

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS**

AMERICAN ACADEMY OF HIV
MEDICINE, *et al.*,

Plaintiffs,

v.

HEALTH RESOURCES AND SERVICES
ADMINISTRATION, *et al.*,

Defendants.

Case No. 1:26-cv-12638-WGY

**REPLY MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR
PRELIMINARY RELIEF UNDER 5 U.S.C. § 705 AND PRELIMINARY INJUNCTION**

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INTRODUCTION

This case seeks to protect the integrity of the Ryan White Program and the health of transgender people living with HIV. As established by Congress, the Ryan White Program seeks to ensure access, retention, and adherence to HIV treatment by providing not only access to HIV treatment for those who cannot afford it but also access to comprehensive care that addresses a patient’s whole health needs, which in turn further ensures retention and adherence to HIV care. Pls.’ Br. 3-5, 15-17. What is more, Ryan White Program funding is targeted towards “populations disproportionately impacted by HIV/AIDS.” 42 U.S.C. § 300ff-121(a). Transgender people are such a population. Pls.’ Br. 2-3. The Challenged Conditions are contrary to these purposes.

The Court’s intervention is urgently needed *now* to prevent irreparable harm to Plaintiffs, transgender people living with HIV, and the Ryan White Program. A preliminary stay is likewise needed to protect the Court’s ability to provide the prospective equitable relief Plaintiffs seek and need. After repeatedly delaying, Defendants issued the Notices of Funding Opportunity (“NOFOs”) in June, with applications due on July 8, 10, and 13.¹ Preliminary relief is warranted to prevent Plaintiffs from having to certify in applications that they will abide by discriminatory terms and to prevent harms that would accrue once any Notices of Award (NOAs) are issued or denied, which will occur between the application deadlines and the term start dates on August 1, September 1, and September 30. Preliminary relief is needed prior to the issuance of any NOAs.²

Throughout their brief, Defendants misrepresent the nature of the Challenged Conditions and fundamentally misapprehend this case. Per Defendants, the Challenged Conditions merely

¹ Dkts. 19-9, 19-10, 19-11; Exhs. J (Part D NOFO) and K-N (version history of NOFOs), Abrigo Reply Decl.

² At a minimum, the Court may enter an administrative stay order to preserve its jurisdiction. *See* Minute Order, *Dellinger v. Bessent, et al.*, No. 25-cv-00385 (D.D.C. Feb. 10, 2025) (collecting cases); *see also United States v. Texas*, 144 S.Ct. 797, 798 (2024) (Barrett, J., concurring) (“[A]n administrative stay buys the court time to deliberate.”); *FTC v. Dean Foods Co.*, 384 U.S. 597, 608 (1966) (holding that a court has “express authority under the All Writs Act to issue such temporary injunctions as may be necessary to protect its own jurisdiction.”).

prohibit the provision of gender-affirming medical care using Ryan White Program funding. But the Challenged Conditions do much more. They require Ryan White funding recipients to abide by the Administration’s view that transgender people do not exist and to refuse to recognize transgender people’s identities even in the provision of HIV treatment. Either way, the Challenged Conditions are contrary to Ryan White Program’s statutory framework and purpose, as deemed by Congress. The Court must assess the Challenged Conditions for what they say, not what Defendants’ lawyers wish they would say in their attempts to evade liability.

ARGUMENT

I. This Court Has Jurisdiction Over Plaintiffs’ Claims.

A. The Tucker Act Does Not Deprive the Court of Jurisdiction.

Defendants challenge this Court’s jurisdiction to entertain Plaintiffs’ claims simply because the Challenged Conditions relate to grant funding and thus, according to Defendants, the Tucker Act deprives this Court of jurisdiction. Defendants are mistaken. First, this Court has jurisdiction over Plaintiffs’ APA claims because “the Tucker Act does not cover challenges to grant funding conditions.” *Rhode Island Coal. Against Domestic Violence v. Bondi*, 794 F.Supp.3d 58, 67 (D.R.I. 2025) (“*RICADV v. Bondi*”). Second, this Court has jurisdiction over Plaintiffs’ constitutional and Affordable Care Act (“ACA”) claims. These claims do not depend on the sovereign immunity waivers in the Tucker Act or APA, nor are they subject to the Tucker Act’s exclusion of such claims.

i. The Court Has Jurisdiction Over Plaintiffs’ APA Claims.

Defendants rely on cases pertaining to grant terminations to argue that the Tucker Act deprives this Court of jurisdiction. Gov’t Br. 12-13 (citing *Dep’t of Educ. v. California*, 604 U.S. 650 (2025), and *Sustainability Inst. v. Trump*, 165 F.4th 817 (4th Cir. 2026)). But this case is not about grants terminations. Plaintiffs “do not challenge conditions, terms, or agency action related to grants that the [government] has previously awarded them; they object to the challenged

conditions only to the extent that they are or will be placed upon grants for which they seek to apply.” *RICADV v. Bondi*, 794 F.Supp.3d at 67. Moreover, Defendants ignore the Supreme Court’s and First Circuit’s latest pronouncements in this area, such as *Nat’l Institutes of Health v. Am. Pub. Health Ass’n*, 145 S. Ct. 2658 (2025) (“*APHA*”), *Massachusetts v. Nat’l Institutes of Health*, 164 F.4th 1 (1st Cir. 2026), and *New York v. Trump*, 171 F.4th 1 (1st Cir. 2026). Under these precedents, “an order prohibiting implementation of agency guidance does not create a problem based on the Tucker Act simply because the guidance ‘discusses internal policies related to grants.’” *New York*, 171 F.4th at 30 (quoting *APHA*, 145 S. Ct. at 2661 (Barrett, J., concurring)). “[P]laintiffs in this case do not challenge any withholding of funds promised under grant agreements.” *Massachusetts*, 164 F.4th at 12; *see also New York v. Kennedy*, 155 F.4th 67, 75 n.4 (1st Cir. 2025) (“Importantly, this case does not challenge the cancellation of grants.”); *New York v. Admin. for Child. & Fams.*, No. 26-CV-00172, 2026 WL 673848, at *11 (S.D.N.Y. Mar. 10, 2026) (“*NY v. ACF*”).

This case is like others where courts have exercised jurisdiction over plaintiffs’ APA claims “because the Challenged Conditions the Government seeks to impose have not become ratified terms to any grant agreement/contract.” *Rhode Island Coal. Against Domestic Violence v. Kennedy*, 812 F.Supp.3d 180, 189 (D.R.I. 2025) (“*RICADV v. Kennedy*”); *see also Illinois v. Noem*, 813 F.Supp.3d 282, 298 (D.R.I. 2025) (“the Tucker Act is clearly inapplicable” “because these are not challenges to the terms and conditions of an executed grant agreement, but rather to the imposition of an allegedly unlawful condition on prospective grant agreements”). Plaintiffs seek to set aside unlawful conditions Defendants have imposed as requirements “to be *eligible*” to receive Ryan White funding. *RICADV v. Bondi*, 794 F.Supp.3d at 67. “The Tucker Act thus poses no bar.” *Id.*

Given this, the Court need not consider the test set forth in *Megapulse, Inc. v. Lewis*, 672 F.2d 959, 964-71 (D.C. Cir. 1982). *See Massachusetts*, 164 F.4th at 10-12. Nonetheless, “in

examining the ‘source of the rights’ and the ‘type of relief sought,’ ... Plaintiffs’ APA claims do not arise out of contractual obligations.” *NY v. ACF*, 2026 WL 673848, at *13 (quoting *Megapulse*, 672 F.2d at 968). For one, “the gravamen of Plaintiffs’ allegations does not turn on contract terms, but the federal statutes ... that Congress put in place,” *id.*, and the Constitution. For another, “Plaintiffs also do not seek to reinstate any contractual grants, nor do they request money damages.” *Id.* Rather, Plaintiffs seek declaratory and prospective injunctive relief, which this Court, and not the Court of Federal Claims (“CFC”), can provide. *See, e.g., RICADV v. Kennedy*, 812 F.Supp.3d at 190; *NY v. ACF*, 2026 WL 673848, at *13.

Furthermore, the Tucker Act itself supports Plaintiffs. The statute provides: “Both the United States Court of Federal Claims and the district courts of the United States shall have jurisdiction to render judgment on an action by an interested party objecting to a solicitation by a Federal agency for bids or proposals for a proposed contract or to a proposed award or the award of a contract or any alleged violation of statute or regulation in connection with a procurement or a proposed procurement.” 28 U.S.C. § 1491(b)(1). And it specifies that in such bid protest cases, “the courts shall review the agency’s decision pursuant to the standards set forth in section 706 of title 5.” 28 U.S.C. § 1491(b)(4). That district courts have jurisdiction over such bid protests illustrates that the APA claims challenging grant conditions and seeking only declaratory and injunctive relief are properly before this Court.³

³ Plaintiffs also note that grants are not contracts within the CFC’s Tucker Act jurisdiction. Under the Federal Acquisition Regulation (“FAR”), a “contract” “do[es] not include grants and cooperative agreements covered by 31 U.S.C. § 6301, et seq.” 48 C.F.R. § 2.101. And Title 31 defines “grant agreements” by their purpose, directing executive agencies to use them when “the principal purpose of the relationship is to transfer a thing of value to the State or local government or other recipient to carry out a public purpose” and where “substantial involvement is not expected between the executive agency and the State, local government, or other recipient when carrying out the activity contemplated in the agreement.” 31 U.S.C. § 6304. Ryan White grant funding is expressly meant “to carry out a public purpose” as contemplated by 31 U.S.C. § 6304, removing it from the FAR’s definition of “contract.” As such, it is not subject to the CFC’s Tucker Act jurisdiction, but rather this Court’s jurisdiction. Plaintiffs acknowledge that *APHA* and *California* involved grants. But those were preliminary determinations made on the Supreme Court’s

In sum, Plaintiffs “do not seek to reinstate any contractual grants, nor do they request money damages,” but rather “seek to vacate the underlying agency policy.” *NY v. ACF*, 2026 WL 673848, at *13. In other words, they “seek prospective reform of agency behavior.” *Am. Ass’n of Physics Tchrs., Inc. v. Nat’l Sci. Found.*, 804 F.Supp.3d 45, 66 (D.D.C. 2025). “The Court can thus exercise jurisdiction to evaluate the agency’s policies and priorities under the APA.” *Id.* at 67.

ii. The Court Has Jurisdiction Over the Constitutional and ACA Claims.

As to the constitutional claims, “Plaintiffs do not need a waiver of sovereign immunity to bring claims against executive officers acting outside the bounds of the Constitution or their statutory authority.” *Id.* at 67 (citing *Larson v. Domestic & Foreign Com. Corp.*, 337 U.S. 682, 689 (1949); *Dugan v. Rank*, 372 U.S. 609, 621-22 (1963)); *see also Trump v. Cook*, No. 25A312, 2026 WL 1855613, at *11 n.2 (U.S. 2026) (“We have often held that plaintiffs may sue in equity without a congressionally-provided cause of action to prevent an injurious act by a public officer.” (cleaned up)). Indeed, courts have routinely exercised jurisdiction over such First and Fifth Amendment claims in cases relating to new conditions on federal funding. *See, e.g., RICADV v. Kennedy*, 812 F.Supp.3d at 197. Of course, by their nature, such claims are not contractual claims within the jurisdiction of the CFC. *See San Francisco A.I.D.S. Found. v. Trump*, 786 F.Supp.3d 1184, 1212 (N.D. Cal. 2025) (“*SFAF*”); *see also Joshua v. United States*, 17 F.3d 378, 379 (Fed. Cir. 1994).

As to Plaintiffs’ ACA claim, Section 1557 incorporates the “rights and remedies” of other civil rights statutes, including Title IX, which includes the right to sue in district court, *see Cummings v. Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212, 218 (2022), and has its own waiver of sovereign immunity, *see* 42 U.S.C. § 18116(a); *cf. Kadel v. N.C. State Health Plan for Tchrs. & State Emps.*, 12 F.4th 422, 439 (4th Cir. 2021), *as amended* (Dec. 2, 2021).

emergency docket. They do not represent the Court’s ultimate views on the merits. *See Trump v. Boyle*, 145 S. Ct. 2653, 2654 (2025) (“[O]ur interim orders are not conclusive as to the merits[.]”).

B. Plaintiffs Have Standing, and Their Claims Are Ripe.

Defendants challenge Plaintiffs’ standing primarily on the grounds that their claims “lack [] ripeness for judicial adjudication.” Gov’t Br. 2; *id.* at 15. Defendants’ argument lacks merit. For one, Defendants ignore that the inquiry into whether a plaintiff is “adversely affected” by an agency action, and thus entitled to bring suit under the APA, “is not especially demanding.” *Food & Drug Admin. v. R. J. Reynolds Vapor Co.*, 606 U.S. 226, 233-34 (2025) (citation modified). “A plaintiff may sue under the APA unless her ‘interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit.’” *Id.* at 233. And here, Provider Plaintiffs and Associational Plaintiffs’ members are regulated by the Challenged Conditions. In the APA context, “if a plaintiff is an object of the action (or forgone action) at issue, then there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it.” *Diamond Alternative Energy, LLC v. Env’t Prot. Agency*, 606 U.S. 100, 112 (2025).

To the extent that ripeness is at issue here, Plaintiffs easily meet “its two prongs—fitness and hardship.” *California v. U.S. Dep’t of Transp.*, 808 F.Supp.3d 291, 306 (D.R.I. 2025); *see also Am. Pub. Health Ass’n v. Nat’l Institutes of Health*, 145 F.4th 39, 50 (1st Cir. 2025) (“[T]he district court clearly had jurisdiction to grant prospective relief that will govern the rather complex ongoing relationships between the Department and grant recipients.” (citation modified)).

“In the administrative law context, fitness for review requires that the action be ‘final agency action’ within the meaning of the APA.” *Illinois v. Fed. Emergency Mgmt. Agency*, 801 F.Supp.3d 75, 88 (D.R.I. 2025) (quoting *Nat’l Park Hosp. Ass’n v. Dep’t of Interior*, 538 U.S. 803, 812 (2003)). And here, the Challenged Conditions are final agency action, as they “clearly represent[] the consummation of [Defendants’] decision-making process regarding the terms and

conditions of those [Ryan White] grants, and this decision imposes concrete legal consequences on” Plaintiffs, “who must choose whether to accede to an allegedly unlawful condition or else forgo ... dollars of federal grant funding.” *California*, 808 F.Supp.3d at 305; *see infra* Section I.D.

The Challenged Conditions constitute action “by which rights or obligations have been determined, or from which legal consequences will flow.” *Illinois*, 801 F.Supp.3d at 88 (citation modified). They state that “[a]ll activities proposed in [an] application” in response to the NOFOs “must align with” the Gender Order, and “awards shall not be used to fund, promote, encourage, subsidize, or facilitate ... denial by the recipient of the sex binary in humans, or the belief that sex is a chosen or mutable characteristic.” Dkt. 19-9 at 4. They also require Plaintiffs to “[a]pply[] sex-based definitions grounded in biological reality,” Dkt. 19-2 at 5, and “recognize that a person’s sex as either male or female is unchangeable,” Dkt. 19-3 at 3. *See Freedom Network USA v. Trump*, No. 25-CV-12419, 2026 WL 800392, at *8 (N.D. Ill. Mar. 23, 2026).

As to the hardship to the parties, courts ask “whether the challenged action creates a direct and immediate dilemma for the parties.” *Illinois*, 801 F.Supp.3d at 88 (citation omitted). Here, Plaintiffs must not only conform their applications to the Challenged Conditions but they must refrain from recognizing their transgender patients’ identities and from providing them with medical treatment for gender dysphoria under any part of the Ryan White Program. *See* Pls.’ Br. 5-7. This places them in the dilemma of having to forego Ryan White funding or being forced to discriminate against transgender patients living with HIV. *See* Pls.’ Br. 20, 26.

As to constitutional ripeness, the imminent loss of funding, or loss of funding eligibility, because of the Challenged Conditions satisfies Article III’s standing requirement. *See PFLAG, Inc. v. Trump*, 769 F.Supp.3d 405, 423 (D. Md. 2025) (finding challenge ripe for judicial review where “HRSA issued a notice to all grant recipients stating that: ‘grant funds may not be used for activities

that do not align with’ the Executive Orders”). A plaintiff’s allegation that they “will likely lose federal funding” is a cognizable injury-in-fact. *SFAF*, 786 F.Supp.3d at 1209-10; *see also Am. Ass’n of Physicians for Hum. Rts., Inc. v. Nat’l Inst. of Health*, 795 F.Supp.3d 678, 693 (2025) (“*GLMA*”) (plaintiffs had standing because they “suffered an injury in fact due to ... the inability to apply for new Grants, related to LGBTQI+ health”); *Washington v. Trump*, 766 F.Supp.3d 1138, 1149 (W.D. Wash. 2025) (“The fact that the loss of funds may have not yet materialized ... does not mean that there is no imminent injury or that Plaintiffs lack standing on this ground.”). Here, the loss of funding or eligibility for funding is attributable to the Challenged Conditions. Pls.’ Br. 7-10, 11.

Lastly, Defendants are incorrect that individual members of the Associational Plaintiffs must participate in order to adjudicate the claims in this case. Gov’t Br. 15-16. Here, Plaintiffs’ claims raise legal questions that can be resolved without the participation of individual members. Indeed, “individual participation is not normally necessary when an association seeks prospective or injunctive relief for its members.” *United Food & Com. Workers Union Loc. 751 v. Brown Grp., Inc.*, 517 U.S. 544, 546 (1996); *see also GLMA*, 795 F.Supp.3d at 694.⁴

C. Defendants Have No Discretion to Impose the Challenged Conditions.

Defendants argue that their decision to impose the Challenged Conditions is “committed to agency discretion” under 5 U.S.C. § 701(a)(2). Gov’t Br. 16–18. Not so. The exemption from judicial review provided in that subsection is “‘quite narrow[.]’” *Dep’t of Com. v. New York*, 588 U.S. 752, 772 (2019) (quoting *Weyerhaeuser Co. v. U.S. Fish & Wildlife Serv.*, 586 U.S. 9, 23 (2018)). It applies only “when the agency action is of a kind ‘traditionally regarded as committed

⁴ Citing to a solitary concurrence by Justice Thomas, Defendants call into question associational standing altogether. Gov’t Br. 16. Their argument borders on the frivolous. The Supreme Court reaffirmed the availability of associational standing in *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 199-200 (2023). *See also Speech First, Inc. v. Whitten*, 145 S. Ct. 701, 703 n.1 (2025) (Thomas, J., dissenting from denial of certiorari) (recognizing that “under our precedents, an association ... can establish standing to sue on behalf of its members”).

to agency discretion,’ or when the relevant statute ‘is drawn so that a court would have no meaningful standard against which to judge the agency’s exercise of discretion.’” *Commonwealth v. Trump*, No. 25-cv-12162, 2026 WL 1584837, at *19 (D. Mass. June 3, 2026). Defendants fail to make either showing. *See New York*, 171 F.4th at 19 (placing burden on Government).

First, “the determination of grant terms and conditions is not a category of decisions traditionally committed to exclusive agency discretion.” *RICADV v. Bondi*, 794 F.Supp.3d at 69. Indeed, “courts have consistently found the opposite to be true.” *RICADV v. Kennedy*, 812 F.Supp.3d at 192 (holding agencies’ decision to “spring[] new conditions” onto federal grants was reviewable under APA); *see also, e.g., Biden v. Missouri*, 595 U.S. 87, 92–96 (2022) (reviewing imposition of new conditions on Medicare and Medicaid grant funds); *City of Providence v. Barr*, 954 F.3d 23, 32–36 (1st Cir. 2020); *Massachusetts v. Dep’t of Agric.*, No. 26-cv-11396, Op. at 41 (D. Mass. June 24, 2026) (ECF 72); *Illinois*, 801 F.Supp.3d at 91 & n.7 (collecting cases “presently reviewing discretionary grant conditions under the APA”). Defendants do not contend otherwise.

Second, contrary to Defendants’ assertion, Gov’t Br. 16–18, Congress *has* provided “meaningful standard[s]” to assess the legality of the Challenged Conditions. *See* Pls.’ Br. 22–26. The Ryan White statute requires Defendants to provide “core medical services” for persons living with HIV. *See, e.g.,* 42 U.S.C. § 300ff-22(a). It then goes on to define those terms. *See, e.g.,* 42 U.S.C. § 300ff-22(b)(3); *see also* Pls.’ Br. 22–23. Moreover, the ACA bars Defendants from “creat[ing] any unreasonable barriers to the ability of individuals to obtain appropriate medical care” or “interfer[ing] with communications regarding a full range of treatment options between the patient and the provider.” 42 U.S.C. § 18114. In short, “this is not a case in which there is ‘no law to apply.’” *Dep’t of Com.*, 588 U.S. at 772–73; *see also Nat’l All. to End Homelessness v. Turner*, No. 25-cv-00447, 2026 WL 883437, at *1, *4 (D.R.I. Mar. 31, 2026) (holding HUD’s new

NOFO conditions reviewable because “statutory framework ... provide[s] meaningful standards”).

Defendants’ reliance on *Lincoln v. Vigil*, 508 U.S. 182 (1993), is therefore misplaced. In *Lincoln*, the Supreme Court held that § 701(a)(2) barred review of an agency’s decision to terminate a program, which was funded through an undifferentiated “lump-sum appropriation.” *Id.* at 184–85. The Court explained that “where ‘Congress merely appropriates lump-sum amounts *without statutorily restricting* what can be done with those funds, a clear inference arises that it does not intend to impose legally binding restrictions” on the implementing agency’s discretion. *Id.* at 192 (emphasis added). But the Court also stressed that when Congress “circumscribe[s] agency discretion to allocate resources by putting restrictions in the operative statutes,” § 701(a)(2) does *not* bar judicial review. *Id.* at 193; *see also Freedom Network USA*, 2026 WL 800392, at *9.

Here, Congress did not just allocate a lump sum: It directed Defendants to help fund the creation of coordinated “systems of care” to reach underserved communities and improve overall health outcomes for people living with HIV. It defined categories of services that should be provided. And it created local planning councils and state consortia to assess local needs. *See* Pls.’ Br. 3–5. Where Congress provides standards to guide spending in this fashion, agencies do not have carte blanche “to disregard [those] statutory responsibilities.” *Lincoln*, 508 U.S. at 193; *see also, e.g., Illinois*, 813 F.Supp.3d at 306–07 (holding *Lincoln* does not bar review of agency decision to impose condition onto program grants because the relevant “statutory and regulatory frameworks” “provide[d] judicially manageable standards for review”). Accordingly, Defendants have failed to establish that the Challenged Conditions are unreviewable under § 701(a)(2).

D. The Challenged Conditions Are Reviewable as Final Agency Action.

The Challenged Conditions are reviewable as “final agency action” under 5 U.S.C. § 704. Not only do Plaintiffs satisfy the two-prong test from *Bennett v. Spear*, 520 U.S. 154 (1997), *see*

supra 6-7, but Defendants fail to acknowledge – let alone rebut – the cases in Plaintiffs’ opening brief that hold that the decision to attach new conditions to NOFOs is final agency action, regardless of whether the grants have yet been awarded. *See* Pls.’ Br. at 13-14 (citing cases).

Plaintiffs’ claims cannot be deflected as “generalized complaints about agency behavior” or a “broad programmatic attack” on all Ryan White Program funding. Gov’t Br. 19 (quotation marks omitted). Rather, Plaintiffs bring a limited challenge to a discrete set of unlawful conditions imposed on Ryan White funds. Specific objections to unlawful conditions are actionable even where they apply program-wide or even across multiple agencies. *See, e.g., New York*, 171 F.4th at 17–18 (rejecting argument that challenge was “an impermissible ‘programmatic attack on [all] federal spending’” where plaintiffs challenged only “discrete, agency-wide categorical freeze that each of the Agency Defendants allegedly put in place”); *Hisp. Affs. Project v. Acosta*, 901 F.3d 378, 388 (D.C. Cir. 2018) (holding challenge was not impermissibly programmatic in nature because plaintiffs challenged an across-the-board agency practice in violation of a specific statutory command); *Massachusetts v. Kennedy*, 783 F.Supp.3d 487, 500 (D. Mass. 2025).

II. Plaintiffs Are Likely to Succeed on the Merits of Their Claims.

A. The Challenged Conditions Are Arbitrary and Capricious.

The Challenged Conditions are arbitrary and capricious because they (i) are contrary to the purpose and structure of the Ryan White program, which aims to provide comprehensive care targeted to underserved populations and informed by local experience; (ii) ignore the scientific evidence before the agency showing the success of an inclusive program in fostering retention in treatment and viral suppression; and (iii) represent an abrupt reversal of agency policy unaccompanied by any consideration of reliance interests or the likely public health impact of excluding and stigmatizing transgender people with HIV. *See* Pls.’ Br. 15–20. Defendants fail to

grapple with these arguments. Gov’t Br. 21–22. They have waived contrary arguments. *See Rivera-Gomez v. de Castro*, 843 F.2d 631, 635 (1st Cir. 1988); *Grafton & Upton Railroad Co. v. Town of Hopedale*, No. 22-cv-40080, 2023 WL 2761205, at *13 (D. Mass. Mar. 31, 2023).

Defendants also fail to demonstrate that they gave *any* consideration to these issues in formulating the Challenged Conditions. Instead, they assert that the Challenged Conditions were adopted to “align with the administration’s goals and the President’s executive orders.” Gov’t Br. 6–7. But merely declaring “changes” in administration “priorities” (Gov’t Br. 22) does not satisfy *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), *cited in* Pls.’ Br. 14. “Everyone agrees that an agency’s change of mind does not itself render the agency’s action arbitrary. What matters is the [agency’s] explanation for its decision.” *Bell Atlantic Tel. Co. v. FCC*, 79 F.3d 1195, 1202 (D.C. Cir. 1996). Yet, Defendants’ have provided no explanation at all.

The closest Defendants appear to come to giving a “reason” for their change in priorities, other than anti-transgender animus, is to prevent Ryan White funds from being used “for purposes unrelated to the statute.” Gov’t Br. 7. But this purported rationale disregards that providing comprehensive medical care and ensuring retention in HIV treatment are, in fact, core purposes of the statute. *See supra* I.C. Defendants assert that they conducted a “systematic review of the grant awards and the agency’s priorities” to “determine whether funding under the Ryan White Program comported with statutory requirements and administrative priorities.” Gov’t Br. 22. But they have provided absolutely no evidence of this alleged review. Defendants assert that “[t]he record shows reasoned consideration,” Gov’t Br. at 22, yet failed to provide any such record. This leaves the Court with no basis to validate the agency’s actions. *See Dep’t of Com.*, 588 U.S. at 780. Defendants effectively tell this Court: “Trust us, we did our job.” That is not enough.

FCC v. Fox Television Stations, Inc., 556 U.S. 502 (2009), is not to the contrary. Per *Fox*,

when an agency’s “new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account,” the agency *must* provide a more robust justification than would suffice for a policy “created on a blank state.” *Id.* at 515. “An agency may not ... depart from a prior policy *sub silentio*. ... [T]he agency must show good reasons for the new policy.” *Id.* “[T]o ignore such matters” is “arbitrary and capricious.” *Id.*; *see also Am. Hosp. Ass’n v. Kennedy*, 164 F.4th 28, 33 (1st Cir. 2026) (record “devoid of evidence” that agency considered “significant reliance interests” is “a critical factor in the analysis of an arbitrary-and-capricious claim”). That is the case here.

B. The Challenged Conditions Are Contrary to Law.

Defendants do not meaningfully respond to Plaintiffs’ claim that the Challenged Conditions run afoul of the Ryan White statute, which requires that gender-affirming medical care be covered as a “core medical service.” Pls.’ Br. 3-5. This alone is sufficient to set aside the Challenged Conditions. Defendants’ failure to address this argument constitutes waiver. *See, e.g., United States v. Cardona*, 88 F.4th 69, 75 n.2 (1st Cir. 2023). As to Section 1554 of the ACA, Defendants ignore Plaintiffs’ cited case law and instead invoke *Rust v. Sullivan*, 500 U.S. 173 (1991), for the assertion that the Supreme Court distinguishes between “regulations that impose burdens on health care providers and their clients and those that merely reflect Congress’s choice not to subsidize certain activities.” Gov’t Br. 21. But unlike *Rust*, this case is not about *Congress* deciding not to fund certain activities. It is about *Defendants* trying to curtail funding for care that Congress has already authorized. *See* Pls.’ Br. 22-23. And Defendants’ actions directly burden access to healthcare, in violation of Section 1554. *See* Pls.’ Br. 23-26.

C. Defendants Lack Authority to Impose The Challenged Conditions.

Defendants argue that the Challenged Conditions do not violate “the Separation of Powers principle” because “[a]gencies naturally exercise interpretive discretion in determining whether

activities fall within or outside a program’s scope.” Gov’t Br. 22. But this begs the question whether Defendants have exercised discretion that Congress intended them to have. It is for this Court to exercise its “independent judgment,” *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412 (2024), to determine whether Defendants have gone “beyond what Congress has permitted [them] to do,” *City of Arlington v. F.C.C.*, 569 U.S. 290, 298 (2013). *See also Nat’l Educ. Ass’n v. U.S. Dep’t of Educ.*, 779 F.Supp.3d 149, 197 (D.N.H. 2025). Defendants have exceeded their mandate by engrafting funding conditions in violation of the Appropriations Clause and by effectively amending the Ryan White statute in violation of Articles I and II. *See* Pls.’ Br. 26-30.

Unlike the lump sum appropriation at issue in *Lincoln*, 508 U.S. at 192, Congress provided direction for how Ryan White funds are to be spent, which sharply limits Defendants’ discretion: to support not just HIV treatment, but *comprehensive* medical care for *all* people living with HIV, targeting underserved communities, with the goal of strengthening retention and adherence. Pls.’ Br. 3-5, 15-17, 21-23. Providing gender-affirming medical care fits within this Congressional mandate, whether or not the statute mentions it “explicitly.” Gov’t Br. 23. It is part of “core medical services,” which encompass “outpatient and ambulatory health services,” including for “co-occurring conditions” such as gender dysphoria. Pls.’ Br. 22-23. Receiving such care maximizes retention and adherence to HIV treatment for transgender people living with HIV. Pls.’ Br. 5. The Challenged Conditions thwart these core Congressional objectives.

Against this powerful showing, Defendants have virtually nothing to say, merely stating—with no support in the statute, the legislative history, the record, or common sense—that gender-affirming care “deviates from the statutory objective of providing treatment for HIV/AIDS” and that barring it “reflects adherence to Congressional intent and statutory boundaries.” Gov’t Br. 24. The opposite is true. Defendants recognize that they must, under the Constitution, act “in

accordance with statutory authorization and not in defiance of it.” Gov’t Br. 24. But they do not explain how denying transgender people medical care that promotes adherence to HIV treatment puts them on the right side of that dichotomy.

In any event, the Challenged Conditions sweep more broadly than merely restricting gender-affirming medical care. They also “condition the issuance of Ryan White grants on whether the recipient promotes ‘gender ideology,’ denies the ‘sex binary’ in humans, [or] expresses the belief that sex is a ‘chosen or mutable characteristic.’” Pls.’ Br. 28; *see* Compl. ¶¶ 164–87. Congress did not authorize such restrictions, which *frustrate* its intent by burdening patient communication and preventing healthcare professionals from treating their transgender patients with respect and dignity. Pls.’ Br. 5-7. These aspects of the Challenged Conditions *also* exceed Defendants’ statutory authority. Pls.’ Br. 28. Defendants offer no response.

D. The Challenged Conditions Unlawfully Discriminate.

Defendants fail to undermine Plaintiffs’ contention that the Challenged Conditions unlawfully discriminate in violation of the ACA and the Fifth Amendment. First, Defendants make only passing reference to Plaintiffs’ allegation that the Challenged Conditions violate Section 1557 of the ACA. But Defendants misapprehend Plaintiffs’ claim: Plaintiffs do not contend that Section 1557 “mandate[s] that covered entities affirmatively fund or seek to benefit any particular group regardless of that group’s minority status.” Gov’t Br. 25. Rather, Plaintiffs assert that the requirement that recipients of Ryan White funding stop respecting their transgender patients’ identities and stop providing necessary gender-affirming medical care because it promotes “gender ideology” is discrimination based on transgender status and sex in violation of Section 1557.

The decision in *West Virginia v. B.P.J.* does not change this analysis. *See* No. 24-38, 2026 WL 1868739 (U.S. 2026). In upholding the state’s law regarding sex-segregated school sports, the Supreme Court emphasized the unique nature of sports and relied on the fact that “Title IX

authorizes separate men’s and women’s sports teams.” *Id.* at *9; *id.* at *18 (Gorsuch, J., concurring) (reaffirming that “discriminating against a person for being homosexual or transgender necessarily entails discriminating against that person at least in part *because of* ... sex” (emphasis added)).

Second, the Challenged Conditions do not survive equal protection scrutiny. Defendants contend the Challenged Conditions classify based on “medical use” and warrant only rational basis review. Gov’t Br. 25. Not so. The Conditions direct that funding recipients: not “promote gender ideology”; “recognize that a person’s sex ... is unchangeable”; and certify compliance with the Gender Order. Beyond simply limiting a specific medical treatment, they constitute a much broader attack on Plaintiffs’ provision of affirming and respectful healthcare to transgender people.⁵

The Supreme Court’s decision in *B.P.J.* underscores that intermediate scrutiny is required for sex-based classifications, such as the ones at issue here. *See* 2026 WL 1868739, at *10.⁶ Indeed, the Challenged Conditions expressly require funding recipients to “[a]pply[] *sex-based* definitions grounded in biological reality,” require recipients to “recognize that a person’s *sex* as either male or female is unchangeable and determined by objective biology,” and “ensure its programs accurately reflect ... the biological reality of *sex*.” Dkts. 19-2 at 5, 19-3 at 4 (emphasis added).

Finally, even if this Court finds that the Challenged Conditions are not subject to intermediate scrutiny, Defendants do not even attempt to rebut the argument that the Challenged Conditions are based upon invidious discrimination, and thus, under binding First Circuit precedent, subject to a more searching review than ordinary rational basis review. *See Massachusetts v. U.S. Dep’t of Health & Hum. Servs.*, 682 F.3d 1, 11 (1st Cir. 2012). And here, the

⁵ In fact, only one NOFO, from 2025, mentions gender-affirming medical care at all. *See* Dkt. 19-4 at 41.

⁶ In *B.P.J.*, the Supreme Court declined to reach the question of whether classifications based on transgender status require heightened scrutiny. 2026 WL 1868739, at *14. However, other courts, including courts in the First Circuit, have found both that classifications based on transgender status are classifications based on sex and that such classifications independently warrant heightened scrutiny. Pls.’ Br. 32-33.

Administration has mounted a sustained campaign against transgender people that is based on animus. *See, e.g., Talbott v. United States*, 176 F.4th 720, 746 (D.C. Cir. 2026) (finding policy excluding transgender people from the military “was premised, at least in part, on a non-legitimate state interest to harm the politically unpopular group of transgender persons”); Pls.’ Br. 34.

E. The Challenged Conditions Violate the First Amendment.

With regards to Plaintiffs’ First Amendment claim, Defendants mischaracterize their extra-statutory limitations as merely “selectively funding a program to encourage certain activities,” Gov’t Br. 27, to avoid the unconstitutional-conditions doctrine, explained in Plaintiffs’ brief (pp. 34-37). But the Challenged Conditions go well beyond not funding a specific activity; they require recipients to discriminate against transgender patients living with HIV by prohibiting providers from acknowledging, affirming, or respecting their identities.

In any event, even in selective subsidy programs, the Government may not leverage discretionary funding criteria into a penalty on disfavored viewpoints or aim at the suppression of dangerous ideas. *See* Pls.’ Br. 36-37; *see also Chiles v. Salazar*, 146 S. Ct. 1010, 1029 (2026) (“[T]he First Amendment stands as a shield against any effort to enforce orthodoxy in thought or speech in this country.”); *FCC v. League of Women Voters of Cal.*, 468 U.S. 364, 380–81, 398–99 (1984); *McGuire v. Reilly*, 386 F.3d 45, 62 (1st Cir. 2004); *Ridley v. Mass. Bay Transp. Auth.*, 390 F.3d 65, 82, 95 (1st Cir. 2004) (“The bedrock principle of viewpoint neutrality demands that the state not suppress speech where the real rationale for the restriction is disagreement with the underlying ideology or perspective that the speech expresses.”). “Where private speech is involved, even Congress’ antecedent funding decision cannot be aimed at the suppression of ideas thought inimical to the Government’s own interest.” *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 548–49 (2001). Nor may the Government “leverage funding to regulate speech outside the contours of

the program itself.” *Agency for Int’l Dev. v. All. for Open Soc’y Int’l, Inc.*, 570 U.S. 205, 214–15 (2013); *see also Thakur v. Trump*, 176 F.4th 1187, 1199-1204 (9th Cir. May 26, 2026) (holding denying funding to DEI-related research constitutes unlawful viewpoint discrimination).

The Challenged Conditions do not merely attempt to prohibit certain aspects of care (notwithstanding that these are permitted by the Ryan White Program); they direct the providers to eschew decency and respect for transgender patients seeking comprehensive HIV care lest providers be punished for promoting gender ideology. They are an unlawful subsidy-as-penalty.

III. Plaintiffs and Their Patients Will Experience Irreparable Harm.

Defendants mischaracterize Plaintiffs’ injuries as “essentially economic.” Gov’t Br. 29–30. Not so. The Challenged Conditions will injure Plaintiffs’ medical practices by forcing them to dismantle integrated systems of HIV care, fracture provider-patient relationships, harm their careers and reputations, and force them to violate their ethical duties. In addition, Defendants ignore the irreparable harm to patients who will lose or have diminished access to HIV care and gender-affirming medical care, which will endanger their health. *See* Pls.’ Br. 7-10, 37-39. These harms cannot be remedied after the fact. Nor can the deprivation of Plaintiffs’ constitutional rights.

The balance of equities and public interest likewise strongly favor relief. Defendants’ sole argument is a supposed fiscal interest in avoiding the expenditure of funds they might later be unable to recover. Gov’t Br. 31–32. But they will award the same amount of funding regardless. Preliminary relief would not enlarge those pools or compel spending outside the Ryan White Program; it would govern only the terms on which HRSA makes the announced awards while this case is litigated. By contrast, preliminary relief would further the public interest. Pls.’ Br. 39-40.

IV. Plaintiffs Are Entitled to the Requested Scope of Relief.

Defendants attempt to reframe the appropriate preliminary relief as overbroad. It is not.

First, contrary to Defendants’ plea, Gov’t Br. 32, “[t]he APA’s remedies are not party-

restricted and allow a court to set aside an unlawful agency action.” *Ass’n of Am. Universities v. Dep’t of Def.*, 806 F.Supp.3d 79, 123 (D. Mass. 2025); *id.* at 120-23 (collecting case law); *see also Career Colleges & Schs. of Texas v. U.S. Dep’t of Educ.*, 98 F.4th 220, 255 (5th Cir. 2024) (“[W]e conclude that the scope of preliminary relief under Section 705 aligns with the scope of ultimate relief under Section 706, which is not party-restricted and allows a court to ‘set aside’ an unlawful agency action.”) (subsequent history omitted); *Afr. Communities Together v. Noem*, 820 F.Supp.3d 48, 72 (D. Mass. 2026) (“relief pursuant to § 705 does not operate *in personam*, but rather functions as a temporary form of vacatur” (citation modified)).

Second, Defendants are wrong to suggest that remand is the appropriate remedy under the APA. Gov’t Br. 30. For one, relief under 5 U.S.C. § 705 seeks only to “preserve status or rights” while a case proceeds. Remand only happens *after* a case is finally adjudicated. For another, “[t]he normal remedy for a successful APA challenge is vacatur of the rule and its applicability to all who would have been subject to it.” *Massachusetts v. Nat’l Institutes of Health*, 770 F.Supp.3d 277, 329 (D. Mass. 2025), *aff’d*, 164 F.4th 1. Moreover, remand would not be appropriate here given “the severity of the errors,” the likelihood that they cannot “be mended without altering the order,” and “the balance of equities and public interest.” *Town of Weymouth. v. Mass. Dep’t of Env’t Prot.*, 961 F.3d 34, 58 (1st Cir.), *on reh’g*, 973 F.3d 143 (1st Cir. 2020). Here, remand would do nothing to cure the fundamental defects that plague the Challenged Conditions, such as them being contrary to law or constitutional rights or power and without authority. *See Centro de Trabajadores Unidos v. Bessent*, 167 F.4th 1218, 1230 (D.C. Cir. 2026); *Ass’n of Am. Universities*, 806 F.Supp.3d at 124.

Third, Defendants err in urging that relief be limited to *only* Provider Plaintiffs, excluding Associational Plaintiffs’ members. Gov’t Br. 32. When organizations establish standing on their members’ behalf, preliminary relief extends to those members who are likely to suffer irreparable

harm. *See N.H. Indonesian Cmty. Support v. Trump*, 157 F.4th 29, 35 (1st Cir. 2025), *cert. denied*, No. 25-899, 2026 WL 1871309 (U.S. June 30, 2026). “[N]o additional showing is necessary to afford relief to all [] members of Organizational Plaintiffs.” *Ass’n of Am. Universities v. Dep’t of Def.*, 792 F.Supp.3d 143, 183 (D. Mass. 2025); *see also Oregon Council for Humans. v. U.S. DOGE Serv.*, 794 F.Supp.3d 840, 896 (D. Or. 2025) (“Within the principles of ... associational standing, the Court properly may order injunctive relief for the Federation’s members.”).⁷

V. A Stay of Preliminary Relief and a Bond Are Inappropriate.

Defendants’ request for a stay pending appeal is procedurally improper. *See* Fed. R. Civ. P. 7(b)(1) (motion required for court order); Fed. R. App. P. 8(a)(1)(A) (motion required for stay order); *PFLAG*, 769 F.Supp.3d at 454. Plus, Defendants cite no authority for their request—beyond a case “setting forth the [stay] factors.” Gov’t Br. 32–33. At any rate, Defendants are unlikely to succeed on appeal and do not face irreparable harm. Defendants’ request for an administrative stay fares no better. The only basis they offer for such a stay is “to seek an emergency, expedited stay from the First Circuit.” Gov’t Br. 33. But here it is Plaintiffs who seek to maintain the *status quo*.

Furthermore, no bond should be required. “Unlike a preliminary injunction, a stay under 5 U.S.C. § 705 does not require the movant to post a bond.” *Nat’l Parks Conservation Ass’n v. Dep’t of the Interior*, No. 26-CV-10877, 2026 WL 1706963, at *27 (D. Mass. June 12, 2026). And the Court should exercise its discretion to forgo a bond. *See* Pls.’ Br. 40. At minimum, any bond should be nominal. *See Maine v. U.S. Dep’t of Agric.*, 778 F.Supp.3d 200, 237–38 & n.13 (D. Me. 2025).

CONCLUSION

The Court should grant Plaintiffs’ motion and enter the proposed order.

Dated: July 2, 2026

⁷ Defendants cite no authority for their assertion that providers should each bring individual cases to receive preliminary relief, Gov’t Br. 31, instead of relying on Associational Plaintiffs’ standing to seek relief for their members.

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CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was electronically filed using the Court's CM/ECF system, and that service was effected by and through the Court's CM/ECF system, which sends it electronically to the registered participants as identified on the Notice of Electronic Filing.

Dated: July 2, 2026

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan (BBO No. 678517)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMERICAN ACADEMY OF HIV
MEDICINE, *et al.*,

Plaintiffs,

v.

HEALTH RESOURCES AND SERVICES
ADMINISTRATION, *et al.*,

Defendants.

Case No. 1:26-cv-12638-WGY

REPLY DECLARATION OF JOSE ABRIGO IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY RELIEF UNDER 5 U.S.C. § 705
AND PRELIMINARY INJUNCTION

I, Jose Abrigo, hereby state and declare as follows:

1. I am Counsel at Lambda Legal Defense and Education Fund and counsel for Plaintiffs in the above-referenced litigation. I am admitted to practice in the State of New York, and I am admitted *pro hac vice* in this matter.
2. I have personal knowledge of the matters stated herein and am competent to testify thereto.
3. I submit this Reply Declaration in support of Plaintiffs' Motion for Preliminary Relief Under 5 U.S.C. § 705 and Preliminary Injunction.
4. Attached hereto as **Exhibit J** is a true and correct copy of the *Notice of Funding Opportunity, Ryan White HIV/AIDS Program Part D Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (WICY) Existing Geographic Service Areas*, Opportunity No. HRSA-26-067, issued by HRSA on June 11, 2026.

5. Attached hereto as **Exhibit K** is a true and correct copy of a July 2, 2026 printout of the Version History webpage on Grants.gov for the funding opportunity titled *Ryan White HIV/AIDS Program Part D Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (WICY) Existing Geographic Service Areas*, Opportunity No. HRSA-26-067.

6. Attached hereto as **Exhibit L** is a true and correct copy of a July 2, 2026 printout of the Version History webpage on Grants.gov for the funding opportunity titled *Ryan White HIV/AIDS Program Part B States/Territories Supplemental Grant Program*, Opportunity No. HRSA-26-074.

7. Attached hereto as **Exhibit M** is a true and correct copy of a July 2, 2026 printout of the Version History webpage on Grants.gov for the funding opportunity titled *Ryan White HIV/AIDS Program Part C Capacity Development Program*, Opportunity No. HRSA-26-061.

8. Attached hereto as **Exhibit N** is a true and correct copy of a July 2, 2026 printout of the Version History webpage on Grants.gov for the funding opportunity titled *Ryan White HIV/AIDS Program Part F Dental Reimbursement Program*, Opportunity No. HRSA-26-085.

Pursuant to 28 U.S.C. § 1746, I declare under the penalty of perjury that the foregoing is true and correct.

Executed on July 2, 2026.

/s/ Jose Abrigo
Jose Abrigo

EXHIBIT J

Notice of Funding Opportunity

Application due 07/13/2026



Health Resources & Services Administration

HIV/AIDS Bureau

Division of Community HIV/AIDS Programs

Ryan White HIV/AIDS Program Part D Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (WICY) Existing Geographic Service Areas

Opportunity number: HRSA-26-067



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Before you begin

If you believe you are a good candidate for this funding opportunity, secure your [SAM.gov](https://sam.gov) and [Grants.gov](https://grants.gov) registrations now. If you are already registered, make sure your registrations are active and up-to-date.

SAM.gov registration (this can take several weeks)

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier (UEI).

[See Step 2: Get Ready to Apply](#)

Grants.gov registration (this can take several days)

You must have an active Grants.gov registration. Doing so requires a Login.gov registration as well.

[See Step 2: Get Ready to Apply](#)

Apply by the application due date

Applications are due by 11:59 p.m. Eastern Time on 007/13/2026.



To help you find what you need, this NOFO uses internal links. In Adobe Reader, you can go back to where you were by pressing Alt + Left Arrow (Windows) or Command + Left Arrow (Mac) on your keyboard.

All activities proposed in your application and budget narrative must align with applicable law, including but not limited to statutes, executive orders, federal regulations and applicable judicial holdings. Accordingly, discretionary awards shall not be used to fund, promote, encourage, subsidize, or facilitate racial preferences or other forms of racial discrimination by the recipient, including activities where race or intentional proxies for race will be used as a selection criterion for employment or program participation; denial by the recipient of the sex binary in humans, or the belief that sex is a chosen or mutable characteristic; illegal immigration; or any other initiatives that compromise public safety. If an application does not align, the application will not receive funding to the extent permitted by law and applicable court orders.



Step 1:

Review the Opportunity

In this step

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Basic information

Health Resources Services Administration

HIV/AIDS Bureau

Division of Community HIV/AIDS Programs

Funding family-centered HIV medical care and support services for low-income women, infants, children, youth with HIV, and their affected families.

Summary

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV care that improves health outcomes and supports viral suppression. Through its Part D program, RWHAP funds local, community-based organizations to provide family-centered medical and specialty care for low-income women, infants, children, and youth with HIV (WICY). Overall, the RWHAP's goal is to improve health outcomes and reduce HIV transmission, especially for people not yet in regular medical care.

Funding details

Application Types: Competing continuation, New

Expected total available funding in FY 2026: \$69,000,000

Expected number and type of awards: 111 Grants

Funding range per award: \$115,000 to \$2,000,000

We plan to fund awards in four 12-month budget periods for a total four-year period of performance from 08/01/2026 to 07/31/2030.

The program and awards depend on the appropriation of funds and are subject to change based on the availability and amount of appropriations.



Have questions?

Go to [Contacts and Support](#).

Key facts

Opportunity name:

Ryan White HIV/AIDS Program
Part D Coordinated HIV
Services and Access to
Research for Women, Infants,
Children, and Youth (WICY)
Existing Geographic Service
Areas

Opportunity number:

HRSA-26-067

Announcement version:

Initial

Federal assistance listing:

93.153

Key dates

NOFO issue date:

06/11/2026

Application deadline:

07/13/2026

Expected award date is by:

08/01/2026

Expected start date:

08/01/2026

See [other submissions](#) for other time frames that may apply to this NOFO.

RWHAP Part D funding methodology

In fiscal year (FY) 2022, the Health Resources and Services Administration (HRSA) initiated the first phase of a Ryan White HIV/AIDS Program (RWHAP) funding methodology for Part D to strategically target RWHAP Part D resources to maximize national impact. The process included an analysis of the Ryan White Services Report (RSR), allocation, and Centers for Disease Control and Prevention (CDC) surveillance data. It also included a review of evidence-informed interventions for women, infants, children, and youth (WICY) and stakeholder input.

To minimize service disruptions and burden on recipients, HRSA implemented an incremental approach, beginning with 22% in 2022. In FY 2026, HRSA will increase implementation to 50%.

The methodology includes:

- **Base funding:** A minimum award of \$115,000 per service area to support program operations.
- **WICY clients served:** Additional funding based on the number of eligible Part D clients reported in the most recent RSR data (2023 for this competition).
 - Approximately 85% of funding was allocated through base funding and client volume.
- **Absence of RWHAP Part A resources:** Additional funding for service areas outside Part A jurisdictions, primarily rural areas.
 - Approximately 15% of funding was based on this factor.

The methodology ensured baseline operational support, minimized funding disruptions by limiting decreases (approximately 20%) and increases (approximately 25%) compared to FY 2025 levels, and maintained continuity of care. HRSA used this approach to establish funding ceilings under the NOFO, which remained a competitive, discretionary opportunity.

Eligibility

You can apply if you are a public or nonprofit private entity (including a health facility operated by or pursuant to a contract with the Indian Health Service, Tribal governments and organizations, and faith based organizations) that provides family-centered care involving outpatient or ambulatory care (directly or through contracts or memoranda of understanding) for women, infants, children and youth (WICY) with HIV/AIDS.

Types of eligible organizations

These types of domestic* organizations may apply:

- State governments.
- County governments.
- City or township governments.
- Special district governments.
- Public and State controlled institutions of higher education.
- Native American tribal governments (Federally recognized).
- Native American tribal organizations (other than Federally recognized tribal governments).
- Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education.
- Nonprofits without 501(c)(3) status with the IRS, other than institutions of higher education.
- Private institutions of higher education.
- For profit organizations other than small businesses.
- Small businesses.
- Faith-based organizations.

*“Domestic” means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Individuals are not eligible applicants under this NOFO.

Other eligibility criteria

- All applicants must meet the basic requirements of a RWHAP Part D Program as outlined in this NOFO and as established in section 2671 of the Public Health Service (PHS) Act.
- This competition is open to current RWHAP Part D recipients and to new organizations proposing to provide RWHAP Part D–funded services, and your application must cover the **entire** geographic service area specified in [Appendix B](#).
- If you apply for more than one service area listed in [Appendix B](#), you must submit a separate application for each. Applications that propose to serve more than one service area in a single application will be deemed ineligible.

Completeness and responsiveness criteria

We will review your application to make sure it meets these basic requirements to move forward in the competition.

We will not consider an application that:

- Is from an organization that does not meet all [eligibility criteria](#).
- Requests funding above the award ceiling shown in the [funding range](#).
- Is submitted after the [deadline](#).
- Does not include all required attachments.

Application limits

You may not submit more than one application for the same service area. If you submit more than one application, we will only accept the last on-time submission.

Cost sharing

This program has no cost-sharing requirement. If you choose to share in the costs of the project, we will not consider it during merit review. Recipients agree that once committed, cost sharing amounts are enforceable and subject to reporting and auditing requirements under 2 CFR 200.

Post-award requirements

Before you apply, make sure you understand the requirements that come with an award.

See [Step 6: Learn What Happens After Award](#) for information on regulations that apply, reporting, and more.

Program description

Purpose

This program funds family-centered HIV care and support services in outpatient or ambulatory settings. It serves low-income women, infants, children and youth with HIV, and their affected family members.

Types of services

- HIV family-centered care includes outpatient or ambulatory care such as:
 - Behavioral health.
 - Nutrition services.
 - Oral health services.
- Specialty care includes, but is not limited to:
 - HIV specialty care.
 - Obstetrics and gynecology.
 - Hepatology.
 - Neurology.
- Support services may include, but are not limited to the following:
 - Family-centered care services such as non-medical case management, child care, housing and other services described in [Policy Clarification Notice \(PCN\) 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds \[PDF\]](#) that address the health care needs of people with HIV to achieve optimal health outcomes.
 - Referrals for:
 - Inpatient hospital services.
 - Other social and support services, as needed.
 - Activities for participation such as:
 - Helping people with HIV and affected individuals participate in the established program, including activities designed to retain youth with HIV.
 - Lastly, information and education about opportunities to participate in HIV/AIDS-related clinical research.

For additional information, please refer to [PCN 16-02 \[PDF\]](#) for a list of RWHAP allowable services and use of funds.

For more details, see [program requirements and expectations](#).

Background

The Ryan White HIV/AIDS Program

The Ryan White HIV/AIDS Program (RWHAP) has [five statutorily defined Parts](#) that provide grants to states, cities, counties, local clinics, and community-based organizations. The grants fund medical care, medication, and essential support services, to meet the needs of people with HIV and family members affected by HIV. Together these grants provide a comprehensive system of care to ensure low-income people with HIV have access to services for early diagnosis of HIV, linkage to care, medically appropriate treatment, retention in care, and sustained viral suppression (a very low or undetectable amount of HIV in the blood).

For nearly four decades, the RWHAP has funded services to provide HIV primary health care, medication, and essential support services, including mental health care, transportation, case management, nutrition, and housing. These services support clients to enter and remain in care, access medications, and reach viral suppression, reducing transmission and lowering health care costs.

Ending the HIV epidemic

Launched in 2020, the Ending the HIV Epidemic in the U.S. (EHE) initiative further expands federal efforts to reduce HIV transmission. For the RWHAP, the EHE initiative expands the program's ability to meet the needs of clients, specifically focusing on linking people with HIV who are either newly diagnosed, diagnosed but currently not in care, or are diagnosed and in care but not yet virally suppressed, to the essential HIV care, treatment, and support services needed to help them reach viral suppression.

Making America Healthy Again

The Ryan White HIV/AIDS Program helps advance the [Making America Healthy Again \(MAHA\)](#) priorities by:

- Expanding access to primary care for people with HIV, particularly those with low incomes, and by
- Strengthening the health workforce.
- Fighting the chronic disease epidemic by providing HIV medical care, treatment, and support services to people with HIV.
- Supporting improved nutrition by providing patient-centered focused medical nutrition therapy and food services.
- Supporting disease prevention through HIV care and treatment services that help people reach viral suppression, so they live longer, healthier lives and do not transmit HIV.

Key accomplishments

- **Nearly 602,000 people with HIV** in the U.S. received life-saving care, medication, and essential support services through the RWHAP, representing over half of all diagnosed with HIV in the U.S. This is an increase of nearly 26,000 clients.
- **More than 91%** of Ryan White HIV/AIDS Program patients receiving HIV medical care were virally suppressed in 2024. This is up from 69.5% of patients virally suppressed in 2010 and significantly higher than the 67.2% virally suppressed nationally among all people with diagnosed HIV.
- **More than 47%** of Ryan White HIV/AIDS Program clients are aged 50 years and older, demonstrating the program's success in supporting older clients and its commitment to addressing the unique needs of people aging with HIV.

Program requirements and expectations

You must provide or coordinate services for **all** the following populations to meet the program's requirements and expectations:

- Family-centered outpatient or ambulatory care and support services for:
 - Low-income women with HIV.
 - Infants (up to two years old) exposed to or with HIV.
 - Children (ages 2 to 12) with HIV.
 - Youth (ages 13 to 24) with HIV.
- Affected individuals in limited situations per [PCN 16-02 \[PDF\]](#).

Family-centered outpatient ambulatory health services may be delivered directly, or through contracts or memoranda of understandings (MOUs).

RWHAP Part D recipients must create a comprehensive and coordinated system of family-centered care and support services for low-income WICY with HIV in their entire service area as listed in [Appendix B](#). Programs should:

- Focus on populations who have the greatest unmet need.
- Improve health outcomes related to:
 - Testing and linkage to care.
 - Retention in medical care.
 - Viral suppression.
 - Reducing new HIV infections in the community.

Ryan White Program 2030

Ryan White Program 2030 (RWP 2030) builds on the foundation of the RWHAP and innovative, low-barrier strategies employed in the *Ending the HIV Epidemic in the U.S.* initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP while expanding efforts to identify and engage individuals with HIV who are undiagnosed or out-of-care. Achieving this goal requires a comprehensive, collaborative approach that builds upon existing successes and resources while fostering innovation.

In alignment with RWP 2030, recipients are expected to implement interventions that are evidence-based, evidence-informed, or emerging strategies that are grounded in data and responsive to the lived experiences of the communities they serve. These approaches are critical for improving health outcomes, reducing HIV-related deaths, and preventing new HIV transmissions. RWHAP Part D programs are expected to select and implement interventions that meet the needs of WICY and WICY populations with greatest need while advancing the goals of RWP 2030.

Minority AIDS Initiative (MAI)

Under section 2693 of the PHS Act, the Minority AIDS Initiative (MAI) addresses the challenges in access, treatment, care, and outcomes for racial and ethnic minorities, including African Americans, Alaska Natives, Hispanic/Latinos, American Indians, Asian Americans, and Native Hawaiians or Pacific Islanders.

MAI funds are granted to health care organizations that provide patient-centered care and services tailored to the needs of racial and ethnic minorities.

HRSA assigns MAI funds to RWHAP Part D WICY recipients based on the percentage of the RWHAP Part D WICY populations served from racial and ethnic minority communities as reported in the most recent *Ryan White HIV/AIDS Program Services Report (RSR)*.

Clinical requirements

Prevention of HIV transmission

Programs are required to follow the [HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#).

Providers should share information that reflects recent advances in HIV prevention, including:

- Viral suppression.
- Pre-exposure Prophylaxis (PrEP).

- RWHAP funds cannot be used for PrEP medications or related medical services, such as clinician visits and laboratory costs. However, RWHAP recipients must refer people who could benefit from PrEP to appropriate HIV prevention service providers in their area.
- Non-occupational Post-Exposure Prophylaxis (nPEP).
 - RWHAP funds cannot be used to pay for nPEP medications or related medical services. However, RWHAP recipients may educate and counsel clients on health and HIV prevention issues, including nPEP. See [Updated guidelines for antiretroviral post-exposure prophylaxis after sexual, injection drug use, or other non-occupational exposure to HIV \[PDF\]](#).

Medical services

- You must develop a comprehensive and coordinated system of family-centered care and support services in an outpatient or ambulatory care setting.
 - This should happen either directly or through contracts or MOUs throughout their entire designated service area (see [Appendix B](#)).

Clinical guidelines

- All clinical care must be provided in accordance with [HHS Clinical Practice Guidelines](#) for HIV/AIDS.
- You are strongly encouraged to require continuing education, as updates are made available. This ensures that staff remain knowledgeable of advances in the treatment of HIV and are familiar with the most recent [HHS Clinical Practice Guidelines](#).

Referral systems

- Programs must have a referral process for allowable services, as outlined in [PCN 16-02 \[PDF\]](#), that are not directly supported by your RWHAP Part D funding, such as:
 - Oral health.
 - Specialty care.
 - Medical case management.
- Referrals, including referral outcomes, should be tracked and monitored in the patient's medical record so follow-up can happen.

Linkage to clinical trials

Section 2671 of the PHS Act requires RWHAP Part D recipients to have a plan to refer patients to biomedical research facilities or community-based organizations that conduct HIV-related clinical trials.

See [the NIH HIV Clinical Trials Network](#) website for protocol details.

Clinical Quality Management (CQM)

Section 2671 of the PHS Act requires RWHAP Part D recipients to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with HHS Guidelines for the treatment of HIV and related opportunistic infections.
- Develop strategies for ensuring such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

Please see [PCN 15-02 : Clinical Quality Management \[PDF\]](#) for information on CQM program requirements.

Coordination/linkages to other programs

Required activities

- Recipients must coordinate with all available and accessible community resources, including federally-funded and non-federally-funded programs.
- Recipients must also coordinate with other health care services under the [Title V of the Social Security Act](#), including programs that promote the reduction and elimination of risk of HIV for youth.
- Recipients must participate in the development of the statewide coordinated statement of need required under the RWHAP Part B.
- Recipients must submit audits every two years to the lead state agency under RWHAP Part B regarding funds spent under RWHAP Part D.

Examples of programs to coordinate with:

- Support service programs such as substance use disorder treatment and housing services.
- Mental health services.

Medicaid provider status and clinic licensure

All applicants, including proposed subrecipients and MOU funded organizations, must:

- Have Medicaid provider status for all primary medical care providers and case management agencies.
- Be fully licensed to provide clinical and case management services, as required by state and local jurisdiction (see [Attachment 12](#)).

Administrative and fiscal requirements

Rapid service delivery

- To comply with [PCN 21-02 : Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program \[PDF\]](#), RWHAP recipients and subrecipients must develop protocols to facilitate the rapid delivery of RWHAP services.
 - This includes providing antiretrovirals to people who are newly diagnosed or re-engaged in care.
- If services begin before formal eligibility or payer source verification, recipients must determine eligibility within a reasonable timeframe.
 - Recipients must also reconcile RWHAP funds to ensure they were only used for allowable costs for eligible people.

Confirming RWHAP eligibility

RWHAP recipients and subrecipients must establish, implement, and monitor policies and procedures to determine eligibility for each client based on:

- HIV status.
- Low income.
- Residency.

We do not require documentation to be provided in-person nor be notarized.

See eligibility requirements ([PCN 21-02 \[PDF\]](#)).

Information systems

Recipients must have an information system that manages and reports, at a minimum, the following administrative, fiscal, and clinical data:

- Client demographic/clinical data and service provision data as required by the Ryan White HIV/AIDS Program Services Report (RSR).
 - See the most recent [Annual RSR Instruction Manual \[PDF\]](#).
- Source and use of program income.
- Services according to funding source.
- Time and effort supported by grant funds.
- Number of people with HIV served.

Service availability

HIV medical services should be available to clients **no later than 90 days** from the RWHAP D award issuance date.

The ability to provide family-centered HIV care includes hiring clinical staff and having the ability to bill for services.

When services are provided through contracts or through an MOU, subawards (contracts or MOU signed by both parties) must be finalized **within 60 days of the award**.

Subawarded services

In addition to the information included in 2 CFR 200.332, subrecipient agreements must include:

- The total number of WICY to be served.
- Eligibility for Medicaid certification of the medical providers and ambulatory care facilities.
- Details of the services to be provided.
- Assurance that providers will comply with RWHAP Part D legislative and program requirements, including:
 - Data sharing.
 - Submission of the RSR.
 - Participation in the CQM program.

Per 2 CFR 200.331–.333, recipients must monitor the activities of their subrecipients as necessary to ensure that the subaward is:

- Used for authorized purposes.
- In compliance with federal statutes, RWHAP legislative and programmatic requirements, regulations, and the terms and conditions of the subaward.

Recipients must also track that subaward performance goals are achieved.

- Recipients must ensure that subrecipients track, appropriately use, and report program income generated by the subaward.
- Recipients must also ensure that subrecipient expenditures adhere to legislative mandates regarding the distribution of funds.

Medication discounts

- HRSA expects RWHAP grant recipients that purchase, are reimbursed for, or provide reimbursement to other entities for outpatient prescription drugs to secure the best prices available for such products.
- They should also maximize results for their organization and patients (see 42 CFR part 50, subpart E).
- Eligible health care organizations and covered entities that enroll in the 340B Drug Pricing Program must comply with all 340B Program requirements.
 - They will also be subject to audit regarding 340B Program compliance.
- See more [details regarding program requirements and eligibility](#).

Program income

All program income generated from awarded funds is additive and must be added to the grant amount and used for otherwise allowable costs. This means it should further the objectives of the RWHAP Part D grant program.

Please see [PCN 15-03: Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income \[PDF\]](#) for more information on the RWHAP and program income.

Financial tracking

Programs must have internal financial controls to:

- Safeguard assets.
- Ensure stewardship of federal funds.
- Manage cash flow to meet daily operations.
- Maximize revenue from non-federal sources.

If patients who need medications are eligible for state drug reimbursement programs funded under RWHAP Part B or other pharmaceutical programs, Part D program recipients should assist them in accessing these resources prior to using RWHAP Part D grant funds for such purposes.

RWHAP Part D funds also may be used to support co-pays and deductibles in cases where other RWHAP funds (Part A, B, or C) are not available.

Statutory authority

42 U.S.C. §§ 300ff-71 and 300ff-121 (§§ 2671 and 2693 of the Public Health Service Act)

Award information

Funding policies and limitations

Changes in HHS regulations

As of October 1, 2025, HHS has adopted [2 CFR Part 200](#), with some modifications included in 2 CFR Part 300. These regulations replace those in 45 CFR Part 75.

Policies

- To make an award, funding must be available and allocated for this program and purpose, at which point we will move forward with the review and award process.
- Have clear policies and good financial practices to avoid spending HRSA funds on unallowable activities. Like other award rules, we may audit your policies, procedures, and controls.
- Support beyond the first budget year will depend on:
 - Appropriation of funds.
 - Your satisfactory progress in meeting the project's objectives.
 - A decision that continued funding is in the government's best interest.
- If we receive more funding for this program, we may:
 - Fund more applicants from the rank order list.
 - Extend the period of performance.
 - Award supplemental funding.

General limitations

- For guidance on some types of costs we do not allow or restrict, see:
 - Project Budget Information in the [Application Guide \[PDF\]](#).
 - [2 CFR Part 200 Subpart E](#) — General Provisions for Selected Items of Cost.
 - Allowable and Unallowable Costs and Activities in the [HHS Grants Policy Statement](#).
- All costs must be [reasonable, necessary, allocable](#) to the award, and adequately documented ([2 CFR 200.403](#)).
- You cannot earn profit from the federal award. See [2 CFR § 200.400\(g\)](#).
- To promote objectivity in research, you cannot have a financial conflict of interest. See [42 CFR 50](#).
- Current appropriations law includes a salary limit of \$228,000 as of January 2026 that applies to this program. You may pay salaries at a higher rate if the rate beyond the salary rate limit (Executive Level II) is paid with non-HHS funds. For

help calculating salaries under this limit, read more at “salary rate limitation” in the [Application Guide \[PDF\]](#).

Program-specific statutory or regulatory limitations

You cannot use funds under this notice for the following unallowable costs (this list is not exhaustive):

- Funding restrictions included in [PCN 16-02 \[PDF\]](#).
- Services that must be paid for by other sources, when available, consistent with the RWHAP payor of last resort requirement in [PCN 21-02 \[PDF\]](#).
- Payments for clinical research.
- Payments for inpatient hospitals, nursing homes, and other long-term care facilities.
- Cash payments to intended clients of RWHAP services.
- Purchase of, or improvement to land.
- Purchase, construction, or major alterations or renovations on any building or other facility (see [2 CFR 200](#) – subpart A Definitions).
- PrEP or nPEP medications or the related medical services. As outlined in the updated [November 16, 2021 RWHAP and PrEP program letter \[PDF\]](#).
- Purchase of sterile needles and syringes for the purpose of hypodermic injection of any illegal drug use. Some aspects of syringe services programs are allowable with HRSA’s prior approval and in compliance with HHS and HRSA policy. See [Syringe Services Programs](#).
- Development of materials designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.
- Research.
- Foreign travel.

RWHAP Part D funds cannot be used to:

- Supplement the maximum cost allowance for services reimbursed by third party payers such as Medicaid, Medicare, or other insurance programs.
 - Please note that recipients cannot use direct or indirect federal funds such as RWHAP Parts A, B, C, and F-Dental to duplicate reimbursement for services funded under Part D.
- Bill services reimbursed by RWHAP Part D to RWHAP Parts A, B, C, or F-Dental.

You must have policies, procedures, and financial controls in place. Anyone who receives federal funding must comply with legal requirements and restrictions, including those that limit specific uses of funding.

- Follow the list of statutory restrictions on the use of funds in Section 4.1 (Funding Restrictions) of the [Application Guide \[PDF\]](#).
 - We may audit the effectiveness of these policies, procedures, and controls. 2 CFR § 200.216 prohibits certain telecommunications and video surveillance services or equipment.
 - For details, see the [HRSA Grants Policy Bulletin Number: 2021-01E \[PDF\]](#).

Payor of last resort

With the exception of programs administered by or providing the services of the Indian Health Service, the RWHAP is the payor of last resort.

Funds may not be used for services already paid for, or that could reasonably be paid for by:

- A state compensation program.
- An insurance policy.
- A federal or state health care program.
- An entity that provides health services on a pre-paid basis.

To comply with [PCN 21-02 \[PDF\]](#), recipients and subrecipients must:

- Establish, implement, and monitor written policies and procedures to identify any other payer sources.
- Vigorously pursue enrollment into health care coverage for which clients may be eligible, starting with, and in the order of employer-sponsored coverage, other private insurance, marketplace insurance, Medicare, and Medicaid.
- Maintain clear documentation of those efforts.

See [Manage Your Grant](#) for other information on costs and financial management.

Indirect costs

Indirect costs are costs you charge across more than one project that cannot be easily separated by project. For example, this could include utilities for a building that supports multiple projects.

To charge indirect costs, you can select one of two methods:

Method 1 – Approved rate. You currently have an indirect cost rate approved by your cognizant federal agency at the time of award.

Method 2 – *De minimis* rate. Per [2 CFR § 200.414\(f\)](#), if you don't have a current indirect cost rate, you may elect to charge a *de minimis* rate. If you choose this method, costs included in the indirect cost pool must not be charged as direct costs.

This rate is up to 15% of modified total direct costs (MTDC). See [2 CFR § 200.1](#) for the definition of MTDC. You can use this rate indefinitely for all your federal awards or until you choose to receive a negotiated rate.

Consider your indirect costs when developing your [budget](#).

Program income

Program income is money earned as a result of your award-supported project activities. You must use any program income you generate from awarded funds for approved project-related activities. Find more about program income at [2 CFR 200.307](#).



Step 2:

Get Ready to Apply

In this step

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Get registered

SAM.gov

You must have an active account with SAM.gov to apply. SAM.gov registration can take several weeks. Begin that process today.

To register:

- Go to [SAM.gov Entity Registration](#) and select Get Started. From the same page, you can also select the Entity Registration Checklist for the information you will need to register.
- You must agree to the [financial assistance general certifications and representations \[PDF\]](#) specifically. Those for contracts are different.

When you register, you will also receive your required Unique Entity Identifier (UEI).

Once you register:

- You will have to maintain your registration throughout the life of any award.
- If your organization has multiple UEIs, use the one associated with your physical location.

If you need additional information about user roles in SAM.gov, see “Get registered: SAM.gov user roles” in the [Application Guide \[PDF\]](#).

Grants.gov

You must also have an active account with [Grants.gov](#). You can see step-by-step instructions at the Grants.gov [Quick Start Guide for Applicants](#) and [How to Apply for Grants](#).

Find the application package

The application package has all the forms you need to apply. You can find it online. Go to [Grants Search at Grants.gov](#) and search for opportunity number HRSA-26-067.

After you select the opportunity, we recommend that you click the Subscribe button to get updates.

Application writing help

Visit [HHS Tips for Preparing Grant Proposals](#).

Visit [HRSA's How to Prepare Your Application](#) page for more guidance.

See [Apply for a Grant](#) for other help and resources.

FAQs will be posted on our TA webpage after the webinar.

Join the webinar

Webinar information will be posted to the Related Documents tab on Grants.gov. We recommend you “Subscribe” to the NOFO on Grants.gov to receive updates when documents are posted.



Have questions? Go to [Contacts and Support](#).



Step 3:

Build Your Application

In this step

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Application contents and format	<u>28</u>

Application checklist

There are two types of forms in Grants.gov.

- Some forms allow you to upload components of your application to the form. These include components like your project narrative, budget and budget narrative, and attachments.
- Other forms are more typical, fill-in-the-blank forms.

Make sure that you have everything you need to apply.

Narratives

Component	Grants.gov form	Included in page limit*?
☐ Project narrative	Project Narrative Attachment form.	Yes
☐ Budget narrative	Budget Narrative Attachment form.	Yes

Attachments

Insert each in the Attachments Form in this order.

Component	Included in page limit*?
☐ 1. Proof of nonprofit status	No
☐ 2. Program-specific line-item budget	Yes
☐ 3. Federally negotiated indirect cost rate	No
☐ 4. Staffing plan and biographical sketches	Yes
☐ 5. Job descriptions for key vacant positions	Yes
☐ 6. Project organizational chart	Yes
☐ 7. Work plan	Yes
☐ 8. Signed and scanned RWHAP Part D additional agreements and assurances	Yes
☐ 9. Map of service area	Yes
☐ 10. List of provider organizations with contracts and/or MOUs	Yes
☐ 11. Letter(s) from RWHAP Part A and/or Part B recipient of record	Yes

Component	Included in page limit*?
☐ 12. Table of provider Medicaid and Medicare numbers (National Provider Identifiers) and clinic licensure status	Yes
☐ 13. – 15. Other relevant documents	Yes

Other required forms

Upload using each required form in Grants.gov.

Component	Included in page limit*?
Application for Federal Assistance (SF-424)	No
Project Abstract Summary form	No
Budget Information for Non-Construction Programs (SF-424A)	No
Disclosure of Lobbying Activities (SF-LLL)	No
Budget Narrative Attachment form	No
Project/Performance Site Location(s)	No
Grants.gov Lobbying form	No
Key Contacts	No

*Only what you attach in these forms counts toward the page limit. The forms themselves do not count.

Application contents and format

This section includes guidance on each component found in the application checklist.

Application page limit: 80 pages

Submit your information in English and express whole number budget figures using U.S. dollars.

Required format for project summary, project narrative, budget narrative, and attachments

Font: A readable font like Arial, Courier, CG Times, or Times New Roman

File format: We only accept the following document formats:

- .PDF - Adobe Portable Document Format
- .DOC/.DOCX - Microsoft Word
- .RTF - Rich Text Format
- .TXT - Text
- .WPD - Word Perfect Document
- .XLS/.XLSX - Microsoft Excel
- .VSD - Microsoft Visio

Size: 12-point font

Footnotes, charts, graphics, and budget tables may be 10-point or higher.

Ink color: Black

Spacing: Single-spaced, including all text and tables

Alignment: Left

Headings: Bold all headings and align left.

Size: 8.5 x 11 (Make sure the print area is set and allows printing to 8.5 x 11.)

Margins: 1-inch on all sides

Footer: On each page as the footer, include your organization's name and page numbers. If a competing continuation or competing supplement, also include your 10-digit award number.

Page numbering:

- Do not number the standard OMB-approved forms.
- Number each attachment page sequentially (that is, 1, 2, 3).
- Reset the numbering for each attachment.
- Treat each attachment as a separate section.

File names: You can find guidance for naming our files in the [Application Guide \[PDF\]](#).

Project narrative

Introduction

In this section, you will describe all aspects of your project. Use the section headers and the order listed.

See merit review criterion 1: [Need](#)

- Clearly state the **entire** service area you plan to serve, as designated in [Appendix B](#), and, if applicable, specify the current recipient for that service area whom you are proposing to replace.
 - Be specific about the geographic boundaries.

Please note:

- All applicants must demonstrate the capacity and readiness to provide comprehensive, family-centered HIV primary care and support services consistent with RWHAP Part D requirements to ensure continuity of care for WICY.
- New applicants are not expected to replicate the current recipient's exact service model.

In your response, include the following:

- Your organization's experience with health care delivery.
- Your organization's experience with the administration of federal funds.
- Your organization's mission statement, a description of your organization's model of care and how you will address access barriers across the entire service areas for WICY with HIV.
- Provide a list of the services you propose to provide for all of the WICY populations with HIV either directly or through referrals, contracts, or memoranda of understanding (MOUs) across the entire service area.

- A description of your organization’s readiness to deliver the proposed services across the entire service area, including the infrastructure in place to begin or continue service delivery with minimal disruption.

Need

See merit review criterion 1: [Need](#)

This section must include the following **three components**:

- Overview of epidemiologic and socio-demographic data.
- Unmet needs.
- Description of the local HIV service delivery system and any recent changes.

Use clear, quantifiable data to show why RWHAP Part D funding is needed in your community.

- Focus specifically on the needs of women, infants, children, and youth (WICY) with HIV.

Component 1: Overview of epidemiologic and socio-demographic data

Present and explain the latest epidemiologic and socio-demographic data that shows the burden of HIV on WICY populations, and any significant changes to these populations **in your service area**.

- This section should use the most recent three years of HIV surveillance data for the full service area from your organization’s patient population:
 - Calendar year (CY) data for:
 - **2022** (January 1 – December 31, 2022).
 - **2023** (January 1 – December 31, 2023).
 - **2024** (January 1 – December 31, 2024).
- For **each** of the three most recent years, provide the following data for the WICY populations, showing the total number of WICY with HIV and numbers for each population separately:
 - Women.
 - Infants (under 2 years old).
 - Children (ages 2–12).
 - Youth (ages 13–24).

- Where applicable, break down the data further (disaggregate) to highlight gaps in health outcomes based on factors such as:
 - Race and ethnicity.
 - Age.
 - Sex.
 - HIV transmission category.
 - Income level (as a percentage of the federal poverty level).
 - Housing status.
 - Health insurance coverage.
 - Education level.
- Use both tables and narrative explanations to present the data and clearly cite all sources.
 - Official data from reliable sources (e.g., state health departments or the CDC) should be used and referenced. Your data must include:
 - The number of newly diagnosed WICY with HIV.
 - The total number of WICY with HIV (prevalence).
 - WICY-specific rates of diseases such as syphilis, gonorrhea, tuberculosis, and Hepatitis C, which may indicate high-risk behaviors associated with HIV transmission.

Note: In this section, give both baseline numbers and percent change (e.g., “From 2022 to 2024, the number of women with HIV increased by 50%, from 100 to 150”).

Component 2: Unmet needs

- Describe the unmet needs by analyzing gaps at each stage of the HIV care continuum for [WICY populations](#) with HIV **served by your organization**.
- Use data to show where individuals have been diagnosed with HIV, but are not actively in care or not receiving necessary services.
- Include estimates from RWHAP Part A or Part B for the entire service area (as defined in [Appendix B](#)), specifically:
 - The number of WICY who are unaware of their HIV status.
 - The number of WICY who are aware of their status but not receiving HIV care.
- Clearly define both the numerator and the denominator for each stage of the continuum.
 - Use the same definitions as those outlined in the HHS Common HIV Core Indicators, including:
 - The [HAB Performance Measure Portfolio](#).

- It is recommended that you present this information in a table format. The left-hand column of the table should list each stage of the care continuum:
 - Total number of WICY with HIV in care.
 - Number of WICY newly diagnosed with HIV (HIV diagnosis).
 - Number of WICY linked to HIV care within 90 days of diagnosis (linkage to care).
 - Number of WICY retained in HIV medical care (retention in care).
 - Number of WICY prescribed antiretroviral therapy (use of ART).
 - Number of WICY who are virally suppressed.
- Across the top row of the table, include separate columns for each calendar year of data you are reporting (e.g., CY 2022, CY 2023, CY 2024).

Sample table: HIV care continuum and related outcomes for WICY, by calendar year

HIV care continuum stage	CY 2022 January 1 – December 31, 2022	CY 2023 January 1 – December 31, 2023	CY 2024 January 1 – December 31, 2024
Total number of WICY with HIV in care			
Number of WICY newly diagnosed with HIV			
Number linked to HIV care within 90 days of diagnosis			
Number retained in HIV medical care			
Number prescribed antiretroviral therapy (ART)			
Number virally suppressed			

Component 3: Description of the local HIV service delivery system and any recent changes

Describe the HIV care and prevention services available to WICY populations throughout the entire service area. Also include any recent changes in the local service delivery system.

Your description should address the following four areas:

1. HIV service providers in the entire service area as listed in Appendix B

- List all public and private organizations that provide HIV services to WICY populations in the target area, including your own organization.
- For each provider, describe:
 - The specific services offered.
 - People and communities disproportionately impacted by HIV served.
 - If available, the annual number of unduplicated WICY clients or patients served.
- [RWHAP Part A and Part B Programs](#) may serve as resources for this section.
- You may present this information in a table format.

Sample table: HIV service providers in the entire service area

Organization	Services provided	Populations served	Annual number of unduplicated WICY clients/patients served

If you are a current RWHAP Part D or a new applicant applying for a service area designated as being “statewide” in [Appendix B](#), please describe the following:

- Your model of care, specifying whether services are delivered:
 - Through a network of satellite clinics, or
 - Via contracts or memoranda of understanding (MOUs) with other providers across the state.
- Any access to care challenges, such as:
 - Transportation barriers for patients or staff
 - Difficulty reaching rural or remote regions
- How your organization provides consultative and telehealth services across the statewide service area for WICY with HIV.

2. Public funding in support of HIV services in the service area

- Identify all federal, state, and local funding sources that support HIV prevention and care services for WICY populations across your entire service area.
- You can include this information in a table for clarity.
 - Additional information about HHS awards is available on the HHS website, [Tracking Accountability in Government Grants System](#).
- In your description, you must state all RWHAP funding sources for your organization, including whether it receives both RWHAP Part C and Part D funding (i.e., you are dually funded), and whether it is a subrecipient of RWHAP Part A and/or Part B.
 - If you receive funding from both Part C and Part D, explain whether the two programs are either:
 - Integrated (for example, sharing resources, leadership, staffing, or service agreements), or
 - Separate (using different leadership, staff, or service agreements).

3. Gaps in local services and barriers to care

- Describe any services that are essential for achieving good HIV health outcomes but are not available in your entire service area for WICY populations.
- Explain the major barriers that prevent WICY clients from getting the services they need.

Approach

See merit review criterion 2: [Response](#)

- Describe the family-centered care and support services you will provide.
 - Include details to help HRSA reviewers understand how these services are delivered and the policies and procedures that ensure they meet professional standards of care.
 - Explain how you will address the unmet needs and gaps identified in your Needs Assessment.
 - Explain how your proposed activities will improve outcomes along the HIV care continuum.
 - For example, if your service area lacks oral health care, explain how you will meet that need.
- Describe the scope of work for each of the services as described, whether delivered directly, through contracts, or memorandum of understanding (MOU).
 - Services must be consistent with [PCN 16-02 \[PDF\]](#) and must address each WICY group (women, infants, children, and youth) to ensure no populations

Note: Your approach should prioritize identifying and serving WICY populations who:

- Are unaware of their HIV status.
- Have been diagnosed with HIV but are not actively in care .
- Are not virally suppressed.

All proposed activities should be designed to support:

- Linkage to care.
- Re-engagement.
- Retention in care.
- Adherence to treatment to reach HIV viral suppression.

Linkage to care

- Describe your organization's current HIV counseling and testing services for all WICY, including services for pregnant women.
 - If you plan to use RWHAP Part D funds for counseling and testing, explain how these services will target high-risk WICY populations and avoid duplicating activities funded by RWHAP, CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), or the state.
- Explain how all WICY who test positive for HIV will be linked to primary medical care and how you will monitor successful linkage rates.
 - Describe your collaboration with other RWHAP programs to enroll and retain clients in care.
 - Describe efforts to provide access to innovative primary care models that support self-sufficiency, such as [direct primary care](#).
- Describe how you will identify WICY with HIV who are no longer engaged in care or are not virally suppressed.
 - Explain the specific outreach, follow-up, and re-engagement strategies you will use, including collaboration with surveillance data to locate and re-link clients.
 - Discuss how you will track re-engagement outcomes over time.

Comprehensive, coordinated systems of care

- Explain how you will deliver comprehensive and coordinated services that meet the HHS guidelines for each WICY population of focus using RWHAP Part D funds to improve outcomes across the HIV care continuum.
- Discuss strategic partnerships with community organizations, public health departments and providers under [Title V of the Social Security Act](#) to share data (consistent with privacy laws) and coordinate efforts to reduce barriers to care.
- Describe how your organization will coordinate services for WICY with other HIV provider organizations within the service area (listed in [Appendix B](#)) to maximize services and avoid duplication with other RWHAP Parts A, B, C, and F-Dental.
- List these partner organizations in [Attachment 10](#).

Medical services

Outpatient/ambulatory health services

- Describe the HIV diagnostic and treatment services you will offer to prevent and manage HIV infection and related conditions. Include:
 - Onsite clinical protocols for new and ongoing patients.
 - Frequency of medical evaluations.

- Provision of medications for HIV and opportunistic infections (both prevention and treatment).
- Describe how you will tailor adherence education and counseling to clients who are not virally suppressed, including intensified support or peer navigation, if appropriate.
- Explain how you will intervene early when clients show signs of falling out of care.
- Discuss the availability of lab services for CD4 counts, viral load testing, and other diagnostic tests.
 - Explain how you will remove financial barriers to accessing these services.
- Describe how you will refer clients to specialty medical care, other health services, and social services to address unmet needs.
 - Explain how you will track whether referrals are completed and what the results are.

Other medical services

- Describe how the services below will be provided to all WICY populations with HIV:
 - Medical case management (MCM).
 - Medical nutritional therapy services.
 - Mental health services.
 - Oral Health Care (diagnostic, preventive, and therapeutic services).
 - Substance abuse outpatient care.
- Explain the availability of the state AIDS Drug Assistance Program (ADAP) or other pharmacy assistance programs.
 - If there is an ADAP waiting list, describe how you will ensure all eligible patients can access necessary HIV medications, vaccines, and related treatments.
- Explain your policies and procedures for after-hours and weekend coverage for urgent or emergency HIV-related medical and dental care.
- Describe how you will coordinate with hospital staff to ensure patients discharged from inpatient care are referred to and retained in outpatient medical care.
- Describe plans to educate WICY about, refer them to, and help them enroll in HIV clinical research trials.
- Describe your planning activities that support youth as they bridge to adult medical care.
 - Include information about the success rates of these care bridges.

Women's health

- Describe your efforts to raise awareness about STI prevention and access to treatment, including vaccinations, for example:
 - Preventing congenital syphilis.
 - Providing HPV vaccines when eligible.
 - Supporting partner notification efforts.
- Describe services for women, including:
 - Pre-pregnancy counseling.
 - Pregnancy care.
 - Chronic disease management.
 - Domestic violence awareness.
- Describe how you will provide or link women to perinatal and postnatal care and support their move back to HIV primary care after delivery.
- Explain how you will provide or refer infants (up to age two) exposed to or living with HIV to pediatric care.

Support services

- Describe how WICY clients will have access to support services that help them achieve positive HIV health outcomes.
 - Include services such as case management, medical transportation, and any other services included in your budget.
 - For each support service you plan to fund, explain how it will be provided and how it will help improve or maintain the health of WICY clients.
- Explain how you will help clients access financial support and services available through federal, state, or local programs that offer health care, mental health care, social services, or other assistance.
- Describe your plans for outreach, enrollment, and re-enrollment of RWHAP clients into health care coverage they are eligible for, including [Direct Primary Care](#).

Involvement of WICY with HIV

- Describe how WICY with HIV are involved in the planning, implementation, and evaluation of your program.
- Explain how you will keep them informed about program activities and provide ways for them to share feedback and suggestions.
- Describe how they will be involved in developing interventions that support linkage to care, retention in care, treatment adherence, and viral suppression across the HIV care continuum.

High-level work plan

See merit review criteria 2: [Response](#) and 4: [Impact](#)

- You must submit a work plan that includes projected measurable objectives for the HIV core medical and support services you propose to provide, as defined by [PCN 16-02 \[PDF\]](#).
- These objectives should cover services to RWHAP-eligible clients described in your [Approach](#) section and should align with the line-item budget and budget narrative.
- You must establish the projected measurable objectives for each year of the four-year project period.
 - HRSA recommends presenting this information in a table with objective areas listed in the left column and columns across the top for each year of the performance period.
- Your work plan objectives are for all clients eligible to receive services funded by RWHAP Part D.
 - You must include objectives for the overall RWHAP Part D program and for each subrecipient, if applicable.
 - You are required to address HIV retention in care and HIV viral suppression in your work plan.
- Action steps, evaluation methods, and responsible staff should not be included here.
 - Do not include services funded by other sources since those should be described in your [Approach](#) section.
 - The work plan also should not include meetings, general outreach activities such as health fairs, or CDC-funded prevention efforts.
- You may choose to develop a more detailed internal work plan for your own use.

Submit the work plan as [Attachment 7](#).

The work plan must cover four major areas:

- Access to care.
- Linkage to care.
- Comprehensive, coordinated systems of care.
- Other medical services (see [other medical services section within Approach](#)).

The performance period is August 1, 2026 to July 31, 2030.

- For each year of this period, provide the requested information under each area listed:
 - August 1, 2026, to July 31, 2027.
 - August 1, 2027, to July 31, 2028.
 - August 1, 2028, to July 31, 2029.
 - August 1, 2029, to July 31, 2030.

Access to care

List the following for each year:

- Total number of WICY clients with HIV enrolled.
- Number of new WICY clients with HIV to be enrolled in care.
- Total number of affected clients who received an HIV RWHAP support service.

Linkage to care

List the following for each year:

- Number of WICY to receive targeted HIV counseling and testing.
- Expected number of positive HIV test results.
- Number of newly diagnosed WICY clients enrolled in primary medical care within one month of diagnosis.
- WICY lost to care who will re-enroll within one month of contact or re-engagement

Comprehensive, coordinated systems of care

List the following for each year:

- Total number of WICY clients with HIV who will receive primary medical care services.
- Number of women (25 years and older) to be provided HIV primary medical care.
- Number of youth (ages 13–24) to be provided HIV primary medical care.
- Number of infants and children to be provided HIV primary medical care.
- Number of HIV-indeterminate infants (up to age 2) followed under surveillance.
- Number of pregnant women to receive perinatal services.

- Number of youth moving to adult medical care.
- Number of patients (specify which WICY populations) to receive treatment adherence services from a credentialed clinician.
- Number and types of specialty referrals.
- Number of strategic partnerships established.
- Number of new clients reached through strategic partnerships.
- Number of existing clients who received services because of a strategic partnership.

Other medical services

If you plan to provide any of the following services to low-income WICY clients with HIV, specify the number of each population (women, infants, children, youth) to be served each year:

- Mental health screening, assessment, and/or treatment.
- Substance use screening and/or treatment.
- Oral health care.
- Medical nutrition screening.
- Medical nutrition therapy provided by a registered dietitian or licensed nutritionist.
- The number of patients for each of the support services needed to help clients meet their HIV health outcomes (for example, non-medical case management, non-emergency medical transportation, translation services).

Resolving challenges

See merit review criterion 2: [Response](#)

In this section, describe:

- Any challenges you expect to face when designing and carrying out the activities in your work plan.
- How you plan to address or overcome these challenges.

Performance management

See merit review criteria 3: [Performance reporting and evaluation](#) and 5: [Resources and capabilities](#)

In this section, describe:

- The goals and objectives of your CQM program.
- How you will evaluate your program.

- Include your quality management activities and the information systems that support them.

CQM program infrastructure

- **Leadership:** Describe how the organization or program leadership is involved in your CQM activity.
- **CQM Committee:** Describe the CQM committee activities, frequency of meetings, and membership.
 - Describe how clinicians, subrecipients, contractors, other stakeholders, and people with lived experience contribute to the committee by developing, implementing and evaluating the RWHAP Part D.
- **CQM Plan:** Describe what your CQM plan will include, how it is approved, and how often.
 - Describe the associated work plan that will guide the CQM plan, include your goals, objectives, timeline, and responsible staff role.
- **Evaluation:** Describe how you will evaluate your CQM program.

CQM performance measures

- Describe your processes for selecting performance measures, including the frequency of data collection, data analysis, validation, and utilization.
- Describe your data sharing processes within your organization, to external stakeholders, and with those with lived experience.

Quality improvement (QI)

- Describe the QI methodology you are using or will use to identify priorities for quality improvement projects.
 - Describe the decision-making process for the development of a QI activity.
- Based on the epidemiological data you provided in the [Need](#) section, describe a QI activity you would plan.
 - You must include a project focused on people with HIV who are not virally suppressed and not medically retained in care and highlight any planned efforts for the WICY populations identified in your needs assessment.

Electronic Health Records (EHR) systems

Keeping accurate records of services provided and clients served is essential for HRSA to carry out the RWHAP legislation and manage grant funding responsibly.

HRSA requires all recipients to:

- Collect medical information at the client level using a unique identifier.

- Track data for all funded services.
- Submit data electronically through the Ryan White Services Report (RSR).

Describe the following:

- The system you currently use to track healthcare service data.
- Your experience and ability to manage, collect and report client-level data as required in the [RSR Instruction Manual \[PDF\]](#).

See the [reporting](#) section for more information.

Sustainability

See merit review criterion 4: [Impact](#)

We expect you to sustain key project elements that improve practices and outcomes for people and communities disproportionately impacted by HIV.

Propose a plan for project sustainability after the period of federal funding ends.

- Describe the organizational resources that you will use to sustain, without additional funds from the federal government, the project activities or enhancements supported by this award beyond the project period.
- Describe the actions you'll take to obtain future sources of funding.
- Discuss challenges that you'll likely encounter in sustaining the program.
 - Include how you will resolve these challenges.

Organizational information

See merit review criterion 5: [Resources and capabilities](#)

Administrative operations

- Describe the scope of your organization's overall activities and explain how the RWHAP Part D program fits within the scope of the organization's mission.
- You must clearly explain why your organization is the most optimal to serve the target WICY populations identified in previous sections.
- Describe how you train staff to deliver high-quality, family-centered HIV care for WICY populations, including regular training aligned with current [HHS guidelines](#) and training provided through [regional or local AIDS Education and Training Centers \(AETC\)](#).

Fiscal operations

- Describe the accounting system you use to track and report financial information.

- Describe the internal systems that are used to monitor grant expenditures and track, spend, and report program income generated by a Federal award.
- Describe how the organization will manage and monitor the performance and compliance of any subrecipients to ensure they meet RWHAP Part D requirements for WICY populations.
- Describe existing systems for maximizing collections and reimbursement for costs of providing medical care and other billable related services.
- Describe your discounted fee schedule and any policies regarding the annual cap on how much an individual patient is charged for HIV services.
 - Describe how you apply and monitor these policies.
- Describe the processes used to assess and recertify client eligibility for RWHAP supported services.

Budget and budget narrative

See merit review criterion 6: [Support requested](#)

Your **budget** should follow the instructions in budget narrative: detailed instructions section of the [Application Guide \[PDF\]](#) and the instructions listed in this section. Your budget should show a well-organized plan.

HHS now uses the definitions for [equipment](#) and [supply](#) in 2 CFR 200.1. The new definitions change the threshold for equipment to the lesser of the recipient's capitalization level or \$10,000 and the threshold for supplies to below that amount.

The total project or program costs are all allowable (direct and indirect) costs used for the HRSA award activity or project. This includes costs charged to the award and non-federal funds used to satisfy a matching or cost-sharing requirement (which may include maintenance of effort, if applicable).

The **budget narrative** supports the information you provide in Standard Form 424-A. It includes an itemized breakdown and a clear justification of the costs you request. The merit review committee reviews both.

As you develop your budget, consider:

- If the costs are reasonable, allowable and allocable, and consistent with your project's purpose and activities.
- The restrictions on spending funds. See [funding policies and limitations](#).

Formatting your program-specific line-item budget

Convert or scan budgets into PDF format for submission.

- Do not submit Excel spreadsheets.
- Submit the program-specific line-item budget in table format, listing the program cost categories.
 - i.e., Medical Service Costs, CQM costs, Support Service Costs, and Administrative Costs across the top.
 - Object class categories (e.g., personnel, fringe Benefits, travel) should be in a column down the left-hand side.

Program-specific line-item budget

- To evaluate applicant adherence to RWHAP Part D legislative budget requirements, you must submit separate program-specific line-item budgets for each year of the four-year project period.
 - You must provide a line-item budget that reflects all costs for proposed activities, including those for subrecipients.
 - If there are no changes to each year of the budget, clearly include each year of the four-year project period at the top of the line-item budget.
 - These budgets should be uploaded as [Attachment 2](#).
- The total amount requested on the SF-424A and the total amount listed on the program specific line-item budget must match.
 - The budget allocations must relate to the activities proposed in the project narrative and the work plan and must include the four allowable RWHAP Part D cost categories:
 - Medical Services.
 - Clinical Quality Management.
 - Support Services.
 - Administrative Costs.
- The Part D base budget requested for each year must not exceed the total award for the service area as listed in [Appendix B](#).
- Personnel should be listed separately by position title and the name of the individual for each position title or note if vacant.

Contracts

- An itemized budget and a narrative justification for each subrecipient must be provided.
- Separate budgets must be established with all subrecipient providers and care must be taken to ensure there is no duplication of effort.
 - Provide a separate line-item budget for each subrecipient provider using the same format as that of the program-specific line-item budget for the applicant organization.
 - The total amount listed in each subrecipient budget should match the total amount listed for that agency on your program-specific line-item budget.

Allowable costs

- RWHAP Part D funds are for the purpose of providing outpatient or ambulatory medical care and support services which assist in the optimization of health outcomes for low-income WICY with HIV.
- HAB expects RWHAP Part D programs to be designed to meet the HIV medical needs of WICY populations before providing support services to affected family members.
 - Support services, such as transportation, childcare, support groups, and translation services, may be offered to affected family members when those services are for the benefit of, and being utilized by, the WICY with HIV at the same time.
- The RWHAP Part D Program divides the allowable costs among four cost categories.
 - These categories are medical service costs, Clinical Quality Management costs, support service costs, and administrative costs.
- Applicants should review the [PCN 16-02 \[PDF\]](#) for allowable uses of RWHAP funds.
 - **Medical service costs** are those costs associated with providing primary medical care and related core medical services for low-income WICY with HIV.
 - **Clinical quality management costs** are costs required to maintain a CQM program to ensure that medical services are consistent with the most recent HHS guidelines.
 - This covers access and quality improvements for HIV health services .
 - CQM expenses must be kept to a reasonable level.
 - **Support service costs** are those costs for services which are needed for individuals with HIV to achieve their HIV medical outcomes.

- **Administrative costs** are those costs to be used by recipients for grant management and monitoring activities, including costs related to any staff or activity unrelated to services, or indirect costs.
 - By law, no more than 10% of the RWHAP Part D award (including the RWHAP Part D supplemental award) can be used for administrative expenses.
 - All indirect costs count toward this 10% limit.
 - Please see [PCN 15-01: Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Part A, B, C, and D \[PDF\]](#) for additional information.
- For each class category, as listed below, the budget narrative must be divided according to the RWHAP Part D cost categories (Medical Services, Support Services, CQM, and Administrative Costs). Descriptions must be specific to the cost category.

Travel: List travel costs according to local and long-distance travel.

- For local travel, outline the mileage rate, number of miles, reason for travel and staff member/people with HIV completing the travel.
- The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.
- Clinical staff traveling to provide care is included under Medical Services, while patient transportation is included in Support Services.
- All other travel to workshops or conferences is included in CQM.
- Allowable travel costs also include attendance for approximately three staff members at the [National Ryan White Conference on HIV Care and Treatment](#), as attendance is expected.
 - Be sure to include the costs in your budget.
 - HRSA expects your organization to support the travel and training for HIV related CME/CEU activities where appropriate and to use your local AETCs as a resource for training needs.

Contractual: Subrecipients providing services under this award must adhere to the same requirements as the recipient.

- The recipient is accountable for:
 - The subrecipient's performance of the project, program, or activity.
 - The appropriate expenditure of funds under the award;
 - Other obligations of the RWHAP Part D award.
- Recipients are required to annually monitor all subrecipients.

- Assurance that subrecipients are computing and reporting program income is a RWHAP requirement.
- Subrecipients must also report and validate program expenditures in accordance with budget categories to determine if legislative mandates are met.
- As a reminder, for subsequent years, the budget narrative should highlight only the changes from year one or clearly indicate that there are no substantive budget changes during the period of performance. Do not repeat the same information across years in the budget narrative.

To create your budget narrative, see budget narrative detailed instructions in the [Application Guide \[PDF\]](#).

Attachments

Place your attachments in this order in the Attachments Form. See [application checklist](#) to determine if they count toward the page limit.

Unless the instructions below require it, do not submit organizational brochures or other promotional materials (for example, slides, films, clips).

Attachment 1: Proof of nonprofit status (if applicable)

Include your proof of nonprofit status (not counted in the page limit). If your organization is a nonprofit, you **must** attach proof. We will accept any of the following:

- A copy of a current tax exemption certificate from the IRS.
- A letter from your state's tax department, attorney general, or another state official saying that your group is nonprofit and that none of your net earnings go to private shareholders or others.
- A certified copy of your certificate of incorporation. This document must show that your group is nonprofit.
- Any of these documents for a parent organization. Also include a statement signed by an official of the parent group that your organization is a nonprofit affiliate.

Attachment 2: Program-specific line-item budget (required)

Submit a PDF document of the program-specific line-item budget for each year of the four-year project period. If your budget will stay the same across all years, you may submit one budget, but make sure each budget period is clearly labeled at the top of the document.

Make sure the budget includes all required items listed in the [budget narrative section](#).

Attachment 3: Federally negotiated indirect cost rate agreement (if applicable)

Submit a copy of the current agreement, if in your application you state that the federally negotiated indirect cost rate agreement is being used for your budget calculations.

Attachment 4: Staffing plan and biographical sketches (required)

Include biographical sketches for staff occupying the key positions. Keep each biographical sketch brief (one paragraph at most). Include the role, responsibilities, and qualifications of proposed project staff, including education, training, HIV experience and expertise.

The staffing plan should include all positions funded by the grant, as well as staff vital to program operations and the provision of RWHAP Part D-supported HIV services regardless of grant payor source. Key staff include, at a minimum, the program coordinator and the program medical director, all medical care providers funded directly or through a contract or covered by an MOU, and the quality management lead. For each staff, indicate the total FTE, all funding sources contributing to that FTE, and the corresponding time and effort. The RWHAP Part D FTE should align with both the line-item budget and the budget narrative. It may be helpful to supply this information in a table. Also, please include a description of your organization's time keeping process to ensure that you will comply with the federal standards related to documenting personnel costs. If a biographical sketch is included for an identified individual whom you have not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 5: Job descriptions for key vacant positions (if applicable)

Describe the roles and responsibilities for key personnel vacancies. Also describe the educational and experience qualifications needed to fill the positions and the FTE associated with the position(s). Limit each job description to one page in length. It may be helpful to supply this information in a table.

Attachment 6: Project organizational chart (required)

Include an organizational chart that clearly shows where the RWHAP Part D program fits within your organization. If the program is divided into departments, the chart should show the professional staff positions that administer those departments, and the reporting relationships for the management of the HIV program.

Attachment 7: Work plan (required)

Attach the work plan for the project that includes all information detailed in the High-level work plan section of the Project Narrative. You must establish measurable objectives and provide them in the four areas stated in the [high-level work plan section](#) of the project narrative for each year of the proposed period of performance (four years). Include objectives for the entire RWHAP Part D program and each subrecipient individually.

HRSA recommends providing this information in a table to outline the work plan.

Attachment 8: Signed and scanned RWHAP Part D additional agreements and assurances (required)

Review the RWHAP Part D Additional Agreements and Assurances located in [Appendix A](#). This document must be signed by the Authorized Organization Representative (AOR), scanned, and uploaded.

Attachment 9: Map of service area (required)

Provide a map of the entire service area as defined in [Appendix B](#), noting all location(s) where the applicant will provide Part D supported services, especially HIV primary medical care services. HAB recommends that you use an official state or local map showing jurisdictional boundaries (such as [U.S. Census Bureau's QuickFacts](#), state public health websites) to display the entire service area.

Attachment 10: List of provider organizations with contracts and/or MOUs (if applicable)

If you propose to work with partners, include a list of all organizations for which signed contracts and letters/MOUs with your organization are available. Include a brief description of the activities/services to be provided by each identified provider organization and the location of the partner(s). Clearly outline the roles of partners, especially if specific WICY populations will not be served using the requested RWHAP Part D funds. HRSA recommends submitting this information in table format. Please be aware that HRSA may request copies of those agreements as part of the post-award administration process.

Attachment 11: Letter(s) from RWHAP Part A and/or Part B recipient of record (required)

Include a letter from the RWHAP Part A and/or Part B Recipient's AOR that documents whether your organization has participated in the RWHAP Part A and/or Part B planning activities, as applicable. Provide requested letter(s) that address why RWHAP Part D funds are necessary to support the needs described in your application, how the proposed services are not duplicative of other available services, and how the proposed services address the gaps in the local HIV care continuum. If this letter cannot be obtained, provide an explanation as to why for this attachment.

Attachment 12: Table of provider Medicaid and Medicare numbers (National Provider Identifiers) and clinic licensure status (required)

Use a table that identifies all providers' Medicaid and Medicare numbers and clinic licensure status. Include the Medicaid and Medicare provider number(s) for employed and contracted primary care and specialty care provider(s). If your jurisdiction does not require clinic licensure, describe how that can be confirmed in state regulation or other information. Official documentation may be required prior to an award being made or in the post-award period.

Attachments 13-15: Other relevant documents

You may use attachments 13 through 15 to add other relevant documents.

Other required forms

You will need to complete some other forms. Upload the following forms at Grants.gov. You can find them in the NOFO [application package](#) or review them and any available instructions at [Grants.gov Forms](#).

Forms	Submission requirement
Application for Federal Assistance (SF-424)	With application.
Project Abstract Summary form	With application.
Budget Information for Non-Construction Programs (SF-424A)	With application.
Disclosure of Lobbying Activities (SF-LLL)	If applicable, with the application or before award.
Budget Narrative Attachment form	With application.
Project/Performance Site Location(s)	With application.
Grants.gov Lobbying form	With application.
Key Contacts	With application.

Form instructions

The [Application Guide \[PDF\]](#) has detailed instructions for:

- The Application for Federal Assistance (SF-424).
- The Budget Information for Non-Construction Programs (SF-424A).

Project abstract summary form instructions

Complete the information in the Project Abstract Summary form. Include the funding amount requested, and specify the proposed service area as listed in [Appendix B](#). Also include a very brief description of your proposed project that includes the needs you plan to address, the proposed services, and the population groups you plan to serve. For more information, see Section 3.1.2 of the [Application Guide \[PDF\]](#).

Important: Public Information

When filling out your SF-424 form, pay attention to Box 15: Descriptive Title of Applicant's Project.

We share what you put there with [USAspending](#). This is where the public goes to learn how the federal government spends their money.

Instead of just a title, insert a short description of your project and what it will do.

[See instructions and examples \[PDF\]](#) .



Step 4:

Understand Review, Selection, and Award

In this step

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Selection process	<u>61</u>
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Application review

Initial review

We will review your application to make sure that it meets [eligibility](#) criteria, including the [completeness and responsiveness criteria](#). If your application does not meet these criteria, we will not fund it. If this is the case, we will notify your authorized official.

We will not review any pages that exceed the page limit.

Merit review

A panel reviews all applications that pass the initial review. You can find more about the merit review process in the [Application Guide \[PDF\]](#). The members use these criteria.

Criterion	Total number of points = 100
1. Need	10 points
2. Response	35 points
3. Performance reporting and evaluation	15 points
4. Impact	10 points
5. Resources and capabilities	20 points
6. Support requested	10 points

Criterion 1: Need (10 points)

See the project narrative [Introduction](#) and [Need](#) sections.

The panel will review your application for how well it describes:

Introduction (4 points)

- The strength of the experience in health care delivery.
- The strength of the experience with the administration federal funds.
- The completeness of the list of the services proposed for women, infants, children, and youth with HIV.
- The completeness of the service area map (as listed in [Appendix B](#)), including:
 - Clear identification of the entire service area as designated in Appendix B.
 - Specific geographic boundaries.

- A complete service area map ([Attachment 9](#)) that accurately shows where RWHAP Part D services will be delivered.
- The organization's readiness and infrastructure to deliver the proposed services across the entire service area with minimal disruption.
- Whether the applicant, if new, identifies the current recipient they propose to replace.
- The model of care and how they address access barriers across the entire service area for WICY with HIV.

Need (6 points)

- The completeness of the epidemiologic and socio-demographic data demonstrating an ongoing and increasing burden of HIV infection among WICY populations in the entire service area.
 - Includes three years of data, presented in tables and narrative form.
- How the narrative on unmet need demonstrates an understanding of service gaps affecting WICY populations.
 - Explains how these groups are highly impacted and require Part D-supported HIV-related health services.
- The description of the local HIV service delivery system, how the evolving healthcare landscape has affected family-centered HIV care and support services for WICY with HIV in the service area.
 - Includes how challenges resulting from these changes have been addressed.
- The identification of all federal, state, and local funding sources that support HIV prevention and care services for WICY in the service area.

Criterion 2: Response (35 points)

See the project narrative [Approach](#), [High-level work plan](#), and [Resolving challenges](#) sections.

The panel will review your application for the following:

Approach (20 points)

- The completeness and strength of the description of family-centered care and support services, including:
 - How they are delivered.
 - Policies and procedures to ensure professional standards.
 - How the proposed activities address unmet needs and gaps to improve outcomes along the HIV care continuum.

- How the proposed scope of work addresses each WICY group (women, infants, children, and youth) to ensure no populations are excluded.
- The completeness and strength of the linkage to care practices.
- The completeness and strength of the comprehensive, coordinated systems of care.
- The completeness and strength of the outpatient/ambulatory health services.
- The completeness and strength of the women's health services.
- The completeness and strength of the other medical services.
- The completeness and strength of the support services.
- The completeness and strength of the involvement of WICY with HIV in program planning, implementation, and evaluation.

High-level work plan (10 points)

- The clarity, completeness, and feasibility of the proposed work plan, including measurable objectives for each year of the performance period.
- Covers four required areas: Access to care, linkage to care, comprehensive, coordinated systems of care, and other medical services.
- The degree to which the proposed approach is responsive to the needs of disproportionately impacted WICY populations.

Resolving challenges (5 points)

- The extent to which likely challenges in designing and implementing work plan activities are discussed.
 - Includes clear approaches to resolve these challenges to ensure the RWHAP Part D program addresses priority WICY populations and gaps in the local HIV care continuum.

Criterion 3: Performance reporting and evaluation (15 points)

See the project narrative [Performance management](#) section.

The panel will review your application for the following:

Evaluation (10 points)

- The strength of the CQM program, including performance measurement and quality improvement activities focused on retention and viral suppression.
- The strength of the proposed CQM program infrastructure, including evidence of key leaders and the CQM plan development process.
- The strength of the narrative describing how people with lived experience are involved in developing, implementing, and evaluating the RWHAP Part D Program.
- The feasibility of the data collection plan and processes, including the frequency of data collection, key activities, and responsible staff.

Performance measurement (5 points)

- The organization's ability to carry out a quality improvement project focused on people with HIV who are not virally suppressed or not retained in care.

Criterion 4: Impact (10 points)

See the project narrative [High-level work plan](#) and [Sustainability](#) sections.

The panel will review your application for the following.

High-level work plan: Attachment 7 (7 points)

- The strength of the proposed work plan as evidenced by measurable and appropriate objectives that reflect:
 - Access to care and linkage to care.
 - Comprehensive, coordinated systems of care.
 - Other medical services.
 - A Clinical Quality Management program.
- The strength of the description of clinical quality management objectives for improving retention in care and viral suppression.
 - Includes WICY disproportionately impacted by HIV currently served by your organization.

Sustainability (3 points)

- The strength of the sustainability plan, including:
 - Available organizational resources.
 - Actions to secure future funding.
 - Strategies to address anticipated challenges.

Criterion 5: Resources and capabilities (20 points)

See the project narrative [Organizational information](#) and [Performance management](#) sections.

The panel will review your application to determine the extent to which:

Organizational information (10 points)

- The applicant describes their organization's overall activities and explains how the RWHAP Part D program fits within the scope of the organization's mission.
- Staff are trained to deliver high-quality, family-centered HIV care for WICY populations,
 - Includes plans for ongoing training aligned with current HHS guidelines and training provided through regional or local AETCs.
- The completeness and adequacy of fiscal operations, including:
 - The accounting system.
 - Internal controls.
 - Processes for tracking, spending, and reporting federal funds, program income, and grant expenditures.

Performance reporting and evaluation (10 points)

- A clear plan is provided to evaluate the program, including quality management activities and the information systems that support them.
- You have the capacity to gather, manage, and use data from your electronic health record system.

Criterion 6: Support requested (10 points)

See the [Budget and budget narrative](#) section.

The panel will review your application to determine:

- How reasonable the proposed budget is for each year of the period of performance.
- How reasonable costs are and how well they align with the project's scope.
- How sufficient the time is for key staff to spend on the project to achieve project objectives.
- How clearly the program-specific line-item budget presents the required cost categories and organizes the object class categories in the correct table format.
- How well the budget narrative justifies and aligns with costs in the line-item budget, including personnel, travel, subrecipients, and other allowable expenses.

We do not consider **voluntary** cost sharing during merit review.

We review your application based on its technical merit.

Risk review

Before making an award, we review your award history to assess risk. We need to ensure all prior awards were managed well and demonstrated sound business practices. We:

- Review any applicable past performance.
- Review audit reports and findings.
- Analyze the budget.
- Assess your management systems.
- Ensure you continue to be eligible.
- Make sure you comply with any public policies.

We may ask you to submit additional information.

As part of this review, we use SAM.gov Entity Information [Responsibility/Qualification](#) to check your history for all awards likely to be more than \$250,000 over the period of performance. You can comment on your organization's information in SAM.gov. We'll consider your comments before making a decision about your level of risk.

If we find a significant risk, we may choose not to fund your application or to place specific conditions on the award.

For more details, see [2 CFR 200.206](#).

Funding priorities

This program includes a funding priority based on an administrative priority. A funding priority adds points to merit review scores if we determine that the application meets the listed criteria. Qualifying for a funding priority does not guarantee that your application will be successful.

HRSA staff, not the merit review panel, will determine the funding priority.

Priority 1: Not currently funded by this opportunity (2 Points)

We will give you a funding priority if:

Your organization does not hold an active award under this opportunity at the time you apply.

Priority 2: Never funded by this opportunity (2 Points)

We will give you a funding priority if:

Your organization has never received an award under this opportunity.

Priority 3: Alignment with Ending the HIV Epidemic in the U.S. (EHE) initiative (2 points)

We will give you funding priority if the following is met:

Your proposal is in an EHE priority state.

There are priority points for the EHE states rather than all EHE jurisdictions because those states have a substantial share of the nation's HIV rural burden. They have fewer large Ryan White HIV/AIDS Program funded programs and persistent gaps in HIV infrastructure, making it difficult for residents in these states relative to other states with more robust HIV infrastructure. Priority points for EHE states are designed to ensure resources explicitly prioritize rural states to achieve nationwide HIV incidence reduction goals.

Selection process

When making funding decisions, we consider:

- The amount of available funds.
- Assessed risk.
- [Alignment with HRSA Mission and Strategic Priorities](#)
- Merit review results. These are key in making decisions but are not the only factor.
- The larger portfolio of HRSA-funded projects, including project type and geographic distribution.

- Fund out of rank order.
- Fund applications in whole or in part.
- Fund applications at a lower amount than requested.
- Decide not to allow a recipient to subaward if they may not be able to monitor and manage subrecipients properly.
- Choose to fund no applications under this NOFO.

Additionally, we may not make an award if you are delinquent on two or more Single Audit Reports.

You cannot appeal a denial, or the amount of funds awarded.

Award notices

We issue Notices of Award (NOA) on or around the [start date](#) listed in the NOFO. See “how we make awards” in the [Application Guide \[PDF\]](#) for more information.

By drawing down funds, you accept the terms and conditions of the award.



Step 5:

Submit Your Application

In this step

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Application submission and deadlines

Your organization's authorized official must certify your application. See the section on [finding the application package](#) to make sure you have everything you need.

Application deadline

You must submit your application by 07/13/2026, at 11:59 p.m. ET.

Grants.gov creates a date and time record when it receives applications.

If you need a deadline extension, see "requesting a waiver" in the [Application Guide \[PDF\]](#).

Submission method

Grants.gov

You must submit your application through Grants.gov. You may do so using Grants.gov Workspace. This is the preferred method. For alternative online methods, see [Applicant System-to-System](#).

For instructions on how to submit in Grants.gov, see the [Quick Start Guide for Applicants](#). Make sure that your application passes the Grants.gov validation checks, or we may not get it. Do not encrypt, zip, or password protect any files.

If Grants.gov rejects your application due to errors, you must correct and resubmit before the deadline.

If you want to know more about correcting errors or tracking your application, you can refer to the A panel reviews all applications that pass the initial review. You can find more about the merit review process in the [Application Guide \[PDF\]](#). The members use these criteria.



Have questions? Go to [Contacts and Support](#).

Other submissions

Intergovernmental review

If your state has a process, you will need to submit application information for intergovernmental review under [Executive Order 12372](#). Under this order, states may design their own processes for obtaining, reviewing, and commenting on some applications. Some states have this process and others do not.

To find out your state's approach, see the list of [state single points of contact \[PDF\]](#). If you find a contact on the list for your state, contact them as soon as you can to learn their process. If you do not find a contact for your state, you do not need to do anything further.

This requirement never applies to American Indian and Alaska Native tribes or tribal organizations.



Step 6:

Learn What Happens After Award

In this step

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1. Review

2. Get Ready
Contacts

3. Build

4. Understand

5. Submit

6. Award

Post-award requirements and administration

Administrative and national policy requirements

There are important rules you need to know if you get an award. You must follow:

- All terms and conditions in the Notice of Award (NOA). We incorporate this NOFO by reference.
- The regulations at [2 CFR Part 200](#), Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, modifications at [2 CFR Part 300](#), and any superseding regulations.
- The [HHS Grants Policy Statement](#). Your NOA will reference this document. If there are any exceptions to the GPS, they'll be listed in your NOA.
- All federal statutes and regulations relevant to federal financial assistance, including those highlighted in [HHS Administrative and National Policy Requirements](#).
- The requirements for performance management in [2 CFR 200.301](#).
- All anti-discrimination laws: By applying for or accepting federal funds from HHS, you certify compliance with all federal antidiscrimination laws and these requirements. Complying with those laws is a material condition of receiving federal funding streams. You are responsible for ensuring subrecipients, contractors, and partners also comply.

Required Alignment with HRSA Mission and Strategic Priorities

Recipients must use funds awarded under this NOFO to implement program goals or agency priorities in accordance with the HRSA [vision, mission, core values, and strategic priorities](#), where authorized by law.

In administering programs under this and all funding announcements, HRSA prioritizes:

- **Evidence-based healthcare:** Funding activities supported by rigorous scientific evidence, particularly for programs serving children and adolescents, where HRSA is committed to approaches that reflect the highest standards of clinical care and child safety.
- **Biological and physiological integrity:** Recognizing the relevance of biological sex to health outcomes, HRSA encourages applicants to account for sex-based health factors in program design, data collection, and service delivery where scientifically appropriate.

HRSA will implement these priorities consistent with applicable laws, regulations, court orders, and all required administrative procedures. Applicants are encouraged to describe how their proposed programs align with these priorities in their project narratives.

Funded activities must advance HRSA's vision of protecting and improving the health and well-being of Americans. The particular focus is on those who are medically vulnerable or live in areas with limited access to care. HRSA's duty is to serve wisely, effectively, and with measurable results that justify every taxpayer dollar invested.

Consistent with HRSA's priorities, in carrying out any project funded under this NOFO, the recipient must adhere to the following principles, where they are consistent with the authority and scope of the award and its activities:

- **Gold standard science:** Design and deliver services using gold standard evidence-based and evidence-informed approaches, establish measurable performance goals, and use data to monitor outcomes and drive continuous improvement.
- **Program integrity and fiscal stewardship:** Recipients must:
 - Administer funds in accordance with all applicable federal statutes,

regulations, and award conditions.

- Maintain strong internal controls.
- Prevent waste, fraud, and abuse.
- **Partnership and local leadership:** Coordinate with state, tribal, territorial, local, and community partners, as appropriate, and tailor services to meet community-identified needs while respecting local decision-making authority.

Recipients must manage any project awarded under this NOFO in accordance with the following objectives in programs authorized to advance them:

Make America Healthy Again (MAHA): While ensuring access to high-quality, affordable physical and mental health care, HRSA prioritizes the health and well-being of all Americans by supporting common-sense, evidence-based health policies that promote:

- Personal responsibility.
- Strong families and communities.
- Proper nutrition.
- The prevention and management of chronic disease.

Child protections, biological integrity, parental rights, and lawful use of funds:

HRSA prioritizes safeguarding children's health and safety by:

- Not supporting medical interventions for gender dysphoria in minors that lack a strong evidence base.
- Applying sex-based definitions grounded in biological reality.
- Supporting parental authority, transparency, and choice in education, including school-based health centers that respect parental rights and religious upbringing.
- Ensuring taxpayer funds do not promote or support elective abortions, consistent with federal law and the Hyde Amendment.

Advancing evidence-based, merit-driven, and ethically grounded health care: HRSA will prioritize unbiased, transparent science; merit-based workforce opportunities; and programs that demonstrate measurable outcomes. HRSA will deprioritize organizations with:

- Conflicts of interest.
- “Harm reduction” models.
- Housing-first approaches.
- Activities that facilitate illegal drug use or unsafe medical practices.

Promoting public safety, lawful use of federal funds, and national health priorities:

To the extent permitted by law, HRSA will align funding with administration priorities by:

- Supporting ending the HIV epidemic through authorized, evidence-based care.
- Reserving benefits for eligible individuals.
- Discouraging illegal immigration and unsafe community practices.
- Prioritizing recipients that enforce public safety, address serious mental illness and substance use through treatment and recovery, and reduce homelessness responsibly.

To the extent allowable by law, under awards, HRSA will give priority to states and municipalities for programs to:

- Enforce prohibitions on open illicit drug use.
- Enforce prohibitions on urban camping and loitering.
- Enforce prohibitions on urban squatting.
- Enforce, and where necessary, adopt, standards that address individuals who are a danger to themselves or others and suffer from serious mental illness or substance use disorder, or who are living on the streets and cannot care for themselves. The approach must be through assisted outpatient treatment or by moving them into treatment centers or other appropriate facilities through civil commitment or other available means, to the maximum extent permitted by law.

HRSA will implement these priorities consistent with applicable laws, regulations, court orders, and any required procedures.

The recipient must demonstrate ongoing compliance with these priorities, in all programs that are authorized to advance them, through program design,

implementation, reporting, and evaluation.

Failure to meaningfully align funded activities with the applicable requirements may result in corrective action, additional reporting requirements, or other actions consistent with federal grant regulations at [2 CFR, part 200](#) and the terms and conditions of this award. This includes termination under [CFR. 200.340\(a\)\(4\)](#) if an award no longer effectuates the program goals or agency priorities.

Cybersecurity

- If awarded, you must develop plans and procedures, modeled after the [NIST Cybersecurity framework](#), to protect HHS systems and data.

Successful applicants under this NOFO agree that:

Where award funding involves:	Recipients and subrecipients are required to:
Implementing, acquiring, or upgrading health IT for activities funded by any entity	Use health IT that meets standards and implementation specifications adopted in 45 CFR 170, Subpart B, if such standards and implementation specifications can support the activity. Visit to 45 CFR 170, Subpart B to learn more.
Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Sections 4101, 4102, and 4201 of the HITECH Act	Use health IT certified under the ONC Health IT Certification Program if certified technology can support the activity.

If standards and implementation specifications adopted in [45 CFR part 170, Subpart B](#) cannot support the activity, recipients and subrecipients are encouraged to use health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the [ONC Interoperability Standards Advisory](#).

Reporting

If you are funded, you will have to follow the reporting requirements in “reporting” section of the [Application Guide \[PDF\]](#). The NOA will provide specific details.

You must also follow these program-specific reporting requirements:

- Progress reports each year
- Annual performance reports.
- The RWHAP Allocation due 60 days after the start of the budget period.
- The RWHAP Expenditure Report due 90 days after the end of the budget period.
- Ryan White Services report each year.
- Audits every two (2) years to the lead state agency for RWHAP Part B, consistent with Uniform Guidance 2 CFR 200 regarding funds expended in accordance with this title, and include necessary client-level data to complete unmet need calculations and the Statewide Coordinated Statements of Need process.
- Integrity and Performance Reporting – The NOA will contain a provision for integrity and performance reporting in FAPIIS, as required in 2 CFR 200 Appendix XII.



Contacts and Support

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Agency contacts	<u>70</u>
Help with systems	<u>71</u>

Agency contacts

Program and eligibility

Division of Community HIV/AIDS Program

HIV/AIDS Bureau

Attn: Ryan White HIV/AIDS Program Part D Coordinated HIV Services and Access to
Research for Women, Infants, Children, and Youth (WICY) Existing Geographic
Service Areas

Health Resources and Services Administration

AskPartD@hrsa.gov

301-945-9638

Financial and budget

Kimberly Dews

Grants Management Specialist

Grants Management Specialist Division of Grants Management Operations Office of
Financial Assistance and Acquisition Management (OFAAM) Health Resources and
Services Administration

kdews@hrsa.gov

301-443-0655

HRSA Contact Center

Open Monday – Friday, 7 a.m. – 8 p.m. ET, except for federal holidays.

Call: 877-464-4772 / 877-Go4-HRSA

TTY: 877-897-9910

[Electronic Handbooks Contact Center](#)

Help with systems

Grants.gov

Grants.gov provides 24/7 support. You can call 800-518-4726, search the [Grants.gov Knowledge Base](#), or [email Grants.gov for support](#). Hold on to your ticket number.

SAM.gov

If you need help, you can call 866-606-8220 or live chat with the [Federal Service Desk](#).

Helpful websites

- [Application Guide \[PDF\]](#).
- [HRSA Grants page](#)
- [HHS Tips for Preparing Grant Proposals](#)
- [Frequently Asked Questions](#)
- [Applicant Training](#)

Appendices

Appendix A: Additional agreements and assurances

Ryan White HIV/AIDS Treatment Extension Act of 2009, RWHAP Part D WICY

The authorized representative of the applicant must include a signed and scanned original copy of the attached form with the grant application. This form lists the program assurances which must be satisfied in order to qualify for a Part D grant.

I, the authorized representative of _____ in applying for a grant under Part D of Title XXVI, section 2671 of the Public Health Service Act (42 USC § 300ff- 71) and section 2693 of the Public Health Service Act, (42 U.S.C. § 300ff-121) as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P. L. 111-87), hereby certify that:

As required in section 2671 subsection (c) - Coordination With Other Entities:

1. The applicant will coordinate activities under the grant with other providers of health care services under this Act, and under Title V of the Social Security Act, including programs promoting the reduction and elimination of the risk of HIV/AIDS for youth;
2. The applicant will participate in the statewide coordinated statement of need under Part B (where it has been initiated by the public health agency responsible for administering grants under part B) and in revisions of such statements;
3. The applicant will every 2 years submit to the lead State agency under section 2617(b)(4) of the PHS Act agency audits regarding funds expended in accordance with this Title and shall include necessary client-level data to complete unmet need calculations and statewide coordinated statements of need process.

As required in section 2671 subsection (d), the applicant will provide information regarding how the expected grant expenditures are related to RWHAP parts A and B planning processes. The applicant will also submit a specification of the expected expenditures and how those expenditures will improve overall patient outcomes as outlined as part of the State plan or through additional outcome measures.

As required in section 2671 subsection (f), the applicant will not use more than 10 percent of grant award for administrative expenses. The applicant will implement a clinical quality management program to assess the extent to which HIV health services

provided to patients under this grant are consistent with the most recent Public Health Service (HHS) guidelines for the treatment of HIV/AIDS and related opportunistic infection, and to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

As required under section 2681: Assure that services funded will be integrated with other such services, coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

As required under section 2684: No funds will be used to fund AIDS programs or to develop materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

I understand I can obtain a copy of the Title XXVI, PHS Act Part D at [Congress.gov](https://www.congress.gov) to gain full knowledge of its contents.

Name: _____ Date: _____ Title: _____

Appendix B: Service areas

These service areas have project periods ending July 31, 2026, and are up for competition for project periods beginning August 1, 2026. New applicants submitting proposals to provide services in an existing service area must identify the entire service area to be served and the current recipient you intend to replace. Each service area is listed separately.

The total funding available for each service area for the delivery of family-centered care services to the WICY population is identified in the “Funding Ceiling” column. Funding requests must not exceed the published funding ceiling amount.

Current RWHAP Part D recipients are encouraged to assess their history of expending Part D funds and to examine all resources available, including program income generated as a result of the RWHAP Part D award, when they consider the funding level for which to apply. Appendix B describes the ceiling amount for each service area; applicants can request a funding level that is less than the listed amount in light of their history of expending Part D funds and availability of other resources. In addition, HRSA reserves the right to fund less than the amount requested based on a history of current RWHAP Part D recipient’s unobligated balances.

Reminder: if you are applying for more than one service area listed in Appendix B, you must submit a separate application for each service area. Each application must address the entire service area.

Current recipient name	City	State	Funding ceiling	Service area
Health Services Center, Inc.	Anniston	AL	\$523,889	Counties in AL: Blount, Calhoun, Chambers, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Marshall, Randolph, Shelby, St. Clair, Talladega, Tallapoosa
University of Alabama at Birmingham	Birmingham	AL	\$877,535	Counties in AL: Autauga, Barbour, Bibb, Blount, Bullock, Butler, Chilton, Choctaw, Clarke, Coffee, Colbert, Conecuh, Covington, Crenshaw, Cullman, Dale, Dallas, Elmore, Escambia, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Russell, Shelby, St. Clair, Sumter, Tuscaloosa, Walker, Washington, Wilcox, Winston

Current recipient name	City	State	Funding ceiling	Service area
University of South Alabama	Mobile	AL	\$462,889	Counties in AL: Baldwin, Mobile
ARCARE	Augusta	AR	\$584,341	Counties in AR: Baxter, Benton, Boone, Calhoun, Carroll, Clark, Clay, Cleburne, Columbia, Conway, Craighead, Crawford, Cross, Dallas, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Springs, Howard, Independence, Izard, Jackson, Johnson, Lafayette, Lawrence, Lee, Little River, Logan, Lonoke, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Pointsett, Polk, Pope, Prairie, Pulaski, Randolph, St. Francis, Saline, Scott, Searcy, Sebastian, Sevier, Sharp, Stone, Union, Van Buren, Washington, White, Woodruff, Yell
Jefferson Comprehensive Care System, Inc.	Pine Bluff	AR	\$366,159	Counties in AR: Arkansas, Ashley, Bradley, Calhoun, Chicot, Clark, Cleveland, Columbia, Crittenden, Cross, Dallas, Desha, Drew, Garland, Grant, Hempstead, Hot Springs, Howard, Jefferson, Lafayette, Lee, Lincoln, Little River, Lonoke, Miller, Mississippi, Monroe, Montgomery, Nevada, Ouachita, Phillips, Pike, Poinsett, Polk, Prairie, Pulaski, Saline, Sevier, St Francis, Union, Woodruff
Maricopa County Special Health Care District D.B.A Valleywise Health	Phoenix	AZ	\$740,584	County in AZ: Maricopa
Alta Med Health Services Corporation	Commerce	CA	\$217,572	County in CA: Orange
Cares Community Health	Sacramento	CA	\$552,831	Counties in CA: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Fresno, Glenn, Madera, Mariposa, Merced, Nevada, Placer,

Current recipient name	City	State	Funding ceiling	Service area
				Plumas, Sacramento, San Joaquin, Sierra, Stanislaus, Sutter, Tuolumne, Yolo, Yuba
Children's Hospital & Research Center	Oakland	CA	\$733,020	Counties in CA: Alameda, Contra Costa
Clinica Sierra Vista	Bakersfield	CA	\$215,482	Counties in CA: Kern, Tulare
Fresno Community Hospital & Medical Center	Fresno	CA	\$537,045	County in CA: Fresno
Santa Rosa Community Health Centers	Santa Rosa	CA	\$291,743	County in CA: Sonoma
The Regents of The Univ. of Calif., U.C. San Diego	La Jolla	CA	\$851,689	County in CA: San Diego
The Regents of The University of California	San Francisco	CA	\$423,372	City and County in CA: San Francisco
University of California, Los Angeles	Los Angeles	CA	\$633,291	County in CA: Los Angeles
University of Southern California	Los Angeles	CA	\$630,166	County in CA: Los Angeles– Service Planning Areas 4 and 6
Regents of The University of Colorado	Aurora	CO	\$699,374	Counties in CO: Adams, Arapahoe, Boulder, Denver, El Paso, Jefferson, Larimer, Pueblo, Weld
Community Health Center Assoc. of	Cheshire	CT	\$718,859	Cities in CT: Bridgeport, Hartford, New Haven, Torrington, Waterbury, Willimantic

Current recipient name	City	State	Funding ceiling	Service area
Connecticut, Inc.				
Connecticut Childrens Specialty Group, Inc.	Hartford	CT	\$324,797	State of Connecticut
Christiana Care Health Services, Inc.	Wilmington	DE	\$635,973	State of Delaware
Bond Community Health Center, Inc.	Tallahassee	FL	\$432,874	Counties in FL: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakull
Florida Department of Health	Orlando	FL	\$756,816	Counties in FL: Brevard, Lake, Orange, Osceola, St. Lucie, Seminole
North Broward Hospital District	Fort Lauderdale	FL	\$1,451,304	County in FL: Broward
University of Florida	Gainesville	FL	\$607,817	Counties in FL: Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia; Counties in GA: Camden, Charlton, Glynn
University of Miami	Miami	FL	\$1,399,470	County in FL: Miami-Dade
University of South Florida	Tampa	FL	\$1,087,917	Counties in FL: Hillsborough, Pinellas
Chatham County Board of Health	Savannah	GA	\$693,752	Counties in GA: Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
Georgia Dept of Public Health	Waycross	GA	\$656,538	Counties in GA: Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tatnall, Tombs, Ware, Wayne

Current recipient name	City	State	Funding ceiling	Service area
Grady Memorial Hospital Corporation D.B.A. Grady Health System	Atlanta	GA	\$917,421	Counties in GA: Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, Walton
Access Community Health Network	Chicago	IL	\$403,793	City in IL: Chicago– Zip codes of 60406, 60411, 60615, 60621, 60636, 60637, 60649, 60653
Cook County Health Bureau	Chicago	IL	\$1,075,789	Counties in IL: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry, Will
Howard Brown Health Center	Chicago	IL	\$523,430	City in IL: Chicago
Near North Health Service Corporation	Chicago	IL	\$174,523	City in IL: Chicago zip codes of 60610, 60613, 60615, 60640, 60651, 60653
University of Illinois	Chicago	IL	\$447,566	Counties in IL: Fulton, Hancock, Henderson, Knox, LaSalle, Marshall, Mason, McLean, McDonough, Peoria, Putnam, Stark, Tazewell, Warren, Woodford
University of Kansas School of Medicine- Wichita Medical Practice Association	Wichita	KS	\$550,504	State of Kansas excluding the Counties of Johnson, Leavenworth, Miami, Wyandotte
Matthew 25 AIDS Services, Inc.	Henderson	KY	\$398,643	Counties in IN: Davies, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick; Counties in KY: Allen, Barren, Breckinridge, Butler, Daviess, Edmonson, Grayson, Hancock, Hardin, Hart, Henderson, Larue, Logan, Marion, McLean, Meade, Metcalfe, Monroe, Nelson, Ohio, Simpson, Union, Warren, Washington, Webster

Current recipient name	City	State	Funding ceiling	Service area
University of Kentucky Research Foundation	Lexington	KY	\$597,257	Counties in KY: Adair, Anderson, Bath, Bell, Bourbon, Boyd, Boyle, Bracken, Breathitt, Carter, Casey, Clark, Clay, Clinton, Cumberland, Elliott, Estill, Fayette, Fleming, Floyd, Franklin, Garrard, Green, Greenup, Harlan, Harrison, Jackson, Jessamine, Johnson, Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher, Lewis, Lincoln, Madison, Magoffin, Martin, Mason, McCreary, Menifee, Mercer, Montgomery, Morgan, Nicholas, Owsley, Perry, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Russell, Scott, Taylor, Wayne, Whitley, Wolfe, Woodford
University of Louisville	Louisville	KY	\$682,232	Counties in IN: Clark, Crawford, Floyd, Harrison, Jackson, Jefferson, Jennings, Ohio, Orange, Perry, Scott, Spencer, Switzerland, Washington; Counties in KY: Allen, Barren, Breckinridge, Bullitt, Butler, Edmonson, Grayson, Hardin, Hart, Henry, Hopkins, Jefferson, Larue, Logan, Marion, Meade, Monroe, Muhlenberg, Nelson, Oldham, Shelby, Spencer, Trimble, Warren, Washington
Acadiana Cares, Inc.	Lafayette	LA	\$238,157	Parishes in LA: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermilion
LSU Health System Health Care Services Division	Baton Rouge	LA	\$400,001	Parishes in LA: Livingston, St. Helena, St. Tammany, Tangiparola, Washington
New Orleans AIDS Task Force	New Orleans	LA	\$945,181	Parishes in LA: Caldwell, East Carroll, Franklin, Jackson, Jefferson, Lincoln, Madison, Morehouse, Orleans, Ouachita, Plaquemines, Richland, St. Bernard, Tensas, Union, West Carroll
Our Lady of The Lake Hospital, Inc.	Baton Rouge	LA	\$571,708	Parishes in LA: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge, West Feliciana
Southwest Louisiana AIDS Council	Lake Charles	LA	\$512,726	Parishes in LA: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis

Current recipient name	City	State	Funding ceiling	Service area
Boston Medical Center	Boston	MA	\$537,877	Counties in MA: Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester; Counties in NH: Hillsborough, Rockingham, Stratford
Dimock Community Health Center, Inc.	Roxbury	MA	\$654,509	City in MA: Boston zip codes of 02115, 02119, 02120, 02124, 02143; City of Cambridge
Greater New Bedford Community Health Center, Inc.	New Bedford	MA	\$254,250	City in MA: New Bedford
Public Health, Massachusetts Dept. of	Boston	MA	\$559,522	Cities in MA: Brockton, Lowell, Worcester
Johns Hopkins University, The	Baltimore	MD	\$770,533	City in MD: Baltimore; Counties in MD: Anne Arundel, Baltimore, Carroll, Harford, Howard, Queen Anne's
Med Star Health Research Institute	Hyattsville	MD	\$482,594	District of Columbia
Ingham, County of	Lansing	MI	\$356,061	County in MI: Ingham County
Michigan Department of Community Health	Lansing	MI	\$1,066,774	State of Michigan
Children's Health Care	Minneapolis	MN	\$673,987	State of Minnesota; Counties in WI: Pierce, St. Croix
Kansas City CARE Clinic	Kansas City	MO	\$672,174	Counties in KS: Johnson, Leavenworth, Miami, Wyandotte; Counties in MO: Andrews, Atchison, Barry, Barton, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Cates, Cedar, Christian, Clay, Clinton, Dade, Dallas, Daviess, DeKalb,

Current recipient name	City	State	Funding ceiling	Service area
				Dent, Douglas, Greene, Grundy, Harrison, Henry, Hickory, Holt, Howell, Jackson, Jasper, Johnson, Laclede, Lafayette, Lawrence, Livingston, McDonald, Mercer, Newton, Nodaway, Oregon, Ozark, Phelps, Platte, Polk, Pulaski, Ray, Shannon, St. Clair, Stone, Taney, Texas, Vernon, Webster, Worth, Wright
Washington University, The	Saint Louis	MO	\$982,484	City in MO: St. Louis; Counties in IL: Clinton, Jersey, Madison, Monroe, St. Clair; Counties in MO: Franklin, Jefferson, Lincoln, St. Charles, St. Louis, Warren
Southeast Mississippi Rural Health Initiative, Inc.	Hattiesburg	MS	\$477,397	Counties in MS: Adams, Amite, Clark, Copiah, Covington, Forrest, Franklin, George, Greene, Hancock, Harrison, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Lamar, Lauderdale, Lawrence, Lincoln, Marion, Newton, Pearl River, Perry, Pike, Simpson, Smith, Stone, Walthall, Wayne, Wilkinson
University of Mississippi Medical Center	Jackson	MS	\$256,641	State of Mississippi
C.W. Williams Community Health Center, The Inc.	Charlotte	NC	\$140,250	Counties in NC: Anson, Cabarrus, Gaston, Iredell, Mecklenburg, Rowan, Stanly, Union; County in SC: York
Central Carolina Health Network	Greensboro	NC	\$613,988	Counties in NC: Alamance, Caswell, Guilford, Montgomery, Randolph, Rockingham, Stanly
Duke University	Durham	NC	\$768,701	Counties in NC: Chatham, Durham, Franklin, Lee, Orange, Wake
East Carolina University	Greenville	NC	\$810,199	Counties in NC: Beaufort, Bertie, Camden, Cartaret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, Washington, Wayne, Wilson

Current recipient name	City	State	Funding ceiling	Service area
Novant Health, Inc.	Winsten Salem	NC	\$504,033	Counties in NC: Brunswick, Columbus, New Hanover, Onslow, Pender
Tri County Community Health Council, Inc.	Newton Grove	NC	\$525,843	Counties in NC: Cumberland, Harnett, Hoke, Johnston, Moore, Richmond, Robeson, Sampson, Scotland
Wake Forest University	Winston Salem	NC	\$623,017	Cities in NC: High Point, Winston-Salem; Counties in NC: Davidson, Davie, Forsyth, Guilford, Iredell, Rowan, Stokes, Surry, Yadkin
Western NC Community Health Services, Inc.	Asheville	NC	\$452,512	Counties in NC: Avery, Buncombe, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
University of Nebraska	Omaha	NE	\$525,262	Counties in IA: Adams, Audubon, Cass, Fremont, Harrison, Mills, Montgomery, Page, Pottawattamie, Shelby, Taylor; State of Nebraska, excluding the counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
Mary Hitchcock Memorial Hospital	Lebanon	NH	\$507,227	State of New Hampshire, State of Vermont
New Jersey Department of Health & Senior Services	Trenton	NJ	\$1,600,514	State of New Jersey
University of New Mexico Health Sciences Center	Albuquerque	NM	\$556,215	Counties in NM: Bernalillo, Cibola, McKinley, Sandoval, San Juan, Valencia
Northern Nevada HIV Outpatient Program,	Reno	NV	\$428,394	Counties in VA: Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Mineral, Pershing, Storey, Washoe, White Pine

Current recipient name	City	State	Funding ceiling	Service area
Education and Services				
University of Nevada-Las Vegas	Las Vegas	NV	\$151,429	County in AZ: Mojave; Counties in NV: Clark, Nye
Albany Medical College	Albany	NY	\$1,012,875	Counties in NY: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington
Community Health Project, Inc.	New York	NY	\$352,341	City in NY: New York
Elmhurst Hospital Center/NYC Health & Hospital Corp.	Elmhurst	NY	\$530,360	County in NY: Queens County zip codes of 11004, 11101, 11102, 11103, 11104, 11105, 11106, 11368, 11369, 11370, 11372, 11373, 11374, 11375, 11377, 11378, 11379, 11385, 11411, 11412, 11413, 11422, 11423, 11426, 11427, 11428, 11429, 11432, 11433, 11434, 11435, 11436, 11691, 11692, 11693, 11694, 11697
Montefiore Medical Center	Bronx	NY	\$1,417,592	County in NY: Bronx
New York City Health & Hospitals Corporation	New York	NY	\$405,897	County in NY: New York zip codes of 10026, 10027, 10030, 10037, 10039
New York University (Inc.)	New York	NY	\$515,191	Counties in NY: New York, Richmond
North Shore University Hospital	Manhasset	NY	\$679,892	Counties in NY: Nassau, Queens
St. Luke's Roosevelt Institute for	New York	NY	\$991,842	County in NY: New York zip Codes of 10001, 10011, 10012, 10013, 10014, 10018, 10019, 10020, 10023, 10024, 10025, 10026, 10027,

Current recipient name	City	State	Funding ceiling	Service area
Health Sciences				10029, 10030, 10031, 10032, 10033, 10034, 10035, 10036, 10037, 10039, 10040
The New York and Presbyterian Hospital	New York	NY	\$540,693	County in NY: Bronx County zip codes of 10451, 10452, 10453, 10454, 10456, 10457, 10458, 10460, 10463, 10468; New York County– Zip codes of 10024, 10025, 10026, 10027, 10030, 10031, 10032, 10033, 10034, 10035, 10037, 10039, 10040
The Research Foundation of State University of New York	Brooklyn	NY	\$275,488	County in NY: Kings
The Research Foundation of State University of New York	Stony Brook	NY	\$587,181	County in NY: Suffolk
The University of Toledo Health Science Campus	Toledo	OH	\$581,230	Counties in OH: Defiance, Fulton, Henry, Lucas, Ottawa, Sandusky, Williams, Wood
University Hospitals of Cleveland	Cleveland	OH	\$423,766	Counties in OH: Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina
University of Oklahoma	Oklahoma City	OK	\$668,233	Counties in OK: Alfalfa, Atoka, Beaver, Beckham, Blaine, Bryan, Caddo, Canadian, Carter, Choctaw, Cimarron, Cleveland, Coal, Comanche, Cotton, Custer, Dewey, Ellis, Garfield, Garvin, Grady, Grant, Greer, Harmon, Harper, Hughes, Jackson, Jefferson, Johnston, Kay, Kingfisher, Kiowa, Lincoln, Logan, Love, McClain, McCurtain, Major, Marshall, Murray, Noble, Oklahoma, Payne, Pontotoc, Pottowatomie, Pushmataha, Roger Mills, Seminole, Stephens, Texas, Tilman, Washita, Woods, Woodward

Current recipient name	City	State	Funding ceiling	Service area
County of Multnomah	Portland	OR	\$391,293	Counties in OR: Clackamas, Columbia, Multnomah, Washington, Yamhill; County in WA: Clark
Accessmatters	Philadelphia	PA	\$993,294	City in PA: Philadelphia
AIDS Care Group	Chester	PA	\$486,645	Counties in PA: Berks, Bucks, Chester, Dauphin, Delaware, Montgomery
City of Philadelphia	Philadelphia	PA	\$493,314	City in PA: Philadelphia zip codes of 19111, 19114, 19115, 19116, 19120, 19121, 19124, 19129, 19132, 19135, 19136, 19140, 19149, 19152
Drexel University	Philadelphia	PA	\$515,916	City in PA: Philadelphia zip codes of 19120, 19122, 19124, 19126, 19133, 19134, 19138, 19140, 19191, 19144
Philadelphia Fight	Philadelphia	PA	\$474,498	City in PA: Philadelphia– Zip codes of 19102, 19103, 19104, 19107, 19108, 19109, 19123, 19125, 19130, 19131, 19139, 19142, 19143, 19145, 19146, 19147, 19148, 19152
UPMC Presbyterian Shadyside	Pittsburgh	PA	\$707,968	Counties in PA: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Somerset, Washington, Westmoreland
Puerto Rico Community Network For Clinical Services, Research and Health Advancement, (PRCONCRA) Inc.	San Juan	PR	\$389,176	Municipalities in PR: Aguas Buenas, Barceloneta, Bayamón, Canóvanas, Carolina, Cataño, Ceiba, Corozal, Dorado, Fajardo, Florida, Guaynabo, Gurabo, Humacao, Juncos, Las Marías, Las Piedras, Loíza, Luquillo, Manatí, Morovis, Naguabo, Naranjito, Río Grande, San Juan, Toa Alta, Toa Baja, Trujillo Alto, Vega Alta, Vega Baja, Yabucoa
University of Puerto Rico	San Juan	PR	\$529,971	Territory of Puerto Rico
AIDS Care Ocean State, Inc.	Providence	RI	\$795,880	State of Rhode Island

Current recipient name	City	State	Funding ceiling	Service area
Eau Claire Cooperative Health Center	Columbia	SC	\$1,206,193	State of South Carolina
Le Bonheur Community Health and Well-Being	Memphis	TN	\$574,724	County in AR: Crittenden; Counties in MS: DeSoto, Marshall, Tate, Tunica; Counties in TN: Fayette, Shelby, Tipton
Vanderbilt University Medical Center	Nashville	TN	\$685,556	Counties in TN: Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, De Kalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, Wilson
Bexar County Hospital District	San Antonio	TX	\$920,581	Counties in TX: Atascosa, Bandera, Bexar, Calhoun, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, and Zavala
Dallas County Hospital District	Dallas	TX	\$817,831	Counties in TX: Callahan, Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, Rockwall
Harris County Hospital District	Houston	TX	\$581,017	County in TX: Harris
Houston Regional HIV/AIDS Resource Group, Inc.	Houston	TX	\$771,037	Counties in TX: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton
Tarrant County Health Department	Fort Worth	TX	\$559,302	Counties in TX: Hood, Johnson, Parker, Tarrant

Current recipient name	City	State	Funding ceiling	Service area
University of Texas Southwestern Medical Center at Dallas	Dallas	TX	\$920,641	Counties in TX: Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, Navarro, Rockwall
Valley AIDS Counsel	Harlingen	TX	\$556,367	Counties in TX: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata
Your Health Clinic	Sherman	TX	\$247,947	Counties in TX: Cooke, Fannin, Grayson
University of Utah	Salt Lake City	UT	\$505,573	State of Utah
Inova Health Care Services	Springfield	VA	\$589,859	Cities in VA: Alexandria, Fairfax, Falls Church, Manassas, Manassas Park; Counties in VA: Arlington, Fairfax, Loudon, Prince William
Rector & Visitors of The University of Virginia	Charlottesville	VA	\$406,251	Cities in VA: Buena Vista, Charlottesville, Fredericksburg, Harrisonburg, Lexington, Staunton, Waynesboro, and Winchester; Counties in VA: Albemarle, Augusta, Bath, Caroline, Clarke, Culpeper, Fauquier, Fluvanna, Frederick, Greene, Highland, King George, Louisa, Madison, Nelson, Orange, Page, Rappahannock, Rockbridge, Shenandoah, Spotsylvania, Stafford, Warren
Harborview Medical Center	Seattle	WA	\$536,037	County in WA: King
Medical College of Wisconsin	Milwaukee	WI	\$1,077,889	State of Wisconsin
West Virginia University	Morgantown	WV	\$250,761	Counties in WV: Barbour, Berkeley, Brooke, Calhoun, Doddridge, Gilmer, Grant, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Lewis, Marion, Marshall, Mineral, Monongalia, Morgan, Ohio, Pendleton, Pleasants, Preston, Randolph, Ritchie, Roane, Taylor, Tucker, Tyler, Upshur, Wetzel, Wirt, Wood

EXHIBIT K



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HRSA-26-067

Ryan White HIV/AIDS Program Part D Coordinated HIV Services and Access

to Research for Women, Infants, Children, and Youth (WICY) Existing

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Health Resources and Services Administration

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Synopsis History:

Version	Modification Description	Updated Date
Synopsis 1		Jun 11, 2026

Forecast History:

Version	Modification Description	Updated Date
Forecast 9	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 8	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 7	Updated the estimated posting date and application due date.	May 14, 2026



Version	Modification Description	Updated Date
Forecast 6	Updated the estimated posting date and application due date.	May 14, 2026
Forecast 5	Updated the estimated application due date.	Apr 20, 2026
Forecast 4	Updated the estimated application due date.	Apr 20, 2026
Forecast 3	Updated the Estimated Post Date	Mar 23, 2026
Forecast 2	Updated the Estimated Post Date	Mar 23, 2026
Forecast 1		Dec 19, 2025

DISPLAYING: Synopsis 1

General Information

Document Type:	Grants Notice	Version:	Synopsis 1
Funding Opportunity Number:	HRSA-26-067	Posted Date:	Jun 11, 2026
Funding Opportunity Title:	Ryan White HIV/AIDS Program Part D Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (WICY) Existing Geographic Service Areas	Last Updated Date:	Jun 11, 2026
Opportunity Category:	Discretionary	Original Closing Date for Applications:	Jul 13, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Opportunity Category Explanation:		Current Closing Date for Applications:	Jul 13, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Funding Instrument Type:	Grant	Archive Date:	Oct 31, 2026
		Estimated Total Program Funding:	\$69,000,000

**Category of
Funding
Activity:**

Health

Award Ceiling: \$2,000,000

Award Floor: \$115,000

**Category
Explanation:**

**Expected
Number of
Awards:**

111

Assistance

Listings:

93.153 -- Coordinated
Services and Access to
Research for Women,
Infants, Children, and
Youth

**Cost Sharing or
Matching
Requirement:**

No

Eligibility

**Eligible
Applicants:**

State governments
City or township governments
Native American tribal governments (Federally recognized)
Small businesses
Private institutions of higher education
Others (see text field entitled "Additional Information on Eligibility" for clarification)
Nonprofits that do not have a 501(c)(3) status with the IRS, other than institutions of higher education
County governments
Native American tribal organizations (other than Federally recognized tribal governments)
For profit organizations other than small businesses
Public and State controlled institutions of higher education
Nonprofits having a 501(c)(3) status with the IRS, other than institutions of

higher education

Special district governments

**Additional
Information on
Eligibility:**

This competition is open to current RWHAP Part D grant recipients and new, eligible applicant organizations proposing to provide RWHAP Part D family-centered care in outpatient or ambulatory care settings to low income women, infants, children, and youth (WICY) with HIV in the entire service area as identified in the FY 2026 NOFO. As identified in section 2671 of the Public Health Service (PHS) Act, eligible applicants include public and nonprofit private entities (including a health facility operated by or pursuant to a contract with the Indian Health Service) that provide family-centered care involving outpatient or ambulatory care for WICY with HIV.

Additional Information

Agency Name: Health Resources and Services Administration

Description: The purpose of the Ryan White HIV/AIDS Program (RWHAP) Part D program is to provide family-centered care in outpatient or ambulatory care settings to low-income women (25 years and older) with HIV, infants (up to 2 years of age) exposed to or with HIV, children (ages 2 to 12) with HIV, and youth (ages 13 to 24) with HIV. The RWHAP Part D funding is intended to improve access to coordinated and comprehensive HIV medical care and support services). The services often include case management, behavioral health, nutrition services, and referrals to specialty care. As the only component of the RWHAP that supports services for affected individuals not living with HIV, Part D may fund services when the primary purpose is to enable the affected individual to participate in the care of a person with HIV, to directly remove barriers to care for the person with HIV, or to promote family stability.

**Link to
Additional
Information:**

**Grantor
Contact
Information:** If you have difficulty accessing the full announcement electronically, please contact:
Ijeamaka Ogbonna
AskPartD@hrsa.gov
AskPartD@hrsa.gov

Similar Opportunities (identified by AI)

HRSA-26-074

HRSA-26-057

HRSA-26-036

HRSA-26-070

SM-26-022

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HRSA-26-074

Ryan White HIV/AIDs Program Part B States/Territories Supplemental
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Synopsis History:

Version	Modification Description	Updated Date
Synopsis 1		Jun 08, 2026

Forecast History:

Version	Modification Description	Updated Date
Forecast 5	Updated the estimated posting date and application due date.	Jun 08, 2026
Forecast 4	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 3	Updated the estimated posting date and application due date.	May 14, 2026
Forecast 2	Updated the estimated posting date and application due date.	May 14, 2026 

Version	Modification Description	Updated Date
Forecast 1		May 06, 2026

DISPLAYING: Synopsis 1

General Information

Document Type: Grants Notice

Version: Synopsis 1

Funding Opportunity Number: HRSA-26-074

Posted Date: Jun 08, 2026

Last Updated Date: Jun 08, 2026

Funding Opportunity Title: Ryan White HIV/AIDs Program Part B States/Territories Supplemental Grant Program

Original Closing Date for Applications: Jul 10, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

Opportunity Category: Discretionary

Current Closing Date for Applications: Jul 10, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.

Opportunity Category Explanation:

Funding Instrument Type: Grant

Archive Date: Aug 01, 2026

Category of Funding Activity: Health

Estimated Total Program Funding: \$48,000,000

Category Explanation:

Award Ceiling: \$9,000,000

Expected Number of Awards: 30

Award Floor: \$500,000

[Assistance](#) 93.917 -- HIV Care

[Listings:](#) Formula Grants

**Cost Sharing or
Matching
Requirement:** No

Eligibility

Eligible Applicants: State governments
Others (see text field entitled "Additional Information on Eligibility" for clarification)

Additional Information on Eligibility: Current recipients funded under HRSA-22-033 (which include all 50 States the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands)

Additional Information

Agency Name: Health Resources and Services Administration

Description: This Ryan White HIV/AIDS Program Part B Supplemental funding is a statutory funding supplement provided through the HIV Care Grant Program. States/territories use RWHAP Part B Supplemental Grant Program funding in conjunction with RWHAP Part B HIV Care Grant Program funding to develop and enhance access to a comprehensive continuum of high-quality care and treatment services for low-income people with HIV. To obtain funding, states/territories must demonstrate that RWHAP Part B supplemental funding is necessary to provide comprehensive HIV care and treatment services for people with HIV in the state/territory.

**Link to
Additional
Information:**

**Grantor
Contact
Information:** If you have difficulty accessing the full announcement electronically, please contact:
Kibibi C. Matthews-Brown
KMatthews-Brown@hrsa.gov

KMatthews-Brown@hrsa.gov

Similar Opportunities (identified by AI)

[HRSA-26-061](#)[HRSA-26-067](#)[HRSA-26-111](#)[HRSA-26-053](#)[HRSA-26-019](#)[Return to top](#)

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HRSA-26-061

Ryan White HIV/AIDS Program Part C Capacity Development
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Synopsis History:

Version	Modification Description	Updated Date
Synopsis 1		Jun 05, 2026

Forecast History:

Version	Modification Description	Updated Date
Forecast 7	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 6	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 5	Updated the estimated posting date, application due date, and archive date.	May 14, 2026
Forecast 4	Updated the estimated posting date, application due date, and archive date.	May 14, 2026 

Version	Modification Description	Updated Date
Forecast 3	Updated estimated post date.	Mar 23, 2026
Forecast 2	Updated estimated post date.	Mar 23, 2026
Forecast 1		Jan 30, 2026

DISPLAYING: Synopsis 1

General Information

Document Type:	Grants Notice	Version:	Synopsis 1
Funding Opportunity Number:	HRSA-26-061	Posted Date:	Jun 05, 2026
Funding Opportunity Title:	Ryan White HIV/AIDS Program Part C Capacity Development Program	Last Updated Date:	Jun 05, 2026
Opportunity Category:	Discretionary	Original Closing Date for Applications:	Jul 08, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Opportunity Category Explanation:		Current Closing Date for Applications:	Jul 08, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Funding Instrument Type:	Grant	Archive Date:	Sep 30, 2026
Category of Funding Activity:	Health	Estimated Total Program Funding:	\$9,000,000
Category Explanation:		Award Ceiling:	\$150,000
Expected Number of Awards:	60	Award Floor:	\$0
Assistance Listings:	93.918 -- Grants to Provide Outpatient Early Intervention Services		

with Respect to HIV
Disease

**Cost Sharing or
Matching
Requirement:** No

Eligibility

Eligible Applicants: State governments
Public and State controlled institutions of higher education
Nonprofits that do not have a 501(c)(3) status with the IRS, other than institutions of higher education
City or township governments
Special district governments
Private institutions of higher education
Native American tribal organizations (other than Federally recognized tribal governments)
Native American tribal governments (Federally recognized)
County governments
Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education

Additional Information on Eligibility: Public or private, non-profit, community-based organization, and tribal (governments, organizations). Foreign entities are not eligible for this award. (§ 2652 of the PHS Act).

Additional Information

Agency Name: Health Resources and Services Administration

Description: The purpose of the Ryan White HIV/AIDS Program (RWHAP) Part C Capacity Development program is to strengthen organizational capacity to increase capacity to develop, enhance, or expand access to high quality HIV primary health care services for low-income people with HIV. The proposed activity should be of a short-term nature and should be completed by the end of the

one-year funding opportunity period of performance. Activities fall under two categories: HIV Care Innovation and Infrastructure Development.

**Link to
Additional
Information:**

**Grantor
Contact
Information:** If you have difficulty accessing the full announcement electronically, please contact:
Brian Fitzsimmons
AskPartCCapacity@hrsa.gov
AskPartCCapacity@hrsa.gov

Similar Opportunities (identified by AI)

HRSA-26-074

HRSA-26-111

HRSA-26-110

HRSA-26-087

HRSA-26-101

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HRSA-26-085

Ryan White HIV/AIDS Program Part F Dental Reimbursement
Program

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Synopsis History:

Version	Modification Description	Updated Date
Synopsis 1		Jun 08, 2026

Forecast History:

Version	Modification Description	Updated Date
Forecast 5	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 4	Updated the estimated posting date and application due date.	May 27, 2026
Forecast 3	Updated the estimated posting date and application due date.	May 14, 2026
Forecast 2	Updated the estimated posting date and application due date.	May 14, 2026 

Version	Modification Description	Updated Date
Forecast 1		May 06, 2026

DISPLAYING: Synopsis 1

General Information

Document Type:	Grants Notice	Version:	Synopsis 1
Funding Opportunity Number:	HRSA-26-085	Posted Date:	Jun 08, 2026
Funding Opportunity Title:	Ryan White HIV/AIDS Program Part F Dental Reimbursement Program	Last Updated Date:	Jun 08, 2026
Opportunity Category:	Discretionary	Original Closing Date for Applications:	Jul 10, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Opportunity Category Explanation:		Current Closing Date for Applications:	Jul 10, 2026 Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Funding Instrument Type:	Grant	Archive Date:	Aug 01, 2026
Category of Funding Activity:	Health	Estimated Total Program Funding:	\$9,000,000
Expected Number of Awards:	50	Award Ceiling:	\$1,200,000
Assistance Listings:	93.924 -- Ryan White HIV/AIDS Dental Reimbursement and	Award Floor:	\$0

Community Based Dental
Partnership Grants

**Cost Sharing or
Matching
Requirement:** No

Eligibility

Eligible Applicants: Private institutions of higher education
Others (see text field entitled "Additional Information on Eligibility" for clarification)
Public and State controlled institutions of higher education

Additional Information on Eligibility: Eligible participants are domestic dental schools and other accredited domestic dental education programs, such as dental hygiene programs or those sponsored by a school of dentistry, a hospital, or a public or private institution that offers postdoctoral training in the specialties of dentistry, advanced education in general dentistry, or a dental general practice residency. Dental education programs must be accredited by the Commission on Dental Accreditation

Additional Information

Agency Name: Health Resources and Services Administration

Description: The purpose of the Ryan White HIV/AIDS Program (RWHAP) Part F Dental Reimbursement Program (DRP) is to improve access to oral health care services for low-income people with HIV, and related education and training to dental providers serving people with HIV. Authorized under section 2692(b) of the Public Health Service Act (42 U.S.C. § 300ff-111(b)), the DRP provides partial reimbursement to eligible dental schools and accredited dental hygiene programs for the unreimbursed costs of oral health care provided to patients with HIV. Eligible institutions may annually apply for reimbursement based on costs incurred in the prior year. Available funds are distributed among all eligible applicants, taking into account the number of

patients with HIV served and the extent of unreimbursed care costs relative to other applicants.

**Link to
Additional
Information:**

**Grantor
Contact
Information:** If you have difficulty accessing the full announcement electronically, please contact:
Catishia Mosley
AskPartFDental@hrsa.gov
AskPartFDental@hrsa.gov

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HRSA-26-074

HRSA-26-061

HRSA-26-067

HRSA-26-111

HRSA-26-053

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