychosocial
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Rossetti, Steven; Career Development Specialist	$ 58,718	0.15	$ 8,808	$ 8,808	$ -	$ 8,808
	Stargardt, Scott; Peer Support Specialist	$ 45,240	0.15	$ 6,786	$ 6,786	$ -	$ 6,786
	Gutierrez, Juan; Computer Educator	$ 21,840	0.15	$ 3,276	$ 3,276		$ 3,276
	Howard, Curtis; Wellness Center Administrative Ast.	$ 50,253	0.15	$ 7,538	$ 7,538	$ -	$ 7,538
	Lujan, Corina; Wellness Services Center Manager	$ 81,408	0.10	$ 8,141	$ 8,141		$ 8,141
	Personnel Subtotal			**$ 34,548**	**$ 34,548**	**$ -**	**$ 34,548**

Fringe			Percent	Program Cost	Direct Costs	Admin Costs	Program Total
	FICA, Insurance, Retirement, Disability, Workers Compensation		27.0%	$ 9,328	$ 9,328	$ -	$ 9,328
	Fringe Subtotal		**27.0%**	**$ 9,328**	**$ 9,328**	**$ -**	**$ 9,328**

Total Personnel							**$ 43,877**

Supplies				Program Cost	Direct Costs	Admin Costs	Program Total
	Office supplies, small tools and equipment			$ 1,000	$ 1,000		$ 1,000
	Computer software and hardware			$ 1,000	$ 1,000		$ 1,000
	Printing/reproduction			$ 1,000	$ 1,000		$ 1,000
	Supplies Total			**$ 3,000**	**$ 3,000**		**$ 3,000**

Other				Program Cost	Direct Costs	Admin Costs	Program Total
	Training/Conferences/Educational Seminars			$ 6,203.00	$ 6,203.00		$ 6,203.00
	Community Advisory Board (CAB)			$ 2,781.00	$ 2,781.00		$ 2,781.00
	Other Total			**$ 8,984.00**	**$ 8,984.00**		**$ 8,984.00**

Direct				$ 55,861	$ 55,861		$ 55,861
Admin	Administration (limited to 10% of total service budget)					$ 5,266	$ 5,266
GRAND TOTAL				**$ 55,861**	**$ 55,861**	**$ 5,266**	**$ 61,127**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 17,056
- Total RW Funding Divided by Total RW Units to be Provided: 3.58

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Psychosocial
Budget Period 3/1/2025 - 2/29/2026

Direct Costs

Personnel **$ 34,548**

Lujan, Corina; Wellness Services Center Manager - 0.10 @ $81,408/year

Develops and implements Community Center programming for clients such as psychosocial activities, bereavement counseling, nutrition counseling, computer skill building, caregiver support groups, fitness and complementary therapies for people living with HIV. Supervises volunteer and peer-led support group leaders. Provides direct health education and psychosocial support counseling/referrals as well as assists clients in delivering peer-led activities.

Rossetti, Steven; Career Development Specialist - .15 @ $58,718/year

Ensures that psychosocial support services compliment client care and services and contribute to desired health outcomes. Develops and leads career and workforce development services for clients to support positive health outcomes and promote self-management skills. Works with clients to link to community and business support services that will support their treatment plans.

Stargardt, Scott; Peer Support Specialist - 0.15 @ $45,240/year

Ensures that psychosocial support services complement client care and services and contribute to desired health outcomes. Develops and leads psychosocial support groups for clients to support positive health outcomes and promote self-management skills. Works with clients to link to psychosocial support services that will support their treatment plans.

Gutierrez, Juan: Computer Educator - 0.15 FTE @ $21,840/year

Ensures that psychosocial support services compliment client care and services and contribute to desired health outcomes. Develops and leads career and workforce development services for clients to support positive health outcomes and promote self-management skills. Works with clients to link to community and business support services that will support their treatment plans.

Howard, Curtis; Wellness Center Administrative Ast. - 0.15 @ $50,253/year

Oversees wellness program activities, schedules attendance, instructors, locations. For direct service delivery of support groups, documents treatments, progress, and outcome for reporting purposes under the direct supervision of Wellness Services Center Manager.

Fringe **$ 9,328**

FICA, Insurance, Retirement, Disability, Workers Compensation

Supplies **$ 3,000**

Office supplies, small tools and equipment

Standard office supplies, tools, and minor equipment (i.e.: paper, related copy supplies, pens, pencils, tablets, paper clips, desk/office supplies, and other miscellaneous items), calculators, printers, scanners, keyboards, mouse, etc. No item's cost exceeds $4.999. Supports 5 Personnel. ~$83/month x grant year 12 months = $1,000.

Computer software and hardware

Medical record and health information systems computer software and hardware costs (less than $4,999 each), necessary to document treatment plans, services provided, track compliance with treatment, health outcomes, test results and other information necessary to provide medical services. Includes the annual software license renewals and maintenance contracts. Supports 5 Personnel ~$83/month x grant year 12 months = $1,000.

Printing/reproduction

Projected costs to cover printed material, copier/duplicating costs and services, flyers, patient educational and information materials, privacy notices and other related reproduction costs associated with the proposed program service. Supports 5 Personnel. ~$83/month x grant year 12 months = $1,000.

Other

Training/Conference/Educational Seminar **$ 8,984**

Costs associated with staff professional development and client educational programming to increase best practices and knowledge about program service delivery and/or education for people living with HIV. Supports 5 Personnel and SOW ~ 82 clients. ~$517/month x grant year 12 months = $6,203

Community Advisory Board

Costs associated with program service delivery for DAP Health's CAB expenditures (e.g. mileage, printing, professional development). SOW ~ 82 clients. ~$232/month x grant year 12 months = $2,781

Direct Costs Total **$ 55,861**

Administrative Costs **$ 5,266**

HRSA - 2 CFR 200.414(f) - 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = 10% Administrative Cost.

DAP Health
Ryan White Part A
Line Item Budget: Food
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Program Total
Personnel						
	Welden, Zayda; Senior Director of Social Services	$ 147,361	0.10	$ 14,736	$ 14,736	$ 14,736
	Key, Brianna; Food & Transportation Pgms Coordinator	$ 59,405	0.30000	$ 17,822	$ 17,822	$ 17,822
	Avila, Joseph; Food & Transportation Pgms Associate	$ 47,840	0.20000	$ 9,568	$ 9,568	$ 9,568
	Personnel Subtotal			**$ 42,126**	**$ 42,126**	**$ 42,126**

Fringe			**Percent**	**Program Cost**	**Direct Costs**	**Program Total**
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 11,374	$ 11,374	$ 11,374
	Fringe Subtotal		**27.0%**	**$ 11,374**	**$ 11,374**	**$ 11,374**

Total Personnel		**$ 53,500**

Supplies				**Program Cost**	**Direct Costs**	**Program Total**
	Food Vouchers/Assistance			$ 383,918	$ 383,918	$ 383,918
	Supplies Total			**$ 383,918**	**$ 383,918**	**$ 383,918**

Direct				$ 437,418	$ 437,418	$ 437,418
Subtotal						**$ 437,418**
GRAND TOTAL				**$ 437,418**	**$ 437,418**	**$ 437,418**
%				100%	100%	100%

* Only include these in "Other" if they are not already included in Indirect

· Total Number of RW Units to be Provided for this Service Category: 36,600 $ 0
· Total RW Funding Divided by Total RW Units to be Provided: 11.95

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Food
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 42,126**

Welden, Zayda; Senior Director of Social Services - 0.10 FTE @ $147,361/year

Provides professional oversight of the delivery of Food Services to ensure consistent and high quality services, client satisfaction, positive health outcomes, progress toward clinical quality improvement measures, compliance with policies and procedures, Standards of Care and National Monitoring Standards.

Key, Brianna; Food & Transportation Programs Coordinator - 0.30 FTE @ $59,405/year

Coordinates the delivery of vouchers, fresh and non-perishable food items and other supportive services under the supervision of the Director of Social Services. Acts as a resource and referral source for clients concerning food and nutritional needs. Prepares accurate, complete and timely documentation for all client interactions, inputs units of service as required. Supervises Food Bank volunteers.

Avila, Joseph; Food & Transportation Programs Associate - 0.20 FTE @ $47,840/year

Coordinates the purchase and distribution of vouchers in accordance with program policies and procedures. Coordinates with case managers, health center and other supportive services under the direct supervision of the Director of Social Services. Acts as a resource and referral source for clients concerning transportation needs to facilitate access to health care. Prepares accurate, complete and timely documentation for all client interactions, amounts distributed and inputs units of service as required.

Fringe **$ 11,374**

FICA, staff insurance, retirement, disability, work's compensation, other benefits

Supplies **$ 383,918**

Food Vouchers/Assistance

Food Services provides monthly gift card / voucher for local grocery stores to assist a Riverside - San Bernardino TGA RWP client with an urgent need for essential items necessary to improve health outcomes, including: food (including groceries and food vouchers), not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another TGA RWP-allowable cost needed to improve health outcomes, as outlined in the Standards of Care Food Services must occur through a gift card or voucher for local grocery stores. SOW ~ 600 clients. Food vouchers at ~$60-$80-/month. ~$31,993/month x grant year 12 months = $383,918.

Direct Costs Total **$ 437,418**

DAP Health
Ryan White Part A
Line Item Budget: Transportation
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Program Total
Personnel						
	Welden, Zayda; Senior Director of Social Services	$ 147,361	0.10	$ 14,736	$ 14,736	$ 14,736
	Key, Brianna; Food & Transportation Pgms Coordinat	$ 59,405	0.30	$ 17,822	$ 17,822	$ 17,822
	Avila, Joseph, Food & Transportation Associate	$ 47,840	0.20	$ 9,568	$ 9,568	$ 9,568
	Personnel Subtotal			**$ 42,126**	**$ 42,126**	**$ 42,126**

Fringe			Percent	Program Cost	Direct Costs	Program Total
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 11,374	$ 11,374	$ 11,374
	Fringe Subtotal		**27.0%**	**$ 11,374**	**$ 11,374**	**$ 11,374**

Total Personnel						**$ 53,500**

Supplies				Program Cost	Direct Costs	Program Total
	Transportation Vouchers			$ 174,548	$ 174,548	$ 174,548
	Supplies Total			**$ 174,548**	**$ 174,548**	**$ 174,548**

Direct				$ 228,048	$ 228,048	$ 228,048
Subtotal						$ 228,048
GRAND TOTAL				**$ 228,048**	**$ 228,048**	**$ 228,048**
%				100%	100%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total RW Units to be Provided for this Service Category: 11,040
- Total RW Funding Divided by Total RW Units to be Provided: 23.92

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Transportation
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 42,126**

Welden, Zayda; Senior Director of Social Services - 0.10 FTE @ $147,361/year

Provides professional oversight of the delivery of MTS to ensure consistent and high quality services, client satisfaction, positive health outcomes, progress toward clinical quality improvement measures, compliance with policies and procedures, Standards of Care and National Monitoring Standards.

Key, Brianna; Food & Transportation Programs Coordinator - 0.30 FTE @ $59,405/year
Provides assistance in retaining/obtaining appropriate MTS services to clients per DAP policies and procedures and related program protocols. Assesses client's immediate needs related to MTS, maintains collaborative partnerships. Works as part of the integrated care team with medical, home care, counseling and education staff to ensure early intervention and continuity of care for clients needing MTS. Maintains accurate, complete and timely documentation of all client evaluations, services provided, including the reporting of units-of-service and other reporting required by funding organizations

Avila, Joseph; Food & Transportation Associate - 0.20 FTE @ $47,840/year
Coordinates the purchase and distribution of vouchers in accordance with program policies and procedures. Coordinates with case managers, health center and other supportive services under the direct supervision of the Director of Social Services. Acts as a resource and referral source for clients concerning transportation needs to facilitate access to health care. Prepares accurate, complete and timely documentation for all client interactions, amounts distributed and inputs units of service as required.

Fringe **$ 11,374**

FICA, staff insurance, retirement, disability, work's compensation, other benefits

Supplies **$ 174,548**

Transportation Vouchers

Transoprtation Services provides monthly bus passes, gas cards and other vouchers for local transportation to assist a Riverside - San Bernardino TGA RWP client with an urgent need to access servcies and care necessary to improve health outcome, not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another TGA RWP-allowable cost needed to improve health outcomes, as outlined in the Standards of Care Transportation Services must occur through a bus pass, gas card or other voucher for local transportaion. SOW ~ 950 clients. Gas card/voucher at $40-$70/month. Bus pass at $17 or $34/month. ~$14,545/month x grant year 12 months = $174,548.

Direct Costs Total **$ 228,048**

DAP Health
Ryan White Part A
Line Item Budget: Dental
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Yamashiro, Ryan; Lead Dentist	$ 225,700	0.3	$ 67,710	$ 67,710		$ 67,710
	Jo, Daniel; Dentist	$ 202,905	0.3	$ 60,872	$ 60,872		$ 60,872
	Kim, Ah Rom; Dental Hygenist	$ 95,663	0.3	$ 28,699	$ 28,699		$ 28,699
	Delval, Ismael; Director of Operations for Dental	$ 103,440	0.3	$ 31,032	$ 31,032		$ 31,032
	Aguirre-Delgadillo, Norma; Reg. Dental Assistant	$ 66,518	0.4	$ 26,607	$ 26,607		$ 26,607
	Placencia, Rosalba; Reg. Dental Assistant	$ 56,888	0.4	$ 22,755	$ 22,755		$ 22,755
	Omens, Kami; Dental Assistant	$ 45,843	0.4	$ 18,337	$ 18,337		$ 18,337
	Leyva, Laurie; Registered Dental Assisitant	$ 50,000	0.4	$ 20,000	$ 20,000		$ 20,000
	Pineda, Monica; Dental Clinic Receptionist	$ 48,402	0.3	$ 14,521	$ 14,521		$ 14,521
	Personnel Subtotal			**$ 290,533**	**$ 290,533**	**$ -**	**$ 290,533**

Fringe			**Percent**	**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	FICA, Insurance, Retirement, Disability, Workers Compensation		27.0%	$ 78,444	$ 78,444	$ -	$ 78,444
	Fringe Subtotal		**27.0%**	**$ 78,444**	**$ 78,444**	**$ -**	**$ 78,444**

Total Personnel							**$ 368,976**

Supplies				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Dental Supplies			$ 32,842	$ 32,842	$ -	$ 32,842
	Dental Laboratory			$ 30,000	$ 30,000	$ -	$ 30,000
	Supplies Total			**$ 62,842.00**	**$ 62,842.00**	**$ -**	**$ 62,842.00**

Direct				$ 431,818	$ 431,818		$ 431,818
Admin	Administration (limited to 10% of total service budget)					$ 43,182	$ 43,182
GRAND TOTAL				**$ 431,818**	**$ 431,818**	**$ 43,182**	**$ 475,000**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

· Total Number of RW Units to be Provided for this Service Category: 10,000
· Total RW Funding Divided by Total RW Units to be Provided: 47.50

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Dental
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 290,533**

Delval, Ismael; Director of Operations for Dental - 0.30 FTE @ $103,440/year

Delivers effective, efficient patient experiences by conducting eligibility screenings and ensuring client is linked to other program staff as appropriate. Participates in dental examinations and procedures in compliance with state guidelines and under appropriate supervisions. Takes and develops X-rays. Works directly with patients with acute needs with regard to eligibility to ensure coordinated referrals with other programs including medical case managers, behavioral health staff and housing department. Manages appropriate billing when other payers are available for covered procedures. Provides professional oversight and direction to team regarding delivery of Oral Health Care to assure compliance with Ryan White policies and procedures, standards of care and other regulations.

Pineda, Monica; Dental Clinic Receptionist - 0.30 @ $48,402/year

Serves as the first point of contact for all patients, responsible for answering phones, scheduling appointments, and other related support services for patients to ensure eligibility for Oral Health Care.

Yamashiro, Ryan; Lead Dentist - 0.30 FTE @ $225,700/year
Examines patient to determine nature of condition, utilizing x-rays, dental instruments, and other diagnostic procedures. Provides overall diagnostic, preventative, therapeutic and emergency primary oral health care to clients to sustain proper nutrition. Diagnoses and treats diseases, injuries, and malformations of teeth and gums, and related oral structures. Cleans, fills, extracts, and replaces teeth, using rotary and hand instruments, dental appliances, medications, and surgical implements. Provides preventive dental services to patient, such as applications of fluoride and sealants to teeth, and education in oral and dental hygiene.'

Jo, Daniel; Dentist - 0.30 FTE @ $202,905/year
Examines patient to determine nature of condition, utilizing x-rays, dental instruments, and other diagnostic procedures. Provides overall diagnostic, preventative, therapeutic and emergency primary oral health care to clients to sustain proper nutrition. Diagnoses and treats diseases, injuries, and malformations of teeth and gums, and related oral structures. Cleans, fills, extracts, and replaces teeth, using rotary and hand instruments, dental appliances, medications, and surgical implements. Provides preventive dental services to patient, such as applications of fluoride and sealants to teeth, and education in oral and dental hygiene. Prepares and adheres to a coordinated Care Treatment Plan with the medical care team as an integrated component to maintain and continue effective complete patient care.

Kim, Ah Rom; Dental Hygenist - 0.30 FTE @ $95,663/year
Provides oral hygiene dental treatment and oral hygiene care and education in accordance with approved guidelines per licensure and state regulations. Screens patients, examines head, neck and oral cavity for disease, removes calculus, stains and plaque from above and below the gum line and instructs patients on proper dental care and diet.

Aguirre-Delgadillo, Norma; Registered Dental Assistant - 0.40 FTE @ $66,518/year
Placencia, Rosalba; Registered Dental Assistant - 0.40 FTE @ $56,888/year
Omens, Kami; Dental Assistant - 0.40 FTE @ $45,843/year
Leyva, Laurie; Registered Dental Assistant - 0.40 @ $50,000/year

Participates in dental examinations and procedures in compliance with state guidelines and under appropriate supervisions. Tasks include supplying instruments/materials to dentist/dental hygienist during procedures, keeping patient's mouth dry and clear by suction or other devices, taking impressions, and preparing temporary crowns. Takes and develops X-rays; applies fluoride and/or sealants. Educates patients on oral hygiene.

Fringe **$ 78,444**

FICA, Insurance, Retirement, Disability, Workers Compensation

Supplies **$ 62,842**

Dental Supplies
Projected costs for syringes, needles, gauze, cotton, plastic trays, protective coverings, bonding and cleaning agents, medications, pins, posts, dental dams, x-ray film, alcohol, tongue depressors, in-office testing supplies and other dental related supplies required to provide patient care services. ~2,737 per month x 12 months = $32,842.

Dental Laboratory

Purchase / procurement of dentures, partials, crowns to improve and maintain the oral health care of patients. ~2,500 per month x 12 months = $30,000.

Direct Costs Total **$ 431,818**

Administrative Costs **$ 43,182**

HRSA - 2 CFR 200.414(f) - 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = 10% Administrative Cost.

DAP Health
Ryan White Part A
Line Item Budget: Housing
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Program Total
Personnel						
	Aitchison, Monica; Housing Programs Manager	$ 92,716	0.10	$ 9,272	$ 9,272	$ 9,272
	Gil Valle, Madal; Housing Case Manager	$ 46,904	0.20	$ 9,381	$ 9,381	$ 9,381
	Gonzalez-Ramos, Alexis; Housing Case Manager	$ 51,563	0.20	$ 10,313	$ 10,313	$ 10,313
	Gonzalez, Janett; Housing Case Manager	$ 49,504	0.20	$ 9,901	$ 9,901	$ 9,901
	Housewright, Zach; Housing Data & Evaluation Specialist	$ 46,904	0.15	$ 7,036	$ 7,036	$ 7,036
	Rodriguez, Marisa; Housing Outreach Navigator	$ 44,728	0.15	$ 6,709	$ 6,709	$ 6,709
	Personnel Subtotal			**$ 52,611**	**$ 52,612**	**$ 52,612**

Fringe			Percent	Program Cost	Direct Costs	Program Total
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 14,205	$ 14,205	$ 14,205
	Fringe Subtotal		**27.0%**	**$ 14,205**	**$ 14,205**	**$ 14,205**

Total Personnel						**$ 66,817**

Supplies				Program Cost	Direct Costs	Program Total
	Emergency Housing Assistance			$ 63,793	$ 63,793	$ 63,793
	Supplies Total			**$ 63,793**	**$ 63,793**	**$ 63,793**

Direct				$ 130,609	$ 130,610	$ 130,610
Subtotal						**$ 130,610**
GRAND TOTAL				**$ 130,609**	**$ 130,610**	**$ 130,610**
%				100%	100%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 10,920
- Total RW Funding Divided by Total RW Units to be Provided: 11.96

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Housing
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 52,612**

Aitchison, Monica; Housing Programs Manager - 0.10 FTE @ $92,716/year

Provides assistance in retaining/obtaining appropriate housing services to clients per DAP policies and procedures and related program protocols. Assesses client's immediate needs related to housing assistance, maintains listing and evaluates housing opportunities appropriate to client needs. Works as part of the integrated care tem with medical, home care, counseling and education staff to ensure early intervention and continuity of care for clients needing housing assistance. Develops relationships with community, state and federal programs related to housing for HIV and low-income individuals. Maintains accurate, complete and timely documentation of all client evaluations, services provided including the reporting of units of service and other reporting required by funding organizations and grants.

Gil Valle, Madal; Housing Case Manager - 0.20 FTE @ 46,904/year
Gonzalez-Ramos, Alexis; Housing Case Manager - 0.20 FTE @ $51,563/year
Gonzalez, Janett; Housing Case Manager - 0.20 FTE @ $49,504/year

Coordinates the delivery of housing and other related supportive services under the supervision of the Housing Coordinator and Director of Social Services. Assists in the documentation of client needs, prepares paperwork necessary document and request payment for housing needs of clients.

Rodriguez, Marisa; Housing Outreach Navigator- 0.15 FTE @ $44,728/year

Reesponsible to work with Property Managers/Landlords, and Private owners within Coachella Valley and Riverside County, to identify/secured housing for people with HIV/AIDS and to find appropriate and safe shelters and emergency housing for home insecure clients while working on opportunities for permanent housing. This position is responsible for assisting clients with housing search and placement along with supportive services that will assist client to sustain permanent housing. In addition, educates the client about basic life skills and tenant rights and prospective landlords/, owners and management companies, about how subsidy programs work and services that can be provided

Housewright, Zach; Housing Data & Evaluation Specialist - 0.15 FTE @ $46,904/year

Assists with coordination of Housing program service delivery. Provides data entry into ARIES, LEO and EHR. Maintains program department files and records. Assists with policy and procedure updates.

Fringe **$ 14,205**

FICA, staff insurance, retirement, disability, work's compensation, other benefits

Personnel Without Benefits

Supplies **$ 63,793**

Emergency Housing Assistance

Emergency Housing Assistance provides payments for emergency/short-term housing and motel vouchers to assist a Riverside - San Bernardino TGA RWP client with an urgent need for essential housing necessary to improve health outcomes, including: utilities and housing not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another TGA RWP-allowable cost needed to improve health outcomes, as outlined in the Standards of Care Housing Services must occur as a direct payment to an agency, landlord, place of business SOW ~ 455 clients. ~$5,316/month x grant year 12 months = $63,793.

Other

Training/conferences/educational seminars

Costs associated with professional development required by contract to increase staff knowledge about and expertise to deliver services to low-income people living with HIV. = $0.

Direct Costs Total **$ 130,610**

DAP Health
Ryan White Part A
Line Item Budget: CQM
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	CQM Costs	Program Total
Personnel						
	Garcia, Rigo; Analytics Manager	$ 117,711	0.1000	$ 11,771	$ 11,771	$ 11,771
	Jones, Matt; Associate Director of Grants Administration	$ 100,000	0.20000	$ 20,000	$ 20,000	$ 20,000
	VanHemert, William; Director of Institutional Giving & Gran	$ 137,976	0.186	$ 25,626	$ 25,626	$ 25,626
	Guay, John; Grants Accounting Manager	$ 111,310	0.200	$ 22,262	$ 22,262	$ 22,262
	Personnel Subtotal			**$ 79,660**	**$ 79,660**	**$ 79,660**

Fringe			Percent	Program Cost	CQM Costs	Program Total
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 21,508	$ 21,508	$ 21,508
	Fringe Subtotal		**27.0%**	**$ 21,508**	**$ 21,508**	**$ 21,508**

Total Personnel						**$ 101,168**

CQM					$ 101,168	$ 101,168
Subtotal						$ 101,168
Indirect						$ -
GRAND TOTAL					**$ 101,168**	**$ 101,168**
%				0%	100%	100%

* Only include these in "Other" if they are not already included in Indirect

Total Cost = Ending the HIV Epidemic: A Plan for America (Other Payers) + Ending the HIV Epidemic: A Plan for America (A+B)

· Total Number of Ending the HIV Epidemic: A Plan for America Units to be Provided for this Service Category: 0

· Total Ending the HIV Epidemic: A Plan for America (Column B) Divided by Total Ending the HIV Epidemic: A Plan for America Units to be Provided: 0

(This is your agency's Ending the HIV Epidemic: A Plan for America cost for care per unit)

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: CQM
Budget Period 3/1/2025 - 2/28/2026

CQM Costs

Personnel **$ 79,660**

Garcia, Rigo; Analytics Manager - 0.10 @ $117,711/year

Performs client-level data entry in electronic health record(s) directly related to delivery of Ryan White Program service categories to support and improve ongoing care and treatment of patient. Analyzes client level data used by program staff to improve the quality of Ryan White service delivery in alignment with clinical quality management plans. Provides professional oversight and submission of the Ryan White Program Services Report (RSR). Performs as the Ryan White Program ARIES Technical Lead (TL).

Jones, Matt; Associate Director of Grants Administration - 0.20 FTE @ $100,000/year

Develops and directs Clinical Quality Improvement/Management program in compliance with Ryan White National Monitoring Standards, federal, state and local regulatory bodies, Ryan White Local Policies & Procedures and IEHPC Standards of Care. Assists with the Ryan White Program Quality Management and QM Technical Lead mechanisms.

VanHemert, William; Director of Institutional Giving & Grants Administration - 0.186 FTE @ $137,976/year

Provides oversight on the Ryan White Program grants and audit management in compliance with Ryan White National Monitoring Standards, federal, state and local regulatory bodies, Ryan White Local Policies & Procedures and IEHPC Standards of Care. Assists with the agencies Ryan White Program Quality Management Plan. Attends the IEHPC meetings as the agency's representative. Performs as the Ryan White Program grants liaison with the San Bernardino County Ryan White Program grantor.

Guay, John; Grants Accounting Manager - 0.20 FTE @ $111,310/year

Provides oversight on the Ryan White Program fiscal and invoice management in compliance with Ryan White National Monitoring Standards, federal, state and local regulatory bodies, Ryan White Local Policies & Procedures and IEHPC Standards of Care. Assists with the agencies Ryan White Program Quality Management Plan. Performs as the Ryan White Program fiscal liaison with the San Bernardino County Ryan White Program grantor.

Fringe **$ 21,508**

Includes: FICA, staff insurance, retirement, disability, work's compensation, other benefits @ rate of 27% of Total Personnel Costs

CQM Costs Total **$ 101,168**

DAP Health
Ryan White Part A
Line Item Budget: Emergency Financial Assistance
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Program Total
Personnel						
	NA					
	Personnel Subtotal			**$ -**	**$ -**	**$ -**

Fringe			Percent	Program Cost	Direct Costs	Program Total
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ -	$ -	$ -
	Fringe Subtotal		**27.0%**	**$ -**	**$ -**	**$ -**

Total Personnel						**$ -**

Supplies				Program Cost	Direct Costs	Program Total
	Emergency Financial Assistance			$ 70,203	$ 70,203	$ 70,203
	Supplies Total			**$ 70,203**	**$ 70,203**	**$ 70,203**

Subtotal						$ 70,203
GRAND TOTAL						**$ 70,203**
%				0%	0%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 565
- Total RW Funding Divided by Total RW Units to be Provided: 124.25

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: Emergency Financial Assistance
Budget Period 3/1/2025 - 2/28/2026

Direct Costs		
Supplies	**$**	**70,203**
Emergency Financial Assistance		
Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a Riverside - San Bernardino TGA RWP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another TGA RWP-allowable cost needed to improve health outcomes, as outlined in the Standards of Care Emergency Financial Assistance (EFA) must occur as a direct payment to an agency or through a voucher program. SOW ~ 35 clients. ~$5,850/month x grant year 12 months = $70,203.		
Direct Costs Total	**$**	**70,203**

DAP Health
Ryan White Part A
Line Item Budget: EIS
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Becker, Caitlin; Early Intervention Specialist	$ 52,998	0.11000	$ 5,830	$ 5,830		$ 5,830
	Cano, Adriana; Early Intervention Supervisor	$ 63,960	0.11000	$ 7,036	$ 7,036		$ 7,036
	Diaz, Julio; Early Intervention Specialist	$ 51,542	0.11000	$ 5,670	$ 5,670		$ 5,670
	Jauregui, Carolina; Early Intervention Specialist	$ 47,216	0.11000	$ 5,194	$ 5,194		$ 5,194
	Merritt, Jacqueline Clare; Early Intervention Specialist	$ 54,731	0.11000	$ 6,020	$ 6,020		$ 6,020
	Smallz, Shelby; Early Intervention Specialist	$ 47,278	0.11000	$ 5,201	$ 5,201		$ 5,201
	Anaya Gonzalez, Maria; Early Intervention Specialist	$ 47,216	0.11000	$ 5,194	$ 5,194		$ 5,194
	Avila, Joseph; Early Intervention Specialist	$ 47,216	0.11000	$ 5,194	$ 5,194		$ 5,194
	Aleman Carrasco, Norma; CH Specialist	$ 44,782	0.11000	$ 4,926	$ 4,926		$ 4,926
	Caballero, Jasmine; CH Specialist	$ 43,680	0.11000	$ 4,805	$ 4,805		$ 4,805
	Campbell, Deo; CH Specialist	$ 48,880	0.11000	$ 5,377	$ 5,377		$ 5,377
	Molina, Alexis; CH Specialist	$ 50,398	0.11000	$ 5,544	$ 5,544		$ 5,544
	Olivares, Angela; CH Specialist	$ 42,370	0.11000	$ 4,661	$ 4,661		$ 4,661
	Roberts-Moreland, Jonathan; CH Specialist	$ 43,680	0.11000	$ 4,805	$ 4,805		$ 4,805
	Ruiz, Natalie; Lead CH Specialist	$ 54,371	0.10000	$ 5,437	$ 5,437		$ 5,437
	De La Cruz, Jose; CH Diagnostic Testing Outreach Coordinato	$ 69,618	0.11000	$ 7,658	$ 7,658		$ 7,658
	Malfavon, Michael; CH Events & Partnerships Coordinator	$ 62,379	0.11000	$ 6,862	$ 6,862		$ 6,862
	Curbow, Ashley; CH Data Mgmt Specialist	$ 47,840	0.10000	$ 4,784	$ 4,784		$ 4,784
	Garcia, Jessica; CH Data Mgmt Specialist	$ 57,782	0.10000	$ 5,778	$ 5,778		$ 5,778
	Muro, Manny; CH Programs Manager	$ 74,312	0.10000	$ 7,431	$ 7,431		$ 7,431
	Grissom, April; CH Senior Programs Manager	$ 83,586	0.10000	$ 8,359	$ 8,359		$ 8,359
	Nebgen, Harlie; MCM & EIS Manager	$ 83,609	0.10000	$ 8,361	$ 8,361		$ 8,361
	Personnel Subtotal			**$ 130,124**	**$ 130,124**	**$ -**	**$ 130,124**

Fringe			**Percent**	**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 35,133	$ 35,133	$ -	$ 35,133
	Fringe Subtotal		**27.0%**	**$ 35,133**	**$ 35,133**	**$ -**	**$ 35,133**

Total Personnel							**$ 165,257**

Travel				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Mileage			$ 5,362	$ 5,362		$ 5,362
	Travel Total			**$ 5,362**	**$ 5,362**		**$ 5,362**

Equipment				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Equipment > $5,000						
	Computer software and hardware			$ 21,360	$ 21,360		$ 21,360
	Equipment Total			**$ 21,360**	**$ 21,360**		**$ 21,360**

Supplies				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Medical supplies			$ 10,000	$ 10,000		$ 10,000
	Supplies Total			**$ 10,000**	**$ 10,000**	**$ -**	**$ 10,000**

Other				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Incentives			$ 18,845	$ 18,845	$ -	$ 18,845
	Outreach and stigma reduction			$ 10,000	$ 10,000		$ 10,000
	Other Total			**$ 28,845**	**$ 28,845**	**$ -**	**$ 28,845**

Direct				$ 230,824	$ 230,824		$ 230,824
Admin	Administration (limited to 10% of total service budget)					$ 23,082	$ 23,082
GRAND TOTAL				**$ 230,824**	**$ 230,824**	**$ 23,082**	**$ 253,907**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 4,050
- Total RW Funding Divided by Total RW Units to be Provided: 62.69

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: EIS
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 130,124**

Grissom, April; CH Senior Programs Manager - 0.10 FTE @ $83,586/year

Provides HIV Care Continuum for HIV Testing and EIS service delivery oversight to/for HIV newly diagnosed, unaware and out of care clients. Develops and directs the delivery of EIS targeted at populations for the agency. Identifies and arranges testing locations within the communities of the Coachella Valley, coordinates with community organizations to have a presence at community programs, health fairs, walks, concerts, etc. for the purposes of linking unaware and out of care to testing and services. Establishes and maintains relationship with community entities and organizations such as other clinic settings who may have contact with demographic populations who have been identified to be at a disproportionate risk for HIV infection to ensure continuity of care.

Muro, Manny: CH Programs Manager - 0.10 FTE @ $74,312

Provides HIV Care Continuum for HIV Testing and EIS service delivery oversight to/for HIV newly diagnosed, unaware and out of care clients. Develops and directs the delivery of EIS targeted at populations for the agency. Identifies and arranges testing locations within the communities of the Coachella Valley, coordinates with community organizations to have a presence at community programs, health fairs, walks, concerts, etc. for the purposes of linking unaware and out of care to testing and services. Establishes and maintains relationship with community entities and organizations such as other clinic settings who may have contact with demographic populations who have been identified to be at a disproportionate risk for HIV infection to ensure continuity of care.

Nebgen, Harlie; MCM & EIS Manager - 0.10 FTE @ $83,609

Establishes and maintains relationship with community entities and organizations for integration and/or coordination with community partners, service providers. Participation in community-wide HIV/AIDS continuum of HIV prevention and care. As needed, attends and provides HIV Care Continuum of Care EIS program service delivery activities. Provides professional oversight and directs the delivery of EIS program. Oversees the coordination and certification of staff to ensure compliance with state and federal requirements.

Curbow, Ashley; CH Data Mgmt Specialist - 0.10 FTE @ $47,840/year
Garcia, Jessica; CH Data Mgmt Specialist - 0.10 FTE @ S57,782/year

Assists with coordination of EIS program service delivery. Provides data entry into ARIES, LEO and EHR. Maintains program department files and records. Assists with policy and procedure updates.

De La Cruz, Jose; CH Diagnostic Testing Outreach Coordinator - 0.11 FTE @ $69,618/year

Establishes and strengthens relationships with Community Partners to expand participation and contributions for EIS program service delivery. Provides outreach and access to/for HIV high-risk populations who may be unaware or out of care. Recruits, trains and manages community outreach volunteers. Attends and oversight at/of community outreach, testing and EIS events.

Anaya Gonzalez, Maria; Early Intervention Specialist - 0.11 FTE @ $47,216/year
Avila, Joseph; Early Intervention Specialist - 0.11 FTE @ $47,216/year
Smallz, Shelby; Early Intervention Specialist - 0.11 FTE @ $47,278/year
Jauregui, Carolina; Early Intervention Specialist - 0.11 FTE @ $47,216/year
Diaz, Julio; Early Intervention Specialist - 0.11 FTE @ $51,542/year
Becker, Caitlin; Early Intervention Specialist - 0.11 FTE @ 52,998/year
Cano, Adriana; Early Intervention Supervisor - 0.11 FTE @ $63,960/year
Merritt, Jacqueline Clare; Early Intervention Specialist - 0.11 FTE @ $54,731/year

Delivers early intervention activities including outreach and support to current clients who have fallen out of care, testing among unaware, out-of-care, newly diagnosed and other populations at high risk of poor health outcomes and transmitting the disease. Provides health literacy assessments for high-risk populations. Directly provides early intervention services including counseling unaware and unmet need individuals with respect to HIV/AIDS risk, testing and care (including all inquiries from anonymous phone calls to professional groups), links clients to testing to confirm HIV and the extent of immune deficiency, intensive support and work to assess need, reduce barriers and link HIV positive to medical care. Provides care coordination with clinical services staff and case managers. Assists clients with referrals to community agencies, government entities and homeless shelters and other programs to reduce barriers to linkage.

Aleman - Carrasco, Norma; CH Specialist - 0.11 FTE @ $44,782/year
Caballero, Jasmine; CH Specialist - 0.11 FTE @ $43,680/year
Campbell, Deo; CH Specialist - 0.11 FTE @ $48,880/year
Molina, Alexis; CH Specialist - 0.11 FTE @ $50,398/year
Olivares, Angela; CH Specialist - 0.11 FTE @ $42,370/year
Roberts-Morehead, Jonathan; CH Specialist - 0.11 FTE @ $43,680
Ruiz, Natalie; Lead CH Specialist - 0.10 FTE @ $54,371

Delivers comprehensive, innovative on-site and off-site HIV testing activities to identify unaware populations and link them to care. Develops strategies and educational programs to encourage regular testing and support early intervention among unaware, out-of-care, newly diagnosed and other populations at high risk of poor health outcomes and transmitting the disease. Conducts pre- and post- test counseling on risk and risk reduction strategies. Makes referrals for linkage to additional testing and medical care as needed. Conducts preliminary assessment of program eligibility. Provides care coordination with clinical staff and case managers.

Malfavon, Michael; CH Events & Partnerships Coordinator - 0.11 FTE @ $62,379/year

Establishes and strengthens relationships with Community Partners to expand participation and contributions for EIS program service delivery. Provides outreach and access to/for HIV high-risk populations who may be unaware or out of care. Recruits, trains and manages community outreach volunteers. Attends and oversight at/of community outreach, testing and EIS events.

Fringe **$ 35,133**

FICA, staff insurance, retirement, disability, work's compensation, other benefits

Travel **$ 5,362**

Fuel/gas of agency vehicles and/or Mileage reimbursement of staff travel for the delivery or improvement of EIS at IRS determined mileage rates. (current IRS rate is applicable). Projected cost including agency vehicle fuel @ $100/month x 12 months = $1,200. Staff travel @ 0.70 x 5,945 miles = $4,162. = $5,362.

Equipment

Equipment > $5,000 **$ 21,360**

Computer Software and Hardware

Medical record and health information systems computer software and hardware costs (less than $4,999 each), necessary to document treatment plans, services provided, track compliance with treatment, health outcomes, test results and other information necessary to provide medical services. Includes the annual software license renewals and maintenance contracts.Monthly cost @ ~1,780 x 12 months = $21,360.

Supplies **$ 10,000**

Medical supplies

Projected costs for medical supplies (such as band aids, gloves, gauze, portable scales, alcohol, tongue depressors) and other supplies required to provide care services to the unaware and unmet need populations for EIS Linkage to Care, as well as serving current patient population. ~ $833 per month x 12 months = $10,000.

Other **$ 28,845**

Incentives

Items purchased such as food, gas gift cards and/or Lyft/Uber to motivate unaware individuals to engage in HIV testing, client program participation / treatment adhearance, access to program service delivery services sites (~ 3x/year). @ $60 per voucher x ~105 clients x ~3 incentive per grant year. = $18,845.

Outreach and stigma reduction

Costs for communications and advertising related to reaching the unaware and unmet need populations and linking them to EIS as well as serving current patient population. ~$833.33/mo x 12 months = $10,000

Direct Costs Total **$ 230,824**

Administrative Costs **$ 23,082**

HRSA - 2 CFR 200.414(f) - 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = 10% Administrative Cost.

DAP Health
Ryan White Part A
Line Item Budget: EIS - MAI
Budget Period 3/1/2025 - 2/28/2026

		Salary	Program FTE	Program Cost	Direct Costs	Admin Costs	Program Total
Personnel							
	Becker, Caitlin; Early Intervention Specialist	$ 52,998	0.10000	$ 5,300	$ 5,300		$ 5,300
	Cano, Adriana; Early Intervention Supervisor	$ 63,960	0.05000	$ 3,198	$ 3,198		$ 3,198
	Diaz, Julio; Early Intervention Specialist	$ 51,542	0.10000	$ 5,154	$ 5,154		$ 5,154
	Jauregui, Carolina; Early Intervention Specialist	$ 47,216	0.10000	$ 4,722	$ 4,722		$ 4,722
	Merritt, Jacqueline Clare; Early Intervention Specialist	$ 54,731	0.10000	$ 5,473	$ 5,473		$ 5,473
	Smallz, Shelby; Early Intervention Specialist	$ 47,278	0.10000	$ 4,728	$ 4,728		$ 4,728
	Anaya Gonzalez, Maria; Early Intervention Specialist	$ 47,216	0.10000	$ 4,722	$ 4,722		$ 4,722
	Avila, Joseph; Early Intervention Specialist	$ 47,216	0.10000	$ 4,722	$ 4,722		$ 4,722
	Aleman Carrasco, Norma; CH Specialist	$ 44,782	0.10000	$ 4,478	$ 4,478		$ 4,478
	Caballero, Jasmine; CH Specialist	$ 43,680	0.10000	$ 4,368	$ 4,368		$ 4,368
	Campbell, Deo; CH Specialist	$ 48,880	0.10000	$ 4,888	$ 4,888		$ 4,888
	Molina, Alexis; CH Specialist	$ 50,398	0.10000	$ 5,040	$ 5,040		$ 5,040
	Olivares, Angela; CH Specialist	$ 42,370	0.10000	$ 4,237	$ 4,237		$ 4,237
	Roberts-Moreland, Jonathan; CH Specialist	$ 43,680	0.10000	$ 4,368	$ 4,368		$ 4,368
	Ruiz, Natalie; Lead CH Specialist	$ 54,371	0.05000	$ 2,719	$ 2,719		$ 2,719
	De La Cruz, Jose; CH Diagnostic Testing Outreach Coordinator	$ 69,618	0.05000	$ 3,481	$ 3,481		$ 3,481
	Malfavon, Michael; CH Events & Partnerships Coordinator	$ 62,379	0.05000	$ 3,119	$ 3,119		$ 3,119
	Curbow, Ashley; CH Data Mgmt Specialist	$ 47,840	0.05000	$ 2,392	$ 2,392		$ 2,392
	Garcia, Jessica; CH Data Mgmt Specialist	$ 57,782	0.05000	$ 2,889	$ 2,889		$ 2,889
	Muro, Manny; CH Programs Manager	$ 74,312	0.05000	$ 3,716	$ 3,716		$ 3,716
	Grissom, April; CH Senior Programs Manager	$ 83,586	0.05000	$ 4,179	$ 4,179		$ 4,179
	Personnel Subtotal			**$ 87,891**	**$ 87,891**	**$ -**	**$ 87,891**

Fringe			**Percent**	**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	FICA, staff insurance, retirement, disability, work's compensation, other benefits		27.0%	$ 23,731	$ 23,731	$ -	$ 23,731
	Fringe Subtotal		**27.0%**	**$ 23,731**	**$ 23,731**	**$ -**	**$ 23,731**

Total Personnel						**$ 111,622**

Travel				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Mileage			$ 3,000	$ 3,000		$ 3,000
	Travel Total			**$ 3,000**	**$ 3,000**		**$ 3,000**

Equipment				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Equipment > $5,000						
	Computer software and hardware			$ 5,741	$ 5,741		$ 5,741
	Equipment Total			**$ 5,741**	**$ 5,741**		**$ 5,741**

Supplies				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Medical supplies			$ 2,000	$ 2,000		$ 2,000
	Supplies Total			**$ 2,000**	**$ 2,000**	**$ -**	**$ 2,000**

Other				**Program Cost**	**Direct Costs**	**Admin Costs**	**Program Total**
	Incentives			$ 12,603	$ 12,603	$ -	$ 12,603
	Outreach and stigma reduction			$ 5,000	$ 5,000		$ 5,000
	Other Total			**$ 17,603**	**$ 17,603**	**$ -**	**$ 17,603**

Direct				$ 139,966	$ 139,966		$ 139,966
Admin	Administration (limited to 10% of total service budget)					$ 13,997	$ 13,997
GRAND TOTAL				**$ 139,966**	**$ 139,966**	**$ 13,997**	**$ 153,962**
%				91%	91%	9%	100%

* Only include these in "Other" if they are not already included in Indirect

- Total Number of RW Units to be Provided for this Service Category: 3,450
- Total RW Funding Divided by Total RW Units to be Provided: 44.63

List Other Payers Associated with funding in Column A: Billable insurances, grants and foundations

DAP Health
Ryan White Part A
Budget Narrative Justification: EIS
Budget Period 3/1/2025 - 2/28/2026

Direct Costs

Personnel **$ 87,891**

Grissom, April; CH Senior Programs Manager - 0.05 FTE @ $83,586/year

Provides HIV Care Continuum for HIV Testing and EIS service delivery oversight to/for HIV newly diagnosed, unaware and out of care clients. Develops and directs the delivery of EIS targeted at populations for the agency. Identifies and arranges testing locations within the communities of the Coachella Valley, coordinates with community organizations to have a presence at community programs, health fairs, walks, concerts, etc. for the purposes of linking unaware and out of care to testing and services. Establishes and maintains relationship with community entities and organizations such as other clinic settings who may have contact with demographic populations who have been identified to be at a disproportionate risk for HIV infection to ensure continuity of care.

Muro, Manny: CH Programs Manager - 0.05 FTE @ $74,312

Provides HIV Care Continuum for HIV Testing and EIS service delivery oversight to/for HIV newly diagnosed, unaware and out of care clients. Develops and directs the delivery of EIS targeted at populations for the agency. Identifies and arranges testing locations within the communities of the Coachella Valley, coordinates with community organizations to have a presence at community programs, health fairs, walks, concerts, etc. for the purposes of linking unaware and out of care to testing and services. Establishes and maintains relationship with community entities and organizations such as other clinic settings who may have contact with demographic populations who have been identified to be at a disproportionate risk for HIV infection to ensure continuity of care.

Curbow, Ashley; CH Data Mgmt Specialist - 0.05 FTE @ $47,840/year
Garcia, Jessica; CH Data Mgmt Specialist - 0.05 FTE @ S57,782/year

Assists with coordination of EIS program service delivery. Provides data entry into HCC, LEO and EHR. Maintains program department files and records. Assists with policy and procedure updates.

De La Cruz, Jose; CH Diagnostic Testing Outreach Coordinator - 0.05 FTE @ $69,618/year
Establishes and strengthens relationships with Community Partners to expand participation and contributions for EIS program service delivery. Provides outreach and access to/for HIV high-risk populations who may be unaware or out of care. Recruits, trains and manages community outreach volunteers. Attends and oversight at/of community outreach, testing and EIS events.

Anaya Gonzalez, Maria; Early Intervention Specialist - 0.10 FTE @ $47,216/year
Avila, Joseph; Early Intervention Specialist - 0.10 FTE @ $47,216/year
Smallz, Shelby; Early Intervention Specialist - 0.10 FTE @ $47,278/year
Jauregui, Carolina; Early Intervention Specialist - 0.10 FTE @ $47,216/year
Diaz, Julio; Early Intervention Specialist - 0.10 FTE @ $51,542/year
Becker, Caitlin; Early Intervention Specialist - 0.10 FTE @ 52,998/year
Cano, Adriana; Early Intervention Supervisor - 0.05 FTE @ $63,960/year
Merritt, Jacqueline Clare; Early Intervention Specialist - 0.10 FTE @ $54,731/year

Delivers early intervention activities including outreach and support to current clients who have fallen out of care, testing among unaware, out-of-care, newly diagnosed and other populations at high risk of poor health outcomes and transmitting the disease. Provides health literacy assessments for high-risk populations. Directly provides early intervention services including counseling unaware and unmet need individuals with respect to HIV/AIDS risk, testing and care (including all inquiries from anonymous phone calls to professional groups), links clients to testing to confirm HIV and the extent of immune deficiency, intensive support and work to assess need, reduce barriers and link HIV positive to medical care. Provides care coordination with clinical services staff and case managers. Assists clients with referrals to community agencies, government entities and homeless shelters and other programs to reduce barriers to linkage.

Aleman - Carrasco, Norma; CH Specialist - 0.10 FTE @ $44,782/year
Caballero, Jasmine; CH Specialist - 0.10 FTE @ $43,680/year
Campbell, Deo; CH Specialist - 0.10 FTE @ $48,880/year
Molina, Alexis; CH Specialist - 0.10 FTE @ $50,398/year @ $43,680/year
Olivares, Angela; CH Specialist - 0.10 FTE @ $42,370/year
Roberts-Morehead, Jonathan; CH Specialist - 0.10 FTE @ $43,680
Ruiz, Natalie; Lead CH Specialist - 0.05 FTE @ $54,371

Delivers comprehensive, innovative on-site and off-site HIV testing activities to identify unaware populations and link them to care. Develops strategies and educational programs to encourage regular testing and support early intervention among unaware, out-of-care, newly diagnosed and other populations at high risk of poor health outcomes and transmitting the disease. Conducts pre- and post- test counseling on risk and risk reduction strategies. Makes referrals for linkage to additional testing and medical care as needed. Conducts preliminary assessment of program eligibility. Provides care coordination with clinical staff and case managers.

Malfavon, Michael; CH Events & Partnerships Coordinator - 0.05 FTE @ $62,379/year

Establishes and strengthens relationships with Community Partners to expand participation and contributions for EIS program service delivery. Provides outreach and access to/for HIV high-risk populations who may be unaware or out of care. Recruits, trains and manages community outreach volunteers. Attends and oversight at/of community outreach, testing and EIS events.

Fringe FICA, staff insurance, retirement, disability, work's compensation, other benefits **$ 23,731**

Travel **$ 3,000**

Mileage reimbursement of staff travel for the delivery or improvement of EIS at IRS determined mileage rates. (current IRS rate is applicable). Projected cost including staff travel @ 0.70 x 4,285 miles = $3,000.

Equipment

Equipment > $5,000 **$ 5,741**

Computer Software and Hardware

Medical record and health information systems computer software and hardware costs (less than $4,999 each), necessary to document treatment plans, services provided, track compliance with treatment, health outcomes, test results and other information necessary to provide medical services. Includes the annual software license renewals and maintenance contracts.Monthly cost @ ~478 x 12 months = $5,741.

Supplies **$ 2,000**

Medical supplies

Projected costs for medical supplies (such as band aids, gloves, gauze, portable scales, alcohol, tongue depressors) and other supplies required to provide care services to the unaware and unmet need populations for EIS Linkage to Care, as well as serving current patient population. ~ $166 per month x 12 months = $2,000.

Other **$ 17,603**

Incentives

Items purchased such as food, gas gift cards and/or Lyft/Uber to motivate unaware individuals to engage in HIV testing, client program participation / treatment adhearance, access to program service delivery services sites (~ 3x/year). @ $60 per voucher x ~70 clients x ~3 incentive per grant year. = $12,603.

Outreach and stigma reduction

Costs for communications and advertising related to reaching the unaware and unmet need populations and linking them to EIS as well as serving current patient population. ~$416.66/mo x 12 months = $5,000

Direct Costs Total **$ 139,966**

Administrative Costs **$ 13,997**

HRSA - 2 CFR 200.414(f) - 10% de minimis rate of modified total direct costs. Administrative costs associated with Finance Department and Grant Department support program personnel: Grant Accounting Manager, Grant Manager, Director of Institutional Giving calculated at .33333% x 3 staff = 10% Administrative Cost.