Memorandum

TO: **Ryan White Administrative Agency Executive Directors**
Ryan White Administrative Agency Contact Persons

FROM: **Debbie Bennett, Acting Unit Director**
Contract Management Unit
Division of Prevention and Preparedness

DATE: **August 24, 2009**

SUBJECT: **Services and Administrative (HIV/RW) Renewal Guidance for 2010-2011 Project Year (04/01/10 – 03/31/11)**

Enclosed are the documents required for your agency's renewal for Services and Administrative (HIV/RW) contract with the Department of State Health Services (DSHS) for the period April 1, 2010 through March 31, 2011. This renewal document will be posted on the HIV/STD Program's website at: http://www.dshs.state.tx.us/hivstd/funding/default.shtm. Instructions for completing the forms are in the renewal document. If you have questions, please contact Susana Garcia, Contract Manager, at (512) 458-7111 ext. 2118.

Please note the following updates for the Project Year 2010-2011 Contract Renewal:

- The administrative and service delivery contract will be combined into one contract (HIV/RW). Therefore, this renewal document will address the administrative and services functions. You will note DSHS is requesting information regarding Ryan White and State Services. The State Services information will be used for next year's renewal (09/01/2010-08/31/2011). However, the contract will only include Ryan White administrative and service delivery allocations. The State Services budget information will be requested during the State Services renewal in the Spring.

  The administrative and service delivery contracts have been combined to simplify the contracting process and to reduce administrative elements applicable to additional contracts.

  DSHS will conduct a technical assistance call on **September 4, 2009 at 10 am** regarding changes to this renewal process. DSHS staff will answer any questions regarding the renewal application and process.

- Contractors **shall not** exceed the allocated administrative amount for the administrative agencies administrative costs during this contract term.

- Prepare a twelve (12) month budget for this contract renewal (04/01/10 – 03/31/11). The breakdown of the service delivery allocation is in pdf file attached. The administration and service delivery allocation is in the *Table A 12 month funding allocations* in this document.

- Revised budget forms are attached. Please note that State Service budget information is not requested at this time. This information will be requested during the next State Services Renewal.

- Revised voucher support form for reimbursement requests is attached for PY 2010-2011.

- Important Due dates:

	Due Date
HIV/RW Renewal Guidance Budget Forms HIV/RW and HIV/SRVS State Services Table 1	October 15, 2009
HIV/RW Table 2 Categorical Budget Justification and/or Fee for Service Form for each subcontractor.	April 30, 2010

Please submit one (1) electronic copy of the renewal to the email address listed below one (1) electronic copy to your Public Health Regional HIV/STD Program Manager. The face page must be scanned in as a .pdf file and sent to:

Hiv-srvscontracts@dshs.state.tx.us
Contract Management Unit
Texas Department of State Health Services

Hard copies of Renewals are not required for submission.

Project Year 2010-2011 Renewal Guidance For Services & Administrative Agency (HIV/RW)

http://www.dshs.state.tx.us/hivstd/funding/default.shtm

Issue Date: August 27, 2009
Due Date: October 15, 2009

Contract Management Unit
Department of State Health Services
1100 W. 49th Street
Austin, Texas 78756-3199

David L. Lakey, M.D.
Commissioner

TABLE A:
HIV/RW 2010: 12 Month FUNDING ALLOCATIONS

(04/01/10 – 03/31/11)

ADMINISTRATIVE AGENCY	HSDA'S SERVED	ADMINISTRATIVE AMOUNT	SERVICE DELIVERY AMOUNT	TOTAL CONTRACT AMOUNT
Lubbock Regional MHMR	Lubbock Amarillo Permian El Paso	**$499,500**	Lubbock $332,554 Amarillo $339,965 Permian $347,404 El Paso $1,063,802 **Total: $2,083,725**	**2,583,225**
Tarrant County Public Health Department	Abilene Fort Worth Wichita Falls	**$216,000**	Abilene $274,442 Fort Worth $821,296 Wichita Falls $211,050 Total: **$1,306,788**	**$1,522,788**
Dallas County Health and Human Services Dept.	Dallas Sherman	**$494,000**	Dallas $2,678,926 Sherman $181,189 Total**:$2,860,115**	**$3,354,115**
Houston Regional Resource Group	Beaumont Lufkin Houston Galveston Tyler Texarkana	**$650,000**	Beaumont $613,288 Lufkin $404,796 Houston $3,027,415 Galveston $567,908 Tyler $759,704 Texarkana $319,704 **Total: $5,692,815**	**$6,342,815**
Brazos Valley Council of Governments	Austin Concho Temple Waco College Station	**$426,000**	Austin $974,727 Concho $183,897 Temple $308,094 Waco $326,897 College Station $292,955 **Total:$2,086,570**	**$2,512,570**
Bexar County	Uvalde Victoria San Antonio	**$255,000**	Uvalde $275,369 Victoria $215,414 San Antonio $855,453 **Total:$1,346,236**	**$1,601,236**
South Texas Development Council	Laredo Brownsville Corpus	**$274,000**	Laredo $413,189 Brownsville $1,042,012 Corpus Christi $530,497 **Total: $1,985,698**	**$2,259,698**
TOTAL		**$2,814,500**	**$17,361,947**	**$20,176,447**

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ORGANIZATION AND CONTENT

SEE EXCEL SPREADSHEETS ATTACHED FOR FOLLOWING FORMS:

- BUDGET SUMMARY FORM & ADMIN & SERVICES SUMMARY
- TABLE 1: SERVICE PRIORITIES AND ALLOCATIONS
- TABLE 2: SUBCONTRACTOR DATA SHEET, REVIEW CERTIFICATION & SERVICES ALLOCATIONS

Department of State Health Services (DSHS)

FORM A: FACE PAGE -This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal and shall be completed in its entirety. Signature of face page certifies to all DSHS and program assurances listed in this renewal document.

APPLICANT INFORMATION

1) LEGAL NAME:

2) MAILING Address Information (include mailing address, street, city, county, state and zip code): Check if address change ☐

3) PAYEE Mailing Address (if different from above): Check if address change ☐

4) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit) : ***The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.***

5) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

If incorporated, provide 10-digit charter number assigned by Secretary of State:

6) Currently operating under a HUB Subcontracting plan on file at DSHS? Yes ☐ No ☐

7) BUDGET PERIOD: Start Date: 04/01/2010 End Date: 03/31/2011

8) COUNTIES SERVED BY PROJECT:

List all counties to be served

9) AMOUNT OF FUNDING REQUESTED:

10) PROJECTED EXPENDITURES

Does applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **

Yes ☐ No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.*

11) PROJECT CONTACT PERSON

Name:
Phone:
Fax:
E-mail:

12) FINANCIAL OFFICER

Name:
Phone:
Fax:
E-mail:

I, the undersigned, am the authorized representative of the applicant filing this contract renewal application. The facts contained herein are true, and the applicant is in compliance with the assurances and certifications contained in the competitive RFP, which is part of the original contract and any prior renewals and amendments. I understand that this contract renewal depends on the truthfulness of this document and on the applicant's continued compliance with the original contract and all its components and amendments.

13) AUTHORIZED REPRESENTATIVE Check if change ☐

Name:
Title:
Phone:
Fax:
E-mail:

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

1) **LEGAL NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.

3) **PAYEE MAILING ADDRESS** - Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

   HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Texas Building and Procurement Commission (TBPC) or another entity.

   MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

   If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

6) **CURRENTLY OPERATING UNDER A HUB SUBCONTRACTING PLAN ON FILE AT DSHS? YES OR NO** - Check the appropriate box to indicate whether or not the applicant is operating under a HUB Subcontracting Plan filed with DSHS under the original competitive RFP. If yes, the applicant must continue to comply with reporting requirements if a renewal contract is executed. Any changes to the budget which affect the HUB Subcontracting Plan must be communicated with the DSHS HUB Coordinator at 1-800-243-7487 or by e-mail at HUB-Contact@dshs.state.tx.us. If no is checked, no further action is required.

7) **BUDGET PERIOD** - Enter budget period as identified in this renewal application.

8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.

9) **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from DSHS for proposed project activities. This amount must match column (1) row J from FORM I: BUDGET SUMMARY.

10) **PROJECTED EXPENDITURES** - If applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year, applicant shall arrange for a financial and compliance audit (Single Audit).

11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.

12) **FINANCIAL OFFICER** - Enter the name, title, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.

13) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant signs in this blank.

15) **DATE** - Enter the date the person authorized to represent the applicant signed this form.

FORM B: CONTACT PERSON INFORMATION

Legal Name of Applicant: _____

This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify, Susana Garcia, Contract Manager, in writing.

Executive Director: _____ Title: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Project Contact: _____ Title: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Financial Reporting Contact: _____ Title: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
URS Data Manager: _____ Title: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Planning Contact: _____ Title: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Clinical Services Contact: _____ Title: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____

FORM C: HIV/RW PERFORMANCE MEASURE Guidelines

Ryan White (HIV/RW) contracts will include the negotiated Table 1 and the total number of unduplicated clients that will, be served as the performance measures.

Performance measures related to access and quality of care must be incorporated in updates to your comprehensive services plan either in the goals and objectives section or attached as an addendum to the plan. **Each AA is required to implement their comprehensive plans; it is required to implement the measures and report your progress in your quarterly report.**

REQUIRED PERFORMANCE MEASURES

Administrative Measures

1. The Contractor will have subcontracted 100% of all Ryan White Service Delivery and/or State Services funds as applicable to the contract, no later than thirty (30) days after the contract year.
2. The Contractor will submit complete quarterly reports according to the Reporting Due Dates listed in this contract.
3. No less than ninety-five (95%) of Ryan White and State Services funds will be expended by the end of the respective contract year.
4. Contractor shall provide programmatic and financial monitoring of subcontractors according to Contractor's established internal policies, procedures, and schedules.
5. Contractor shall implement a quality management (QM) system according to the Contractor's established QM Plan.
6. Contractor shall distribute all service delivery funds according to the service priorities and allocations established in its approved Comprehensive HIV Services Plan, and make reallocations in accordance to DSHS policy.

Service Delivery Measures

7. Contractor shall **ensure** that no more than ten percent of the services allocation is expended by service providers (subcontractors) for administrative costs.
8. Contractor shall use these funds to provide at least one service to (insert #) unduplicated clients during Project Year (PY) 2010 (04/01/10 – 03/31/11). Objectives related to the # of persons and units to be provided must be reflected on Table 1: Services Priorities, Allocations, and Objectives.
9. Complete Table 1 for each HSDA.
10. Contractor shall monitor the delivery of HIV services against the Estimated Units of Services shown in Table 1 of the applicant's most recent application for delivery of service.
11. Contractor shall meet any other performance measures required in the final, approved supplemental performance measures (Table 1) to deliver these services.

State Services Measures

12. Contractor shall use these funds to provide at least one service to (insert #) unduplicated clients during Project Year (PY) 2011 (09/01/10 – 08/31/11). Objectives related to the # of persons and units to be provided must be reflected on Table 1: Services Priorities, Allocations, and Objectives.
13. Complete Table 1 for each HSDA.
14. Contractor shall meet any other performance measures required in the final, approved supplemental performance measures (Table 1) to deliver these services.

FORM C: HIV/RW PERFORMANCE MEASURES

Applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements listed in the PERFORMANCE MEASURES Guidelines.

FORM D: HIV/RW SERVICE SYSTEM OBJECTIVE GUIDELINES

Applicant must write service system improvements for administrative functions and identify proposed target levels. The objectives and levels of performance will be negotiated through the contract development process. Objectives must be reported for the entire HIV Administrative Service Area (HASA).

Requirements

1. Identify three (3) performance objectives from your Comprehensive HIV Services Plan that you plan to focus on for PY 2010-2011.

FORM D: HIV/RW SERVICE SYSTEM OBJECTIVES

Applicant agrees that system objective(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see RWAA Service System Objective Guidelines) associated with the services proposed in this renewal application.

FORM E: HIV/RW WORK PLAN Guidelines

The work plan has been divided into the different activities the Administrative Agency is responsible for delivering; Administration and Services. The work plan must describe the following: a)how the applicant will use funds to meet service objectives for medical and psychosocial support and improve service delivery systems, b)how it ties to the goals and objectives of the current Comprehensive HIV Services Plan for their HIV administrative service area (HASA).

Administrative

1. Identify activities the Administrative Agency has planned for PY 2010-2011 related to planning, data, quality management, and contract monitoring that is other than the routine required monitoring.
2. Identify activities the Administrative Agency has in place to minimize lapsing funds for the Administrative Agency, Service Delivery, HOPWA, and State Services contracts.

Ryan White and State Service Allocations and Delivery

3. For each service category allocation describe how the allocation was made. Note that these descriptions must reflect submissions on Table 1 and each description must include:
    a. What data was used to make the decision to allocate to that category and at that level,
    b. How the allocation is coordinated across funds in each area,
    c. How the goals and objectives support the goals of the comprehensive plan,
    d. The method used to estimate the # of clients and units of service.

FORM E: HIV/RW WORK PLAN

Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this renewal application. A maximum of five additional pages may be attached if needed.

FORM G Categorical Budget Justification Example

Submit a budget justification that follows the below example. Administrative Agencies must also complete the budget summary forms in the excel spreadsheet.

Cost Categories	Administrative $81,557	Service Delivery $25,000	Total $106,557
A. PERSONNEL	$ 44,604		$44,604
Example: Executive Director (Gonzales) $3,200/monthly X 5% X 12 = $1920 Oversees all program activities. Ensures compliance with contract requirements. Provides program/financial information to the Board of Directors. Acts as agency personnel director and public spokesperson. Supervises Program Manager.	$ 1,920	$ 0	$ 1,920
Quality Management Coordinator (Jones) $1,500/monthly X 10% X 12 = $1800 Facilitate collaboration and work with subcontractors, planning bodies and service systems in gathering and analyzing data for purposes of gathering data to evaluate the effectiveness of funded services.	$ 1,800	$	$ 1,800
Program Manager (Watson) $2,580/monthly X 40% X 12 = $12,384 Supervises AA program activities. Provides needed staff training. Designs and maintains data collection system. Prepares all required program reports. Evaluates staff performance and conducts quality assurance.	$ 12,384	$	$ 12,384

	HIV Planner (McDade) $2,375/monthly X 100% X 12 = $28,500 Evaluate the effectiveness of services, the adequate delivery of services to special populations, facilitate collaboration, implementing a system of gathering current epidemiology HIV/AIDS data for planning purposes.	$ 28,500		$ 28,500
B.	FRINGE BENEFITS	$ 13,176	$ 0	$ 13,176
	Example: FICA: 7.65% x salaries = Insurance: $2,160 x 3.55 (# of FTEs) = Worker's Comp: 2.0% x salaries = $ Unemployment: 2.7% x salaries = $	$ 3,412 7,668 892 1,204	$ 0 0 0 0	$ 3,412 7,668 892 1,204
C.	STAFF TRAVEL	$ 1,977	0	$ 1,977
	Example: Expenses for 3 staff members, Planner, Data Analyst, Data Manager to attend the Texas HIV/STD Conference: Airfare @ $175 X 3 staff = $525 Lodging @ $85 X 4 days X 3 staff = $1,020 Meals @ $36 X 4 days X 3 staff = $432 ***State mileage rate is .55***	$ 525 1,020 432	$	$ 525 1,020 432
D.	EQUIPMENT	$	$	$ None Requested
E.	SUPPLIES	$ 1,200	$ 0	$ 1,200
	Example: General office supplies to be used by all staff members- $100 mo x 12 mo	$ 1,200	$ 0	$ 1,200
F.	CONTRACTUAL	$ 20,000	$ 25,000	$ 45,000

	Example ABC Nonprofit providing non-medical case management to HIV+ clients. Nurse to provide medical case management monitoring for the D, E, F HSDA's.	 $20,000	$ 25,000	 25,000 $20,000
G.	OTHER	$ 600		600
	Printing and reproduction of materials including client brochures and referral cards. $50 per month x 12 months = $600	600		600
H.	TOTAL DIRECT COSTS [Enter the total of A - G above]	$	$	$
I.	INDIRECT COSTS	$ 0	$	$
	Indirect costs are based on (mark the statement that is accurate): ☐ The **maximum rate** allowed under an indirect cost rate agreement approved by a federal cognizant agency or state single audit coordinating agency. A copy of the current rate is attached behind the Budget. **Expired rate agreements are not acceptable.** ☐**Less than the maximum amount** allowed by a federal cognizant agency or state single audit coordinating agency. A copy of the current rate is attached behind the Budget. ☐ (Applies to local governments only) The **maximum rate** allowed under an indirect cost rate proposal prepared in accordance with OMB Circular A-87. A copy of the indirect cost rate proposal certification and supporting documents is on file and is subject to review by DSHS fiscal monitors, or any of its duly authorized representatives, as well as duly authorized federal or state authorities. ☐(Applies to governmental entities only) **Less than the maximum amount** allowed under an indirect cost rate proposal prepared in accordance with OMB Circular A-87. A copy of the indirect cost rate proposal certification and supporting documents is on file and is subject to review by DSHS fiscal monitors, or any of its duly authorized representatives, as well as duly authorized federal or state authorities ☐The **maximum amount** calculated under a cost allocation plan must be submitted for review to DSHS no later than the 60th calendar day after the effective date of the contract. ☐**Less than the maximum amount** calculated under a cost allocation plan that must be submitted for review to DSHS no later than the 60th calendar day after the effective date of the contract.			

FORM H
HIV/RW VOUCHER SUPPORT FORM
Summary of Ryan White Expenditures
To be submitted with EACH reimbursement request

Administrative Agency:_____Submission Date:___/___/___

Contact Person: _____Phone: _____

SERVICE DATES: _____

Contract Amount	

Administration:

Expenditure Category	Amount Of Expenditure
Administration: H25	**$**
Planning and Evaluation: 079	**$**
Quality Management: K18	**$**

Services:

Subcontractor Direct Services Costs: 424	**$**
Subcontractor Administrative Costs: 297	**$**
Total Expenditures this voucher	**$**

REQUIREMENTS FOR HIV SERVICES CONTRACTS

The face page also certifies that all below requirements and assurances shall be followed by each Administrative Agency and their subcontractors.

HIV CONTRACTOR ASSURANCES
All contractors shall abide by all policies and assurances of the HIV/STD Prevention and Care Branch that apply to the programs being provided. The HIV Contractor Assurances are located on the HIV website at: http://www.dshs.state.tx.us/hivstd/funding/docs/HIV_Contractor_Assurances.pdf. A list of policies applicable to all HIV and STD contractors is provided at the agency's website at http://www.dshs.state.tx.us/hivstd/policy/policies.shtm.

DSHS ASSURANCE AND CERTIFICATIONS
All contractors shall abide by the DSHS Assurance and Certifications located at:
http://www.dshs.state.tx.us/hivstd/funding/2009_Fed_HIV/attachment_1.doc

CONTRACTOR ASSURANCE REGARDING PHARMACY NOTIFICATION
All contractors shall ensure that pharmacies providing prescriptions to HIV services clients do not fill medications on deceased clients, the contractor provides assurance to the Department of State Health Services that it will notify client's pharmacy when a client dies.

APPENDIX A: PROGRAM REQUIREMENTS FOR SERVICES CONTRACTS
All contractors shall ensure that program requirements listed in Appendix A are fulfilled. Appendix A is located at: http://www.dshs.state.tx.us/hivstd/funding/docs/Appendix_A.pdf.

APPRENDIX B: GLOSSARY HIV-RELATED SERVICE CATEGORIES AND ADMINISTRATIVE SERVICES (RDR*DEFINITIONS APPLIED)
All contractors shall ensure that program requirements listed in Appendix B are fulfilled. Appendix B is located at: http://www.dshs.state.tx.us/hivstd/funding/docs/Appendix_B.pdf.