INTEGRATING MENTAL HEALTH & HIV CARE: CALL FOR APPLICATIONS FOR IMPLEMENTATION SITE PARTNERS

UNT Health
FORT WORTH
INSTITUTE FOR
HEALTH DISPARITIES

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1. Overview

Initiative Summary

This funding is part of the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program. This initiative aims to:

1. Support RWHAP-eligible organizations with implementing interventions that improve mental health and HIV care for people who are not in care or have trouble staying in care.
2. Evaluate how these interventions work using implementation science to understand what is effective and why.
3. Share lessons learned and practical tools so other organizations can adapt and replicate successful strategies.

This initiative is collaboratively led by two main partners: an Implementation Technical Assistance Provider (ITAP) and an Evaluation Provider (EP). The ITAP, University of North Texas Health Science Center at Fort Worth (UNT Health) will fund up to 10 implementation sites.

Funding Information

Funding is available under the UNT Health federal award number: 6 U90HA55065-01-03.

Maximum Award Amount

UNT Health will award up to 10 Implementation Sites. Sites may receive up to $700,000 across the project period of September 1, 2026 - July 31, 2029. This includes:

- Up to $275,000 per year for Years 1 and 2.
- Up to $150,000 for Year 3 to support sustainability and transition activities.

Funding is contingent upon availability of funds and satisfactory progress towards initiative expectations.

Allowable Activities

Implementation sites are expected to adhere to the funding policies and limitations of award number: 6 U90HA55065-01-03. Funding is intended to support activities related to implementing intervention strategies within an integrated HIV and mental health service delivery framework. Allowable activities may include strengthening coordination between HIV and mental health services, supporting implementation of intervention activities, participating in training and technical assistance (TTA), and collecting and reporting required data for the multi-site evaluation.

The final year of funding will emphasize: 1) collaborating on evaluation data analysis and dissemination; 2) sustainability planning; and 3) the integration of intervention strategies into existing organizational workflows and service delivery models to support continued implementation beyond the project period. All funding is contingent upon the availability of funds and satisfactory progress toward project goals and requirements.

Funding Policies and Limitations

Unallowable costs

You cannot use funds under CFA for the following:

- Charges that are billable to third-party payers such as private health insurance, prepaid health plans, Medicaid, or Medicare.
- To directly provide medical or support services (for example, HIV care, counseling, and testing) that supplant existing services.
- Cash payments to intended recipients of RWHAP services.
- Purchase or construction of new facilities, or capital improvements to existing facilities.
- Purchase or improvement to land.
- Fundraising expenses or lobbying activities and expenses.
- Syringe Services Programs that have not received HRSA's prior approval or do not comply with HHS and HRSA policy.
- To develop materials designed to directly promote or encourage intravenous drug use or sexual activity.
- Pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) medications or related medical services. (Please note that RWHAP recipients and subrecipient providers may provide prevention counseling and information to eligible clients' partners—see RWHAP and PrEP Program Letter, November 16, 2021.)
- International travel.

Indirect costs

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

To charge indirect costs, organizations must apply the appropriate rate as follows:

- Organizations with a federally negotiated indirect cost rate must use that rate.
- Organizations without a negotiated rate may apply the de minimis rate of 15% of modified total direct costs (MTDC), in accordance with 2 CFR 200.414(f).

- This rate is 15% of modified total direct costs (MTDC). See % of modified total direct costs (MTDC). See 2 CFR 200.1 for the definition of MTDC. You can use this rate indefinitely.

Program income

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

Eligibility

Applicant Eligibility

Eligible applicants include domestic entities eligible for funding under Ryan White HIV/AIDS Program (RWHAP) Parts A–D of Title XXVI of the Public Health Service (PHS) Act.

The following types of domestic organizations may apply:

- Public and nonprofit private entities.
- State and local governments.
- Academic institutions.
- Local health departments.
- Nonprofit hospitals and outpatient clinics.
- Community health centers receiving support under Section 330 of the Public Health Service (PHS) Act.
- Faith-based and community-based organizations.
- Indian tribes or tribal organizations with or without federal recognition.

For the purposes of this initiative, domestic refers to the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.

Individuals are not eligible for this Call for Application.

Client Eligibility

Clients served under this initiative must meet RWHAP eligibility criteria. This initiative focuses on people with HIV who are out of care or experiencing barriers to retention in care, and who also have mental health conditions.

Timeline

- The anticipated project period spans September 1, 2026, through July 31, 2029.

- **Note:** Awarded implementation sites will be expected to attend a multi-site meeting in the Washington, D.C. area September 29th and 30th, 2026.
- The anticipated Call for Application timeline includes:

Key Dates	Date
Anticipated CFP Release Date	May 1st, 2026
Informational Webinar	May 15th, 2026
Application Due Date	June 15th, 2026
Interview Dates (Top 20 Applicants)	July through August
Expected Award Notification	August 30th, 2026
Anticipated Implementation Start Date	September 1st, 2026

2. About the Initiative

Background

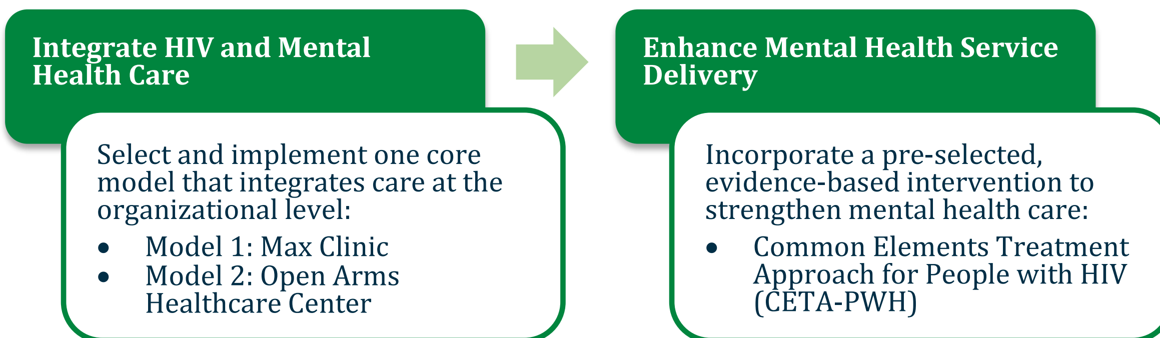
People with HIV are more likely to experience one or more co-occurring mental health conditions compared to people without HIV. Common conditions include depression, anxiety, and post-traumatic stress disorder. Untreated mental health conditions among people with HIV are associated with reduced quality of life and poorer health outcomes, including lower rates of viral suppression and increased mortality.

Mental health also affects whether people stay in HIV care. Approximately 21 percent of people with HIV in the United States were out of care between 2018 and 2020. People who are out of care are more likely to report mental health symptoms as a barrier to accessing or remaining in HIV medical care. They also report poorer overall health and greater unmet medical and mental health needs. It is estimated that approximately 60 percent of HIV transmissions occur among people with HIV who are not engaged in care. These challenges highlight the need for interventions that address mental health as a critical component of HIV care engagement.

Although this initiative focuses on mental health, it is important to recognize that mental health conditions often occur within a broader context of stigma, structural barriers, and social drivers of health that affect people with HIV. These factors can influence an individual's ability to access and remain engaged in care and may contribute to poorer health outcomes, including lower rates of viral suppression and increased health care utilization. Addressing mental health needs within HIV care settings using an **integrated service delivery framework** is therefore a critical strategy for improving engagement and retention in care and supporting better long-term health outcomes for people with HIV.

Purpose

This initiative aims to strengthen the capacity of Ryan White HIV/AIDS Program (RWHAP) eligible organizations to address the intersection of HIV and mental health through an adapted integrated service framework. Sites will:



Both Max Clinic and Open Arms are comprehensive, client-centered approaches designed to improve health outcomes for people with HIV. Pairing CETA-PWH with these models is designed to improve engagement and retention in HIV care among people with HIV and co-occurring mental health conditions by strengthening coordination between HIV medical care and mental health services.

In addition to implementing these interventions, sites will participate in robust training, technical assistance, and evaluation processes to understand what it takes to implement these interventions within RWHAP-eligible settings, as well as share lessons learned and practical tools so other organizations can replicate successful strategies.

Initiative Partners

Implementation sites will collaborate with the following initiative partners:

- **Implementation Technical Assistance Provider (ITAP):** UNT Health is responsible for selecting up to 10 implementation sites for the initiative and managing funding in line with federal rules. It will also provide and track implementation site technical assistance, work closely with the EP to stay aligned with the evaluation, and lead communication and dissemination efforts,
- **Evaluation Provider (EP):** JSI Research & Training Institute, Inc. is responsible for leading the multi-site evaluation of the initiative and providing evaluation-related technical assistance to implementation sites.
- **HRSA HIV/AIDS Bureau (HAB):** HRSA HAB administers the RWHAP Part F SPNS Program. They are responsible for supporting collaboration among all initiative partners, sharing relevant information and resources, reviewing and contributing to project activities, and helping share best practices with the broader RWHAP community.

Key Definitions

ADAPT-ITT

An eight-phase framework used to systematically adapt evidence-based interventions for a new target population or implementation setting. It emphasizes assessing the needs of the population, selecting and refining an intervention with stakeholder and expert input, training implementers, and pilot testing the adapted approach before broader implementation.

Implementation Science

The study of methods to promote or improve the systematic uptake of effective intervention strategies by public health practice, program, and policy. Intervention strategies may occur at the system, community, organization, and individual levels. Under RWHAP, successful intervention strategies positively impact health and quality of life for people with HIV.

Out of care or experiencing barriers to retention in care:

- Newly diagnosed with HIV within the past 12 months, or
- Diagnosed with HIV more than 12 months ago but not fully engaged in care either by:
  - Not attending at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year.
  - Being at risk of disconnecting from care by missing their last appointment in the last six months, leaving incarceration, or having another high-risk factor.
  - Not being virally suppressed—defined as having a viral load of 200 copies/mL or more—at the time of enrollment.

Description of Interventions

Max Clinic

Definition	
Max Clinic is a low-barrier, integrated care model designed to engage and retain people with HIV who experience complex psychosocial challenges (e.g., mental illness, substance use, homelessness, trauma). From a clinical perspective, the model is grounded in client centered care and relationship-based engagement. It improves outcomes by embedding HIV care within a multidisciplinary system that coordinates medical, behavioral health, and social services, addressing both clinical and social drivers of disengagement. Max Clinic is defined by core functions that promote consistency in care delivery while allowing flexibility to meet client needs. These elements reflect best practices in engaging high-acuity, high-barrier populations.	
Core Elements	
1. **Multidisciplinary Team-Based Care** A collaborative care model that integrates medical providers, behavioral health clinicians, case managers, and peer navigators. Integrated teams are essential for clients whose mental health and social instability directly impact medical adherence.	• Supports whole-person care by addressing co-occurring mental health, substance use, and medical needs. • Reduces fragmentation and improves continuity of care. • Peer involvement enhances trust, engagement, and cultural relevance.
2. **Intensive Outreach and Engagement** Proactive, persistent outreach to identify and re-engage clients who are out of care. Engagement is	• Uses relationship-centered, individualized engagement strategies. • Emphasizes consistency and trust-building over time.

relational. Repeated, respectful outreach can repair mistrust and support re-entry into care.	• Recognizes disengagement as part of the clinical process rather than failure.
3. Low-Barrier Access to Care Flexible, accessible care delivery designed to reduce systemic and psychological barriers. Reducing barriers decreases shame, avoidance, and dropout—especially for clients with trauma, executive dysfunction, or unstable living conditions.	• Walk-in availability and flexible scheduling. • Simplified enrollment and re-entry processes. • Minimizes punitive or exclusionary policies (e.g., for missed appointments).
4. Adherence Support Individualized strategies to support consistent medication use. Adherence is behavioral and contextual, not just medical. Interventions should address root causes, not just symptoms.	• May include directly observed therapy, regimen simplification, and behavioral interventions. • Addresses underlying barriers such as mental health symptoms, substance use, and cognitive load.
5. Incentive-Based Engagement Use of structured incentives to reinforce engagement in care and treatment adherence. Incentives can support engagement, particularly in high-need populations, but should be paired with efforts to build intrinsic motivation and autonomy.	• Incentives tied to clinic attendance, medication adherence, or health milestones. • Helps offset competing survival needs and reinforces positive behaviors.

Duration and Frequency

Ongoing (not time-limited):
Clients remain in the model long term, with intensity adjusted based on need. Chronic instability and relapse cycles require sustained, flexible support rather than time-limited interventions.

Implementation Settings

Care settings should prioritize accessibility and integration with wraparound services.

- Co-location or close coordination with pharmacy, labs, behavioral health, substance use treatment, and social services.
- Co-located services reduce dropout risk and improve follow-through on both medical and behavioral health interventions.

Staffing Considerations

- Multidisciplinary teams typically include medical providers, case managers, outreach staff, and behavioral health clinicians.
- Higher staff-to-client ratios are recommended due to client complexity and unpredictability.
- Suggested: 1 FTE medical case manager per 20–25 clients (flexible based on acuity).
- Staff should have experience with HIV, mental health, substance use, and community resources, along with strong relational skills.
- Staff capacity, training, and support (including supervision) are critical to prevent burnout and maintain quality care.

Implementation Considerations

Traditional HIV care models often underserve individuals with high psychosocial complexity. Barriers such as housing instability, poverty, trauma, and substance use increase the risk of disengagement.

This model shifts care from compliance-focused to engagement-focused, aligning with client centered principles.

The Max Clinic model addresses these gaps by:

- Prioritizing flexibility over rigidity.
- Embedding behavioral health and social care into medical services.
- Using adaptive, patient-centered approaches.

Successful implementation requires:

- Organizational commitment to low-barrier, non-punitive care.
- Flexible funding and resource allocation.
- Strong community partnerships.

Citations

Dombrowski, J. C., Ramchandani, M., Dhanireddy, S., Harrington, R. D., Moore, A., & Golden, M. R. (2018). The Max Clinic: medical care designed to engage the hardest-to-reach persons living with HIV in Seattle and King County, Washington. *AIDS Patient Care and STDs, 32*(4), 149-156. https://pmc.ncbi.nlm.nih.gov/articles/PMC5905858/pdf/apc.2017.0313.pdf.

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Open Arms

Definition
Open Arms is an integrated, patient-centered care delivery model that supports improved HIV outcomes through coordinated provision of HIV primary care, behavioral health services, medication adherence support, and wraparound social services. From a clinical provider perspective, the model prioritizes timely engagement in care, rapid initiation or continuation of antiretroviral therapy (ART), and proactive identification and management of psychosocial and structural barriers that may impact retention in care and viral suppression.
Core Elements
1. **Case Management:** A structured clinical support function for assessing patients’ medical, psychosocial, and service needs, with coordinated referrals, follow-up, and care transitions. In practice, case managers collaborate closely with providers to deliver individualized care coordination, facilitate access to services, monitor patient progress, and promote continuity across HIV care, behavioral health, and supportive services.
2. **Rapid HIV Primary Care Initiation:** A clinical workflow that enables immediate or expedited linkage to HIV care, including prompt medical evaluation and rapid initiation or continuation of ART when clinically indicated. Providers play a central role in ensuring timely treatment decisions and reducing delays in care engagement.

3. **Behavioral Health Care:** An integrated clinical process for routine screening, assessment, and management of mental health and substance use conditions. Providers either deliver treatment directly or coordinate closely with behavioral health specialists to ensure timely access to care that supports adherence and sustained engagement.
4. **Adherence Support:** A structured, often pharmacist-supported intervention focused on optimizing ART adherence. From a provider standpoint, this includes patient education, counseling, management of side effects, evaluation of drug interactions, and reinforcement of strategies to incorporate treatment into daily routines. At minimum, providers ensure systematic identification and resolution of adherence barriers and ongoing treatment support.
5. **Social Support Services:** A coordinated approach to addressing social needs that impact clinical outcomes. Providers and care teams facilitate connections to services such as transportation, nutrition support, housing assistance, and legal resources to reduce barriers to consistent care engagement.

Duration and Frequency

Ongoing (not time-limited):
Clients receive multidisciplinary services from all components within the model with no set time limit to service provision. Client needs determine the intensity and frequency of service provided.

Implementation Settings

Care settings should prioritize accessibility and integration with wraparound services.

- Co-location or close coordination with pharmacy, labs, behavioral health, substance use treatment, and social services.
- Co-located services reduce dropout risk and improve follow-through on both medical and behavioral health interventions.

Staffing Considerations

- Multidisciplinary teams typically include medical providers, case managers, outreach staff, and behavioral health clinicians.
- Staff should have experience with HIV, mental health, substance use, and community resources, along with strong relational skills.
- Pharmacist-led adherence support is emphasized in this model. Close coordination with pharmacy services is a prominent characteristic for successful implementation of the model

Implementation Considerations

From a clinical implementation perspective, Open Arms functions as a flexible service delivery model	**The Open Arms model addresses these gaps by:** • Coordinating HIV care, behavioral health, and supportive services.

rather than a rigid protocol. Its effectiveness relies on the consistent execution of core clinical and supportive functions, including case management, rapid ART initiation, behavioral health integration, adherence support, and linkage to social services. These functions may be adapted to fit different clinical environments, staffing configurations, and workflows, if care coordination and patient-centered service integration are maintained (Melvin & Gipson, 2019).	• Supporting rapid ART initiation and timely linkage to care. • Providing case management and adherence support. • Allowing flexibility in staffing, workflows, and service delivery. **Successful implementation requires:** • Strong interdisciplinary collaboration. • Access to behavioral health and pharmacy support. • Reliable referral pathways for social services. • Capacity to support rapid treatment initiation. • Clear workflows for care coordination, follow-up, and adherence support.

Citations

Melvin, S. C., & Gipson, J. (2019). The Open Arms Healthcare Center's integrated HIV care services model. *Preventing Chronic Disease, 16*, 180633. https://doi.org/10.5888/pcd16.180633.

Open Arms Healthcare Center. (n.d.-a). *Behavioral health*. https://www.oahcc.org/behavioral-health.

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Mental Health Intervention Adaptation: CETA-PWH

Definition
CETA-PWH is a modular, evidence-based mental health intervention designed to address depression, anxiety, trauma-related symptoms, and other behavioral health conditions among people with HIV. It can be delivered at varying levels of intensity based on organizational capacity, workflow, partnership structure, and client need. CETA-PWH applies a "common elements" framework, selecting targeted cognitive behavioral therapy (CBT) components according to an individual's symptom profile.
Core Elements
1. **Engagement and Education:** A structured approach to orient clients to the link between mental health and HIV care engagement, including clear expectations for participation and available support.
2. **Ongoing Symptom Assessment and Monitoring:** A standardized process for tracking behavioral health symptoms and client progress over time to guide care planning and follow-up.
3. **Behavioral Activation and Coping Support:** Application of practical, evidence-informed strategies to support re-engagement in meaningful activities and strengthen coping when depression, stress, or low motivation impact HIV care.
4. **Cognitive and Problem-Solving Strategies:** Use of structured techniques to address maladaptive thinking patterns, stigma-related distress, and concrete life stressors affecting treatment engagement and retention.
5. **Trauma-Responsive Support:** Identification and management of trauma-related symptoms that may interfere with HIV care engagement, aligned with site capacity and referral resources.
6. **Safety-Responsive Processes:** Established protocols for identifying and addressing acute safety concerns, including suicidality or other immediate behavioral health risks, with appropriate escalation and referral pathways.
Adaptation Considerations for Max Clinic
CETA-PWH can be integrated into Max Clinic's multidisciplinary, low-barrier care model by embedding brief, flexible CBT-informed interventions into team-based workflows, including outreach, walk-in encounters, and adherence support activities. Its modular structure supports delivery by a multidisciplinary team — including peer navigators—and aligns with intensive engagement strategies and incentive-based approaches by addressing underlying behavioral health drivers of disengagement while reinforcing consistent participation in care.
Adaption Considerations for Open Arms
CETA-PWH can be integrated into Open Arms' existing case management and behavioral health workflows by embedding brief, targeted CBT elements into

routine assessment, care coordination, and adherence support activities. Its flexible, modular design aligns with rapid care initiation and multidisciplinary collaboration, allowing providers to address mental health, adherence barriers, and social needs in a coordinated, time-efficient manner that supports sustained HIV care engagement.

Citations

Pence, B. W., Darnell, D., Ranna-Stewart, M., Psaros, C., Gaynes, B. N., Grimes, L., Henderson, S., Parman, M., Filipowicz, T. R., Gaddis, K., Dorsey, S., & Mugavero, M. J. (2024). Provocative findings from a transdiagnostic counseling intervention to improve psychiatric comorbidity and HIV care engagement among people with HIV: A Pilot Randomized Clinical Trial. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 97*(1), 68-77. https://pmc.ncbi.nlm.nih.gov/articles/PMC11315358/pdf/nihms-1991264.pdf.

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3. Program Expectations for Implementation Sites

Selected implementation sites will participate in a 35-month initiative focused on improving engagement in HIV care among people with HIV and co-occurring mental health conditions through an integrated service delivery model. Implementation sites will work closely with the project's ITAP and EP and will participate in required program activities throughout the project period.

During the initiative period, implementation sites will:

Staffing Expectations

At a minimum, you should designate:

- 0.5 FTE responsible for project management and coordination activities, including day-to-day implementation, coordinate participation in technical assistance activities, serve as the primary point of contact with the project team.
- 0.5 FTE responsible for managing data collection and evaluation activities (e.g., evaluator, data manager, coordinator).
    - Evaluation staff will coordinate with the EP, participate in EP-led evaluation training and technical assistance, and maintain regular communication with their assigned EP TA coaches through standing calls.
    - Responsibilities include coordination and implementation of evaluation activities with support from the EP; and managing all aspects of evaluation data, including collection, cleaning, and reporting through REDCap. This includes abstracting clinical HIV outcomes and mental health related data, such as electronic health records and/or internal databases for enrolled participants at specified intervals.

    - **Note: Evaluation staff must remain separate from intervention staff and should not implement intervention activities.**
- Sufficient staffing to implement the selected integrated care model.

Consider dedicating existing staff to this project to support sustainability.

Intervention Implementation Expectations

Your organization will implement and adapt one of the following strategies:

- **Model 1:** Max Clinic and CETA-PWH; integrating CETA-PWH within Max Clinic's service delivery model.
- **Model 2:** Open Arms and CETA-PWH; integrating CETA-PWH within Open Arms' service delivery model.

You should expect to:

- Participate in a structured intervention adaptation process to tailor one of the above intervention strategies to their local context while maintaining alignment with core program components.
- Identify eligible clients and support participation in intervention activities.
- Coordinate HIV care and mental health services to support engagement, retention in care, and continuity of services.
- Maintain fidelity to the core elements of either strategy implemented throughout the duration of the initiative.

TTA Participation Expectations

As part of this initiative, you will receive tailored TTA designed to support and not add burden to your work. TTA is a collaborative resource to help your team strengthen implementation, navigate challenges, and integrate mental health and HIV care into your existing workflows and in ways that are practical and responsive to your setting. Through ongoing, flexible support, TTA will build on your site's strengths while helping ensure high-quality implementation and improved outcomes for the communities you serve. TTA will also support sites in meeting evaluation requirements, including data collection and reporting, in coordination with the Evaluation Provider (EP).

TTA modalities include:

- **Needs and Readiness Assessment** to understand your site's context, strengths, and priorities.
- **Tailored TTA Planning and Implementation Support** aligned with your planned intervention, workflows and overarching goals.
- **Community of Practice** opportunities to connect with and learn from peer sites.
- **Resource Sharing** including tools, templates, and practical guidance.

- **Ongoing TA Support** through coaching, problem-solving, and regular check-ins.

What to Expect from TTA Support

Throughout the project period, TTA will be structured to provide the right level of support at the right time, from initial onboarding to ongoing implementation and continuous improvement. The activities below reflect how support will be delivered over time.

Activity	Description	Frequency, Time, and Format
Getting Started: Building a Strong Foundation		
Project Orientation	Opportunity to orient your team to the project and TA journey	1-hour Virtual
Needs and Readiness Assessment	A collaborative step to understand your site's context and inform a tailored TA plan	30-45 minutes Online/Web-based
Ongoing Implementation Support		
TTA Progress and Support Meetings	Regular check-ins to support implementation, troubleshoot challenges, and track progress	Monthly 1-hour Virtual
Site Monitoring Visit	An opportunity for deeper engagement with your team to review implementation progress, strengthen alignment with core intervention components, and ensure compliance with program requirements. These visits are designed to be collaborative and supportive, with a focus on problem-solving, shared learning, and strengthening implementation in your local context.	Annual 1-1.5 days In-person
Evaluation-focused TTA (led by Evaluation Partner)	Training, coaching, and data support for evaluation activities	Ongoing (monthly check-ins; initial training at project start) Virtual and In-person
As-Needed TTA Support	Flexible, responsive support based on emerging needs	Ad hoc Virtual and/or In-person
Learning, Adaptation, and Peer Connection		
Community of Practice Sessions	Opportunities to connect with peer sites, share experiences, and learn from one another	Timing and frequency will be decided based on the needs of the initiative Virtual
Multisite Meetings (First meeting: September 29-30, 2026)	Initiative-wide meetings designed to support cross-site	Bi-annual 2-2.5 days

Activity	Description	Frequency, Time, and Format
	learning and program improvement	In-person (Washington D.C.)
TTA Feedback and Adaptation Interviews	Structured opportunities to reflect on what's working, identify challenges, and inform ongoing improvements	Quarterly 1-hour Virtual

Implementation sites will participate in required monitoring activities and comply with applicable Ryan White HIV/AIDS Program policies and federal requirements, with support from the project team.

Multisite Evaluation Participation Expectations

Providers at implementation sites are expected to actively support participation in a multisite evaluation assessing both implementation processes and intervention outcomes.

You should expect to:

- Collaborate with the Evaluation Partner (EP) to carry out site-level evaluation activities within clinical workflows.
- Participate in evaluation-related training and technical assistance (TTA) to ensure adherence to protocols.
- Identify, recruit, consent (as applicable), enroll, and conduct follow-up with clients participating in evaluation activities.
- Accurately collect, document, and submit required clinical and evaluation data in accordance with established protocols and timelines.
- Adhere to all data reporting standards, including requirements for data security, client privacy, and confidentiality (HIPAA compliance).
- Comply with Institutional Review Board (IRB) requirements, including completion of necessary documentation and adherence to approved protocols.
- Contribute to the collection and reporting of both client-level data and implementation-related data. This includes documenting clinical workflow integration, adaptations to intervention delivery, barriers and facilitators encountered, and relevant organizational or care delivery context.

Human Subjects Research

The multisite evaluation involves human subjects' research. The evaluation plan, data collection tools, and protocols must receive IRB approval prior to the start of the evaluation activities.

- All program implementation and evaluation staff must complete Human Subjects Research training and submit certificates of completion to the EP.

- Each implementation site must apply for and obtain IRB approval before any participant recruitment may begin. The EP will provide support in obtaining IRB approval. Sites that do not have an IRB may use the EP's IRB. Sites using an external IRB should include any associated costs in their budget.

Implementation of the Multisite Evaluation at the Site-Level

At the start of the project, each implementation site will meet with their EP coaches to review proposed project activities and complete an evaluation capacity assessment and an implementation site evaluation plan. The evaluation plan will outline standard operating procedures for conducting the evaluation at their site and ensure alignment with multisite evaluation goals.

Specific evaluation activities include:

- Recruitment and enrollment of participants in the evaluation.
- Administration of baseline and follow-up data collection with participants.
- Sites may use grant funds for non-cash or non-cash-equivalent incentives for the evaluation, which should be included in the site's budget.
- Adherence to evaluation protocols for multi-site evaluation, including required data collection activities, observing confidentiality and data storage and protection protocols.
- Collaboration with JSI to ensure the site has received IRB approval to begin evaluation.
- Working with the EP to set up and execute data use agreements and/or business associates agreements to allow for data transfer and sharing.
- Development of a system and workflow to obtain informed consent and baseline data from clients prior to any participation in evaluation activities.
- Protocol for secure storage of confidential information, including consent forms.
- Collection and submission of all data through REDCap, a secure, HIPAA-compliant online data collection portal, via direct data entry and/or upload.
- Data collection activities, including administering participant surveys, conducting periodic chart reviews to abstract data, and reviewing and cleaning data prior to submission.
- Program leadership and implementation teams will complete regular organizational assessments, staff surveys, and interviews to provide information on adaptations, facilitators and barriers to intervention implementation.
- Program leadership and staff will collect and submit information and cost data related to delivering the intervention at specified time points.

Multisite Evaluation Client Recruitment and Incentives

Implementation sites may use project funds for **non-cash participant incentives** associated with evaluation activities, consistent with Ryan White HIV/AIDS Program requirements. Cash incentives and cash-equivalent payments are not allowed.

- RWHAP funds may not be used for cash payments to service recipients, including cash incentives or payments for RWHAP services.
- Allowable alternatives include store gift cards, vouchers, coupons, or tickets that can be exchanged for specific goods or services (e.g., food or transportation) that support the goals of the program.
- Store gift cards that can be redeemed at a single merchant or an affiliated group of merchants for program-related goods or services are also allowable as participant incentives.
- Recipients must administer voucher and store gift card programs so that they cannot be exchanged for cash or used for unallowable items and must maintain systems to track disbursed vouchers and store gift cards.
- General-use prepaid cards (cash-equivalent), such as cards with logos for Visa, MasterCard, or American Express, are not allowed, including cobranded cards that carry both a merchant and payment network logo.

Collaboration and Reporting Expectations

You will collaborate with the project team to support successful implementation of the initiative.

You should expect to:

- Participate in regular project meetings and program updates.
- Share implementation experiences, challenges, and lessons learned.
- Document and share implementation procedures, workflows, and processes to support program learning and dissemination activities associated with the SPNS initiative.
- Contribute to dissemination activities designed to share lessons learned and implementation experiences with the broader HIV care community.
- Comply with reporting requirements and other program expectations throughout the project period.
- Submit monthly progress reports and invoices and adhere to all data reporting requirements as outlined by the EP and ITAP.

4. How to Apply for Funding

Call for Applications Process

This Call for Applications is comprised of a multi-step process:

- An application submission.
- Needs assessment survey completed by applicants selected for interview.
- Organizational interviews of the top 20 applicants.

Organizational Interviews

The 10 highest scoring applicants for each intervention will be invited to participate in a virtual interview. Before the interview, selected applicants will complete a brief needs assessment survey to provide additional information about organizational readiness, implementation capacity, staffing, training and technical assistance needs, data and evaluation capacity, and anticipated implementation barriers. Survey responses will be used to guide the interview discussion.

The purpose of the interview is to gain a better understanding of your organization's infrastructure, proposed implementation approach, and experience providing services to people with co-occurring HIV and mental health conditions.

You should expect to:

- Participate in a 90-minute interview approximately between July 1 through July 15.
- Have all key personnel present for the interview, along with at least one clinician (e.g., physician, nurse practitioner, physician assistant, clinical therapist) if they are not already part of key personnel.
- Provide a 15-minute presentation describing your proposed approach to implementing the intervention.
- Be ready to give a short virtual tour of the main location where the integrated care model will be implemented.

Application Completeness and Responsiveness Criteria

Applications will be reviewed to ensure they meet minimum eligibility and submission requirements before continuing through the review process.

Applications will not be considered if:

- They are submitted by organizations that do not meet all eligibility criteria described in this CFP.

- They request funding above the maximum award amount specified in the Funding Information section.
- They are submitted after the application deadline.

Applicants must submit a complete application that includes all components described in this section. Applications should clearly demonstrate the organization's experience, capacity, and readiness to implement intervention activities and fulfill all initiative requirements. Submitted applications will be reviewed and scored according to the criteria outlined below.

There are two distinct methods of applying for this initiative:

- One application for one of two integrated care models.
- One application for both integrated care models.

If you apply for both models, you will be selected for only one. The final decision on which model you will be funded for will be made after the interview process.

Application Format

Applications must be submitted through the project's REDCap application portal. Applicants will enter required application information directly into the REDCap submission form. In addition, applicants must upload a PDF file for the Project Narrative and Required Supporting Documentation.

Your submission should include:

Component	Expectation	Included in page limit?
Abstract	Provide a one-page abstract summarizing your proposed participation in the initiative.	No
Application Narrative	The application narrative may not exceed: • Submission for one model: **12 pages**. • Submission for two models: **15 pages**. Pages should be single spaced with a minimum of .5 margins and 12-point font for narrative sections. Tables may be used with a minimum 10-point font.	Yes
Budget (SF-424A)	Ensure alignment with CFA funding information. Provide separate line-item budgets for each year of the three-year	No

	period of performance, using the Section B Budget Categories of the SF-424A and breaking down sub-categorical costs as appropriate.	
Budget Justification	Provide a detailed budget justification that explains and supports all proposed costs, including personnel, fringe, travel, equipment, supplies, contractual costs, participant support costs, other direct costs, and indirect costs, as applicable. Costs should be reasonable, allowable, and clearly connected to proposed project activities.	No
Biosketches	Include biosketches for key personnel only.	No
Institutional Letter of Commitment	Include a signed letter of commitment from organizational leadership confirming support for the proposed project, participation in required project activities, and commitment to meeting reporting, evaluation, and fiscal requirements.	No
Letters of Commitment from Partners	Only include letters of commitment if you are partnering with a mental health service organization (include a letter for each organization). Letters of commitment should clearly describe the organization's alignment with the project, the specific ways it will support or collaborate, and its commitment to contributing to the success of the proposed activities throughout the grant period.	No

Application Narrative Sections

Statement of Need (15 Points)

Project Narrative Requirements	Our Priorities & Expectations
Describe the need for improved mental health services and engagement in care among people with HIV within the proposed service area. This includes: • Mental health service needs among people with HIV in the proposed service area. • Barriers to engagement and retention in care for people with HIV and co-occurring mental health conditions. • Gaps in services related to coordination of HIV care and mental health services. • How the implemented intervention will support people with HIV who are out of care. • Specific areas within the organization where this funding could support improvements for initiatives aimed at reducing barriers to care and increasing access to services. • How the proposed implementation approach of either strategy will fill gaps identified within the local context. • How the proposed approach goes beyond standard service delivery to improve engagement and retention in HIV and mental health care.	• Statements of need should be specific to the proposed service area, not only a general description of HIV and mental health. • Applicants should use local, organizational, or regional data where available to document need Statements of need should relate to one or more areas: • High incidence rates of HIV and mental health conditions • HIV outcomes that are below national or state benchmarks • Differences in care or outcomes based on patient characteristics • Documented provider shortage areas Please ensure descriptions align with current presidential executive orders.

Organizational Capacity (15 Points)

Project Narrative Requirements	Our Priorities & Expectations
Describe your organization's experience and capacity to provide services to people with HIV and support integrated HIV care and mental health service delivery. Include: **Current organizational service delivery capacity:** • Experience serving people with HIV, including providing HIV-related medical and/or support services. • Capacity to support integrated service delivery that addresses both HIV care and mental health needs. • Relevant wraparound services and supports currently available within the organization. **How clients currently access HIV and mental health services:** • Whether services are provided internally or through formal partnerships • How mental health services are coordinated with HIV care • Engagement and follow-up strategies to support ongoing utilization of care. • Existing barriers within organization's routine healthcare service delivery. **Capacity to participate in the SPNS initiative** • Capacity to implement intervention activities and participate in required training and technical assistance (TTA) and multi-site evaluation activities throughout the project period.	• Provide evidence that your organization maintains a comprehensive range of wraparound services and support that is tailored to client and community need. • Emphasize your understanding of initiative requirements beyond direct service provision. • Identify existing barriers in routine service delivery and explain how the proposed project would strengthen access, coordination, engagement, or retention in care. • Demonstrate that your organization has the staffing, organizational buy-in, leadership support, and operational capacity to participate in required training, technical assistance, multi-site evaluation, reporting, and dissemination activities throughout the project period.

Initiative Description and Implementation Approach (25 Points)

Project Narrative Requirements	Our Priorities & Expectations
Based on the service model(s) you are proposing to implement, describe how intervention activities will be integrated within your existing HIV and mental health service delivery system. Include: **Max Clinic Model Integration & Implementation** Only include if you are applying to implement this model. • Provide an explanation of how the Max Clinic's core service components are currently delivered, along with a plan outlining how any components not presently offered will be implemented. • Provide an explanation of how the CETA-PWH core intervention components are currently delivered, along with a plan outlining how any components not presently offered will be implemented. • Describe how the organization will ensure intervention activities are delivered consistently within routine service delivery. • Detail staffing roles that will support implementation. **Open Arms Model Integration & Implementation** Only include if you are applying to implement this model. • An explanation on how the Open Arms core service components are currently offered. • A plan detailing how the following core components will be implemented if those components are not already offered. • An explanation on how the core components of CETA-PWH are currently offered.	• Provide evidence of an existing integrated HIV and mental health care service delivery system. • Demonstrate a comprehensive understanding of the core components of the integrated care model(s) you are applying for. • Demonstrate that the integrated care model(s) you are proposing align with your existing organizational structure and can be implemented and fully operational on an accelerated timeline. • Ensure all proposed approaches align with funding policies and limitations.

• A plan detailing how the core components of CETA-PWH will be implemented if those components are not already offered. • How the organization will ensure intervention activities are delivered consistently within routine service delivery. • Staffing roles that will support implementation. **Anticipated Organizational Changes and Capacity Needs** • How will either strategy build the organization's capacity to integrate HIV care and mental health services. **Client Recruitment & Engagement** • How eligible clients will be identified and recruited to participate in intervention activities. • Existing barriers within organization's routine healthcare service delivery.	

Multisite Evaluation Participation (20 Points)

Project Narrative Requirements	Our Priorities & Expectations
Describe your organization's capacity to participate in the multisite evaluation. Include: • Experience collecting and managing client-level data related to HIV care or other health programs. • Experience submitting data through systems such as REDCap. ○ If not using REDCap, justify the use of a similar EHR data system. • Experience working with Institutional Review Boards (IRBs) for research or program evaluation activities or plans to work with an IRB for this project. • Proposed staffing plan to support evaluation activities. • Approach for recruiting and enrolling eligible participants into evaluation activities and maintaining follow-up participation. Include in your approach the number of participants you propose to serve.	• Who will be responsible for collecting and submitting evaluation data. • Describe their experience with client-level data collection, program reporting, data quality checks. • Effective and efficient collection, tracking, and maintaining client-level data that is secure and accurate. • How your organization will maintain participant follow-up, reduce missing data, and communicate evaluation-related challenges in a timely manner. • Plans to maintain consistent client enrollment throughout the enrollment period.

Technical Assistance and Capacity Building Needs (15 Points)

Project Narrative Requirements	Our Priorities & Expectations
Describe your organization's technical assistance (TA) and capacity building needs to successfully implement the proposed approach within the project period. Include needs related to: • The integrated care model(s) you are applying for. • Adapting CETA-PWH into your proposed model(s). • Participating in an implementation science-driven multi-site evaluation. • Developing materials that share lessons learned and practical tools to help other organizations adapt and replicate successful strategies. • Anticipated TA needs related to implementing the proposed model and CETA-PWH • Describe TA needs related to implementation planning, workflow development, staff roles, supervision, fidelity monitoring, and documenting adaptations. • Describe TA needs related to participation in a multisite evaluation, including data collection, data submission, participant follow-up • Identify any major organizational barriers that may affect implementation, such as staffing limitations, data system limitations, leadership engagement, competing priorities, or limited experience with federally funded projects.	• Applicants should clearly distinguish between existing organizational strengths and areas where TA or capacity building support is needed. • TA needs should be specific, realistic, and directly related to implementing the proposed intervention, participating in the evaluation, and meeting project requirements. • Applicants should demonstrate that their TA needs are feasible to support through training, coaching, consultation, tools, and structured monitoring.

Sustainability (10 Points)

Project Narrative Requirements	Our Priorities & Expectations
Describe how your organization will sustain intervention activities beyond the project period. Include: • Strategies for sustaining intervention activities after the project period. • Plans for integrating intervention activities into existing programs, services, or funding streams. • Potential funding, billing, reimbursement, grant, partnership, or in-kind support strategies that may support continuation of services. • Plans to use project data, evaluation findings, client outcomes, or lessons learned to support sustainability planning and decision-making. • Organizational commitment to sustaining integrated HIV and mental health service delivery.	• Evidence that the organization has experience managing varied funding streams or identifying new funding opportunities to support ongoing services. • Demonstrated leadership commitment to maintaining integrated HIV and mental health service delivery beyond the grant period. • Realistic plans to embed intervention activities into routine workflows, staffing roles, supervision structures, partnerships, or existing service lines.

Application Review Criteria Summary

Applications will be reviewed using a 100-point scoring system. Reviewers will score applications based on the completeness and quality of responses to the narrative sections outlined in the table below.

Project Narrative Review Criterion	Total Points = 100
Statement of Need	**15**
Organizational Capacity	**15**
Project Description and Implementation Approach	**25**
Evaluation Capacity	**20**
Technical Assistance and Capacity Building Needs	**15**
Sustainability	**10**

Following the scoring process, the project team may also consider additional factors in the final selection of implementation sites, including:

- Geographic distribution across implementation sites.
- Variation in organizational size, structure, and service delivery settings.
- Potential for successful implementation and cross-site learning.

The project team will select up to ten implementation sites through this competitive process. Selected sites will be notified after the review process is completed and may be invited to participate in follow-up discussions to finalize their participation in the initiative.

5. Next Steps and Contact

Application Resources and Next Steps

Organizations interested in applying are strongly encouraged to attend the **informational webinar scheduled for May 15, 2026**, which will provide an overview of the initiative and the upcoming Call for Proposals.

Following the release of the CFP, additional information regarding the application process, including access to the REDCap application portal, will be provided to interested applicants.

CFA Contact Information

Questions regarding this Call for Proposals may be directed to:

ITAP

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Project Director, Integrating Mental Health and HIV Care Across Implementation Sites Initiative
UNT Health
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EP

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Responses to frequently asked questions may be shared with prospective applicants to ensure consistent and accurate information.