CITY OF CLEVELAND DEPARTMENT OF PUBLIC HEALTH

2025 COMMUNITY DEVELOPMENT BLOCK GRANT(CDBG) AIDS PREVENTION PROGRAM

2025-2027

Request for Proposals

Date of Issuance:

Monday, November 4, 2024

Applications Due:

Friday, December 6, 2024, by 4:00 p.m.

The City of Cleveland
Application to Request Funding

2025 Community Development Block Grant (CDBG)

Due via email to OHAS@ClevelandOhio.gov by Friday, December 6, 2024

Projected Funding Available: **$121,986**

Funding Period: January 1, 2025, through December 31, 2025

Eligible Applicants: Private, non-profit organizations incorporated in Ohio serving clients living within the city of Cleveland with valid 501(c)3 status from the IRS and local government units.

Eligible Recipients: Agencies will describe the populations selected to focus on for programming and the steps taken to identify and address the needs of these populations. Federal and local priorities include emphasis on:

- Men who have sex with men (MSM)
- Youth ages 13-24
- People with HIV/AIDS who are out of care
- Persons who have been recently diagnosed with HIV/AIDS
- Persons who are not virally suppressed
- Disproportionately affected populations such as Black/African American and Hispanic/Latino populations

Eligible Activities:

1. Conduct targeted HIV testing for Men Who Have Sex with Men (MSM) with XX clients.
2. Conduct targeted HIV testing for youth ages 24 and under for XX clients.

3. Conduct targeted HIV testing for Black, African American, Hispanic, and Latino persons with XX clients.
4. Provide group-based sexual health education to XX participants.
5. Complete XX PrEP Program referrals.
6. Complete XX HIV treatment, STI testing and treatment, and mental health service referrals.
7. Conducted capacity-building activities that support staff of local prevention and care organizations.
    a. This may include technical assistance, professional development opportunities, new program support, coordination of funding efforts, and identifying gaps.

Submission and Review:

Email one application to: OHAS@ClevelandOhio.gov by Friday**,** December 6, 2024.

Proposals will be reviewed objectively to make funding recommendations to the City of Cleveland. The recommendations will be presented to the CDPH administration for consideration. Final funding decisions will be made by the Director and presented to Cleveland City Council for approval.

APPLICATION INSTRUCTIONS:

- All new and existing projects will be required to answer all applicable questions in this application form.
- To complete this form, click on the boxes highlighted in gray and enter your response.
- For each section, please check the 'Yes' or 'No' box that corresponds with the program you are applying for.
- Please do not change the form, rearrange the questions, or delete any sections.
- Please ensure you submit all required attachments in Section 6.
- Please include a Program Budget using the attachment provided.

- If you have questions regarding this application, please contact HIV/STI Project Coordinator, Tiffany Greene, via email at TGreene@ClevelandOhio.gov.

2025 CDBG Program Application

Applicant:

(Full legal name as it appears on your agency's Articles of Incorporation)

Address:

City: **County**: **State**: **Zip**

Executive Director's Name:

Grant Contact Person's Name:

Telephone: **Fax**:

Email:

Applicant Federal Tax ID Number:

CDBG funding is limited to service for those persons with HIV/AIDS who reside in the City of Cleveland.

Project Identification:

(Name of Agency)

Total amount of funds requested under this application: $

To the best of my knowledge and belief, all data in this application are true and correct. The application has been duly authorized by the governing body of the applicant, and the applicant will comply with all federal CDBG program regulations and local government reporting requirements if granted.

Name of Authorized Representative & Title	**Telephone Number**
Signature of Authorized Representative*	**Date Signed**

* You may print/sign/scan, enter initials or paste an electronic signature.

1. HIV PREVENTION STRATEGIES

This is a request for HIV Prevention Strategies: ☐ **YES** ☐ **NO**

Amount being requested for HIV prevention activities: $ _____

Anticipated Program Income: $ _____

Total HIV Prevention budget: $ _____

Briefly describe how you propose to use the HIV prevention funds requested. If your agency currently receives HIV prevention funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1.Number of persons to receive HIV prevention services (HIV Testing outreach setting, STI Testing or referrals)	
2. Number of persons to receive outreach and educational services	
3. Number of persons at risk to receive prevention services such as Pre-exposure prophylaxis	
4. Number of persons to receive linkage to care and treatment services such as substance use care and HIV Outpatient or ambulatory health services	

2. HIV TESTING IN CLINIC SETTINGS

This is a request for HIV testing in clinic settings: ☐ **YES** ☐ **NO**

Amount being requested for HIV testing in clinic setting activities: $ _____

Anticipated Program Income: $ _____

Total HIV testing in clinic setting budget: $ _____

Briefly describe how you propose to use the funds requested for HIV testing in a clinic setting. If your agency currently receives HIV testing in clinic setting funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	**Projections for 1/1/2025-12/31/2025**
1.Number of persons with HIV/AIDS to receive HIV testing in clinic setting	
2.Number of other persons in to receive STI screening (Syphilis, Chlamydia, Gonorrhea)	
3.Total number of persons to receive PrEP or referral for PrEP services	

3. HIV CAPACITY BUILDING SERVICES

This is a request for HIV capacity-building services: ☐ **YES** ☐ **NO**

Amount being requested for HIV capacity building services activities: $ _____

Anticipated Program Income: $ _____

Total HIV capacity building services budget: $ _____

Briefly describe how you propose to use the HIV capacity building services funds requested. If your agency currently receives HOPWA HIV capacity-building services funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1.Number of persons (staff or non-staff) to receive HIV capacity building services.	

4. PRIORITIZED POPULATION STRATEGY

Briefly describe how you propose to reach prioritized populations.

5. PROGRAM AND AGENCY DESCRIPTION

All agencies are requested to answer the following questions. Those with an asterisk (*) denotes factors identified by the Cleveland Department of Public Health as pertinent to funding allocation decisions.

1. **Describe the organization's history and mission.** (500 words or less)

2. **Describe the proposed CDBG project(s), including the testing, education, outreach, referrals, PeP and PrEP, and linkage to care for HIV positive individuals.** (500 words or less)

3. **Using data, describe the need for the proposed project within the geographic area to be served. Include information on how the proposed project impacts the community efforts to end the HIV epidemic. *** (500 words or less)

4. **What was the process used to determine whether these services were appropriate and needed for the area? Who was involved, and in what way were persons with HIV/AIDS included in the planning process?** (500 words or less)

5. **Describe the coordination of the proposed project with other programs reducing new HIV infections or serving persons with HIV/AIDS. Include how you will ensure that there is no duplication of services.** (500 words or less)

6. **Describe your project's plan for connecting your participants with healthcare, and particularly to HIV/AIDS diagnosis-specific healthcare. Provide data on successful healthcare enrollment. *** (500 words or less)

7. **Using data, describe how your project successfully reduces participants' viral load while enrolled in your program or linkage services. *** (500 words or less)

8. **Discuss the organization's capacity to implement the program and ability to manage the grant. Include any previous CDBG grant management experience and experience with other city or federal grants. *** (500 words or less)

9. **Describe the extent of inclusion of persons with HIV/AIDS in the project's planning, or history. *** (500 words or less)

10. **Describe other successes and challenges the project has faced in providing services.**

***** (500 words or less)

6. REQUIRED ATTACHMENTS: Please submit the documents listed below with your application.

1. Corporate Resolution, signed by a representative of your Board of Directors, stating the name and title of the authorized representative of the agency to enter into a contract with The Cleveland Department of Public Health should this application be approved. (Note: The signature on the letter and the authorized representative of the agency may not be the same person)

2. List of the Board of Directors/Trustees

3. Certification that no part of the net earnings of the organization are used to the benefit of and board member, founder, contributor, or individual who is not a consumer of the organization.

4. Program Budget. Please use the Program Budget spreadsheet, included with this application.

AGENCIES NOT CURRENTLY OPERATING A CDBG PROGRAM MUST ALSO ATTACH:

1. Non-profit certification-IRS 501(c)3 ruling letter

2. Most recent audit. If most recent audit is not complete prior to the application deadline, the audit must be submitted to the city within 30 days after the receipt of the auditor's report, but not later than nine months after the end of your fiscal year.

3. Proof that among the purposes of the organization (as stated in the by-laws or articles of incorporation) significant activities related to providing services or housing to persons with acquired immunodeficiency syndrome or related diseases are included.

PROGRAM BUDGET FORM

Name of Agency: _____ **Name of Fiscal/Lead Agency: _____** **Name of Program/Project: _____**	**Total Project Budget: _____** **Total request to CDPH: _____**		
Project Income	**Anticipated**	**Committed**	**Total**
Income/Revenue			
CDPH (Itemize below)			
Foundations			
Government Contracts			
Corporations			
Other			
Total Project Income			
Expenses	**CDPH Request**	**Other Funding**	**Total**
Direct Program/Project Expenses			
Personnel Expenses			
Salaries and Wages			
Benefits			
Non-Personnel Expenses			
Contract Services/Consultant Fees			
Program supplies			
Transportation/mileage			
Other (specify)			
Subtotal Direct Program/Project Expenses			
Overhead			
Rent			
Utilities			
Technology Costs			
Shared Office Supplies			
Development/Fundraising			
Accounting/Audit			
Insurance			
Other (specify)			
Subtotal Overhead (not to exceed 10% of project/program expenses subtotal)			
Total Expenses			
Excess (Deficiency)			