Form 2 - RFP PROPOSAL

**PROPOSAL INSTRUCTIONS:** Fill out this document and upload the document into PartnerGrants. An Offeror can only apply for one distinct program per proposal. Offerors may submit multiple proposals for different programs, which may include programs in different service categories. All questions are in green text boxes. Click on the text boxes beneath the questions to type in your answers. Any required attachments are indicated by a  symbol, and drop-down menus are indicated by a  symbol.

**Please note:** Only name uploaded documents with letters and numbers. To reduce possible submission and/or review delays, please ensure any attached file from your local drive DOES NOT contain any special characters. Letters and numbers are acceptable.

**The total word count limit is 15,000 for this entire word document (including proposal questions and your answers).** The word count is indicated below left on your screen or if you go to the top of the screen to Search “word count”. **The total number of words already included in this proposal is ~4,588. Please ensure your proposal is less than 10,412 words, or 15,000 total with the questions and instructions included.**

**Table 1: Required APH Documents**. The following must be completed and/or submitted in PartnerGrants:

|  |  |  |
| --- | --- | --- |
| **Form Number** | **Title** | **Guidance** |
| 1 | Offer Sheet | Forms 1-4 must be filled out, signed, scanned, and uploaded into PartnerGrants.  **Due Tuesday, February 20,** 2024 **at 3 PM CST** |
| 2 | RFP Proposal |
| 3 | Program Budget and Funding Summary |
| 4 | COA Certifications and Disclosures |

**PART I. Fiscal and Administrative Capacity - Unscored**

**Pre-Application**

**Annual Agency Threshold Application:** The **Annual Agency Threshold Application** must be completed in PartnerGrants by or before the Intent to Apply deadline stated in the Offer Sheet. This form must be submitted once per 12 months and remains valid for all competitions closing within that time. This threshold will be reviewed by APH staff, and the agency will be notified once approved.

**RFP Intent to Apply:** After submitting the Annual Agency Threshold Application, the agency will be able to submit an **Intent to Apply** through this RFP Opportunity. Intent to Apply forms will only be approved and access to Final Proposals granted once the Annual Agency Threshold Application approval has been verified. A separate Intent to Apply form must be completed for each Proposal. Offerors may submit multiple Proposals to an RFP.

**Agency Information**

No points are assigned to questions in this section, but a response is required for each question. All Proposals must have satisfactory answers in this section to be evaluated for potential award. If this question was referenced in Exhibit C - Scope of Work, the letter and number reference is included in parentheses at the end of the question.

**Name of your Organization:** Click or tap here to enter text.

**Program Name:** Click or tap here to enter text.

**Total Amount Requested:** Click or tap here to enter text.

1. Does your organization have the ability to meet Austin Public Health’s Social Services [Insurance Requirements](https://www.austintexas.gov/sites/default/files/files/Health/Social%20Services/INSURANCE%20Requirements-%20Soc%20Serv%20contracts%20(Rev%2004-2019).pdf) prior to entering into a contract? Provide any additional information.

Click or tap here to enter text.

1. Will your organization be able to meet all the Terms and Conditions listed in Exhibit E-Standard Boilerplate and Exhibits? Provide any additional information.

Click or tap here to enter text.

1. Provide a brief description of the Agency applying for this funding (e.g., mission statement).

Click or tap here to enter text.

1. What is your organization’s annual budget?

Click or tap here to enter text.

1. Provide the following contact information for the person in your organization authorized to negotiate Agreement terms and render binding decisions on Agreement matters.

**Name:** Click or tap here to enter text.   
**Title:** Click or tap here to enter text.   
**Email Address:** Click or tap here to enter text.   
**Phone:** Click or tap here to enter text.

1. **Emergency Response:** In the event of a public health emergency, what response services would your agency be prepared to provide to support Austin Public Health and the City of Austin’s response? (Exhibit C – Scope of Work, Section V)

Click or tap here to enter text.

**Part II. SCORED SECTIONS - Total Points Available: 100**

**Offerors must answer every question and every part of each question. Any required attachments are indicated by a**  **symbol, and drop-down menus are indicated by a**  **symbol.**

**Please note:** Only name uploaded documents with letters and numbers. To reduce possible submission and/or review delays, please ensure any attached file from your local drive DOES NOT contain any special characters. Letters and numbers are acceptable.

**Section 1: Experience and Cultural Competence**

Offerors must demonstrate that they, members of their board, or leadership staff have experience delivering high quality services listed in the Scope of Work, Section VI. Services Solicited in Austin/Travis County for a minimum of 2 years.

**AGENCY EXPERIENCE & PERFORMANCE:**

1. Describe your experience (a minimum of two years) providing each of the services listed in the Scope of Work, Section VI. Services Solicited.

Click or tap here to enter text.

1. Demonstrate with past performance your agency's/program's ability to meet goals and make a positive impact on the community. Please upload previous performance reports from the last two years that demonstrate the services listed in the Scope of Work, Section VI. Services Solicited and summarize in your answer here below. These can include quarterly performance reports or annual reports provided to community or agency leadership that, when combined, demonstrate at least two years of performance.

Please  attach performance reports.

Please explain if you are not able to provide these reports, if you are submitting other reports, or if you have any clarification that is being provided to respond to this question.

Click or tap here to enter text.

 **Check here to indicate that** past performance reports are attached to the proposal in PartnerGrants.

**PRINCIPLES OF SERVICE DELIVERY**

1. **Experience with Government Health Program Grant Management** Describe your organization’s previous experience in successful government health program grant management, including compliance with the Texas Department of State Health Services' (DSHS) HIV and STD Program Operating Procedures and Standards.

Click or tap here to enter text.

1. **Organizational Standing Delegation Orders:** Describe your Organizational Standing Delegation Orders’ adherence to CDC Clinical Guidelines for STI and HIV Testing and Treatment.

Click or tap here to enter text.

1. **Status Neutral HIV Prevention and Care:** Describe program Status Neutral HIV Prevention and Care practices.

Click or tap here to enter text.

1. **APH/HRAU Rapid start Standard of Care:** Describe program adherence to Rapid stART standard of care as established by APH/HRAU

Click or tap here to enter text.

1. **Austin HIV Planning Council Service Standards:** Describe program adherence to Austin HIV Planning Council Service Standards for City of Austin General Funds.

Click or tap here to enter text.

1. **Public Health Follow-up Program:** Describe processes for working with the local Public Health Follow-up Program to expand partner elicitation and notification measures for individuals who test positive for HIV.

Click or tap here to enter text.

1. **Plan for long term HIV care and treatment:** Describe plan for client treatment or referral for long term HIV-care and treatment after termination of funds available through this RFP.

Click or tap here to enter text.

1. **Doxy PEP treatment guidelines:** Describe adherence to established guidelines for Doxy PEP treatment, such as those by the National Coalition of STD Directors.

Click or tap here to enter text.

1. **Trauma-Informed Practices:** Describe existing and planned strategies for providing programming and services that integrate trauma-informed practices into services delivery environments and processes.

Click or tap here to enter text.

1. **Language Access Planning:** Describe your language access plan (LAP). If you are in development of the LAP, describe the process for receiving input and the steps remaining to finalize the LAP. Specifically describe how the LAP impacts different types of services included, but not limited to:

* Outreach
* Intake
* Service Delivery

Please  attach appropriate LAP policies and procedures.

Click or tap here to enter text.

 **Check here to indicate that** appropriate LAP policies are attached to the proposal in PartnerGrants.

**CULTURAL COMPETENCE & RACIAL EQUITY**

City of Austin’s definition of Equity is the condition when every member of the community has a fair opportunity to live a long, healthy, and meaningful life. Equity is embedded into Austin’s values system and means changing hearts and minds, transforming local government from the inside out, eradicating disparities, and ensuring all Austin community members share in the benefits of community progress.

Equity is one of six strategic anchors of the City of Austin’s strategic direction, and a core value driving the implementation of City services. To advance equitable outcomes, the City of Austin is leading with a lens of racial equity and healing.

1. **Equitable Service Delivery:** Describe your experience reaching and successfully serving diverse communities including the identified service populations from the Priority Populations section of Exhibit C – Scope of Work, such as but not limited to:

* LGBTQIA+ community , especially Black MSM, Latinx MSM, White MSM, transgender and gender non-binary people of color.
* Latina WSM
* Black women
* Persons with HIV (PWH)
* Youth up to 24 years of age
* Persons who inject drugs (PWID)

 Please attach appropriate documents such as policies, demographic reports, etc. to support your described experience.

Click or tap here to enter text.

 **Check here to indicate that,** if applicable, documents demonstrating experience are attached to the proposal in PartnerGrants.

1. Rate your organization for each of the following questions with “Planning Stage,” “Implementation Stage,” or “Fully Integrated Implementation.” **Use the**  **drop down** menu to choose and then explain your answer in the next box.

|  |  |  |
| --- | --- | --- |
| **Racial Equity Self-Assessment Item** | **Choose from the** Dropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... **drop down menu the option that describes your stage of implementation: Planning; Implementation; or Fully Integrated Implementation.** | **Describe what your agency’s board, staff and programs are doing to implement these items.** |
| 1. We have access to data on racial/ethnic disparities to guide our work. | Click here for Drop Down Menu Dropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... | Click or tap here to enter text. |
| 1. Our work includes performance measures to determine how well we are doing to address racial disparities. | Click here for Drop Down Menu Dropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... | Click or tap here to enter text. |
| 1. Our board has developed and implemented a plan to address racial disparities in our programs and in our organization. | Click here for Drop Down MenuDropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... | Click or tap here to enter text. |
| 1. Our agency has anti-racist policies and procedures which intend to demonstrate the commitment of conducting day-to-day operations and governance in an anti-discriminatory and anti-racist manner and environment. | Click here for Drop Down MenuDropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... | Click or tap here to enter text. |
| 1. Our agency staff at all levels participate in community workgroups/task groups aimed at addressing racial disparities. | Click here for Drop Down MenuDropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... | Click or tap here to enter text. |
| Our agency hosts or participates in training events dedicated to improving equitable outcomes. | Click here for Drop Down Menu Dropdown Menu Select Option Form - Dropdown Menu Icon, HD Png ... | Click or tap here to enter text. |

**Section 2: Program Design**

**PROGRAM WORK STATEMENT**

In this section, keep answers concise and only describe concrete services and actions of the program you are proposing. Answer each item fully, making sure to address each part of each question.

1. **Program Goals and Objectives:** Describe the program type you propose and the purpose of the program, including goals, objectives, and how program success is defined.

Click or tap here to enter text.

1. **Program Clients Served:** Describe the program clients for this proposal.

Click or tap here to enter text.

1. **Outreach:** Describe the outreach strategies the program will use to reach clients and traditionally hard-to-reach populations.

Click or tap here to enter text.

1. **Program Services and Delivery:** Provide a description that addresses the entire scope of the proposed program including:

a) an overview of the program strategy/strategies for service delivery.

b) a detailed description of program activities, including how services are delivered.

c) if submitting on behalf of a collaborative (a subgrantee agreement between another agency or agencies with the Offeror serving as the APH Grantee and primary fiscal agent), a description of the framework and how the activities described in the Scope of Work will be delineated and how accountability will be maintained.

Click or tap here to enter text.

1. **Program Accessibility:** Briefly describe how the program will actively seek to eliminate barriers to services, such as lack of transportation, limited communication and contact, and other barriers.

Click or tap here to enter text.

1. **Referrals:** Briefly describe how the program offers access to referrals and information on how to access other services and providers. Name specific community partners if referrals networks are already identified or in place. If referral networks are not yet in place, describe the process and timeline for implementing partnerships.

Click or tap here to enter text.

1. **Evidence-Based Practices:** Briefly describe how the program incorporates evidence-based practices per Exhibit C – Scope of Work.

Click or tap here to enter text.

1. **Collaboration with Community:** Briefly describe how the program joins in collaboration with the community, including councils, work groups, or other community-based stakeholder meetings related to services for HIV and STI’s.

Click or tap here to enter text.

**Section 3: Data-Informed Program Management**

The ability to collect, track, and report client demographics and program output(s) and outcome(s) is a priority for the City.

**DATA MANAGEMENT**

1. **Data Security and Systems Management:** Describe the systems that your organization has in place to collect and report program data, including data required to report on performance measures. Include data management process and flow, and how data will be collected and stored. Describe your organization’s process of internal controls and systems implemented to ensure data accuracy and data security. Include who has access to the data, what kind of training is provided to staff to ensure data is collected accurately, completely, and securely.

Click or tap here to enter text.

1. **Quality Improvement and Feedback:** Describe how data are used in your organization for identifying problems in (1) program design, (2) service delivery, (3) expenditures, and (4) equity, and how that information is used to improve practices and program effectiveness. Please respond to each item.

Click or tap here to enter text.

**PERFORMANCE MEASURES**

1. **Please provide: A) Output Measure(s) and B) Outcome Measures below.**

**31A**. **Output Measures**: Provide a proposed 12-month goal for the number of unduplicated clients served by the total program as well as any additional context. The goal should be based on past performance experience, budgeted program costs, and best estimates.  The contract goal for unduplicated clients served should be for the total program including City funding and all other funding sources.

This output will be a cumulative unduplicated count of all individuals who received testing and treatment for HIV, chlamydia, gonorrhea, syphilis, and hepatitis C. Each client should be reported within this measure only once during the contract period.

Proposals must include the following output:

|  |  |  |
| --- | --- | --- |
| **Type of Output** | **Output Wording** | **12-month Goal #** |
| Required Output | Total Number of Unduplicated Clients Served per 12-month period | Click or tap here to enter goal #. |

**31Ai**. Describe how the data will be calculated for the output.

Click or tap here to enter text.

**31Aii.** Provide an explanation for determining the annual goal.

Click or tap here to enter text.

**31Aiii.** Describe how demographic and eligibility data will be collected from clients and the method for reporting this data.

Click or tap here to enter text.

**31B**. **Social Services Outcome Measures**: Awarded agency will be required to report on each of the following outcomes, and to reach specific goals stated here. Numerators and denominators will be negotiated upon agreement award.

**Check the box under each outcome below to confirm adherence.**

|  |  |
| --- | --- |
| **Outcome 1:** | **12-month Goal** |

|  |  |  |
| --- | --- | --- |
| **Numerator**: Number of individuals who report improvement in physical, mental, emotional, or social functioning |  | To be determined |
| **Denominator**: Number of individuals receiving services through APH funding |  | To be determined |
| **Outcome**: Percent of individuals who achieve healthy outcomes as a result of receiving services through APH funding |  | To be determined |

**Note:** This outcome will be a cumulative count of the following outcomes, listed below, for all individuals who received testing and treatment for HIV, chlamydia, gonorrhea, syphilis, and hepatitis C. The following outcomes are specific to different types of HIV and STI testing and treatment.

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |
| --- | --- |
| **Outcome 2:** | **12-month Goal** |

|  |  |  |
| --- | --- | --- |
| **Numerator**: Number of individuals started on HIV treatment within 72 of preliminary HIV+ test result |  | To be determined |
| **Denominator**: Number of newly diagnosed HIV+ individuals |  | To be determined |
| **Outcome**: Percent of newly diagnosed individuals linked to Rapid stART within 72 hours |  | 80-90%, to be determined |

**Patient Exclusions:**

1. Patients who died at any time during the measurement period

2. Patients whose residency moved outside the 10-county service delivery area during the measurement period

3. Patients who were incarcerated more than 6 months during the measurement period

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |
| --- | --- |
| **Outcome 3:** | **12-month Goal** |

|  |  |  |
| --- | --- | --- |
| **Numerator**: Number of newly diagnosed persons in the denominator who attended a routine HIV medical care visit within one month of diagnosis |  | To be determined |
| **Denominator**: Number of persons newly diagnosed with HIV infection in a 12-month measurement year |  | To be determined |
| **Outcome**: Percentage of persons newly diagnosed with HIV infection who attended a routine HIV medical care visit within one month of diagnosis |  | 80-90%, to be determined |

**Patient Exclusions:**

1. Individuals who died at any time during the measurement period

2. Individuals whose residency moved outside the 10-county service delivery area during the measurement period

3. Individuals who were incarcerated more than 6 months during the measurement period

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |  |
| --- | --- | --- |
| **Outcome 4** |  | **12-month Goal** |
| **Numerator:** Number of patients in the denominator who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period | To be determined | |
| **Denominator:** Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period |  | To be determined |
| **Outcome:** Percentage of individuals, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits | To be determined |  |

Patient Exclusions:

1. Patients who died at any time during the 12-month measurement period

2. Patients whose residency moved outside the 10-county service delivery area during the measurement period

3. Patients who were incarcerated more than 6 months during the measurement period

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |  |
| --- | --- | --- |
| **Outcome 5** |  | **12-month Goal** |
| **Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year | To be determined | |
| **Denominator:** Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year |  | To be determined |
| **Outcome:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year | 80-90%, To be determined |  |

**Patient Exclusions:**

1. Patients who died at any time during the measurement period

2. Patients whose residency moved outside the 10-county service delivery area during the measurement period

3. Patients who were incarcerated more than 6 months during the measurement period

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |  |
| --- | --- | --- |
| **Outcome 6** |  | **12-month Goal** |
| **Numerator:** Number of individuals who complete full treatment | To be determined | |
| **Denominator:** Number of individuals who tested positive for syphilis |  | To be determined |
| **Outcome:** Percent of individuals who tested positive for syphilis and were successfully treated | To be determined |  |

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |  |
| --- | --- | --- |
| **Outcome 7** |  | **12-month Goal** |
| **Numerator:** Number of individuals who complete full treatment | To be determined | |
| **Denominator:** Number of individuals who tested positive for chlamydia |  | To be determined |
| **Outcome:** Percent of individuals who tested positive for chlamydia and were successfully treated | To be determined |  |

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |  |
| --- | --- | --- |
| **Outcome 8** |  | **12-month Goal** |
| **Numerator:** Number of individuals who complete full treatment | To be determined | |
| **Denominator:** Number of individuals who tested positive for gonorrhea |  | To be determined |
| **Outcome:** Percent of individuals who tested positive for gonorrhea and were successfully treated | To be determined |  |

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

|  |  |  |
| --- | --- | --- |
| **Outcome 9:** |  | **12-month Goal** |
| **Numerator:** Number of individuals who complete full treatment | To be determined | |
| **Denominator:** Number of individuals who tested positive for hepatitis C tests |  | To be determined |
| **Outcome:** Percent of individuals who tested positive for hepatitis C and were referred to appropriate care | To be determined |  |

**Check here to indicate that program will report on this outcome,** to be determined upon agreement award.

**Section 4: Cost Effectiveness**

**PROGRAM STAFFING AND TIME**

1. Describe the overall staffing plan to accomplish activities in the proposed program, including project leadership, reporting responsibilities, and daily program operations.

Click or tap here to enter text.

1. In the box below briefly describe position descriptions, education, licenses, credentials, qualifications, background check requirements and/or certifications required for staff members and/or volunteers that work directly with clients in the proposed program.

Required Attachments:  Attach job/position descriptions of program staff and/or volunteers working with clients. Offerors may attach up to 5 additional pages that include job/position descriptions or summaries as supplemental documentation for this question.

Click or tap here to enter text.

**Check here to indicate that** job/position descriptions are attached to proposal in PartnerGrants (as applicable).

1. What training will be provided for program staff to ensure effective program services?

Click or tap here to enter text.

1. Complete the Program Staffing form below.

**Instructions:**

1. List CITY FUNDED positions FIRST, then list OTHER-FUNDED Staff positions that will be working on the program that you are applying for in this RFP. If you have several volunteers who are certified to provide key programmatic services, please list them in this table as well.
2. List position titles only (do not include staff names) for all staff – programmatic, administrative, and executive level – who will be partially or totally funded by the requested CITY FUNDING portion of the Budget in this proposal.
3. Provide the corresponding percentages of Full Time Equivalent (FTE) positions for each position.
4. Click on the + button to add more rows, as needed.
5. Total all full and partial FTE positions at the bottom.

Example:

|  |  |  |
| --- | --- | --- |
| **Funding Source** | **Title** | **FTE** |
| *APH Social Services* | *Program Director* | 0.20 |
| *APH Social Services* | *Executive Director* | 0.05 |
| *Travis County HHSD* | *Case Managers* | 2.00 |
| *NA* | *Volunteers* | 8.00 |
|  | *Total FTEs* | *10.25* |

|  |  |  |
| --- | --- | --- |
| **Funding Source** | **List Program Staff by Title**  **(City-funded positions first, then Other Funded positions)** | **Program Staff FTE Amount**  **(may be less than 1.0 FTE if an individual is spending partial time on the program)** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click here to enter FTE. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click here to enter FTE. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click here to enter FTE. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click here to enter FTE. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click here to enter FTE. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click here to enter FTE. |
|  | **TOTAL FTEs =** | Click here to enter TOTAL FTEs. |

**PROGRAM BUDGET AND FUNDING SUMMARY**

1. Complete Form 3 - Program Budget and Funding Summary (Excel spreadsheet) and upload completed document into PartnerGrants to complete this question. There are four tabs in the spreadsheet: Instructions, Budget and Narrative, SubGrantee Budget, and Cost Per Client.

**Note:** Funds must be utilized for direct health care provisions including operating expenses, clinical services, lab, medications, and training

**Required Attachment:** Attach Form 3 – Program Budget and Funding Summary in Partnergrants

**Check here to indicate that** Form 3 – Program Budget and Funding Summary is attached in Partnergrants.

**General Form 3 Program Budget and Funding Summary Instructions**

Form 3 - Program Budget and Funding Summary is a spreadsheet intended to capture the budget of the proposed program, including City funding as well as program funding from other sources.

The Instructions tab contains instructions on how to fill out each section. Any activities or eligible costs for which the Offeror does not intend to request funding, or apply funds from other sources, should be left empty.

In general, Offerors must:

* Enter all line-item amounts as whole dollars
* Apportion your funding request into 12 months of funding
* Include Other Funding for the first program period (12 months) in the Budget
* Do not erase or change formulas or functions - only enter information into the orange-colored cells
* If a formula error is discovered, please alert your Solicitation Point of Contact as soon as possible. Excel formulas and functions exist throughout the workbook and across worksheets to limit the necessity of the applicant to enter duplicitous information
* Ensure all line-item amounts, subtotals, and totals are in WHOLE DOLLARS and are correct
* For every budget line containing a requested amount of City of Austin funding, enter a short description or list of items included in that budget line in Column E
* Do not enter narrative for budget lines that are blank or budgeted amounts from Other Funding

1. Provide the total amount of City funding requested for the **12-month period**.

Enter $ Total amount of City funding requested.

In the text box below, include a summary description of the budget justification for the program strategy/strategies. Explain how the amount requested was calculated for the service type, intensity, duration, staffing, etc.

**Note:** Funds must be utilized for direct health care provisions including operating expenses, clinical services, lab, medications, and training

Click or tap here to enter text.

**COST EFFECTIVENESS**

1. Explain how you have considered efficient allocation of financial and staff resources when determining the budget and staffing plan for the proposed program. Describe how the amount requested will provide maximum impact with the most efficient allotment of resources.

Click or tap here to enter text.

1. **Livable Wage:** How have you considered City of Austin SD23 EOA.C.3 – Dollars-per-hour wage that an individual must earn to support a family in Austin when considering staff compensation? How will you use compensation strategies that promote tenure and reduce the likelihood for staff attrition, and aim to promote all staff earning the minimum livable wage in Austin/Travis County?

Click or tap here to enter text.

1. Enter below the average cost per client from the Form 3 - Program Budget and Funding Summary spreadsheet (cell B7 on the Cost per Client tab).

Enter $ Average Cost per Client.

Describe in the text box below how you calculated that amount and why the cost per client is appropriate for the level of services being provided.

Click or tap here to enter text.