The Boston Public Health Commission
Request for Proposals (RFP)

FY 2027: Community-Based Prevention: HIV, STIs, Mpox, and Hepatitis C

Infectious Disease Bureau
Boston Public Health Commission
1010 Massachusetts Ave., 2nd Floor
Boston, MA 02118

TIMELINE

Dates	Activity
Thursday, April 23, 2026 at 11:00 AM	**Release of RFP**
RFP documents will only be available for downloading from the BPHC website. Hard copies will not be available.	Click here to view the Posted RFP on BPHC Website or copy and paste URL address below: **https://www.boston.gov/bid-listings**
Tuesday, May 5, 2026 (10:00am-12:00pm)	**Bidders' Conference**
Infectious Disease Bureau staff will review the RFP document and answer questions. **Applicants must register to participate.** Participation is strongly encouraged.	Click here for registration link or copy and paste URL address below: **https://bphc-org.zoomgov.com/meeting/register/aZXVSEzuQ1a3aXYpC5wGfw**
Monday, May 11, 2026 (5:00 PM)	**Deadline to Submit Letters of Intent**
A Letter of Intent is strongly encouraged if an agency intends to apply for funding, however, it does not bind or act as a commitment to submit a proposal. A Letter of Intent template is provided in this RFP.	**Email to:** communityprevention@bphc.org by May 11, 2026 at 5:00 PM
Thursday, May 14, 2026 (5:00 PM)	**Deadline to Submit Questions**
All questions regarding this RFP must be submitted via email.	**Submit via email to**: communityprevention@bphc.org by May 14, 2026 at 5:00 PM
Wednesday, May 20, 2026	**Responses to Questions**
Responses to all submitted questions will be posted at this link. Individual responses will not be provided.	Click here to view Q&A or copy and paste URL address below: **https://www.boston.gov/bid-listings**
Friday, May 22, 2026 (5:00 PM)	**Proposals Due**
Applications may only be submitted electronically. Narrative and tables must be in PDF format. Agency proposed budget must be submitted in Excel.	**Submit via email to**: RFR@bphc.org and cc: communityprevention@bphc.org

Table of Contents

PART 1: NARRATIVE *6*

Introduction 6

PART 2: LOCAL EPIDEMIOLOGY OF HIV, STIs, MPOX AND HEPATITIS C *6*

A. HIV Infection 6

B. Sexually Transmitted Infections (STIs) 8

C. Mpox 10

D. Hepatitis C Virus 10

PART 3: DATA RESOURCES *12*

PART 4: GOALS AND OBJECTIVES *13*

PART 5: GUIDING PRINCIPLES *13*

A. Health Equity: 13

B. Evidence-Based Activities: 13

C. Prevention Strategies: 13

D. Compliance: 14

E. Transparency: 14

F. Collaborations and Partnerships: 14

G. Partnerships between clinical and community-based providers: 14

H. Quality Assurance: 14

I. Process and Outcome Measures: 14

J. Quality Improvement: 15

K. Accessibility: 15

L. Syndemic approach: 15

M. Sex positivity: 15

N. Trauma-informed care: 15

O. Anti-Stigma Approach: 16

PART 7: ADVANCES IN THE FIELD, ALLOWABLE INTERVENTIONS, APPROACHES, AND SETTINGS *16*

Advances in the Infectious Disease Prevention Field 16

A. Behavioral interventions/Distributing Prevention materials: 16

B. PrEP/PEP: 17

C. Doxy PEP: 17

D. Test-and-Treat Strategies: 18

E. Mpox Vaccination: 18

Allowable Interventions 18

A. Engagement: ... 18
B. Individual and group-level education and health promotion: ... 19
C. Materials distribution: ... 19
D. Supplies and resources to support immediate needs: ... 19
E. Incentives: ... 19
F. HIV/STI/HCV Testing: ... 19
G. Facilitated access to clinical services: ... 19
H. Supported referrals: ... 19
I. Peer-led programs: ... 20

Allowable Settings and Venues of Services ... 20

PART 8: FUNDING OVERVIEW ... 21
A. Available Funds ... 21
B. Funding Structure ... 21
C. Payment Structure ... 22

PART 9: REQUIRED PROGRAM ELEMENTS ... 22

PART 10: ELIGIBILITY CRITERIA ... 23

PART 11: PROGRAM RULES ... 24
A. Award Conditions ... 24
B. Service Expectations and Program Implementation ... 24
C. Monitoring Calls ... 25
D. Reporting Requirement ... 25
E. Best Practices and Learning Meetings ... 26
F. Site Visits ... 27
G. Incentives ... 27
H. Flyers, Promotional and Educational Materials ... 27
I. Compliance ... 27
J. Corrective Actions ... 27
K. Conflict of Interest ... 27

PART 12: HIV/STI DIVISION FISCAL RULES ... 28

General Expectations: ... 28
A. Contract ... 28
B. Invoicing ... 28
C. Cost Reimbursement ... 29
D. Fiscal Compliance ... 31
E. Audits ... 32
F. Payments ... 32
G. Budget Revisions ... 32
H. Budgets ... 32

PART 13: APPLICATION PROCESS ... 34
A. General Preparation Instructions ... 34
B. Submission Instructions ... 35
C. Review and Selection Process: ... 35

PART 14: BPHC RIGHTS AND RESPONSIBILITIES ... 36
A. Communication: ... 36
B. Cancellation: ... 36
C. Insufficient Response: ... 36
D. Debriefings ... 36

PART 15: APPLICATION CHECKLIST ... 37

PART 16: COMMUNITY-BASED PREVENTION RFP APPLICATION ... 38

Section 1: Cover Page/Organizational Information ... 38

Section 2: Target Population and Need ... 38

Section 3: Organizational Capacity ... 39

Section 4: Program Description ... 39

A. Intervention(s) ... 39
B. Goals ... 40
C. Objectives ... 40
D. Activities ... 40
E. Partnerships (to be completed by Agencies applying in "Partnership") ... 40
F. Collaborations ... 41
G. Reporting ... 41

Section 5: Quality Assurance Plan ... 41

Section 6: Process And Outcome Measures Plan ... 42

Section 7: Budget and Budget Justification ... 42

Section 8: Tables ... 43

Section 9: Attachments ... 43

Section 10: Post-Award Documentation ... 43

PART 1: NARRATIVE

Introduction

Through this Request for Proposals (RFP) the Boston Public Health Commission (BPHC) Infectious Disease Bureau (IDB) HIV and STI Services Division seeks to lower the incidence of Human Immunodeficiency Virus (HIV), Sexually Transmitted Infections (STIs), mpox, and Hepatitis C Virus (HCV) among individuals living in Boston, particularly in those communities with the highest rates of infection. In preparation for this RFP, BPHC's Infectious Disease Bureau HIV and STI Services Division conducted multiple provider convenings. These included conversations with Ending the HIV Epidemic grantees and with providers addressing the cluster of HIV among people who inject drugs in Boston in order to assess the status of infectious disease risk, factors affecting access to testing, linkage to care, and care adherence, the sufficiency of existing prevention and care networks, coordination and information sharing among providers, and how funder policies and procedures influence the ability to meet community needs.

BPHC IDB HIV and STI Services Division has met regularly with their counterparts at the Massachusetts Department of Public Health (MDPH) Bureau of Infectious Disease and Laboratory Sciences (BIDLS) to gather relevant epidemiological data and to assess the current status of state infectious disease programming, funding streams, and related policies.
The IDB HIV and STI Services Division has also reviewed scientific literature to identify evidence-based infectious disease prevention interventions, with special attention to health equity and emergent biomedical prevention strategies.

PART 2: LOCAL EPIDEMIOLOGY OF HIV, STIs, MPOX AND HEPATITIS C

A. HIV Infection

Overview: In Boston between 2022 and 2024, 352 new diagnoses of HIV were reported, a rate of 17.4 cases per 100,000 population. This incidence rate is the sixth highest among cities and towns in Massachusetts. Cases increased in 2023 and 2024 over 2022, but reduced access to testing and care related to the COVID-19 pandemic may have suppressed HIV testing and diagnoses from 2020 to 2022. The number of cases reported in 2024 (120) is nearly identical to the average annual number of cases reported 2018-2023 (118), suggesting a steady-state annual rate of new infections in Boston.

Neighborhood: Among Boston neighborhoods, the highest rates of new HIV diagnoses during 2022-2024 occurred among residents of **Mattapan** (44 cases/100,000 population) and the **South End** (43/100,000), followed by Dorchester (26.4/100,000), Roxbury 25.0/100,000), Hyde Park (23.7/100,000), and East Boston (22.4/100,000). HIV incidence rates in the remaining Boston neighborhoods were significantly lower (range 0 to 10.4/100,000). Of note, cases are assigned to the neighborhoods where individuals reside, not necessarily where they may have engaged in HIV risk behaviors. Additionally, some new diagnoses may not represent new infections, but may instead be new reports of known infections, for example among individuals who were previously diagnosed with HIV in their countries of origin.

Race/ethnicity: Black Non-Hispanic (Black NH) individuals represented 50% of new HIV cases during this period, and 31% were **Hispanic/Latinx,** while members of these communities each represent only about 18% of Boston residents. The impact of racism on life expectancy and health outcomes among Black NH residents of Boston, particularly those living in the neighborhoods of Roxbury, Dorchester, Mattapan, East Boston, and Jamaica Plain, is the focus of the City's Live Long and Well initiative. Racial/ethnic disparities in HIV incidence and viral suppression contribute to inequities in life expectancy, cancer rates, and chronic disease outcomes.[1][2][3]

Exposure mode: Between 2022 and 2024, the most common exposure mode for individuals newly diagnosed with HIV was men who have sex with men (**MSM**) at 39% of all new cases, followed by those with "no identified risk" (**NIR**) at 24% of new cases. Among these NIR cases, 76% were male at birth, 60% were Black NH, 31% were Hispanic/Latinx, and 69% were non-US born. Fourteen percent of new infections were among women who were assigned to the **Presumed Heterosexual** [4] exposure

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[1] Pellegrino RA, Rebeiro PF, Turner M, Davidson A, Best N, Shaffernocker C, Kheshti A, Kelly S, Raffanti S, Sterling TR, Castilho JL. Sex and Race Disparities in Mortality and Years of Potential Life Lost Among People With HIV: A 21-Year Observational Cohort Study. Open Forum Infect Dis. 2022 Dec 19;10(1):ofac678. doi: 10.1093/ofid/ofac678. PMID: 36726547; PMCID: PMC9879712.
[2] Ahmad, S., Maqsood, M., Atiq, S., Tehreem, E., & Shah, M. (2025). 2331P Racial and geographic disparities in HIV-associated cancer mortality: A 22-year U.S. population-based study. *Annals of Oncology, 36* (Supplement 2), S1277. https://doi.org/10.1016/j.annonc.2025.08.2947
[3] Asogwa, N, Petrovic, M, Ling, J. et al. RACIAL & ETHNIC DISPARITIES IN CARDIOVASCULAR DISEASES RISK AMONG HIV-INFECTED PATIENTS. *JACC.* 2024 Apr, 83 (13_Supplement) 2063.**https://doi.org/10.1016/S0735-1097(24)04053-1**
[4] Presumed heterosexual exposure includes individuals assigned female at birth with no history of injection drug use who report having sex with an individual who identifies as male of unknown HIV status and risk.

mode, and 10% were reported as having injection drug use (**IDU**) as their mode of HIV exposure. Much smaller numbers of new infections were reported as MSM/IDU and Heterosexual exposure, figures too small to be detailed here due to suppression rules that protect patient confidentiality.

Sex: Overall, in Boston 72% of new diagnoses of HIV 2022-2024 were among people who were assigned **male** sex at birth. Among people assigned **female** sex at birth, the overwhelming majority were **Black NH** and **non-US born**, and most were reported with **Presumed Heterosexual** mode of exposure (followed by **NIR**).

Exposure mode by neighborhood: The proportion of new HIV cases by mode of exposure varied by neighborhood. In the most affected neighborhood of Mattapan **NIR** was the largest exposure category (43%) followed by **MSM** (30%), and in the South End **IDU** exposure was most common (44%) with a smaller proportion of **MSM** (14%). In the less affected neighborhoods of Dorchester **MSM** (32%) and **NIR** (31%) were the dominant exposure categories, followed by **Presumed Heterosexual** (21%); in Roxbury **MSM** led among exposure modes (46%) followed by **Presumed Heterosexual** (26%); in Hyde Park the greatest proportion of cases were **NIR** (44%) followed by **MSM** (20%); in East Boston the great majority of cases were among **MSM** (79%).

Non-US place of birth: A majority (53%) of new diagnoses of HIV in Boston were among **non-US born** individuals. As noted above, some of these infections may have been acquired and previously diagnosed in individuals' country of origin.

Age: The distribution of new cases by age cluster around the **30-39** (37%) and **20-29** (29%) age groups, with meaningful numbers of new diagnoses among individuals age 40 and older.

B. Sexually Transmitted Infections (STIs)

Statewide, the incidence of bacterial STIs (chlamydia, gonorrhea, and syphilis) had been rising in recent years, with an apparent peak in 2022-2023 (noting that diagnoses of STIs were likely suppressed during the COVID-19 pandemic). Trends in Boston diverge somewhat from these

statewide patterns. The average annual number of diagnoses of chlamydia in Boston in 2022-2024 was 5,734, down from 5,777 in 2018-2021. By comparison, average annual cases of gonorrhea among Boston residents have increased (2,533 in 2022-2024 vs. 2,063 in 2018-2021), as have cases of syphilis (356 in 2022-2024 vs. 326 in 2018-2021).

The incidence of these infections varies by sex. Individuals assigned **female** sex at birth represented 56% of chlamydia cases in Boston 2022-2024, while individuals assigned to **male** sex at birth represented 72% of gonorrhea cases and 87% of syphilis cases in Boston for the same period.

Racial/ethnic disparities in STI incidence are evident in Boston during the period 2022-2024, with **Black NH** individuals representing 31%, 28%, and 29% of cases of chlamydia, gonorrhea, and syphilis, respectively. **Hispanic/Latinx** individuals represented 20% of chlamydia cases and 31% of syphilis cases in Boston for this period. For comparison, both communities represent about 18% of Boston residents. Hispanic/Latinx individuals were not overrepresented among gonorrhea cases (17% of gonorrhea cases were among Hispanic/Latinx individuals). Due to reliance on laboratory reporting for most chlamydia and gonorrhea cases, race/ethnicity identifiers are unknown or labelled as "other" for 33% and 27% of these infections, respectively, reducing the ability to fully describe the magnitude of racial/ethnic disparities.

The majority of chlamydia cases (51%) were reported among individuals age **20-29**; 41% of gonorrhea cases were reported among individuals ages 20-29, and 30% were among those age **30-39;** he greatest share of (33%) of syphilis cases were among individuals ages **30-39**, and 28% were among those aged **20-29** years.

While the **Dorchester** neighborhood is home to approximately 17% of Boston residents, 33% of chlamydia, 31% of gonorrhea, and 31% of syphilis cases in Boston were diagnosed among residents of Dorchester in 2022-2024. Neighborhoods overrepresented among incident bacterial STI infections from 2022-2024 (in order of rate per 100,000 population) were for chlamydia: **Chinatown, Roslindale, Fenway/Kenmore, South Boston, and Jamaica Plain**; for gonorrhea: **Back Bay, South**

End, Mattapan, Roxbury, and Fenway/Kenmore; for syphilis: **Back Bay, South End, Dorchester, East Boston, and Mattapan**.

C. Mpox

Mpox is a communicable viral infection which causes painful skin lesions and can be transmitted during sexual activity or other close contact. A global outbreak of mpox occurred in 2022, particularly circulating among men who have sex with men (**MSM**). In 2022, 115 cases of mpox were identified among Boston residents. Sporadic cases of mpox were identified in Boston in 2023 and 2024, with an increase in cases in late 2025 and early 2026. Black NH and Hispanic/Latinx individuals have been overrepresented among individuals recent diagnosed with mpox, comprising a combined 52% of cases in Boston. 68% of cases have been among individuals who were not previously vaccinated for mpox. Given the infectiousness of this virus continued public health vigilance, referral of suspect cases to medical care, and immunization of at-risk individuals are warranted.

D. Hepatitis C Virus

Infections with hepatitis C virus (HCV), which can cause serious liver disease, peaked in Massachusetts in 2017 and have since declined dramatically. Prior to 2007, hepatitis C infections were largely confined to individuals born during the “baby boom” years (1946-1964) and related to the receipt of untested blood, blood products, tissues, and organs during medical procedures before the virus was discovered and these materials and their donors were tested for infection. In 2007, hepatitis C infections in Massachusetts began to increase significantly among a younger cohort of individuals linked to the sharing of injections and possibly intranasal drug equipment, particularly the non-medical use of opioids.[5] HCV can also be transmitted sexually and from a pregnant individual to their newborn. Racial/ethnic disparities in the rates of hepatitis C infection are evident statewide, particularly among Black NH and Hispanic/Latinx individuals. The expansion of harm reduction services in Massachusetts, including in Boston, and the advent of curative oral therapies for hepatitis C infection appear to have significantly reduced the incidence of these infections in recent years. However, untreated hepatitis C infections remain prevalent, particularly among **people who inject**

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[5] Aaron S, McMahon JM, Milano D, Torres L, Clatts M, Tortu S, Mildvan D, Simm M. Intranasal transmission of hepatitis C virus: virological and clinical evidence. Clin Infect Dis. 2008 Oct 1;47(7):931-4. doi: 10.1086/591699. PMID: 18764772; PMCID: PMC6545569.

drugs. Therefore, ongoing efforts in prevention, testing, and referral to medical care remain necessary to further contain this virus.

Hepatitis C virus (HCV) continues to pose an ongoing public health concern in Boston, with transmission closely linked to substance use. Between 2017 and 2025, a total of 2,970 confirmed HCV cases were reported among Boston residents. Annual cases declined from 584 in 2017 to 211 in 2025, with a temporary drop during the COVID-19 period followed by modest increases in 2023–2024.

HCV cases are distributed across racial and ethnic groups, with White residents accounting for 35.2% of cases and Black and Latinx residents each representing approximately 18% of cases. However, interpretation is limited by a substantial proportion of missing race/ethnicity data (25.9%). Males represent a disproportionate share of cases (66.5%), compared to 33.5% among females.

Among cases with known exposure, 82.9% are associated with injection drug use (IDU), highlighting the strong link between HCV transmission and the opioid epidemic. However, missing exposure data remains a limitation, underscoring the need for improved surveillance and reporting.

Overall, while case counts have declined over time, ongoing transmission, demographic disparities, and the strong association with IDU indicate a continued need for targeted screening, linkage to care, harm reduction services, and improved data completeness to support HCV prevention and elimination efforts in Boston.

PART 3: DATA RESOURCES

- *Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences; data as of 07/01/2025 and are subject to change*
- Boston's Live Long and Well Agenda; available at https://www.boston.gov/departments/boston-public-health-commission/bostons-live-long-and-well-agenda
- MDPH 2024 Integrated HIV, STD, and Viral Hepatitis Report slide set; available at https://www.mass.gov/doc/2024-integrated-hiv-std-and-viral-hepatitis-report-slideset/download
- MDPH HIV Data Dashboard; available at https://www.mass.gov/info-details/hiv-data-dashboard
- MDPH HIV City/Town and Suffolk County data; available at https://www.mass.gov/doc/hiv-dashboard-citytown-and-suffolk-county-data/download
- MDPH Mpox Data Reporting; available at https://www.mass.gov/info-details/mpox-data-reporting
- MDPH 2024 Viral Hepatitis Surveillance Report (Hepatitis A, B, and C); available at https://www.mass.gov/doc/2024-viral-hepatitis-surveillance-report-hepatitis-a-b-and-c/download

PART 4: GOALS AND OBJECTIVES

The primary goal of work funded through this RFP is to reduce the incidence of HIV, STIs (chlamydia, gonorrhea and syphilis), mpox, and HCV among persons residing in the City of Boston. This RFP focuses on populations at high risk for these infections as defined by data showing higher incidence rates, emphasizing those who are from marginalized/underserved populations including but not limited to: MSM (particularly MSM of color and including both younger [25 and under] and older [50+] MSM); women of color; transgender individuals; people who use substances (in particular injectable substances); and non-US born individuals. The RFP aims to support focused efforts to reach residents of the most affected neighborhoods (see epidemiologic data above), those who are experiencing homelessness or housing instability, people facing food insecurity, individuals born outside of the United States, individuals with behavioral health concerns, and those engaged in commercial or survival sex work.

This RFP also aims to address broader health disparities in specific Boston neighborhoods consistent with the goals of the Live Long and Well Agenda which highlights the impacts of racism on life expectancy, cancer rates, and chronic disease outcomes for the Boston's Black residents.

PART 5: GUIDING PRINCIPLES

A. **Health Equity:** Funded programs will focus on addressing infectious disease disparities linked to race/ethnicity, geography, sexual orientation, gender identity, immigration status, and socio-economic status.
   Programs are encouraged to engage communities in the development and delivery of services, recognize the impact of structural and social determinants of health, and incorporate approaches that support empowerment, confidentiality, and equitable access to care.
B. **Evidence-Based Activities:** BPHC strongly encourages all applicants to base their education and outreach efforts on the best science currently available.
C. **Prevention Strategies:** Prevention strategies should promote initial and long-term behavior change, including health care engagement, such as regular testing, staying adherent to medication regimens and the use of harm reduction practices. Applicants will describe the intervention to be used, the evidence that supports its use, and how it will be adapted to meet the

needs of their target population. Priority will be given to proposed projects which are designed with the flexibility to reach traditionally underserved and hard-to-reach populations. Any proposed prevention strategies focused on behavior change must also link to biomedical interventions.

D. **Compliance:** All applicants must adhere to the programmatic and fiscal requirements outlined in this RFP, including those described in the Program Rules section. By submitting a proposal, the applicant indicates acceptance of these requirements and agrees to comply with them.
E. **Transparency:** Funding and funded activities are considered information in the public domain.
F. **Collaborations and Partnerships:** Applicants submitting collaborative proposals must clearly describe the relationships among the co-applicants, delineate responsibilities and respective scopes of work, identify the lead agency which will also be the fiscal conduit, and provide respective budgets for each partner. As BPHC's contractual relationship is with the lead agency/fiscal conduit, the lead agency/fiscal conduit is responsible for ensuring effective communication with the subcontractor(s) and they must describe how they will work together to meet their objectives and reporting requirements to BPHC.
G. **Partnerships between clinical and community-based providers:** Funded programs will maintain active collaborations and partnerships of across clinical and community-based organizations to maximize the seamless transition from prevention programs to clinical care.
H. **Quality Assurance:** Applicants must describe how they will ensure that services are delivered with quality, consistency and responsiveness to participant needs.
   Quality assurance focuses on how activities are implemented and how organizations monitor and support the delivery of services. This may include approaches to staff support, use of standard protocols or curricula and ongoing review of service delivery.
   Quality assurance activities may include simple and practical approaches such as staff training and supervision, use of standardized materials or guidelines, participant feedback or satisfaction surveys, and periodic internal check-ins to ensure activities are being delivered as intended.
I. **Process and Outcome Measures:** Applicants must describe how they will assess the reach and effectiveness of their proposed activities through appropriate process and outcome measures. Process measures describe the activities carried out (e.g., number of individuals reached or services delivered), while outcome measures reflect changes resulting from those activities (e.g.,

changes in knowledge, engagement in services, acceptance of testing, linkage to care, or uptake of prevention strategies).

These measures can be assessed using simple and practical approaches, such as sign-in sheets, referral tracking, or brief pre- and post-activity questions or surveys. Measures should be feasible, appropriate to the scope of the program and aligned with the proposed activities.

J. **Quality Improvement:** BPHC defines Quality Improvement as a deliberate process to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes. The purpose of continuous quality improvement programs is to improve services and processes by identifying problems, implementing and monitoring corrective action and studying its effectiveness.

K. **Accessibility:** Funded programs will ensure equitable access to services by addressing linguistic, cultural, and disability-related barriers. This includes providing appropriate auxiliary aids and services, as defined by the ADA, to support effective communication for individuals with disabilities.

All program materials and communications, including print, digital, and web-based content, must be designed with accessibility in mind (e.g., clear formatting, readable font sizes, sufficient color contrast, and compatibility with assistive technologies such as screen readers) to ensure usability for individuals with low vision, blindness, color blindness, or other disabilities. Applicants are encouraged to align with established accessibility standards, including ADA guidance[6], WCAG[7], and Section 508[8].

L. **Syndemic approach:** Funded services will recognize that racism, homophobia, transphobia, xenophobia, and other forms of oppression make individuals vulnerable to multiple infectious diseases and will aim to develop strategies that address this overlapping risk.

M. **Sex positivity:** Funded programs will be founded in a sex-positive framework recognizing the importance of healthy sexuality, consent, sexual pleasure, and relationship satisfaction in their messaging; abstinence-only health education proposals will not be considered.

N. **Trauma-informed care:** Funded programs will observe and integrate the principles of trauma-informed care recognizing the particular needs of individuals who are survivors of violence, abuse,

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[6] www.ada.gov
[7] https://www.w3.org/WAI/standards-guidelines/wcag/
[8] https://www.section508.gov/

neglect, and other traumatic experiences (including sexual assault, intimate partner violence, and the experience of international migration) and design the delivery of service to meets these needs through the building of safety, trust, empowerment, and self-determination.

O. **Anti-Stigma Approach:** Programs funded through this RFP are required to incorporate an anti-stigma approach in the design and delivery of services. Stigma related to HIV, STIs, mpox, HCV, sexual orientation, gender identity, substance use, and other intersecting factors must be addressed as a barrier to accessing prevention, testing, and care.

PART 6: IMPLEMENTATION REQUIREMENTS

Funded programs must demonstrate how they will implement the following:

A. Create welcoming, inclusive, and affirming environments for all participants.
B. Use culturally and linguistically appropriate, non-judgmental, and person-centered communication.
C. Ensure staff are trained in anti-stigma, trauma-informed, and culturally responsive practices.
D. Protect participant confidentiality and build trust, particularly for communities disproportionately impacted.
E. Engage community members in program design and implementation to ensure services reflect lived experience.
F. Identify and address program-level and structural barriers that contribute to stigma.

Programs must describe how these approaches are applied in practice and how they will monitor and strengthen efforts to reduce stigma over time. Programs may be asked to demonstrate implementation of these approaches through program monitoring, reporting, or site visits.

PART 7: ADVANCES IN THE FIELD, ALLOWABLE INTERVENTIONS, APPROACHES, AND SETTINGS

Advances in the Infectious Disease Prevention Field

A. **Behavioral interventions/Distributing Prevention materials:** While the HIV/STI/HCV prevention field has a long history of individual-, group-, and community-level behavioral

interventions (e.g., promotion of condom use, skills development in sexual risk and consent communication, building of self-efficacy in utilizing prevention strategies) their absolute impact on individual behavior over time may be limited and their effect on population-level disease incidence is difficult to demonstrate. While personal health promotion skills are an essential component of any disease prevention strategy, they need to be complemented with biomedical interventions (PrEP/PEP, vaccination, testing, treatments to achieve cure/viral suppression) that have demonstrated their power to significantly reduce individual and community-level transmission. Health education and personal health promotion skill building also should be accompanied by the distribution of safer drug use and safer sex use materials to prevent and reduce the risk of infectious disease transmission through harm reduction.

B. **PrEP/PEP:** Antiviral medications to prevent HIV infection have been approved in the United States for pre-exposure use (PrEP) since 2012 and for post-exposure use (PEP) since 2005. However, estimates based on pharmacy and survey data indicate that the full benefit for these preventive strategies have not been utilized by all at-risk individuals. PrEP utilization is lower among Black and Latinx individuals and among women, likely due to structural barriers to accessing healthcare. Given the high prevention efficacy (over 99%) of these medications to prevent HIV infections, all at-risk individuals should be encouraged by funded prevention providers to consider PrEP and be assisted in accessing PrEP and PEP. Certain PrEP options, particularly more recently approved long-acting injectable formulations, are indicated for individuals who may not be able to maintain regimens of daily oral dosing of PrEP medications.

C. **Doxy PEP:** The timely administration of the common antibiotic, doxycycline, has been shown to significantly reduce the risk of acquiring infection with bacterial STIs (chlamydia, gonorrhea, and syphilis).[9] Individuals who are likely to be exposed to one or more of these infections (particularly individuals with a prior history of an STI) should be encouraged to consider having a personal supply of doxycycline for post-exposure prevention use. Funded prevention providers should be prepared to encourage their at-risk program participants to consider doxy PEP and to facilitate their access to this medication.

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[9] Luetkemeyer AF, Donnell D, Dombrowski JC, Cohen S, Grabow C, Brown CE, Malinski C, Perkins R, Nasser M, Lopez C, Vittinghoff E, Buchbinder SP, Scott H, Charlebois ED, Havlir DV, Soge OO, Celum C; DoxyPEP Study Team. Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections. N Engl J Med. 2023 Apr 6;388(14):1296-1306. doi: 10.1056/NEJMoa2211934. PMID: 37018493; PMCID: PMC10140182.

D. **Test-and-Treat Strategies:** Testing at-risk individuals for STIs and support for rapid treatment of individuals who test positive (and their sexual partners) has long been a standard component of STI prevention. Prevention providers, working with state-funded field epidemiologists, have important roles to play facilitating access to timely and complete treatment of STIs. Since the advent of short-course Directly Acting Antiviral oral therapies to treat HCV infection to cure, it is also a priority for individuals at high risk of HCV infection (e.g. people who use injectable substances) to test for HCV infection, and if positive, be supported in accessing these treatments. Similarly, most individuals living with HIV who start and remain on effective antiviral treatments are able to achieve viral suppression, eliminating the risk of transmission of HIV to their sexual partners and greatly reducing transmission via injection drug equipment sharing. All funded prevention providers need to play a role in helping individuals with one of these infections to access medical care and be supported in adhering to their treatment regimens.

E. **Mpox Vaccination:** Since the global outbreak of mpox infections vaccination with two doses of JYNNEOS vaccine has proven to be an effective prevention strategy, particularly in at-risk communities (e.g. among MSM).[10] Prevention providers have an important role to play educating members of at-risk communities about the prevention of mpox, the value of two doses of JYNNEOS vaccine, and how to access it.

Allowable Interventions

Applicants may propose a combination of allowable interventions listed below; however, not all listed interventions are required. Programs should select and design activities that are responsive to the needs of priority populations, aligned with the goals of this RFP, and clearly connected to the proposed program approach. All interventions should incorporate harm reduction principles and be culturally and linguistically responsive.

A. **Engagement:** Efforts to engage members of at-risk communities in prevention services, including, online and in-person health education efforts, programmatic in-reach and

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Deputy NP, Deckert J, Chard AN, Sandberg N, Moulia DL, Barkley E, Dalton AF, Sweet C, Cohn AC, Little DR, Cohen AL, Sandmann D, Payne DC, Gerhart JL, Feldstein LR. Vaccine Effectiveness of JYNNEOS against Mpox Disease in the United States. N Engl J Med. 2023 Jun 29;388(26):2434-2443. doi: 10.1056/NEJMoa2215201. Epub 2023 May 18. PMID: 37199451; PMCID: PMC10962869.

structured referrals from partner organizations, and embedding of staff in social/commercial venues.

B. **Individual and group-level education and health promotion:** Evidence-based single-session and multi-session interventions that educate on the nature, transmission, and prevention of infectious diseases, build skills in using risk and harm reduction methods, and develop capacity to communicate about disease risk and risk reduction.

C. **Materials distribution:** Making risk reduction and harm reduction materials available to support prevention strategies.

D. **Supplies and resources to support immediate needs:** Funds may be used food and transportation to support linkage to care as well as similar material supports for individuals during isolation periods (e.g. following or pending mpox diagnosis) and to support expedited partner therapy for STIs and PEP.

E. **Incentives:** Incentives are an allowable expense to support participant recruitment and retention, subject to the following guidelines:

    a. Incentives cannot be in the form of cash. Gift cards are allowable, provided that all BPHC policies are followed.
    b. Agencies must follow their internal policies for tracking incentives, and BPHC must have these policies on file.
    c. Incentive amounts, structure, and any limitations will be reviewed for compliance with BPHC policy.

F. **HIV/STI/HCV Testing:** Offering and delivering approved tests for a range of infectious agents, including rapid tests, self-collected specimens, and professionally collected blood/urine/oral/rectal specimens for submission to laboratory testing

G. **Facilitated access to clinical services:** Active, supported navigation to PrEP, PEP, vaccination, and infectious disease treatment, including embedding of clinical capacity within community-based organizations and other formal collaborations between CBOs and clinical providers

H. **Supported referrals:** Active, supported referrals to harm reduction services, behavioral health services, economic supports, and social services including leveraging established relationships with receiving providers, supporting program enrollment, assisting with initial transportation, and conducting follow-up to ensure successful linkage.

l. **Peer-led programs:** The integration of trained members of the service population in the delivery of prevention programs serving as peer leaders of the program to enhance linguistic and cultural competency to build trust and support participant engagement and self-efficacy.

Allowable Settings and Venues of Services

Services may be provided in a range of settings and venues to effectively reach priority populations. Applicants are encouraged to deliver services in locations that are accessible, community-based, and responsive to where individuals live, work, and socialize.

Allowable settings and venues include:

- On-site at clinical and community-based organization offices and facilities, including community health centers
- Private gatherings and educational sessions, including those hosted in housing settings and social settings
- Commercial venues such as clubs, bars, stores/shops, barbershops, hair and beauty salons, and restaurants
- Civic organizations and faith-based organizations
- Community events such as health fairs
- Online platforms and mobile applications
- Mobile units
- Shelters
- Recovery and substance use disorder (SUD) treatment programs
- Correctional settings

Other appropriate settings will be considered.

PART 8: FUNDING OVERVIEW

The following sections outline available funding, award structure, and payment terms:

A. Available Funds

Total funds for the first year available under this RFP is up to $1.4 M.

Contract Period: July 1, 2026 – June 30, 2027 (with continuation through June 30, 2030 pending funding and performance)

***B.* Funding Structure**

BPHC is committed to addressing racism and the health and social impacts of systemic inequities. This commitment is reflected not only in the services we support, but also in how we invest public resources.

As part of this commitment, we encourage applications from a diverse range of businesses and organizations, including those owned by individuals from historically underrepresented communities, as well as local organizations. This includes Minority-owned, Women-owned, Veteran-owned, Disability-owned, and LGBTQ+-owned businesses.

BPHC IDB will be awarding contracts in the average approximate range of $100,000 to $300,000.

Awards below $100,000 will not be issued under this RFP.

Organizations may apply for funding through this RFP either independently or in partnership, in alignment with eligibility and funding requirements.

a. **Apply as a Single Agency:**
   Organizations may apply independently for funding within the $100,000–$300,000 range.
b. **Apply in Partnership:**
   Organizations may submit a joint application with one or more partners within the same $100,000–$300,000 funding range. In this model, one organization must serve as the lead agency and fiscal conduit. A Memorandum of Understanding (MOU) is required for all partner organizations outlining roles, responsibilities, and scope of work within the collaborative model.

Organizations that are not 501(c)(3) entities and/or are seeking funding under $100,000 are not eligible to apply as a lead applicant. However, these organizations may participate in the initiative as partners within an application submitted by an eligible 501(c)(3) lead organization.

For the purposes of this RFP, the lead applicant is the organization that submits the proposal and holds the contract with BPHC. A partner is an organization that contributes to program implementation as a subcontractor under the direction of the lead applicant but does not hold a direct contract with BPHC.

C. **Payment Structure**

Contracts awarded under this RFP will operate on a cost reimbursement basis. This means that organizations will be reimbursed for allowable expenses after costs have been incurred and invoiced. Payments are typically processed on a net 30-day basis following submission and approval of invoices.

Applicants should consider their organization's capacity to manage program expenses prior to reimbursement, as advance payments are not provided under this funding structure.

PART 9: REQUIRED PROGRAM ELEMENTS

The following elements outline the core expectations for all programs funded through this RFP. These requirements are intended to ensure that funded activities align with BPHC priorities, reflect current standards of care, and support effective and equitable delivery of prevention services.

Applicants should describe how their proposed program will incorporate these elements, as appropriate to the scope and design of their activities.

All funded providers must:

A. Focus their efforts on individuals, communities, and neighborhoods at documented higher risk of HIV, STI, mpox, and/or HCV infection as described in the epidemiologic summary.
B. Center health equity into all services.
C. Incorporate harm reduction, sex-positive, trauma informed and anti-stigma principles and approaches into their services.

D. Incorporate access to infectious disease testing, PEP/PrEP, vaccination, and infectious disease treatment into their services either by direct delivery or by collaborative relationships with clinical providers; community-based organizations must establish and maintain written collaborative relationship(s) with at least one clinical organization for these health care services; embedding of clinical services in community-based services is particularly encouraged.
E. Link all individuals identified as confirmed or presumed case of HIV infection to care as soon as possible within 7 days of identification or positive test result consistent with Rapid Start standards of care; link all individuals identified as a confirmed or presumed case of a bacterial STI to care within 72 hours of identification or positive test result; link all individuals identified as a confirmed or presumed case of HCV infection to care within 30 days of identification or positive test result; link all individuals suspected of an active case of mpox immediately to health care for timely diagnosis and management.
F. Coordinate with BPHC Infectious Disease Bureau public health nurses, around individuals diagnosed with mpox to provide material support (including for individuals undergoing mandatory quarantine) and assistance with partner notification and post-exposure prophylaxis. Also coordinate as needed with BPHC Infectious Disease Bureau Division of Education and Community Engagement and HIV/STI Services Division to coordinate outreach, engagement and messaging to address outbreaks.
G. Coordinate with MDPH Partner Services field epidemiologists around individuals identified with priority infections as defined by MDPH to ensure access to partner notification supports and additional health care referrals.
H. Include quality assurance practices as part of their model to ensure that all activities are of high quality, delivered with fidelity to evidence-based models, and acceptable to their clients.

PART 10: ELIGIBILITY CRITERIA

To be considered for funding, applicants must meet the following criteria:

A. **501(c)(3) Status:**

Agency must be recognized as a tax-exempt nonprofit organization under Section 501(c)(3) of the Internal Revenue Code. Organizations may apply either independently or as the lead

agency in a collaborative partnership. In collaborative applications, the lead agency must meet all eligibility requirements and assume primary responsibility for program implementation, fiscal management, and reporting.

B. **Boston-based and Serving Boston Residents:**
Agencies must be based in Boston and provide services to residents of Boston. Proposed programs and activities must primarily benefit Boston residents, and applicants should clearly describe their connection to the communities they serve, including geographic focus areas and priority populations.

PART 11: PROGRAM RULES

A. Award Conditions

BPHC may withdraw or modify an award if an agency is not making adequate progress. This includes progress toward program goals, completion of contract deliverables, timely use of funds, and compliance with reporting and data submission requirements

B. Service Expectations and Program Implementation

Agencies are expected to deliver services that align with the activities proposed in their scope of work. This may include outreach, testing, linkage to care, education, harm reduction, and peer-based approaches, etc.

These expectations are based on Boston data, public health practice, and input from providers and community partners. The goal is to ensure services are consistent, high quality, and responsive to community needs. By accepting funding, agencies agree to follow these expectations and any additional guidance provided by BPHC.

a. **Testing:** Testing must follow approved protocols and ensure confidentiality. Agencies should explain the testing process clearly and provide basic pre and post-test information. Agencies must have a plan to respond to reactive or positive results and ensure individuals are connected to care within required timelines outlined in this RFP.

b. **Linkage and Navigation:** Agencies are expected to support individuals in connecting to care and services. This includes scheduling appointments, coordinating with partners, and following up. Agencies should track how many individuals are referred and, when possible,

how many successfully connect to services

c. **Harm Reduction and Materials Distribution**: Agencies may distribute prevention and safer sex and or safer use materials to prevent transmission of infectious diseases. Agencies should provide clear instructions on use and track the quantity of materials distributed.

d. **Education and Health Promotion:** Education activities should provide clear and accurate information about HIV, STIs, mpox, and Hepatitis C. This may include individual or group sessions. Agencies should track the number of participants engaged and the type of activity delivered.

e. **Supported Referrals:** Referrals should be supported in a way that increases the likelihood that individuals connect to services. Agencies should track referrals made and, when possible, whether they were completed.

f. **Peer Based Approaches:** Programs that include peer staff should ensure peers are trained and supported. Agencies should define peer roles and track peer-led activities where applicable. BPHC may provide additional guidance and support to help agencies meet these expectations.

C. Monitoring Calls

Agencies are required to participate in regular monitoring calls with BPHC. These calls are used to review program progress, discuss challenges, review data and spending, and provide support.

D. Reporting Requirement

Reporting is required for all funded agencies. Reports must be submitted on time and be complete. Delays or missing reports may affect payments, continuation of funding, or eligibility for future funding. Reporting is also used to understand how programs are performing and where support may be needed.

a. **Progress Reporting**

Funded agencies are expected to submit biannual progress reports in the format and timeline provided by BPHC: **15th of January/15th of July**.

Reports should include updates on program activities, staffing, progress toward goals, challenges, including underspending, unmet service needs, and plans to address identify issues.

Agencies are expected to show progress in both programming implementation and spending in line with the approved scope of work. Additional information may be requested to assess program performance and effectiveness.

b. **Data Reporting**

Agencies must submit monthly data for all services delivered under this contract using the BPHC designated data platform (E2Education&Outreach). Data must be submitted by the 15th of the month following the reporting period. BPHC will provide guidance on data definitions, reporting expectations, training and use of the designated data system.

Data must be complete, accurate, and reflect services delivered during the reporting period. **At a minimum, agencies are expected to report numeric data that reflects program activity and reach. This includes:**

a. Number of individuals reached through outreach
b. Number of individuals receiving testing services
c. Number of tests conducted, by type if applicable
d. Number of individuals with reactive or positive results
e. Number of individuals linked to care
f. Number of referrals made and, when possible, completed
g. Number of participants engaged in education or group activities
h. Number of prevention or harm reduction materials distributed

Agencies must ensure client confidentiality and follow applicable privacy requirements when collecting, storing, and reporting data. Reported data will be used by BPHC to monitor performance, identify gaps, provide technical assistance, and inform funding decisions. Agencies should come prepared to share updates and may be asked to provide documentation.

E. Best Practices and Learning Meetings

Agencies are required to attend periodic meetings organized by BPHC. These meetings support shared learning across programs and provide ongoing guidance and technical assistance.

F. Site Visits

The Boston Public Health Commission (BPHC) will conduct site visits to ensure that Community-Based Prevention funds are used appropriately, contractual requirements are met, and technical assistance is provided as needed. Each funded agency will receive at least one site visit every grant year (July 1 through June 30) during the contract period.

G. Incentives

a. Incentives may be used to support participation in program activities.
b. Incentives may not be provided in the form of cash. Gift cards are allowable, provided all BPHC policies are followed.
c. Agencies must follow internal policies for tracking incentives, and these policies must be on file with BPHC.
d. Incentive amounts and structure are subject to review and approval.
e. Agencies must maintain documentation of incentive distribution.

H. Flyers, Promotional and Educational Materials

Agencies may promote their programs to reach priority populations. All materials developed with BPHC funding must include the BPHC logo or acknowledgment of BPHC as the funding source and must be submitted for review and approval prior to dissemination. Agencies should allow at least two weeks for review. Materials should reflect the communities being served and be easy to understand and accessible.

I. Compliance

Agencies must follow all reporting and fiscal requirements. Failure to do so may affect funding. Agencies are responsible for ensuring subcontractors follow all program rules and reporting requirements.

If an agency does not meet requirements, BPHC will provide written notice and outline steps to correct the issue. If issues are not resolved, this may result in probation, suspension, or termination of the contract.

J. Corrective Actions

If corrective actions are required, agencies must report on their progress as requested by BPHC.

K. Conflict of Interest

Agencies must follow their own conflict of interest policies. Staff may not participate in

pharmaceutical sponsored activities while on BPHC funded time.

PART 12: HIV/STI DIVISION FISCAL RULES

General Expectations:

The BPHC Infectious Disease Bureau, HIV/STI Services Division expects all contracted agencies to expend 100% of their award in accordance with all BPHC policies. Funded agencies will only be reimbursed for deliverables that have been approved in their Scope of Services and Budget upon receipt of appropriate invoices and supporting documentation. Agencies that wish to revise their Scope of Services or allowable costs must submit a proposal to revise the scope/budget prior to any change. BPHC will notify the agency whether the change is approved or not. In addition, it may be required that a program/agency audit be submitted. Failure to meet these expectations may result in corrective action, including delayed reimbursement, additional monitoring, or contract enforcement, up to and including suspension or termination of the contract.

A. Contract

A complete and signed contract packet should be returned by the agency withing the time frame specified by BPHC to avoid delays in contract execution. BPHC will generate a Purchase Order (PO) number within 30 days of receipt of the signed contract.

B. Invoicing

General Information

a. Agencies must use the standard invoice template provided by the Infectious Disease Bureau Fiscal team. Invoices must include agency name and billing address, BPHC Purchase Order (PO) number, current approved budget, invoice amount, cumulative billing, remaining balance, and unique invoice number. Payments are cost reimbursement and are based on the approved budget. Only line-item budgeted expenses are reimbursed. Invoices must be formatted by computer; handwritten invoices are not acceptable.
b. Agencies must have their invoices signed by a program representative or a contract specialist before submission for reimbursements to BPHC.
c. Invoices should be submitted monthly, within 15 days of the month's end. Each day thereafter will be considered late, therefore non-compliant. Invoices must represent actual monthly expenses. The final invoice must be submitted by **July 15, 2027**.

d. Invoices without the required information or documentation will not be processed for reimbursement. Instead, the agency will be informed of the deficiency to be corrected, and the invoice will be deleted from our system. The agency will need to resubmit the invoice. Corrected invoices will be processed upon resubmission and are not guaranteed expedited processing.
e. An invoice must be submitted to BPHC for each month in the contract period. **If no contracted activities occur in a given month, there will be no reimbursable costs; an invoice with a $0 month total must be submitted**.
f. An invoice requesting payment for **stipend** reimbursement should have the staff's name, the dates, place and hours of services, and a copy of the check. **Cash stipends are unallowable**.
g. An invoice requesting payment for **incentives** reimbursement should have a list of all the clients that received the incentives, the cost per client (cost should be in accordance with the current approved budget and scope of service), the date of distribution and proof of receipt by the client. Agencies with incentives must have a policy on how incentives are distributed and tracked at the agency level. Said policy must be available for review by BPHC at any time during the fiscal year.
h. Any revised or supplemental invoices are to be clearly labeled as such by including the word **"Revised"** or **"Supplemental"** in the **"Invoice Number"** notation and incorporated within the unique invoice number (i.e., SUPPJUL2027). Under any circumstances an invoice number should exceed 20 characters. Retroactive billing may only occur when the expense is not billed to another funding source. Documentation of bills to other funding sources may be required.
i. Monthly invoices containing all the required information will be paid within 30 days of receipt. The 30-day payment period starts over for corrected invoices. Reimbursement may be held, if required reports and data have not been received by BPHC or if fiscal documentation is incomplete. BPHC will communicate with agencies regarding any outstanding items needed to process payment.

Invoices are sent to: IDBinvoices@bphc.org

C. Cost Reimbursement

a. Appropriate supporting documents for monthly cost reimbursement invoices include:
    - Payroll registers and labor distribution reports
    - Purchase requisitions accompanied with vendor invoice copy

- Cancelled checks
- Copies of vendor invoices
- Copies of reimbursement/voucher forms

b. The budget on the invoice must show the exact **approved contract budget**. The name of each staff member must be noted next to each position on the invoice. Actual monthly payroll expenses paid (**not accrued**) are billed on the invoice. The year-to-date amounts in the "Cumulative" billing column must be correct. Also, the salaries and FTE's which are billed must correspond to the approved contract budget. If any of these are incorrect on an invoice, it will not be processed. A budget revision request and/or revised invoice may be submitted.

c. The fringe rate must be the agency's internal audited fringe rate, with a maximum of 62%. Verification of this rate is subject to audit (Fringe is defined as: government mandated and employer selected employee benefits including social security; unemployment, workers and disability compensation, retirement programs, and health insurance).

d. Indirect costs are funded at a maximum of 15% of the total direct program costs. Only agencies with a certified HHS-negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certification of Indirect Costs may use indirect costs. Indirect costs are all expenses not directly associated with a specific program, which are necessary for the management of the whole agency. It may include space, management, clerical and support personnel, office materials, leasing of office equipment, advertising, postage, printing, insurance and other related expenses.

   If the agency has never before had a negotiated indirect cost rate, the agency may utilize the de minimis rate, up to the 15% cap noted above. Agencies using administrative costs, which may include but are not limited to indirect costs, must still adhere to the current 15% cap. All administrative costs must be itemized in the agency's budget.

   Please Note: The calculation of administrative costs is not related to the de minimis indirect costs rate. The de minimis indirect cost rate may be used by any non-federal entity that has never received a negotiated indirect cost rate. When applying the de minimis rate, costs must be consistently charged as either direct or indirect costs and may not be double charged or inconsistently charged as both. The de minimis rate does not require documentation to justify its use.

e. Vehicle mileage is reimbursed according to the IRS rate and current BPHC policy. Vehicle mileage reimbursement is restricted to travel within the City of Boston. Parking and tolls can only be reimbursed if there is a receipt.
f. Meal's consumption must be related to program activities and must specify the function or purpose on the receipt and include a copy of the sign-in sheet.
g. Supplies, equipment, etc. must be accompanied by a copy of the original vendor invoice and proof of payment. Also, the agency must specify if they are requesting reimbursement for a portion of the invoice and where the remaining portion of the bill is being charged to.
h. Project funds may not to be used to pay City citations, tickets, taxes or fines. BPHC will not reimburse these items' costs.

D. Fiscal Compliance

a. An agency may be held in non-compliance at the end of each month if they do not meet the invoicing requirements. This includes non-submission of invoices, or late invoices. If the invoice is incorrect and/or incomplete, it will be returned to the agency and the agency will be required to submit new corrected information.
b. Contract expenses, as shown on invoices, are reviewed each quarter of the fiscal year. Agencies are expected to spend at least 25% of the program's annualized budget each quarter (based on the program's actual expenditures). The agency is informed after the first quarter, in writing, of any under billing. Chronic underbilling may result in a reduction in the total award amount of the contract.
c. On a case-by-case basis: Contract spending may differ from each personnel line item by no more than 10% monthly, for example if you are projected to bill a monthly salary of $500 (annual salary of $6000), you may spend up to $550 within that line per month (therefore, cannot exceed $6600 annually) with the sufficient back up. For Other Direct Costs items, e.g. if you are budgeted for a $1000 office supply line for the year, you may spend up to $1100 within that line (you may bill this in one month or it may be divided between several months). Both of these stipulations are as long as the total amount billed does not exceed the budget's maximum obligation. Overspending will not be reimbursed.
d. Funds awarded in one fiscal year may not be used in a subsequent fiscal year.

E. Audits

Agencies that expend $1,000,000 or more in Federal awards during a fiscal year must have a **Single Audit** of their financial records conducted in accordance with the 45 CFR Part 75 Subpart F. Agencies that expends less than $1,000,000 in Federal awards for the fiscal year are exempt from the Federal audit (**Single Audit**) requirement for that year; however, their complete financial records must be available for review or audit by appropriate officials of the Federal agency, pass-through entity, and the Government Accountability Office (GAO).

All agencies are required to submit their most recent **Single Audit Report** (if applicable) and their **Financial Statement Audit Report with Management Letter** to **AuditReports@bphc.org**, no later than **June 30, 2027**.

If electronic submission is not possible, mail a hard copy of the audit reports to:

Post-Award Grants Director
Boston Public Health Commission
1010 Massachusetts Ave, 6th Floor
Boston, MA 02118

F. Payments

Agency invoices will be paid only by ACH – Direct Deposit. Agencies must enroll for direct deposit at the start of the fiscal year, before the first invoice payment request is submitted. Agencies may request the ACH – Direct Deposit form from their Fiscal Coordinator. Completed ACH – Direct Deposit forms should be sent to the Boston Public Health Commission via **Vendor@bphc.org**.

G. Budget Revisions

Contract budgets are not changed without the approval of the Boston Public Health Commission. A revised budget request in the same format as the contract budget accompanied by a budget justification for each line-item of proposed revisions is required. If the budget revision does not match the most up to date contract budget, it will be returned to the agency. Complete instructions are available under the budget revision section of the HIV/STI Services Division Provider manual. Budget revisions will **not** be accepted after **April 1, 2027.**

H. Budgets

The following is a description of the terms used on agency budgets. Budgets cover a **twelve-month** period and are presented in whole dollars (no cents).

- The “**Direct Cost**” column indicates the position title.
- The “**Personnel**” column indicates the name of the staff person occupying the position. Revisions should be submitted with staff first initial and last name (e.g., J. Smith). Enter “TBH” if the position is currently vacant.
- The “**Salary**” column reflects a Full Time Equivalent (1 FTE total) salary.
- The “**FTE**” column is the percentage of time (carried to no more than **two** decimals) that the position listed is paid for by the grant. To meet audit requirements, employees cannot exceed a total FTE of 1.0 across all funding sources.
- The “**Months**” column is the number of months the position listed will be occupied in the contracted period.
- The “**Annual**” column is the total salary amount that will be paid by the grant in a twelve-month budget period for the listed position based on the given “**FTE**” and “**Months**.”
  Annual Salary Calculation: (Salary/12months) x FTE x Months = Annual Salary
- The “**Fringe**” rate must be the agency’s internal audited fringe rate, with a maximum of **62%.** Verification of this rate is subject to audit. Fringe is defined as: government mandated, and employer selected employee benefits including social security, unemployment, workers and disability compensation, retirement programs, and health insurance.
- The “**Other Direct Cost**”, expense line items’ titles should be specific (e.g., Food, Office Supplies, etc.).
- The “HHS Indirect Approved Rate” line item is capped at 15%. Agencies who wish to use an indirect rate must provide documentation of Certificate of indirect costs that is **HHS-negotiated**, signed by an individual authorized to sign on behalf of the agency. Any other Federal or State agency that has conducted and issued an audit report of the agency’s indirect cost rate that has been developed in accordance with the requirements of the cost principles contained in 48 CFR part 31 will also be accepted.
- The “***Administrative Costs”*** line items should be specific. These costs include recognized over-head activities, including rent, utilities, and facility costs. It also applies to the costs of management and oversight of the specific program funded. It includes program coordination, clerical, financial, and management staff not directly related to patient care;

program evaluation; liability insurance; audits; computer hardware/software not directly related to patient care. Administrative Costs are funded at a maximum rate of 15% of the total direct program costs. Agencies are responsible for preparing a project budget that meets administrative cost guidelines and provides expense reports that track administrative expenses.

- The ***"Service Award Total"*** is the sum of the direct care total and the administrative or indirect rate cost total.
- Refer to Table 3-4: Budget Template (Excel format) for a sample budget

PART 13: APPLICATION PROCESS

Applicants are encouraged to review the following process and timelines carefully to ensure timely and complete submission of all required materials.

Bidders' Conference:
A virtual Bidders' Conference will be held to review the RFP and respond to questions from prospective applicants. Applicants must register to participate. Attendance is strongly encouraged.
Date: May 5, 2026
Location: Virtual, click here for registration link

Following the Bidders' Conference, applicants will have the opportunity to submit written questions.

Letter of Intent (LOI):
Organizations interested in applying are strongly encouraged to submit a Letter of Intent (LOI) using the template provided in this RFP.
Date: May 11, 2026
Email to: communityprevention@bphc.org

Questions and Responses:
Applicants are encouraged to submit any questions related to this RFP via email.
Date: May 14, 2026 by 5:00 PM
Email to: communityprevention@bphc.org

Responses to all submitted questions will be compiled and posted on May 20, 2026.

A. General Preparation Instructions

a. Applications must be in English
b. Use 12 pt font size
c. Use one-inch margins on all sides (top, bottom, left, and right).

d. Text should be double-spaced
e. Number all pages of the application consecutively, including tables
f. The application narrative should not exceed **20 pages.** Attachments are additional and **will not** count towards the 20-page narrative.
g. The proposal must be organized in accordance with the RFP Application provided and follow the order of sections outlined in the application.
h. Budgets and Agency Funding tables must be submitted in MS Excel format
i. The full proposal must be submitted as a PDF file. If your organization is not familiar with creating or converting documents to PDF format, you can follow this link to watch a step-by-step instruction video. Applicants are encouraged to reach out with questions if additional support is needed.

B. Submission Instructions

a. The deadline for submitting the proposals is **May 22, 2026 by 5:00 PM**.
b. Submit proposals to RFR@bphc.org and cc: communityprevention@bphc.org
c. There will be no exceptions to the May 22, 2026 by 5:00 PM submission deadline.

C. Review and Selection Process:

All proposals will be reviewed using a standardized evaluation process, including scoring based on established criteria. The review criteria and corresponding point values are outlined in the table below.

Review panels may include BPHC staff and external reviewers, as appropriate. Final funding decisions will be made by BPHC, informed by the review process, with BPHC reserving the right to make final award determinations.

Review Criteria	Possible Points
Section 2: Target Population and Need	15
Section 3: Organizational Capacity	15
Section 4: Program Description	35
Section 5: Quality Assurance Plan	10
Section 6: Process And Outcome Measures Plan	15
Section 7: Budget and Budget Justification	10
Total	100

PART 14: BPHC RIGHTS AND RESPONSIBILITIES

A. Communication:

The Boston Public Health Commission (BPHC) is responsible for all pre- and post-award activities associated with this Request for Proposals (RFP). This includes communication with applicant agencies, oversight and monitoring of all funded projects, and the development of evaluation standards and reporting mechanisms to assess the impact of funded activities.

B. Cancellation:

BPHC reserves the right to cancel this RFP at any time during the proposal review process or prior to award if it is determined to be in the best interest of BPHC or the City of Boston. BPHC also reserves the right to reject any or all proposals. Notice of such cancellation or rejection will be provided to applicants or potential applicants, as appropriate.

C. Insufficient Response:

If BPHC determines that no satisfactory proposals have been received for a particular service, BPHC reserves the right to:

a. Provide the service directly;
b. Negotiate with successful applicants for related services to incorporate the unmet service into an existing scope; or
c. Re-issue (re-bid) the RFP for the specific service area.

D. Debriefings

Following the issuance of award notifications, any applicant may request a debriefing to:

a. Review the RFP process and award summary; and
b. Discuss the basis for funding decisions with BPHC staff.
c. Requests for debriefings must be submitted via email (communityprevention@bphc.org) by **July 1, 2026**, to:
   Idalin Andrades
   Program Director
   Prevention and Early Intervention
   Infectious Disease Bureau
   Boston Public Health Commission
   1010 Massachusetts Avenue, 2nd Floor
   Boston, MA 02118

BPHC will make reasonable efforts to accommodate debriefing requests in a timely manner. Please note that all award decisions are final and not subject to appeal.

PART 15: APPLICATION CHECKLIST

The following checklist outlines all required components of the application. Applicants should use this checklist to ensure that all sections, tables and attachments are complete and submitted in the required order. **Incomplete applications will not be considered**.

APPLICATION NARRATIVE

__________ **Section 1:** Cover Page/Organizational Information
__________ **Section 2:** Target Population(s) and need
__________ **Section 3:** Organizational Capacity
__________ **Section 4:** Program Description including Intervention(s), Goals, Objectives, Activities, and Collaborations
__________ **Section 5:** Quality Assurance Plan
__________ **Section 6:** Process and Outcome Measures Plan
__________ **Section 7:** Budget and Budget Justification

TABLES (Tables are **<u>in addition</u>** to the 20-page limit for the application narrative)

__________ Table 1: Organization Diversity Form
__________ Tables 2.1-2.3: Target Population
__________ Table 3: Organization Partnership
__________ Table 3-4(as applicable): Budget Template, Excel format

ATTACHMENTS (Attachments are **<u>in addition</u>** to the 20-page limit for the application narrative)

__________ Cover Page
__________ Certificate of Authority
__________ Verification of 501 (c) (3) status
__________ Verification of SAM.gov registration status
__________ Resumes for all key staff roles involved in program implementation
__________ Memorandum of Understanding (MOU) or similar agreement outlining the roles and responsibilities of all partner organizations (if applying in partnership).
_________ Budget Justification

Signature of individual authorized to sign contracts for agency as noted on the Certificate of Authority:

Name: ________________________________

Signature: _____________________________ Date: ____________________

PART 16: COMMUNITY-BASED PREVENTION RFP APPLICATION

The following section is intended to guide applicants in describing their proposed program, the populations to be served, and the approach to delivering services.

Applicants must **complete all sections** of the application narrative in accordance with the guidance provided under each section and ensure responses are aligned with their proposed activities. Responses should be clear, focused, and provide sufficient detail to describe the proposed work.

Applicants are also required to submit a complete budget and budget narrative, along with all required attachments as outlined in this RFP. **Incomplete applications will not be considered.**

Section 1: Cover Page/Organizational Information

Applicants must complete the Cover Page included in this RFP and submit it as part of their application. The Cover Page captures required organizational and contact information and must be signed and completed in full. Below is a list of some of the elements that are required on the cover page:

- Organization name
- Contact person (name, title, email, and phone number)
- Executive Director Contact information (name, email, and phone number)
- Organization address
- FIN#
- Partnering organization(s), if applicable
- Lead agency (if applying in partnership)
- 501(c)(3) status or fiscal sponsor (if applicable)
- SAM.gov registration status

Required Attachment(s):

a. Cover Page
b. Certificate of Authority
c. Verification of 501 (c) (3) status
d. Verification of SAM.gov registration status
e. Table 1: Organization Diversity Form

Section 2: Target Population and Need

Describe the population(s) your program will serve and the specific needs your proposed activities will address.

Your response should address:

A. **Who you will serve**
    - Key characteristics of your target population(s), as applicable (e.g., age, gender identity, sexual orientation/behavior, race/ethnicity, language, place of birth, or risk factors)

B. **Where services will be delivered**
   - Boston neighborhood(s) or settings your program will focus on

C. **Estimated reach**
   - Approximate number of individuals you expect to serve each year

D. **Why this population**
   - A brief explanation of why this population is a priority for your program (this may be based on your experience, community knowledge, or available data)

E. **Barriers and needs**
   - Key challenges or barriers faced by the population(s) (e.g., access to care, stigma, language, housing instability, behavioral health needs)
   - How your program responds to those needs

Required Attachment(s):

a. Tables 2.1-2.3: Target Population

Section 3: Organizational Capacity

Describe your organization's experience and capacity to implement the proposed program.

Your response should address:

- Experience working with the target population(s) described above
- Relevant services or programs your organization has implemented
- Existing partnerships or collaborations that support this work
- Staff roles or team structure that will support program implementation
- Organizational strengths that position you to carry out the proposed activities

Required Attachment(s):

a. Table 1: Organization Diversity Form
b. Resumes for all key staff roles involved in program implementation

Section 4: Program Description

Describe your proposed program, including the interventions, goals, activities, and partnerships that will support the delivery of services to your target population(s).

A. **Intervention(s)**

Identify the intervention(s) or services you propose to deliver and explain why they are appropriate for your target population(s).

Your response should address:

- The name and type of intervention(s) or services
- Why these approaches are appropriate for the population(s) you intend to serve

- Any relevant evidence, experience, or rationale that supports your approach
- How the proposed intervention(s) will incorporate or connect participants to biomedical prevention strategies (e.g., PrEP/PEP, HIV/STI testing, vaccination, or treatment services)

B. Goals

Describe the primary goals of the proposed intervention(s) in terms of the intended prevention impact for program participants.

Your response should address:

- The intended outcomes for participants (e.g., behavior change, risk/harm reduction, increased testing, initiation or uptake of biomedical prevention such as PrEP/PEP, improved access to health care services)
- How these goals respond to the needs identified in Section 2

C. Objectives

Describe the specific and measurable objectives that will support your program goals.
Your response should address:

- Quantifiable targets (e.g., number of individuals reached, number of services delivered, number of referrals made)
- How these objectives relate to your proposed activities

D. Activities

Describe how you will deliver the proposed intervention(s).
Your response should address:

- Where services will take place (e.g., health center, community settings, mobile unit, virtual)
- Days, hours, and locations of activities
- Frequency and duration of services
- Key staff roles involved in program implementation

E. Partnerships (to be completed by Agencies applying in "Partnership")

If applying in partnership, describe the structure of the partnership and how it will support your program in meeting the prevention and health care needs of your target population(s). For any agencies applying as a partnership, one agency must be identified as the lead agency and the lead agency must be the fiscal conduit for the partnership. **If you are not applying in partnership, skip this and move to part F.**

Your response should address:

- The lead agency and all partner organizations included in the application
- The role and responsibilities of each partner organization
- How the partnership will support program implementation and service delivery
- How the lead agency will ensure communication and coordination across partners in meeting BPHC requirements

Required Attachment(s):

a. Memorandum of Understanding (MOU) or similar agreement outlining the roles and responsibilities of all organizations in the partnership.
b. Table 2: Organization Partnership

F. Collaborations

Describe any collaborations that will support service delivery, even if your organization is not applying as part of a formal partnership (see Part E). For the purposes of this section, “collaboration” refers to coordination with other agencies without a fiscal relationship. Collaborating organizations are not subcontractors or partners but have agreed to work together to support and advance the goals of the initiative.

Your response should address:

- Key organizations you will collaborate with (e.g., clinical providers, community-based organizations)
- The role of each collaborating organization in supporting prevention, testing, treatment, or linkage to care
- How these collaborations will support access to services for your target population(s)

G. Reporting

Confirm your ability and willingness to report program data and submit narrative reports as outlined in the Reporting Requirements in the Program Rules section of this RFP.

Section 5: Quality Assurance Plan

Describe your organization’s approach to ensuring the quality and consistency of services delivered.

Your response should address:

- Staff training and ongoing support related to program delivery
- Supervision and oversight of staff (e.g., observation, feedback, or coaching)
- Processes for reviewing program data and making improvements, as needed
- Methods for gathering and incorporating participant feedback (e.g., satisfaction surveys or informal feedback)

- How your organization ensures services are delivered in a respectful and participant-centered manner.

Section 6: Process And Outcome Measures Plan

Describe how your organization will track and assess both the implementation and effectiveness of proposed activities.

Your response should address:

- Process measures (e.g., number of individuals reached, services delivered, or referrals made)
- Outcome measures (e.g., changes in knowledge, engagement in services, linkage to care, or uptake of prevention strategies)
- The tools or methods you will use to collect this information (e.g., sign-in sheets, referral tracking, brief pre- and post-activity questions or surveys)
- How your proposed measures are feasible and appropriate to the scope of your activities
- How data will be used to inform or improve program activities

Section 7: Budget and Budget Justification

Applicants must submit a complete budget and corresponding budget justification that clearly describes how requested funds will support the proposed program activities. Budget and Budget narrative are **in addition** to the 20-page limit for the application narrative.

To support budget development, two sample budget templates are provided. One sample reflects a budget that includes a federally negotiated indirect cost rate. The second sample provides a fully itemized (line-item) budget for organizations that do not have a negotiated indirect cost rate. Applicants should use the format that best aligns with their organization's fiscal structure.

Budget templates are provided in Excel format, and applicants must submit their budget using the Excel template provided.

For additional guidance on allowable costs and budget requirements, applicants should refer to the Fiscal Rules section of this RFP (HIV/STI Fiscal Requirements).

Your response should Include:

- A complete budget using the appropriate Excel template provided
- A budget narrative that explains each cost and how it supports the proposed activities
- Alignment between the budget, budget narrative, and the proposed program activities
- Consistency with the requirements outlined in this RFP

Required Attachment(s):

- **a.** Table 3-4: Budget Template, Excel format
- **b.** Sample Budget Justification

Section 8: Tables

Applicants must submit all required tables listed below as part of their application. Tables are **in addition** to the 20-page limit for the application narrative.

A. Table 1: Organization Diversity Form
B. Tables 2.1-2.3: Target Population
C. Table 3: Organization Partnership/Collaboration

Section 9: Attachments

Applicants must submit all required attachments listed below as part of their application.

Attachments are **in addition** to the 20-page limit for the application narrative.

A. Certificate of Authority
B. Verification of 501 (c) (3) status
C. Verification of SAM.go registration status
D. Resumes for all key staff roles involved in program implementation
E. Memorandum of Understanding (MOU) or similar agreement outlining the roles and responsibilities of all partner organizations (if applying in partnership).

Section 10: Post-Award Documentation

The following documents are **not required at the time of application submission**. This information is provided so applicants can understand and plan for requirements that will be requested if selected for funding.

Applicants are strongly encouraged to review the list below to determine their readiness to meet contracting requirements if awarded.

A. Business Profile
B. Available Appropriation
C. Board of Directors list
D. Organizational Chart
E. BPHC Business Associate Agreement
F. BPHC Living Wage Agreement
G. Certificate of Non-Collusion
H. Job descriptions for positions supported by this proposal
I. Evidence of General Liability and Workers Compensation Coverage

FY 2027: Community-Based Prevention
HIV, STIs, Mpox, and Hepatitis C

Letter of Intent

A Letter of Intent is strongly encouraged if an agency intends to apply for funding, however, it does not bind or act as a commitment to submit a proposal .

Legal Name of Applicant Organization: ____

Address: ____

City, State, Zip: ____

Telephone: ____

Executive Director Name: ____

Phone Number: _______________ **E-mail Address:** ______________________________

Please Check here if applying in Partnership: ☐

If Yes, list all Partnering Organizations:

____

____

____

Please indicate the status of the applicant organization:

☐ Organization is a federally recognized 501(c)(3) nonprofit

☐ Registered and active in SAM.gov

☐ Organization is located in the City of Boston

☐ Organization is serving City of Boston Residents

Authorized Signature as noted on the Certificate of Authority:

Name: ______________________________ Signature: ________________________

Title: ______________________________ Date: ______________________________

FY 2027: Community-Based Prevention
HIV, STIs, Mpox, and Hepatitis C

Cover Page

Legal Name of Applicant Organization: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________________

FIN#: ______________________________

Name of Person Submitting this Application: ______________________________

Phone Number: ____________ **E-mail Address:** ______________________________

Executive Director Name: ______________________________

Phone Number: ____________ **E-mail Address:** ______________________________

Please Check here if applying in Partnership: ☐

If Yes, list all Partnering Organizations:

____

____

____

Please indicate the status of the applicant organization:

☐ Organization is a federally recognized 501(c)(3) nonprofit

☐ Registered and active in SAM.gov

☐ Organization is located in the City of Boston

☐ Organization is serving City of Boston Residents

Submission of the proposal and signature below indicates the intention of the applicant to comply with the goals, guidelines, and other elements of the request for proposal

Authorized Signature as noted on the Certificate of Authority:

Name: ______________________ Signature: ______________________

Title: ______________________ Date: ______________________

FY 2027: Community-Based Prevention
HIV, STIs, Mpox, and Hepatitis C

Table 1: Organization Diversity Form

This form is intended to provide a general overview of the diversity of your organization's workforce, including paid staff, leadership, and volunteers. BPHC is committed to advancing health equity and supporting programs that are culturally and linguistically responsive to the communities they serve.

Information provided in this form will help assess the extent to which an organization's staff and leadership reflect the populations they intend to reach, and their capacity to deliver services in a manner that is responsive to the cultural, linguistic, and social needs of those communities.

		Paid Staff	**Board of Directors**	**Unpaid Staff/Volunteers**	**Total**
Gender	# Male				
	# Female				
	# Non-Binary				
	Total				
Ethnicity	# Hispanic or Latino/a				
	# Not Hispanic or Latino/a				
	Total				
Race	# American Indian/ Alaskan Native				
	# Asian/Pacific Islander				
	# Black				
	# Multiracial				
	# White				
	Total				

FY 2027: Community-Based Prevention
HIV, STIs, Mpox, and Hepatitis C

Table 3: Organization Partnerships

This form is intended to document formal partnership arrangements included in the proposed program. For the purposes of this RFP, partnerships refer to organizations that are part of a joint application and will contribute to program implementation under the direction of the lead applicant.

Applicants should list all partner organizations included in the application, describe their roles, and indicate whether a Memorandum of Understanding (MOU) or similar agreement is in place. These partnerships should reflect how the proposed program will be implemented and how responsibilities are shared across organizations to support service delivery.

Name of Lead Agency: ____

Subcontracted Agency Name	MOU in Place	Agency Role
	☐ Yes ☐ No	☐ Clinical Partner ☐ Community Partner ☐ Outreach/Engagement Partner ☐ Fiscal Agent ☐ Other(specify): __________
	☐ Yes ☐ No	☐ Clinical Partner ☐ Community Partner ☐ Outreach/Engagement Partner ☐ Fiscal Agent ☐ Other(specify): __________
	☐ Yes ☐ No	☐ Clinical Partner ☐ Community Partner ☐ Outreach/Engagement Partner ☐ Fiscal Agent ☐ Other(specify): __________
	☐ Yes ☐ No	☐ Clinical Partner ☐ Community Partner ☐ Outreach/Engagement Partner ☐ Fiscal Agent ☐ Other(specify): __________
	☐ Yes ☐ No	☐ Clinical Partner ☐ Community Partner ☐ Outreach/Engagement Partner ☐ Fiscal Agent ☐ Other(specify): __________

Note: Organizations applying in partnership must attach a Memorandum of Understanding (MOU) or similar agreement outlining the roles and responsibilities of all organizations in the partnership.

FY 2027: Community-Based Prevention
HIV, STIs, Mpox, and Hepatitis C

Table 2: Demographics of Target Population

Table 2.1: Age grouping of target population

Age Group	Number	Percentage
Under 15		
15-19		
20-29		
30-39		
40-49		
50 and above		

Table 2.2: Gender breakdown of target population

Gender	Number	Percentage
Female		
Male		
Transgender		
Non-Conforming		

Table 2.3: Race of the target population

Race	Number	Percentage
American Indian/Alaskan Native		
Asian/Pacific Islander		
Black/African American		
Hispanic/Latino		
White		
Multiracial		

Sample Budget Justification

CITY OF BOSTON
INFECTIOUS DISEASE BUREAU
FY 2025
JULY 1, 2026 – JUNE 30, 2027
Community Based Prevention
Agency name

Direct Cost

Program Coordinator:
Conduct one-on-one prevention counseling sessions and Group Level Interventions with high-risk individuals. Coordinate street and neighborhood outreach activities.

Program Coordinator:
Conduct one-on-one prevention counseling sessions and Group Level Interventions with high-risk individuals. Coordinate street and neighborhood outreach activities.

Program Coordinator:
Conduct one-on-one prevention counseling sessions and Group Level Interventions with high-risk individuals. Coordinate street and neighborhood outreach activities.

Peer Leader:
Co-Facilitates Group Level Interventions with Program Coordinator, required as part of the curriculum chosen for this intervention.

Fringe:
Government mandated and employer selected employee benefits including social security, unemployment, workers & disability compensation, retirement programs, and health insurance.

Other Direct Cost

Incentive:
Incentives will be used as part of the contract budget to support participant engagement and retention, and encourage uptake of prevention service, helping ensure successful program implementation and outcomes.

Educational Supplies:
Funding will be used to purchase condoms and lubricant for participants as part of the intervention. Funds from this line item will also be used to purchase postcards for supported referrals.

HHS Indirect Approved Rate /Administrative Cost

15% Indirect Expenses:
Funds which contribute to the costs of running the program, such as office rent, liability insurance, etc. This line is not intended to cover all program-related expenses.

*** Note: If your agency does not have a negotiated rate, include all relevant line items under administrative costs in your budget and provide justification for each item.**

Infectious Disease Bureau
Education & Outreach

Agency:______________

Certificate of Authority

(For Corporations Only)

__________________, 20__
(Current Date)

At a meeting of the Directors of the ______________________________________
(Name of Corporation)
duly called and held at ____
(address)
on the ______________ day of _________________________, 20___, at which a

quorum was present and acting, it was VOTED, that ______________________________
(Name)
the ____ of this corporation is hereby
(Office)
authorized and empowered to make, enter into, sign, seal and deliver on behalf of this

corporation a contract for ____
(Describe Service)
with the Boston Public Health Commission, and if required by such contract, a

performance bond in connection therewith.

I do hereby certify that the above is a true and correct copy of the records, that

said vote has not been amended or repealed and is in full force and effect as of this date,

and that ____ is the duly elected
(Name)
____.
(Office)

Of this corporation

Attest

(Affix Corporate Seal) ____
(Clerk or Secretary of the Corporation)

[corpcert.doc]