

**New York State Department of Health (NYSDOH)  
Updates/Questions and Answers Comprehensive Adolescent Pregnancy  
Prevention (CAPP) Request for Applications (RFA) # 1007301230**

The responses to questions included herein are the official responses by NYS DOH from potential applicants and are hereby incorporated into the RFA # 1007301230 issued on September 13, 2010. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.

**Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA**

1. Section V. G., Page 37, Term of Contract has been modified. "The RFA states on page 37: "It is expected that contracts resulting from this RFA will have the following time period: 1/1/11 through 12/31/11 with four annual renewals depending on performance and availability of funding". In place of annual renewals for Years 2-5, the Department may instead elect to establish a single four-year contract for Years 2-5 of this initiative. Should this occur, awardees will be provided with additional guidance at that time."
2. Attachment 1a: "NYS Pregnancy Rates by ZIP Codes 2006-2008" has been updated to correct the county assignment for several ZIP codes.
3. Attachment 1b: "NYS Teen Birth Rates by ZIP Code 2006-2008" has been updated to correct the county assignment for several ZIP codes.

Please refer to these updated tables for adolescent pregnancy and birth rates by ZIP code. The updates were posted on the NYSDOH's public website on 9-20-10 at:  
<http://www.health.state.ny.us/funding/rfa/1007301230/index.htm>

4. Attachment 3: Comprehensive, Age Appropriate, Evidence-Based, and Medically Accurate Sexuality Education program list has been revised to include evidence-based programs consistent with lists provided by U.S. Department of Health and Human Services, National Campaign to Prevent Teen and Unplanned Pregnancy, and Advocates for Youth.

**Additional Key Information**

Due to numerous questions received on the following topics, the following information is provided to reinforce key requirements in the RFA. Individual questions received on these topics are also addressed in the questions and answers that follow.

1. As stated in Section II. C., page 10-11, for Component A, an organization may submit only one application in response to this RFA – i.e., the same organization may not apply for funding under both Component A and Component B, and may submit only one application for Component A. In the event that an organization submits more than one application in response to this RFA, the Department will contact the applicant to ask them which application they would prefer to be reviewed. An organization that applies for funding under either Component A or Component B may also be included as a partner or subcontractor in another organization's application.

2. As stated in Section II.C. Minimum Eligibility Requirements, page 11, applicants not approved under Article 28 of the Public Health Law to provide family planning services **must** provide a letter from one or more family planning provider serving the targeted community stating their intent to collaborate with the **CAPP** applicant organization/agency. The letter needs to indicate the provider's willingness to accept referrals, including referrals of Medicaid clients; appropriate assessment and referral; ability to provide a full range of medical family planning services; and follow-up agreements. It is expected that family planning providers funded by the DOH will accept referrals.

3. Component A, Core Strategy 1, page 13, requires sexuality education programming for youth ages 10 to 21 years of age which **must** be an evidence-based program chosen from the list provided in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network. In addition, projects are strongly encouraged to incorporate programming for parents, caregivers and other adults in the community, which may not be evidence-based, to provide improved knowledge and communication skills related to adolescent sexual health and risky behaviors.

## **Questions and Answers for the Comprehensive Adolescent Pregnancy Prevention RFA**

### **General Questions for Component A and Component B**

**1. Question:** I am unable to access the full RFA through the funding page of NYSDOH website. Would you be able to send it to me as an attachment?

**Answer:** The CAPP RFA may be found on the NYSDOH web site at:  
<http://www.health.state.ny.us/funding/rfa/1007301230/index.htm>

**2. Question:** I'm contacting you to find out whether it's possible to get a copy of the CAPP application in word format. There is a team of us working on the application and so it would be easier for us to manage it if we can reduce the tasks that we are required to carry out into a condensed version of the whole application. Please let me know if that is possible and thank you for your assistance.

**Answer:** No, the main body of the RFA is only available in a pdf format. Attachments that need to be filed out and submitted as part of your application are available in Word and Excel formats. You may locate the CAPP RFA and the fillable version of these attachments at:  
<http://www.health.state.ny.us/funding/rfa/1007301230/index.htm>

**3. Question:** I would appreciate very much if you can e-mail the budget pages for the new grant application in Excel format.

**Answer:** The budget pages are available in Excel format posted on the NYSDOH's public website along with the CAPP RFA at:

<http://www.health.state.ny.us/funding/rfa/1007301230/index.htm>

**4. Question:** If another question arises after today (following the 10/1/10 Applicant Conference) is there a way we can get it answered or does our opportunity to ask questions end with this conference call?

**Answer:** The deadline for questions was September 30, 2010.

**5. Question:** Will an agency that applies for Component A be disqualified if a different agency applies for Component B but includes the same agency for the purpose of reducing barriers to adolescent access to clinical services? Can an agency be a subcontract on another organization's application?

**Answer:** As stated in the CAPP RFA Section II. C., page 10, an organization may submit only one application in response to this RFA. An organization that applies for funding under either Component A or Component B may also be included as a partner or subcontractor in other organization's applications.

**6. Question:** Are two funding streams being collapsed and is there a reduction in funding?

**Answer:** This procurement combines funding from Community Based Adolescent Pregnancy Prevention and Adolescent Pregnancy Prevention Services, with no anticipated reduction in funding.

**7. Question:** Attachment 1 Figure 3, the data by race and ethnicity, does not have information on Native Americans and Asian Pacific Islanders. I was wondering what the reason was for that omission and can we infer anything from that omission?

**Answer:** Data for these subgroups are not provided because the availability of state data for Native Americans and Asian Pacific Islander populations is limited. You may choose to use national numbers and extrapolate them for your region.

**8. Question:** Why does the document table for Pregnancy Rates state "Teen Pregnancy Rates" (1a)?

**Answer:** Please refer to the Attachment 1a. Footnote which states: Pregnancy rates are the number of births per 1,000 females age 15 to 19 years.

**9. Question:** While reading through the CAPP RFA I see that the applications will be reviewed by a NYSDOH team of reviewers. Does this mean staff only or will you be recruiting peer reviewers as well? If so please let me know how to apply.

**Answer:** Review teams are comprised of Department of Health staff. As stated in the CAPP RFA Section II. F, page 24, applications will be reviewed and scored by a NYSDOH team of trained reviewers using a standardized review tool developed specifically for this RFA.

**10. Question:** I am trying to find the eligibility requirements for this grant.

**11. Question:** We hope we are eligible for the grant for CAPP. We are a family practice office for 30yrs. How do we proceed?

**Answer** to Questions 10 & 11: The eligibility requirements are stated in the CAPP RFA, for Component A in Section II. C., page 10-12, Requirements and for Component B in Section III.C., page 27-28, Requirements.

**12. Question:** Will the Vendor Responsibility Attestation, Attachment 11c, be made available on the website for applicants to download?

**13. Question:** We are currently a vendor under the APPS Program. Do we need to submit another Vendor Responsibility Form with this application?

**Answer** to Questions 12 & 13: As stated in the CAPP RFA Section V. I. page 38; Vendor Responsibility Questionnaires need to be completed by all applicants, either on-line or via paper. Both formats can be accessed via the website(s) as stated in the RFA on page 38.

**14. Question:** Program accessibility requirement – that it be accessible to all people with disabilities. Our programs operate in some schools which are not disability accessible. Do we have to not operate then in those schools?

**Answer:** If educational programs are provided at schools that are not accessible, the applicant needs to ensure that students with disabilities at that school have access to the same educational programs in the most integrated setting possible.

**15. Question:** Our agency is exploring becoming a VISTA sponsorship. Can we use this funding towards a VISTA placement?

**Answer:** The requested funding needs to be consistent with the proposed scope of services and be reasonable and cost effective. CAPP funds cannot be used to replace funds available from other resources.

**16. Question:** Can we have a listing of current Community Based Adolescent Pregnancy Prevention (CBAPP) and Adolescent Pregnancy Prevention Services (APPS) providers across the state?

**Answer:** Current CBAPP and APPS providers are listed below.

**Adolescent Pregnancy Prevention and Services Providers:**

Allegany County Community Opportunities and Rural Development, Inc.

Board of Cooperative Education Services for the Second Supervisory Dist. Of Sullivan County

Buffalo Federation of Neighborhood Centers, Inc.

Community Counseling Mediation Services

CAMBA, Inc.

Catholic Charities Neighborhood Services, Inc.

Catholic Charities of Cortland

Chautauqua Opportunities, Inc.

City of Rochester

Claremont Neighborhood Centers, Inc.

Columbia Opportunities, Inc.  
Community Action of Orleans and Genesee Inc.  
Girls Incorporated of the Greater Capital Region, Inc.  
Loisaida, Inc.  
Maternal-Infant Services Network of Orange, Sullivan and Ulster Counties, Inc.  
Mothers & Babies Perinatal Network of South Central N.Y., Inc.  
North Country Prenatal/Perinatal Council, Inc.  
New York Council of Nonprofits, Inc.  
Oswego County BOCES  
Planned Parenthood of New York City, Inc.  
REACH CNY, Inc  
Saint Johns Riverside Hospital  
Suffolk Network on Adolescent Pregnancy, Inc.  
The National Sorority of Phi Delta Kappa Beta  
Young Women's Christian Association of Ulster County, Inc.

**Community Based Adolescent Pregnancy Prevention Providers:**

Charles B. Wang Community Health Center, Inc.  
Children's Aid Society  
City of Rochester Bureau of Youth Services  
Committee for Hispanic Children and Families, Inc  
Community Healthcare Network  
Diaspora Community Services Inc. /Haitian Women's Program Inc.  
Harlem RBI Inc.  
Hudson Headwaters Health Network  
Hudson River Healthcare  
Inwood House, Inc.  
Long Island Jewish Medical Center / Schneider Children's Hospital  
Maternal-Infant Services Network of Orange, Sullivan and Ulster Counties, Inc.  
Mount Sinai Adolescent Health Center  
Native American Community Services  
New York Presbyterian Hospital  
North Country Prenatal/Perinatal Council, Inc.  
NYCHHC Harlem Hosp  
Planned Parenthood Hudson Peconic  
Planned Parenthood Mid-Hudson Valley  
Planned Parenthood Mohawk-Hudson  
Planned Parenthood Nassau County  
Planned Parenthood of New York City  
Planned Parenthood Rochester/Syracuse  
Planned Parenthood South Central  
Planned Parenthood Southern Finger Lakes  
Planned Parenthood Western New York  
REACH CNY, Inc.  
Suffolk Network on Adolescent Pregnancy, Inc  
St. Barnabas Hospital  
Staten Island University Hospital  
Syracuse Model Neighborhood Facility

The Child Center of NY, Inc.  
Threshold  
Upper Hudson Planned Parenthood  
Urban Health Plan, Inc.  
Wayne County Action Program, Inc.

**17. Question:** When scoring the proposals, will additional points be awarded to agencies receiving funding for APPS and CBAPP in the past or is presently performing programs under APPS?

**Answer:** The criteria for scoring reflects the RFA requirements on page 10-12 for Component A and pages 27-28 for Component B.

**18. Question:** The Suffolk County data for teen births omits Brentwood (11717), a very high impact community. Can someone please give us the data?

**19. Question:** I don't see 14608 in the list of teen pregnancy ZIP codes in the new RFA. 14608 is included in the teen birth and ASHNI list. Can you tell me the teen pregnancy rate for 14608 for 2006 to 2008 so we can keep our web site updated and our members informed? 14608 is a high poverty ZIP code with a large population and high rates of teen birth.

**20. Question:** We have a question on the updated ZIP code data. There are ZIP codes missing from our county's Pregnancy Rate table, which shows up in the Birth Rates table and vice versa. More precisely ZIP codes 10927, 10977, 10923, 10993 and 10974 are missing from the Pregnancy Rate table while ZIP code 10962 appears in our Pregnancy Rate table but not in the Birth Rate table.

**Answer to questions 18, 19, & 20:** Attachment 1a: "NYS Pregnancy Rates by ZIP Codes 2006-2008" and Attachment 1b: "NYS Teen Birth Rates by ZIP Code 2006-2008" have been updated. Please refer to these updated tables for adolescent pregnancy and birth rates by ZIP code. The updates have been posted on the NYSDOH's public website at:  
<http://www.health.state.ny.us/funding/rfa/1007301230/index.htm>

### **Completing the Application**

**21. Question:** We are based at a hospital so although our staff may be representative of our community, our board of directors is not necessarily representative of the community that we serve. Do you have any guidance on how to respond to that as part of our eligibility requirements?

**Answer:** Please refer to page 19 of the RFA, for direction completing the Organizational Experience and Capacity Section of your application.

**22. Question:** What is the required format for the proposal narrative? What are the required font size, margins, and line spacing? Is there a required header?

**23. Question:** As we understand from page 33, the cover page, budget and attachments can all be single spaced while the narrative is to be double spaced. If we embed tables in the narrative, however, can they be single spaced and can we use a 10 point font for those embedded tables?

**Answer to Questions 22 & 23:** Tables may be single spaced, see CAPP RFA Section IV. A., page 33 for formatting requirements.

**24. Question:** Please advise whether the letters of support should be written to the agency that is applying for the funding or if they should be addressed to Carolyn Perry, NYS Department of Health, Bureau of Maternal and Child Health.

**25. Question:** Are letters of support required? If so—where would they go (and do they count in page totals)?

**26. Question:** Are letters of support required and where would they go?

**Answer to questions 24, 25, & 26:** General letters of support are not required but applicants may choose to include them in their applications. Please refer to page 19 of the RFA for specific letter requirement for those applicants that are not approved under Article 28 of the Public Health Law to provide family planning services. Any letters of support may be addressed to the agency applying for funding and should be included as appendices to your application, as noted on page 19 (Component A) and page 30 (Component B) of the RFA.

**27. Question:** Is there a particular format or specific information that should be included in the letters of commitment from project partners?

**Answer:** There is no specific format or information required for general letters of commitment. As stated on pages 14 and 19 of the RFA, Component A applicants who are not approved under Article 28 of the Public Health Law to provide family planning services **must** provide a letter from one or more family planning provider serving the targeted community stating their intent to collaborate with the **CAPP** applicant organization/agency. The letter needs to indicate the provider's willingness to accept referrals, including referrals of Medicaid clients; appropriate assessment and referral; ability to provide a full range of medical family planning services; and follow-up agreements. It is expected that family planning providers funded by DOH will accept referrals.

## **General Budget**

**28. Question:** Is there a required or recommended amount % for "in kind support" in this grant?

**Answer:** There is no in-kind match requirement in this grant, but as stated in the CAPP RFA Section II. C., page 12, preference will be given to applicants that demonstrate in-kind project support. Also, as stated in Section III. E., page 32, in-kind services indicate an organizational commitment to this project. All in-kind contributions to the project should be shown on your budget.

**29. Question:** Budget Table A-1: Should the "incumbent name" column be hidden or showing? It's currently hidden in the spreadsheet and not showing when the RFA is printed.

**Answer:** Incumbent names can be included on Budget Form B-1.

**30. Question:** Who needs to attend the two-day providers' meeting in Albany, program and finance representatives? (Application Content Component A, Budget and Staffing Plan, c) Administrative Expenses p. 23 of RFA)

**Answer:** There is no specific requirement on who from an organization attends the meeting. The topics discussed at these meetings are most relevant to the project director and a fiscal representative.

## **Component A: Comprehensive Adolescent Pregnancy Prevention (CAPP) Community-Based Initiative**

### **Eligibility**

**31. Question:** Minimum requirements of applicants- we are not an approved Article 28, so we must provide a letter from the family planning provider that is approved under Article 28 to offer these services, right? Do they have to prove that they are an Article 28 by sending in proof that they are licensed to provide these services in addition to the letter describing what they do?

**32. Question:** For an applicant who is not an Article 28 family planning service provider, do each of the family planning service providers providing a letter have to be an approved Article 28 provider?

**33. Question:** When you are talking about a large rural county that has two Article 28 clinics, one serving half the county and the other one serving the other half of the county and it is over an hour drive, do both article 28 clinics have to be involved?

**34. Question:** What if there are competing applications from the Article 28 family planning provider and another applicant and the family planning provider will not give that letter?

**Answer to questions 31, 32, 33, & 34:** As stated in Section II. C., page 11, applicants not approved under Article 28 of the Public Health Law to provide family planning services **must** provide a letter from one or more family planning provider serving the targeted community stating their intent to collaborate with the **CAPP** applicant organization/agency. The letter needs to indicate the provider's willingness to accept referrals, including referrals of Medicaid clients; appropriate assessment and referral; ability to provide a full range of medical family planning services; and follow-up agreements. If you choose to establish referral agreements with more than one provider, all must meet the criteria listed in the RFA. It is expected that family planning providers funded by DOH will accept referrals.

**35. Question:** Regarding the Article 28 provider -Is it required under the application to have a sub-contracting relationship? Or is that a choice of the lead applicant?

**Answer:** It is the choice of the lead applicant, a sub-contract is not required, but we do require the letter from the Article 28 provider saying that they will accept referrals.

**36. Question:** Is there any degree of oversight or supervision required of us regarding the Article 28 providers?

**37. Question:** If we subcontract or refer out for family planning services, will that program need to be audited by DOH as well as the lead agency?

**Answer to questions 36 & 37:** DOH does not audit sub-contractors. Article 28 providers have their own standards of operation. If you subcontract with them, you have a fiscal oversight responsibility as well as assuring they are meeting their program deliverables. Please note as stated on page 15 of the RFA that this initiative does not fund direct clinical/medical/laboratory services and supplies.

**38. Question:** On page 11, it states that there must be a collaborative agreement with a family planning office that serves that targeted community. Define “serves that targeted community” as it relates to proximity to that community.

**Answer:** Serves refers to the target community, intent to collaborate and a willingness to accept referrals, including referrals of Medicaid clients; appropriate assessment and referral; ability to provide a full range of medical family planning services; and follow-up agreements.

**39. Question:** Is the referral entity for family planning services required to accept both male and female patients?

**Answer:** Yes.

**40. Question:** Our potential program will operate under a health center provider sponsored by a hospital. Based on their current Article 28 provider status, the health center will not be able to provide a letter as they have no plans to collaborate with other family planning providers. In accordance with the CAPP guidelines, is our potential program still eligible to apply without the letter based on the health center’s Article 28 provider designation through the hospital? In other words, is the legal organization with Article 28 provider status only allowed to apply if the CAPP applicant has no plans to collaborate with other family planning providers?

**Answer:** Applicants not approved under Article 28 of the Public Health Law to provide family planning services **must** provide a letter from one or more family planning provider serving the targeted community stating their intent to collaborate with the **CAPP** applicant organization/agency. The letter needs to indicate the provider’s willingness to accept referrals, including referrals of Medicaid clients; appropriate assessment and referral; ability to provide a full range of medical family planning services; and follow-up agreements. Applicants that are themselves approved under Article 28 to provide family planning services and who will provide such services to individuals referred by their CAPP program do not need to submit a letter.

**41. Question:** I am writing to seek your assistance in determining whether our agency is eligible to apply for the CAPP grant (Component A). We are a non-profit 501 (c) (3) organization and not a health facility licensed under Article 28 of the NYS Public Health Law.

**Answer:** See page 11 of the RFA for eligibility requirements. Applicants not approved under Article 28 of the Public Health Law to provide family planning services must include a letter from one or more family planning providers serving the targeted community stating their intent to collaborate with the CAPP applicant's organization.

## **Project Requirements**

**42. Question:** On page 18 it asks us to identify health disparities. Does this refer to any health disparity or only those related to sexual health?

**Answer:** Applicants should identify general disparities in the community, with a focus on 10-21 year olds.

**43. Question:** For Component A: Description of Project Narrative (Page 20) is not consistent with the list in Attachment 7A, after Community Needs and Resources Assessment is Proposed Activities. Should it be Description of Project Narrative? Where does the Work Plans go?

**Answer:** Attachment 7a is a reminder checklist, not a requirement of the RFA. The CAPP RFA, Section IV. A., page 33-34, Application Format provides detail for the format of applications.

**44. Question:** If we propose to cover two different counties in two different Tiers, do you require two separate budgets? Two separate work plans?

**45. Question:** There needs to be only one budget and one work plan correct? No matter how many ZIP codes served or how many sites where the program is housed?

**46. Question:** If an agency ends up serving more than one ZIP code area or county, are multiple work plans and budgets required for each funding proposal? Can budgets and work plans cross-reference each other and split staff and/or line items, or should they be distinct and totally separated?

**Answer to questions 44, 45, & 46:** As stated in the CAPP RFA Sections II.E.7. Work Plan, page 22 & II.E. 8., Budget and Staffing Plan, page 22, are to submit one work plan and one budget for their application.

**47. Question:** Should we write our application to include the age group and gender that are in the RFA and later we can make an amendment to that if we want to include other age groups in that?

**Answer:** The RFA states male and female adolescents, age 10 to 21 years of age, are eligible for services in this RFA. Each project determines their target population, which may be a subset of the 10 to 21 year old population, based on the community needs and asset assessment. If you are selected to receive an award, subsequent modifications to your proposal may be considered in consultation with your DOH project manager provided eligibility requirements are met.

**48. Question:** The RFA states that eligible youth are ages 10 -21. Are we required to serve that entire age range or are we permitted to serve a subset of that age range? For example, can we serve you ages 15-19?

**49. Question:** The RFA states on page 9, “the project is to serve male and female adolescents age 10 to 21.....” Does this mean that we must serve this entire age group or can we serve a subset or subsets of age groups within the 10-21 age range?

**50. Question:** Is it allowable to serve up to age 24?

**51. Question:** Can you serve children less than 10 years of age?

**Answer to questions 48, 49, 50, & 51:** Male and female adolescents, age 10 to 21 years of age, are eligible for services in this RFA. Each project determines their target population, which may be a subset of the 10 to 21 year old population, based on the community needs and asset assessment.

**52. Question:** Are we required to incorporate all the activities discussed in all four Core Strategies or can we choose from among the different activities discussed within each Core Strategy?

**Answer:** As stated in Section II D., page 12-13, all proposed projects need to include activities to implement all four of the core project strategies, see pages 13 – 17 for guidance on program activities.

**53. Question:** Are we required to implement all of the Core Strategies or are there a minimum number of strategies to use?

**Answer:** All four Core Strategies need to be implemented. There is one exception to this rule: Applicants who propose to limit programming to a single county that has a total county ASHNI below 200 (see Attachment 2) may request funding to implement a limited scope of programming. The limited programming includes Core Strategy 1 and a mechanism to refer youth to comprehensive reproductive healthcare and family planning services for teens to prevent pregnancies, STDs, and HIV/AIDS.

**54. Question:** If an agency receives alternate pregnancy prevention funding, is it allowable to replicate services at another site for this particular initiative?

**Answer:** Yes, the same services could be provided to a different group of youth, as long as it is not a duplication of efforts or supplanting of funds.

**55. Question:** In 4. Organizational Experience and Capacity, under item “a” (page 19 of the RFA) applicants are requested to: “Describe the agency and any proposed subcontractor’s mission; including the mission statement(s) as an appendix to the application.” The current appendix list does not include this. If we include the mission in the narrative, but do not include a separate appendix, would this reduce our score?

**Answer:** As stated in Section II. E. 4. Page 19, describe the agency and any proposed subcontractor’s mission; include the mission statement(s) as an appendix to the application. It is not clear what you mean by “the current appendix list”. If you are referring to section K Appendices on page 40, this section does not relate to materials to be submitted with your application, rather it is a list of appendices that are to be part of a contract resulting from this RFA for successful applicants.

## **ASHNI**

**56. Question:** I believe there is an error in the Albany County ASHNI, because 12203 includes many of the better neighborhoods in Albany County & has the highest ASHNI 12210 & 12207 are the inner city high risk neighborhoods and the need is not reflected in the ASHNI. Could you please clarify this?

**57. Question:** We are concerned with the accurateness of the ASHNI rates. For instance, 14301, which has the highest teen pregnancy rate and teen birth rate in the county has a relatively low ASHNI rate (60.6) listed 5<sup>th</sup> in the county, and is the lowest for the city of Niagara Falls. Is this ASHNI rate accurate? If so, why would a ZIP with the high teen pregnancy and birth rates not be the highest priority?

**58. Question:** I want to make sure that an ASHNI rate in an area that we serve is correct. One ZIP code that we serve has the highest teen pregnancy rate in the county yet; the ASHNI rate is listed as about 4<sup>th</sup> or 5<sup>th</sup> down.

**Answer to questions 56, 57, & 58:** The Adolescent Sexual Health Needs Index (ASHNI) is not exclusively related to the teen pregnancy rate. The ASHNI takes into consideration a multiple key factors related to these outcomes, including the size of adolescent population, actual number of adolescent pregnancies and STD cases, pregnancy and birth rates, and specific demographic and community factors, which are significantly, associated with adverse sexual health outcomes as described in the CAPP RFA Section II. B., page 9. You may include multiple zip codes in your service area as determined by your needs assessment.

**59. Question:** How do you calculate ASHNI score (minimum score of 200)?

**Answer:** As stated in the CAPP RFA Section II.C., page 11, the ASHNI score is calculated by locating each ZIP code in your proposed service area on Attachment 2 and finding the associated ASHNI score for that ZIP code. The ASHNI score for all ZIP codes in your proposed service area are added together to calculate a total project ASHNI.

**60. Question:** The ZIP codes for the ASHNI needs to be an average not the total?

**Answer:** No, as stated in Section II.C., page 11, the ASHNI score for each target ZIP code is calculated by locating each ZIP code in your proposed service area on Attachment 2, and adding together the associated ASHNI scores for each ZIP code.

**61. Question:** We have one of our sites is a large city school with multiple zip codes served by the school. The ASHNI score becomes a little difficult to compute. 60% of the school is served by 4 or 5 ZIP codes and then there's scattered various other ZIP codes included. What's the best way to handle that? Do we need to describe how many students from the school reside in each ZIP code? And then you add them and there's no averaging.

**62. Question:** Should organizations within Tier 2 who serve a very small number of youth from Tier 1 be able to calculate ZIP codes for the ASHNI score or should they just make a statement within the narrative explaining how they would serve some young people from those ZIP codes in Tier 1?

**Answer to questions 60, 61 & 62:** In your application describe your proposed geographic service area as a distinct target community in terms of ZIP codes, as stated on page 11 and page 18, 3.a. of the RFA. The ASHNI score for each target community/proposed service area is calculated by locating each proposed ZIP code on Attachment 2, and finding the associated ASHNI score for that ZIP code. If a project proposes to serve more than one ZIP code, the ASHNI score for all target ZIP codes are added together to calculate a total project ASHNI. ASHNI scores are added together, not averaged. It is acceptable to serve individuals who reside outside of your target community/proposed geographic service area.

### **Service Area**

**63. Question:** Are we allowed to go beyond two counties? Could we serve three counties?

**64. Question:** What should an applicant do if it plans to cover more than 2 counties? (e.g. 3 counties, from different Tiers)...Or are we limited to only 2 counties max?

**65. Question:** Is it feasible/allowable for an applicant to create a proposal that involves 2 counties with an ASHNI score over 200, plus an additional targeted ASHNI zip code with a score under 200? If so, how is that funded?

**Answer to questions 63, 64, & 65:** As stated in Section II. C page 11, outside of New York City, applicants may propose to provide project activities in no more than two counties. New York City applicants may propose to serve any combination of the five boroughs (i.e., Bronx, Kings, New York, Queens, Richmond counties) provided the work scope is achievable. You may be a sub-contractor in additional counties.

**66. Question:** If we are applying for two counties within two different Tiers, do we need to submit two separate proposals?

**Answer:** No, as stated in the CAPP RFA Section II. C., page 10, an organization may submit only one application in response to this RFA – i.e., the same organization may not apply for funding under both Component A and Component B, and may submit only one application for Component A. As stated on page 11 of the RFA, outside of New York City, applicants may propose to provide project activities in **no more than two counties**. New York City applicants may propose to serve any combination of the five boroughs (i.e., Bronx, Kings, New York, Queens, Richmond counties) provided the work scope is achievable. The single application may include multiple counties.

**67. Question:** If an agency applies for two separate counties in two separate Tiers, does that then mean that if we apply for something in Tier 3 and Tier 4 and are awarded it at the Tier 3 amount that that award for Tier 4 is now not taken?

**68. Question:** If the above question is no, meaning we just need to submit one proposal, can we apply for the maximum for each Tier? For instance, if we are applying for a county in Tier 2 with a max \$550K and a county in Tier 3 for \$400K, can we in apply for a total of \$950K?

**69. Question:** Can an applicant serve two counties in different Tiers?

**70. Question:** May an agency submit an application for two counties that are in different Tiers, e.g. Orange Tier 3 and Sullivan Tier 4? If so, how is the award dollar range calculated?

**71. Question:** If we propose to cover two counties in two different Tiers, what dollar amount can we apply for? For example, if we choose to serve a Tier 3 county (maximum \$400,000) and a Tier 4 county (\$200,000 maximum), can we apply for \$600,000 or only up to the highest maximum of the two counties, \$400,000?

**72. Question:** If the funding area proposed is comprised of counties from 2 different Tiers what is the maximum funding amount possible? Is the amount the maximum for the Tier with a higher funding limit or the lower Tier amount or a combination or average (or other formula)?

**Answer to questions 67, 68, 69, 70, 71, & 72:**

It is acceptable to propose services in two counties that fall into two different tiers. As stated in the CAPP RFA Section II. F., Review and Award Process, page 24, projects that include services in two counties will be funded at the higher Tier level. Applicants may request up to the maximum award amount corresponding to the higher Tier as described. You will not get additional funding for the lower tier. The requested funding needs to be consistent with the proposed scope of services and be reasonable and cost effective.

**73. Question:** Is there a suggested minimum number of youth we should seek to serve in our program?

**74. Question:** Is there a suggested unit cost for the program, perhaps expressed in suggested dollars per youth served?

**Answer to questions 73 & 74:** No. As stated in the CAPP RFA Section II. F., page 25, the scope of the proposed service needs to match the requested funding.

**75. Question:** If an organization is planning on serving youth from a large number of ZIP codes, will all the ZIP codes need to be listed in the narrative? (Section.E.3a.)

**Answer:** Yes, they should be included in the Project Summary on page 18.

**76. Question:** The school districts in Suffolk County may not want all the services that we're going to offer. So, we might hand-select different services for each of the school districts. We know the minimum score is 200 but the total score that we're looking at is 665. So, we're trying to get a sense of if you want us to saturate into one community or if we should spread the services out and not be over-ambitious.

**Answer:** That decision needs to be made by the applicant based on your assessment of the community needs and resources and if applicable with input from your community advisory group. The requested funding needs to be consistent with the proposed scope of services and be reasonable and cost effective.

**77. Question:** In our CAPP application, we plan to provide programming in a range of ASHNI ZIP codes in three New York City boroughs – the Bronx, Brooklyn, and Manhattan. However, based on the funding available, it does not seem feasible to provide a comprehensive community

effort in each borough. Would it be possible to focus on one borough in our submission, and agree to partner with another CAPP grantee that would focus on another? Given that there will be up to 25 CAPP grantees for NYC; our hope was that there would be a coordinated effort to address this Core Strategy.

**Answer:** As stated in Section 2 C, page 10 to 11, an organization that applies for funding under either Component A or Component B may also be included as a partner or subcontractor in another organization's application.

**78. Question:** Would service in two contiguous Tier 4 counties double the award amount or would it be limited to the \$150,000-\$200,000 stated in the RFA?

**79. Question:** We would like to provide a full scope of services for the entirety of two counties which are both Tier 4 counties in the RFA. When added together, the ANSHI scores total over 200. Would this project then be eligible for Tier 3 funding, from the minimum to the maximum? (RFA pg.25)

**Answer to questions 78 & 79:** The maximum awards stated for each Tier are for the entire project, not per county. As stated in the CAPP RFA Section II. F, page 25, if an applicant propose to serve two counties in Tier 4, a single award will be made in the amount established for Tier 4, ranging from approximately \$150,000 to \$200,000.

**80. Question:** Can we still choose to compete for this funding in Tier 4 as a two county program? (RFA pg.25)

**Answer:** Yes, you may provide a full scope of services for the entirety of two counties which are both Tier 4 counties in the RFA if when added together, the ANSHI scores total over 200.

**81. Question:** Is the award amount for Tier 1 of \$300,000 to \$500,000 per year or over the entire contract?

**Answer:** Award levels stated are per year, for a five year period, based on the availability of funding.

**82. Question:** For applicants in New York City, is it permissible to select a target area that is smaller than a full county? In other words, rather than applying to serve all of Brooklyn, we would like to apply to serve a neighborhood in Brooklyn that is made up of just two contiguous ZIP Codes that together have an ASHNI greater than 200. Is this permissible?

**Answer:** Yes, the requirement is that Applicants propose a defined service area with a minimum total project ASHNI score of 200 for the community (ies) the project plans to serve. As stated on page 9 of the RFA, the ASHNI will be used to identify eligible target communities, to prioritize the selection of funded projects, and to determine the amount of funding that funded projects are eligible to receive. The requested funding needs to be consistent with the proposed scope of services and be reasonable and cost effective.

**83. Question:** Our program serves homeless youth in NYC who by definition don't have fixed addresses so we could potentially list all the ZIP codes in NYC. If we do that does our

involvement in a community advisory council have to reflect those ZIP codes or does our community advisory council serve the ZIP codes where our facilities are located and where we do outreach?

**Answer:** You can make an estimate from the region where the majority of youth are coming from. We would expect you to be involved in a community advisory council in the geographic area where you are located.

**84. Question:** If we targeting an area of Brooklyn that comprises several ZIP codes am I correct in assuming that all ZIP codes must have an ASHNI higher than 200?

**Answer:** No, the ASHNI scores for all the ZIP codes added together need to total over 200.

**85. Question:** Previously, both APPS and CBAPP have been required to serve a specific percentage of the targeted ZIP codes while also serving the rest of the county. What is the expectation for this contract?

**Answer:** In your application describe your proposed geographic service area as a distinct target community in terms of ZIP codes, as stated on page 11 and page 18, 3.a. of the RFA. High-need areas have been identified based on an Adolescent Sexual Health Needs Index (ASHNI). A minimum total project ASHNI score of 200 is required to be eligible for funding. We have not set a specific percentage, but you are expected to serve the highest need areas.

## **Coordinator**

**86. Question:** What additional functions are allowed under the full-time coordinator position?

**Answer:** As stated on page 10, the full-time coordinator is expected to perform the essential tasks required to administer the project; be the lead in programmatic activities; and ultimately responsible for the successful completion of the project/contract.

**87. Question:** Are there specific requirements about qualifications of the CAPP project director?

**Answer:** The requirements are set by the lead agency and should be consistent with the roles and responsibilities of the project.

**88. Question:** Is there a designated number of hours for the 100% full-time coordinator?

**Answer:** It should be consistent with the full-time designation of the applicant agency.

**89. Question:** Does the person hired as the director or coordinator need to be an existing staff member or can a new staff member be hired to have sole responsibility of running and maintaining the program?

**Answer:** This is a decision of the applicant organization, however if using existing staff, they must be 100% on the project.

**90. Question:** If we propose to serve two counties in two different Tiers, are we required to have two directors/coordinators or is one coordinator sufficient to oversee two counties?

**Answer:** As stated in the CAPP RFA Section II. C., page 10, Requirements (Component A), the applicant organization/agency, if awarded a contract, will be responsible for: employing a 100% full-time CAPP project director/coordinator within their organization. A single coordinator may oversee the entire project.

**91. Question:** With regard to the 100% coordinator or director: Can they be 100% time and effort of this project or can they be a 100% employee with the agency and spend a significant amount of time and effort on this project?

**Answer:** The project coordinator is to be 100% time and effort on this project, as noted on page 10.

**92. Question:** Can you sub-contract the full-time CAPP Coordinator to another organization?

**Answer:** No. As stated in the CAPP RFA Section II. C., page 10, the applicant organization/agency, if awarded a contract, will be responsible for: employing a 100% full-time CAPP project director/coordinator within their organization.

### **Core Strategy 1**

**93. Question:** Is the maximum amount \$500,000 for a CBO that is providing evidence-based programming, but does not have an Article 28?

**Answer:** The maximum amount of funding varies by Tier; refer to Section II.F., page 24 to 25, for funding amounts. The additional funding of up to \$50,000 for Article 28 applicants to support information communication technologies, as described on page 25 of the RFA, is in addition to the award ranges stated for each Tier.

**94. Question:** There are programs that are researched only with certain ages but listed in the RFA as appropriate for more ages, or other inconsistencies, for example:

- Age Differences: BART – ETR says High School only, RFA says MS and HS, 14-18 yrs
- Setting Difference: BART - ETR says CBOs, RFA says Schools and CBOs
- Targeted Ethnicity Difference: BART and Be Proud Be Responsible tested only with African American populations but say it has been implemented with a more diverse audience.

In these cases which criteria should we go by when choosing (and implementing) the programs: what the RFA states, what the curricula state, or only the population it was researched with?

**Answer:** Refer to the information found in the RFA, Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised).

**95. Question:** Are evidence-based interventions restricted to serving specified ages and genders?

**Answer:** Refer to Attachment 3, the list of evidence-based programs provides this guidance specific to each program.

**96. Question:** “Promoting Health among Teens” Abstinence-Only Intervention is listed as an approved curriculum, but the RFA states that “Applicants who propose to implement abstinence-only programs will be disqualified.” Is it OK to include this intervention as long as we also include other approved comprehensive programming?

**Answer:** This is a comprehensive initiative. As stated in the RFA, Core Strategy 1 requires comprehensive, age appropriate, evidence-based, and medically accurate sexuality education to promote healthy sexual behaviors including abstinence, delay the onset of sexual activity and reduce the practice of risky sexual behaviors among youth. Educational programming should be comprehensive including providing a full range of information and skills which includes abstinence (not abstinence only); methods to reduce risky behaviors, prevent pregnancy, STDs and HIV; and increase access to comprehensive sexual health care for adolescents. If *Promoting Health Among Teens!* is utilized, it will have to be adapted to meet the requirements of this RFA. Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network.

**97. Question:** Would an applicant be allowed to continue to implement a comprehensive evidence-based program (Focus on Youth) that was on the approved list in last year’s CBAPP expansion RFA, as long as the applicant also plans to implement one or more of the programs on the list in the CAPP RFA?

**Answer** Core Strategy 1 requires sexuality education programming for youth ages 10 to 21 years of age which **must** be an evidence-based program chosen from the list provided in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network. Applicants may implement other programming as determined by the community needs assessment under Core Strategy 2 through 4, provided programming meets the requirements of the RFA.

**98. Question:** Do the evidenced-based curriculums have to be conducted with fidelity or is there room for adaptation?

**99. Question:** Can we provide one or two session programs in addition to the research based curriculum under Core Strategy 1?

**100. Question:** Is there a minimum timeframe when providing educational services to youth (APPS previously expected 190 days or more)? For example, can we provide eight one hour sessions over eight weeks (one session per week)? Can we provide those same one hour sessions in a shortened timeframe (one session daily for eight days)? Is there any difference in reporting these two education examples, and will they satisfy the curriculum education goal in the same way?

**101. Question:** Can you add something on to an evidence-based programming or does it have to be a part of an evidence-based programming?

**102. Question:** There are some cases where they are not explicit who delivers the curriculum so I wasn’t sure how much flexibility there was. Should I assume its staff who should implement it?

**Answer to questions 98, 99, 100, 101 & 102:** As stated in the CAPP RFA, Section II. D. Core Strategy 1, page 13, once a project is notified of their award under this RFA, NYSDOH and the DOH-funded COE will collaborate with each individual CAPP project to implement their selected comprehensive, age appropriate, evidence-based, and medically accurate sexuality education pregnancy prevention program. Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network.

**103. Question:** If none of the evidence-based programs appear to include a peer based approach and we are interested in using a peer based approach would that go under Core Strategy 3 or would I just use the evidence-based program and even though they don't talk about a peer based approach use peers to implement it?

**Answer:** See response to question 108. Using peers to implement an evidence-based program which is not part of the evidence-based program would be considered an adaptation. Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network. You may also consider peer-based approaches for other core strategies.

**104. Question:** Is there a minimum time frame that we would be required to work with youth when providing educational service to youth? Previously in APPS we were required to serve them for minimum of 190 days.

**Answer:** No. Timeframes for evidence-based programming in Core Strategy 1 should be consistent with the evidence-based program selected as described in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Timeframes for activities in other Core Strategies will be dependent on each individual project's needs assessment and proposed activities.

**105. Question:** If in Core Strategy 1 we are delivering evidence-based programming to large groups of students in school settings and then for Core Strategy 2 we want to target smaller groups of immigrant youth, LGBTQ youth or teen moms that we have identified. We would educate the smaller groups using evidence-based programs specifically designed for these particular populations. This lack of knowledge has been identified as a barrier to engaging them in family planning services and texting may be used as a strategy to engage them. Would this be included with Core Strategy 1 or 2?

**Answer:** It could potentially be included in either Core Strategy. Core Strategy 1 includes the delivery of the evidence-based programming for eligible adolescents age 10 to 21 years and Core Strategy 2 addresses access to reproductive health services.

**106. Question:** If we propose to serve two counties, can we use two different curriculums?

**107. Question:** If we are providing an education program for a classroom where the students are academically behind can we use a curriculum designed for a lower grade level?

**Answer to Questions 106 & 107:** Programs are not restricted to using a single curriculum. As stated in the CAPP RFA Section II. D. Work Scope, page 13, a program should be selected based

on the target community, culture (ethnicity, race, religion, language, ability, gender, and sexual orientation), setting (individual, small and/or large groups) and venue (schools, faith-based institutions, community centers, institutional settings or community organizations) to be served.

**108. Question:** Can peer leaders provide education/workshops to the community that is not from the list of evidence-based curricula?

**Answer:** Core Strategy 1 requires sexuality education programming for youth ages 10 to 21 years of age which **must** be an evidence-based program chosen from the list provided in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network. In addition, projects are strongly encouraged to incorporate programming for parents, caregivers and other adults in the community, which may not be evidence-based, to provide improved knowledge and communication skills related to adolescent sexual health and risky behaviors.

**109. Question:** Are we allowed to use peer to peer educators as part of the program?

**Answer:** Yes, but peer educators may only deliver the sexuality education programming in Core Strategy 1, for youth ages 10 to 21 years of age, if it is consistent with the evidence-based model. You may also consider peer-based approaches for other core strategies.

**110. Question:** Can we train teachers to learn and facilitate evidence-based curriculum within their schools, along with our provision of the evidence-based curricula, and peer education?

**Answer:** Yes, as stated in the CAPP RFA Section II. D, page 16, CAPP project staff will function as experts in the community to enhance community knowledge and provide community resources related to adolescent sexual health. The lead agency staff are expected to be the lead in programmatic activities; assure evidence-based curriculum is implemented with fidelity; and ultimately responsible for the successful completion of the project/contract.

**111. Question:** Core Strategy 1, can we have other strategies within that Core Strategy that are not evidence-based?

**Answer:** Core Strategy 1 requires sexuality education programming for youth ages 10 to 21 years of age which **must** be an evidence-based program chosen from the list provided in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). In addition, projects are strongly encouraged to incorporate programming for parents, caregivers and other adults in the community, which may not be evidence-based, to provide improved knowledge and communication skills related to adolescent sexual health and risky behaviors.

**112. Question:** Is there a preference for in-school or out of school comprehensive sex education programming?

**113. Question:** Is it advisable to conduct services in both middle schools and high schools simultaneously?

**Answer to questions 112 & 113:** The service delivery setting and age group is determined by the applicant's community needs assessment.

**114. Question:** A high school principal asked if participation in a research based curriculum class could be counted as an elective credit towards graduation.

**Answer:** This question is outside the scope of this RFA and should be directed to the Department of Education.

**115. Question:** Do all activities in Core Strategies 1 have to be evidence-based programs?

**116. Question:** Are we limited to the list of curricula in Attachment 3 or can we use others if they are evidence-based?

**117. Question:** Can an already existing, well-established teen pregnancy prevention program be used in lieu of one of the evidence-based programs listed in Attachment 3 of the announcement to satisfy Core Strategy 1?

**118. Question:** In Core Strategy 1, we're only allowed to pick from the list of evidence-based program. We have our own evidence-base program supported by studies. Are we restricted to only using that in Core Strategy 3 or can that be used in conjunction with the ones on your list? And if we can only use that program with Core Strategy 3, we can only spend up to 25% of our funding on that.

**Answer to questions 115, 116, 117 & 118:** As stated in the CAPP RFA Section II. C., page 11, this RFA specifically requires that projects are to implement, age appropriate, evidence-based, and medically accurate sexuality education, which includes abstinence (not abstinence only), to address the needs of project's primary target population (eligible adolescents age 10 to 21 years) from the list of resources in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Additional programming offered for parents, caregivers and other adults in the community to provide improved knowledge and communication skills related to adolescent sexual health and risky behaviors is not required to be evidence-based.

**119. Question:** How do we handle implementing evidence-based curriculum if schools/agencies requesting single educational sessions? Page 13

**Answer:** Core Strategy 1 requires sexuality education programming for youth ages 10 to 21 years of age which **must** be an evidence-based program chosen from the list provided in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network. The applicant would need to evaluate the appropriate setting for the implementation of evidence-based curriculum.

**120. Question:** Is it possible to conduct secondary pregnancy prevention services under Core Strategy 1 even though there is no evidence-based program specifically for secondary prevention?

**121. Question:** There are no evidence-based curricula for secondary prevention so does that mean we include everything under Core Strategy 3?

**Answer to questions 120 & 121:** Evidence-based pregnancy prevention programs may be used for prevention of second pregnancies unless the program specifically indicates it is not effective for prevention of repeat pregnancies. You may also incorporate secondary prevention activities related to Core Strategy 2 and Core Strategy 3.

**122. Question:** Can a subcontractor do only a part of the curriculum or would every subcontractor have to do the same approved evidence-based program? Some of our subcontractors have particular strengths in some of the core areas but don't have everything. Would they have to implement all aspects of the model we choose?

**Answer: Subcontractors are allowable, however,** implementation must be consistent with the requirements of the evidence-based program.

**123. Question:** We have been working with the Children's Aid Society Carrera Program and have some adaptation approved in the past by OCFS and DOH. Once we get the contract might we be able to adapt some aspects of the model?

**Answer:** In Core Strategy 1, applicants must propose implementation of an evidence-based program with fidelity. Any proposed adaptations would be made during the contracting process with oversight from the DOH and the COE to assure that they are consistent with the criteria established by the Centers for Disease Control and Healthy Teen Network.

**124. Question:** Can other objectives be included in Core Strategy 1 in order to prepare for the delivery of evidence-based programming? This could include professional training required to deliver the evidence-based program?

**Answer:** Yes, provided the proposal is reasonable in scope and cost effective.

**125. Question:** Where should parent/youth communication strategies be included?

**Answer:** Depending on what type of activities you propose, parent/youth communication could be included in Core Strategies 1 and/or 3.

**126. Question:** Can we create our own curriculum to implement programs such as service learning or training adult parents to become educators? Page 13

**127. Question:** With regard to workshops for parents, since there are no programs in the list that are evidence-based for parents, is our assumption correct that we can use programming that we have developed that is currently being evaluated?

**128. Question:** A discussion about parents under Core Strategy 1, it seems fairly clear to me that any activity related to them and their involvement would not go under strategy 3 regardless of evidence-based content.

**129. Question:** Is there anywhere that parent/child programming can be used?

**Answer to questions 124, 125, 126, 127, 128 & 129:** Section II. D., pages 13-16, Core Strategies 1 and/or Core Strategies 3 provides examples of parent/child activities. Core Strategy 1 requires sexuality education programming for youth ages 10 to 21 years of age which **must** be an evidence-based program chosen from the list provided in Attachment 3 (see Modifications to the Comprehensive Adolescent Pregnancy Prevention RFA, Attachment 3-Revised). Any potential adaptations will be consistent with guidelines on program adaptation from the Centers for Disease Control and Prevention (CDC) and Healthy Teen Network. In addition, projects are strongly encouraged to incorporate programming for parents, caregivers and other adults in the community to provide improved knowledge and communication skills related to adolescent sexual health and risky behaviors which may not be evidence-based.

**130. Question:** Core Strategy 4, can programming that is not evidence-based be used if that is what is assessed by the community? For instance puberty education programming or parent/child programming?

**Answer:** Core Strategy 4 refers to the community advisory council activities and does not required evidence-based programming.

**131. Question:** On page 16, it says that no case management will be funded. In our community, we have youth who are looking for more of an ongoing relationship with our staff and it would meet their needs with regard to teen pregnancy prevention. What's the reason for having no case management funded through this and can you provide a definition of what case management is?

**Answer:** Case management model varies by program, but, generally includes: intake, screening, assessment, and reassessment, development of a service plan, coordination of services, monitoring and follow-up, access to crisis intervention, counseling, and exit planning. Core Strategy 1 and Core Strategy 3 provide opportunities for long-term relationships with young people through comprehensive, age appropriate, evidence-based, and medically accurate sexuality education, activities, and other services i.e. mentoring, long term service learning programs, etc.

**132. Question:** For the pregnant and parenting teens we serve – I know that case management is no longer part of this, it is described as long-term relationships - could we serve them through one of the evidence-based program such as TOP – Teen Outreach Program - as long as for the time limit that that program requires through service-learning projects?

**Answer:** There is no specific time limit on programming; the length of programming should be consistent with the evidence-based program selected.

## **Core Strategy 2**

**133. Question:** If we are going to set up workshops for youth to talk about sexuality with 6-8 kids for the purpose of engaging them in health care centers, can this be placed under Core Strategy 2?

**Answer:** Yes, if young people's knowledge on how to access family planning services has been identified as a barrier within your community.

**134. Question:** If we want to disseminate information about family planning services, does this have to be part of an evidence-based programming?

**Answer:** This topic could be included in Core Strategy 2 or as part of evidence-based programming in Core Strategy 1.

**135. Question:** As stated in Section II. D., page 15, Core Strategies: The RFA states that a maximum of 25% of core funding may be used to support expansion of clinical services. Will this grant pay for additional time for an NP or MD to provide staffing?

**Answer:** As stated in Section II. D., page 15, a maximum of 25% of grantee funding may be used to support comprehensive multidimensional program activities and/or specific activities that reduce identified community barriers to adolescents' accessing clinical services that are not otherwise appropriately classified as "offering and arranging". Additional clinical staffing may be an allowable expense if it was a specific identified barrier to adolescents' accessing clinical services. Additional examples of allowable expenses in this category are provided on page 15 of the RFA and include expanding clinic operating hours, additional clinic staffing during peak adolescent service times, staffing costs associated with extending clinic hours to serve adolescents, improving the proximity and accessibility of clinics to target populations, and specific costs associated with establishing clinic services in remote underserved locations, including staffing and basic infrastructure/overhead costs (e.g., rent, utilities, telephone).

Note: While CAPP funding may be used to help improve access to family planning services for adolescents, these funds cannot supplant existing funds or available funding from other sources.

**136. Question:** Can linking males to medical care (including STD and HIV screening as necessary) be a project under Core Strategy 2? Page 15

**Answer:** Yes.

**137. Question:** One-day programs that help build a relationship between educator and audience, as well as the prevention staff and the school or community center leading to multi-session programs – are they allowable and if yes, what Core Strategy do they fit under?

**Answer:** This could be an allowable activity under Core Strategy 2, Core Strategy 3, and/or Core Strategy 4 depending on the program topic and audience. Also note, this relates to the Q&A 119.

### **Core Strategy 3**

**138. Question:** Clarify what is meant by the word educational within the Core Strategy 3 description (page 15).

**Answer:** Examples of educational opportunities are included on page 16, Section II. D.

**139. Question:** May grantees subcontract or partner with a CBO (indicated by a Letter of Commitment) to fulfill Core Strategy 3?

**Answer:** Yes, subcontracting may be proposed. As stated in the CAPP RFA Section II. C. page 10, the applicant organization/agency, if awarded a contract, will be responsible for: performing the essential tasks to administer the project; be the lead in programmatic activities; and ultimately responsible for the successful completion of the project/contract.

**140. Question:** Under Strategy 3, child care is mentioned as an allowable expense and later it is categorized as not allowable. Which is correct?

**Answer:** As stated in Section II. D. Strategy 3, page 16, special considerations which include providing child care and/or a child friendly environment may be necessary to engage parenting teens in order to ensure access to programming. In the context of providing the activities listed above child care is an allowable expense. However, this initiative will not fund direct services including child care provided for reasons other than participation in the above mentioned programming.

**141. Question:** We are a current provider and we subcontract to provide our youth a summer youth employment opportunity. Would we no longer be able to do that under this RFA? To clarify the job training component, it specifies in the RFA employment placement– if we had a program that includes professional job training without any placement would that be OK?

**Answer:** These funds may not be used to supplant funds available from other resources, such as the Department of Labor job training programs. Core Strategy 3 includes the topic: educational and career success, which includes developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and work productivity. If your community needs assessment determines that educational and career success is a need in your community and it is not available from other sources, these activities could be incorporated as developing skills for employment preparation, job seeking, and work-place productivity and would be considered in your proposal. Communities should coordinate and maximize the resources available.

**142. Question:** Can we partner with a secondary prevention program that already exists to provide youth development programming?

**Answer:** Yes, if programming was identified as necessary programming as a result of the project's community needs assessment and also meets the criteria described in Section II. D. Core Strategy 3, page 15-16.

**143. Question:** Can you give some examples of what would not be fundable for Core Strategy 3, educational/social/cultural/recreational positive youth development activities?

**Answer:** As stated on page 16, this initiative will not fund direct services such as case management, GED preparation, employment placement, mental health counseling, crisis intervention, and child care or services that are available through other resources. However, applicants should incorporate partnerships and strategies to identify needs for such services and make referrals to address the needs that have been identified.

## **Core Strategy 4**

**144. Question:** Clarify needs assessment: difference between Core Strategy 2. (page 14, 3<sup>rd</sup> full paragraph) and Core Strategy 4 (page 17, 3<sup>rd</sup> paragraph)? Are both required? Can we allocate funds towards that?

**Answer:** Core Strategy 4 incorporates barriers identified in Core Strategy 2. While this is not a specific requirement, it is recommended and essential for program planning. Funds may be included for program planning, including needs assessment.

**145. Question:** We are a new provider. Is there any way to find out if there are existing community advisory councils within our communities that we could be a part of?

**Answer:** We will be providing a list of successful applicants to facilitate coordination at the community level. You may participate in an existing advisory council in your community. See also Q&A #16 for a list of current CBAPP and APPS providers.

**146. Question:** We recently learned that the NYC Department of Health and Mental Hygiene were awarded a CDC TPP grant to spearhead community-wide pregnancy prevention efforts in the South Bronx. Would it be possible to work under this group as part of the CAPP local communities efforts in this area of NYC? Given that there is an impressive influx of teen pregnancy prevention funding being funneled into communities in the next five years, we want to do everything possible to ensure that this is a coordinated and smart effort, but also want to follow CAPP guidelines so that we present the most competitive application possible. Please advise.

**Answer:** Yes, as stated on page 17 funded projects are to be an active participant on a community advisory council that intends to improve the target community's living environment relevant to the prevention of adolescent pregnancy, STDs and HIV/AIDS rates.

**147. Question:** Can you offer guidance about what is expected for the Community Advisory Council's annual assessment and community plan? Page 17.

**Answer:** Please refer to Attachments 4 and 5.

**148. Question:** If we apply for two counties in two different Tiers, do we need two advisory boards?

**Answer:** As stated in the CAPP RFA Section II. D, Core Strategy 4, page 17, if the CAPP project proposes to serve separate and distinct communities, they are expected to participate in a community advisory council for each community.

**149. Question:** If we are proposing to serve two contiguous ZIP codes in New York City, that make up a single neighborhood, would that be considered just one community and we would be required to participate in a single community advisory council?

**Answer:** Each applicant is expected to define their individual community. If you define that as a single community, you would participate in a single community advisory council.

**150. Question:** Are there a required number of people that should be on the advisory board?

**Answer:** No.

**151. Question:** At the bottom of page 16 under Core Strategy 4, the RFA states: “In order to assure optimal sexual health for adolescents in identified communities, projects are expected to engage their community in actions that change social norms that improve sexual health outcomes. What is meant by the word “actions”?”

**Answer:** This refers to activities that would be conducted in the community. As described on pages 16-17, CAPP project staff will function as experts in the community to enhance community knowledge and provide community resources related to adolescent sexual health; identify and utilize existing community resources and maximize the use of federal or other state, private and local resources; educate community members and decision makers; and, collaborate with local youth, families, schools, family planning providers and other community stakeholders; be an active participant on a community advisory council that intends to improve the target community’s living environment relevant to the prevention of adolescent pregnancy, STDs and HIV/AIDS rates; provide guidance, and direction for a coordinated community plan that is aimed at reducing adolescent pregnancy, STD, and HIV/AIDS rates in the proposed target community.

**152. Question:** We understand the need for Core Strategy 4, but are concerned that this design will result in multiple Community Advisory Councils and be a duplication of efforts (particularly in such a dense geographic area like New York City). Could this be an organized effort that is redesigned and finalized once all CAPP grantees are known? Our concern is that this was an issue with APPS contracts and there does not seem to be an effort to change this for the CAPP initiative. Will NYSDOH be helpful in coordinating this effort for each core community?

**Answer:** As stated on Section II. D., page 17, funded projects are to be an active participant on a community advisory council. Following award announcements, efforts will be made to facilitate coordination of funded projects in communities to reduce duplication of efforts.

**153. Question:** Can CAPP applicants from the same target community join together to form a Community Advisory Council? Page 17

**Answer:** Yes.

### **Limited Scope Programming**

**154. Question:** Can you apply for the \$50K limited programming for another county if you are already applying for two separate counties?

**155. Question:** Is there any flexibility to serving two Tiers as well as a limited scope award?

**Answer to questions 154 & 155:** No. As stated in Section II. C., page 11, outside of New York City, applicants may propose to provide project activities in no more than two counties. Further, as stated in the CAPP RFA, Section II. C., page 11, applicants who propose to limit programming to a single county that has a total county ASHNI below 200 may request funding to implement a limited scope of programming as described in Section II.D, Work Scope.

**156. Question:** If one was to propose the \$50,000 for the limited a scope of programming in a county that does not have a high ASHNI, would you still be required to have a fulltime coordinator?

**Answer:** While the coordinator may not be a full time employee, the applicant would be expected to employ and designate an individual that would be responsible for the oversight and implementation of the limited scope programming. The designated individual will be accessible to the department including by e-mail.

**157. Question:** I am looking for clarification on an eligibility question that came up while reviewing the RFA for the new CAPP initiative. On page 24 under the "Review and Awards Process" Section it states "Applicants must propose a defined service area with a minimum total project ASHNI score of 200 for the community(ies) that the project plans to serve, except for applicants who propose to serve one county in Tier 4 that has a total ASHNI below 200. Applicants who do not propose a minimum total project ASHNI score of 200 will be disqualified, except for applicants who propose limited programming to serve one county in Tier 4 that has a total county ASHNI below 200." Nowhere else in the RFA does it specify that limited programming can only take place in the Tier 4 counties. Ultimately I am looking to find out whether Richmond County, located in Tier 1 but has no ZIP codes with an ASHNI of 200, is eligible to apply?

**Answer:** As stated in the CAPP RFA Section II. D, page 12-13; II. E.6, page 20; and II. F, page 24, applicants who propose to limit programming to a single county that has a total county ASHNI below 200 may request funding to implement a limited scope of programming. The total county ASHNI is inclusive of all of the ZIP codes in a county. It may be calculated by locating every ZIP code in the county on Attachment 2, finding the associated ASHNI score and adding them all together for a county total. Richmond County has an ASHNI score above 200 and is not eligible for limited program funding.

**158. Question:** Applying to implement limited scope programming, is a Community Advisory Council still required? And I assume there would not be a coordinator required for that amount of money?

**Answer:** There is no requirement for a Community Advisory Council. While the coordinator may not be a full time employee, the applicant would be expected to employ and designate an individual that would be responsible for the oversight and implementation of the limited scope programming. The designated individual will be accessible to the department including by e-mail.

**159. Question:** So the limited scope programming would provide the evidence-based program and possibly some other activity?

**Answer:** As stated in Section II.D., page 12-13, the limited programming includes Core Strategy 1 and a mechanism to refer youth to comprehensive reproductive healthcare and family planning services for teens to prevent pregnancies, STDs, and HIV/AIDS.

## **Communication Technology**

**160. Question:** Page 18 and 21, Additional funding, a) plan for information technologies: There is no page limit specified. Are we to include this description in our 6 page limit for the Project Narrative Section, or are we allowed additional pages in our response?

**161. Question:** What is the page limit for the additional funding section under part 6, description of Program Narrative?

**162. Question:** Does the description of the additional funding that is required in the Summary section also need to be included in these two pages?

**163. Question:** How should the additional funding request be included in the budget documentation? Within which pages of the excel document should it be listed?

**164. Question:** Are there separate budget forms for the additional \$50,000 to maximize the use of information communication technologies? (Pg. 14 of RFA final paragraph) a. If this should be included in the regular budget forms, where should this be included?

**165. Question:** How do we apply for the additional \$50,000 for communication technology?

**166. Question:** If we are applying for the additional funding, are we to prepare a narrative on it that is added to the **Project Summary** –or- is it a separate narrative in addition to the Project Summary that is evaluated as either pass/fail?

**167. Question:** In Section II. E. of the RFA, Application Content, does the information for Additional Funding that must be provided under 3. Project Summary and 6. Description of Project Narrative counts towards the page limit for these sections, or is additional space allowed to provide this Additional Funding information?

**168. Question:** Is the Work Plan for the additional technology money separate or included within the core strategies they address?

**Answer to questions 160, 161, 162, 163, 164, 165, 166, 167 & 168:** There are no additional pages allowed for your response related to information technologies. Your plan for additional funding for information technologies should be incorporated into your project summary, description of Project Narrative, Work Plan and Budget.

**169. Question:** Our agency does not have the Article 28 status but we have a CBAPP grant and sub-contract with another agency who is an Article 28. Can a lead agency that is not an Article 28 subcontract for the \$50,000 additional award?

**170. Question:** The addition \$50,000 funding will be awarded to only Article 28 clinics, not to CBO's who link up with an Article 28 facility and utilize it for social networking and education? Is this correct?

**Answer to questions 169 & 170:** Only applicants who are approved under Article 28 of the Public Health Law to provide family planning services are eligible to apply for that funding.

Agencies who are not Article 28 providers are not eligible to apply for the additional funding. See Section II. F. page 25 for guidance.

**171. Question:** How will the additional funding awards for “information communication technologies” be determined? What stipulations and/or guidance will accompany these funds?

**Answer:** Funding for information communication technologies will be considered as part of the overall project plan. See Section II. D., page 14-15 for examples of activities. Additional guidance for use of these funds will be provided during the contracting process.

**172. Question:** For the additional \$50,000 award - Can you clarify what communication technologies would be appropriate?

**Answer:** As stated in Section II.D., page 14-15, specific examples include: text appointment reminders; daily reminders for oral contraceptives and other medications; using “waiting time” to offer educational presentations or videos and/or to elicit information about sexual history/other sensitive subjects through a computer assisted questionnaire system. This funding is intended to go beyond a media campaign. See the guidance on pages 14-15.

**173. Question:** Does the maximum funding amount for Tier 1 include the additional \$50,000 for communication technology strategies?

**Answer:** No.

**174. Question:** Can the additional \$50,000 for technology (pg 14) be used to pay staff salaries to administer tech initiative?

**Answer:** Yes.

**175. Question:** The \$50,000 additional dollars for information and technology, can that be a subcontracted service?

**Answer:** Yes.

**176. Question:** If we apply for two counties in two different Tiers, is the \$50,000 additional funding for communication technologies available for each Tier (\$100,000 for use in two Tiers)?

**Answer:** No. The maximum award amount is up to \$50,000 for communication technologies.

**177. Question:** Is the \$50,000 additional funding for communication technologies available as one-time-only funding, or will it be available annually?

**178. Question:** Is the \$50,000 award being provided annually (so, up to a total of \$250,000), or is this a one-time award to be expended ONLY during the first year of CAPP contracts?

**Answer to questions 177 & 178:** The \$50,000 for this activity is per year, for a total of up to \$250,000 over the 5-year project period depending on performance and availability of funding. It is expected that contracts resulting from this RFA will have an initial contract year of 1/1/11-

12/31/11. In place of annual renewals for Years 2-5, the Department may instead elect to establish a single four-year contract for Years 2-5 of this initiative. Should this occur, awardees will be provided with additional guidance at that time."

**179. Question:** Is there a formula or guidance for "information communication technologies" about funding requested for staff time vs. equipment and on-line costs? (%)?

**Answer:** Each individual project will develop a plan to expend funds in order to maximize the use of information communication technologies and improve service delivery and decrease barriers to reproductive healthcare and family planning services for adolescents in their community. This plan will be based on the community needs assessment.

### **Offering and Arranging**

**180. Question:** Can you give examples of "Offering and Arranging"?

**Answer:** Examples of Offering & Arranging are provided on pages 10, 14 and 15 of the RFA. Please refer to Attachment 6 for additional detailed guidance on Offering and Arranging of family planning services.

**181. Question:** Would marketing funds be considered Offering and Arranging?

**Answer:** Refer to Attachment 6, Offering and Arranging Definition and Activities for Component A, for a description of dissemination of written and oral information about available family planning health services.

**182. Question:** How do we place Offering and Arranging on the budget tables? Some of the programming we want to provide is in the classroom during school hours and some of it is at CBOs during out-of-school time. Would that still go under classroom presentations, which is the second column? Or is that just for in school?

**Answer:** Evidence-based educational programming offered under Core Strategy 1 can be listed under classroom presentations, regardless of the setting in which it is conducted.

**183. Question:** The community advisory council—is that considered to be an Offering and Arranging? If so, would the coordination of that fall under the 75% or the 25% of the budget?

**Answer:** Some of the activities of the community advisory council may be considered Offering and Arranging activities. Refer to Attachment 6, Offering and Arranging Definition and Activities for Component A. As stated in the RFA on pages 10, at least 75% of each grantee's award should be used to support activities related to Offering and Arranging of family planning services. The remaining 25% of each grantee's award may be used to support other activities related to any of the four core strategies that are not appropriately classified as Offering and Arranging.

**184. Question:** Would an additional after school health clinic (e.g. new teen clinic at a provider site) count as Offering and Arranging (within the 75%) and be fundable in this grant?

**Answer:** As stated in the RFA on pages 10, at least 75% of each grantee's award should be used to support activities related to Offering and Arranging of family planning services. The remaining 25% of each grantee's award may be used to support other activities related to any of the four core strategies that are not appropriately classified as Offering and Arranging. Direct provision of family planning services would not be included in the offering and arranging of family planning services. Refer to Attachment 6 for a description of Offering and Arranging services. It may be fundable under the remaining 25% of an award if it meets the criteria described on page 15 related to allowable expenses to reduce identified community barriers to adolescents' accessing clinical services.

**185. Question:** In the overview it talks about 75% of the award being used to support Offering and Arranging and the other 25 % for other comprehensive program activities. Does this apply also to limited scope programming?

**Answer:** Yes, the work of the limited scope programming includes Core Strategy 1 and a mechanism to refer youth to comprehensive reproductive healthcare and family planning services for teens to prevent pregnancies, STDs, and HIV/AIDS. These would be predominately offering and arranging.

**186. Question:** The top of page 14 provides information on Offering and Arranging services as part of Core Strategy 1. It is still unclear to me whether those strategies under O & A need to be a part of the evidence-based curriculum.

**Answer:** Much of the evidence-based curriculum in Core Strategy 1 will meet the criteria for Offering and Arranging. See page 10, pages 12-15 and Attachment 6 for additional guidance.

**187. Question:** If a community-based organization is being supported by health care facilities to have referral services, are we required to classify it as Offering and Arranging and have our budget reflect that in our budget as well?

**Answer:** Making referrals is Offering and Arranging.

## **Work Plan**

**188. Question:** On page 21, G says, "describe the community's involvement in the project plan". Is the project plan the same as the work plan?

**Answer:** The work plan includes the activities to accomplish the project plan for your community.

**189. Question:** In the narrative, the Work Plan is separate from the project description so you need both.

**Answer:** Yes.

**190. Question:** What demographic and service information (data) will we need to gather for each customer? Service provided?

**Answer:** Successful applicants will be provided with reporting formats after awards are made.

**191. Question:** Can you explain the process and outcome evaluation processes mentioned in RFA for the contract implementation process?

**Answer:** Components of outcome and process evaluation processes are the when, what, whom, where, who, and how much. Outcome objective is a description of time, the targeted health problem, target population (overall), geography, staff responsible, and quantity of change overall. Process objective is a description of the time, targeted intervention, targeted population (sub set) geography, staff responsible, and amount necessary to effect change. Also, stated in the CAPP RFA Section II.E.7., page 22, the COE will work with each individual project and NYSDOH to develop and conduct an evaluation for their local project and for the overall CAPP initiative.

**192. Question:** In the work plan template under Evaluation it states that we would submit the outcomes during the contract implementation process. What does that mean and what do you expect us to provide to you with the proposal? Does this mean that the State will be working with us to implement the evaluation methods?

**193. Question:** How in depth do we need to describe our evaluation process?

**Answer to questions 191 & 192:** Your application should describe the overall evaluation process. Specific evaluation plans will be developed in conjunction with the Department of Health and the Center of Excellence during the contract implementation process.

**194. Question:** But it still needs to be outlined in our proposal?

**Answer:** Yes.

**195. Question:** What is considered an acceptable percentage of grant funds for program evaluation? Is there a recommended percentage or requirement?

**Answer:** There is no recommended percentage or requirement.

**196. Question:** Will we be able to count curriculum education for males towards our outcomes? (RFA pg.13)

**Answer:** Yes, CAPP community-based projects are to serve both males and females.

**197. Question:** To clarify, are we correct in thinking that applicants DO NOT need to fill out the evaluation section of the work plan, because grantees will be assisted in this process?

**Answer:** No, applicants are to complete all sections of the work plan.

**198. Question:** Is there a target number for referrals that we make to health centers and if so, are we expected to track them?

**Answer:** No.

**199. Question:** What kind of data collection will be required?

**Answer:** That will be provided to successful applicants during the contracting process.

## **Eligible Costs**

**200. Question:** Can Community Advisory Council members be compensated for their participation and if so are there any guidelines for that?

**Answer:** No, they may not be compensated.

**201. Question:** Our agency plans to select more than one evidence-based curriculum, because we plan to propose to work in several different settings and with diverse groups of youth. Are we correct in assuming that our budget will need to include the full cost of obtaining the training (and paying licensing fees, if any) required for our local staff to deliver all the curricula we choose?

**Answer:** Yes, these are allowable expenses.

**202. Question:** If several grantees choose the same curricula, will NYSDOH (or the component B grantee) consider negotiating for regional or state-wide training opportunities for the selected evidence-based curricula, to reduce the cost across?

**Answer:** Following award announcements, efforts will be made to facilitate coordination of funded projects in communities to reduce duplication of efforts. Projects will be encouraged to coordinate these trainings in their region. The Component B is independent of Component A and is not responsible for this training.

**203. Question:** For the purposes of the Budget Table A-1 Personal Service; would the Controller, Bookkeeper, Executive Director (the people who don't necessarily work directly providing the services) be put into column 10. Also, do the CAPP Coordinator and CAPP Assistant have to be spread throughout columns 5-10?

**204. Question:** Budget Table A personal service, controller, executive director, bookkeeper, the persons not directly involved, would they be put into column 10?

**205. Question:** The coordinator and assistance would be spread throughout the budget pages 5 - 10?

**Answer to questions 203, 204, & 205:** Yes, depending on whatever their specific duties entail.

**206. Question:** The grant will not pay for STD testing supplies but will the grant pay for HIV testing supplies?

**Answer:** As stated on page 15, the initiative will **not** fund other direct clinical/medical/laboratory services and supplies.

**207. Question:** The stated: NYS funded administrative cost are generally no more than 10% cost allocation of your budget and must be identified and shown in line item detail.....Does this mean that any line item administrative cost allocated to this program cannot be more than 10%. It does not state total administrative cost can be more than 10%.

**Answer:** As stated in the CAPP RFA Section II. E. 8., page 22-23, Administrative Expenses [personal service and other than personal service (OTPS)] should be in line item detail and not exceed 10% of the amount requested from the state under the RFA. Lump sum administrative costs or rates will not be considered. Total administrative costs exceeding 10% should be substantially justified in order to be considered as potentially acceptable and fundable.

**208. Question:** There is a 10% administrative cost associated with this RFA are the following positions associated with the administrative costs such as quality assurance, trainer, reporting, evaluation and data entry?

**Answer:** Administrative costs include personnel not directly involved with the program such as audit, bookkeeping, maintenance.

**209. Question:** If a fiscal person is assigned to this grant are they considered an administrative cost?

**Answer:** It is an Administrative cost.

**210. Question:** What about other positions such as quality assurance to the grant, reporting, trainers, etc?

**Answer:** They are not included in administrative costs. Administration is for those who provide indirect services not directly involved with the grant process- budgeting, payroll, etc. Quality Assurance would be involved directly with the grant.

**211. Question:** On page 20 it says that we need to include a plan to train staff and provide on-going professional development. Where would training such as disability awareness show up in the budget? Which category would that be?

**Answer:** These expenses should be included in OTPS.

**212. Question:** On page 22, the budget requires line item administrative costs (which are not to exceed 10% of the requested amount). Is this, for example, 5% of the time of the CFO at a salary of \$xx? Along the same lines, items such as office supplies or utilities expense used by program staff are frequently allocated by an FTE percentage but are not considered administrative costs but rather program or "other" expenses. How are they to be considered for this proposal?

**Answer:** Administrative costs are those costs that do not directly relate to implementation of the work plan. Payroll, human resources, and audit are examples. These costs cannot exceed 10% of the total amount being requested from the state, not 10% per budget line. Non-personal service costs may be included with a cost allocation methodology based on FTEs or other method used consistently throughout the budget. However, claims must be based on actual expenses incurred during the period being claimed.

**213. Question:** Can funding support the inclusion of line items for travel expenses for youth to travel to family planning clinics or presentations relating to the services proposed? Can line items be included for incentives to engage young people in the program?

**Answer:** As noted in Section II. D., page 15, providing for individual and/or group discussions about the full range of methods of family planning and family planning services and assisting with arranging visits to medical family planning providers is allowable. This may include assisting with transportation arrangements to effectively obtain family planning services. Incentives for program participation are not allowable program expenses.

**214. Question:** On Page 22, Section C you discuss administrative costs but also state that you require funds being set aside for an Albany grantee meeting. Is it reasonable to assume the grantee meeting travel should be a separate line item and not part of administrative costs and hence not part of the detailed administrative costs justification?

**Answer:** These costs would typically be included under travel.

**215. Question:** Is there a requirement that family planning services be free? There's no requirement that they be free or on a sliding fee scale?

**Answer:** The initiative requires projects ensure access to comprehensive reproductive healthcare and family planning services for teens to prevent pregnancies, STDs, and HIV/AIDS. The community advisory council needs to identify and address any barriers adolescents face while accessing family planning services in their community, which could include financial barriers. Title X guidelines stipulate that a schedule of discounts must be developed and implemented with sufficient proportional increments so inability to pay is never a barrier to service.

**216. Question:** Are transportation expenses for teen patients to transport them to/from a family planning clinic (including a teen clinic) allowable in this grant (to reduce barriers and improve accessibility to target populations) -- and if so is it considered Offering and Arranging?

**Answer:** Yes assisting with transportation could be considered Offering and Arranging if it is an identified barrier. Refer to Attachment 6, Offering and Arranging Definition and Activities for Component A.

**217. Question:** We plan on building into the year one budget time for hiring and training staff to use the evidence-based curriculum. If we are doing workshops in schools, then with a January budget start date that could mean that our workshops aren't operational until the fall. Is this allowed?

**Answer:** The requested funding needs to be consistent with the proposed scope of services and be reasonable and cost effective.

**218. Question:** Can you clarify what it would mean to be in partnership with an organization that is also applying, but not sub-contract?

**Answer:** A subcontract implies that there is a fiscal relationship between organizations and the subcontracted organization would be included in the lead organization's budget. A partnership is a collaborative relationship between organizations that does not necessarily imply a fiscal relationship.

**219. Question:** In Section II. E. 8. f., Budget and Staffing Plan, the RFA indicates that we may not use funds to purchase either condoms or pregnancy tests. However, as a not-for-profit community-based agency, both those items have been of great help to us in accessing/servicing kids. Prohibiting us from spending a few hundred dollars on these items will restrict some of our normal outreach, linkages to schools and so on. Could this limitation be re-considered for CBO's?

**Answer:** These are not allowable expenses under this RFA. Free condoms are available from the NYS Department of Health condom program at:  
<http://www.nyhealth.gov/diseases/aids/facts/condoms/nyscondom.htm>

**220. Question:** Snacks and other small incentives are of critical importance in serving kids, especially when conducting programming outside of school. Are these items allowed in the budget?

**221. Question:** Can incentives be used to engage youth? (examples: trinkets, bags, condoms, gift cards, graduations)

**222. Question:** What does the initiative allow regarding food and graduations specifically?

**Answer to questions 220, 221 & 222:** Nutritious snacks are allowable expenses; further guidance will be provided during the contracting process. Incentives for program participation are not allowable program expenses. Condoms are available for free at the website listed in response to Question # 219 above.

**223. Question:** We give out key chains and that sort of thing that has reference to our website address printed on them and we give them out for community awareness so that it might drive people to the website making people aware of the problem and maybe giving a kid a t-shirt that just finished a 16 week reducing the risk program in an effort to drive more kids to the program. Are those allowable expenses under this RFA?

**Answer:** These items would be considered incentives and are not allowable expenses under this procurement.

**224. Question:** Can agencies purchase incentives with other funds to encourage participation?

**Answer:** Yes.

**225. Question:** There is no mention about stipends being included, especially if we are working to train teens as peer leaders. Is that going to be an allowable cost?

**Answer:** Yes, stipends are an allowable expense. Stipends would be payment for service provided, i.e. peer education.

**226. Question:** Could we pay peer educators an hourly rate instead of a stipend if they were doing work for the program?

**Answer:** Yes.

**227. Question:** Is it acceptable to provide an incentive for teen parents who will participate in a focus group?

**Answer:** Incentives for participation in focus groups is an allowable expense at the level approved by the Institutional Review Board approval process for the project.

**228. Question:** Basic needs are increasingly in demand – calls for infant formula, diapers and non-perishable food items. We can obtain these cheaply thru our local Food Bank. Are these expenses permitted?

**Answer:** These are not allowable expenses under this RFA; other resources in the community should be used.

**229. Question:** Can we offer mini-grants to other youth organizations on a creative and competitive basis?

**Answer:** Mini-grants would have to be procured on a competitive basis. Mini-grants are an item to be negotiated during the contracting process.

**230. Question:** We plan to provide the Making Proud Choices curriculum to youth during both in-school and out-of-school hours. For the after school sessions, in budget table A-1, should this go under community education and outreach? These are formal presentations, similar to what would be provided during school hours (and categorized under classroom presentations) By formatting it this way in the budget, is NYSDOH trying to determine how much of the budget is supporting work in school settings specifically. Is NYSDOH also interested in knowing how much of the budget is being applied to providing evidence-based programs?

**Answer:** The budget format supports documentation necessary for federal Medicaid matching funds. Any evidence-based sexuality education provided to groups of young people should be categorized as classroom presentation, regardless of the setting in which it is conducted.

## **Miscellaneous**

**231. Question:** How will the CAPP funds available interface with the recently announced Tier 1 and Tier 2 federal sex education funding, PREP funding, and abstinence funding awards (OAH announced on 9/30/10)?

**Answer:** We will make every effort to coordinate activities between the various programs.

**232. Question:** When will successful applicants be notified? Will it be in time to begin services on January 1, 2011?

**233. Question:** When do you anticipate announcing the award winners?

**234. Question:** What is the timing for awards?

**235. Question:** Though we recognize that New York State has the goal of having this program begin on January 1st, what is the plan for extending the current contracts beyond December 31st if awards are not announced by December 1st?

**236. Question:** If funding announcements are late, what will happen to the contracts that are currently supporting projects? Is there a possibility of an extension of funding?

**237. Question:** If awarded a grant, should we expect to begin working on Jan. 1, even if we haven't received an executed contract?

**238. Question:** When will implementation of services begin?

**Answer to questions 232, 233, 234, 235, 236, 237 & 238:** Every effort will be made by the Department to announce awards and begin contracts by 1/1/11.

### **Component B: Improving Community Healthcare Services for Adolescents Initiative Requirements**

**239. Question:** Is the Center of Excellence (COE) available to consult on proposal development?

**Answer:** The DOH funded COE is not available to consult on proposal development.

**240. Question:** Is the work plan to be submitted for Component B for all five years or for one year?

**Answer:** The Work Plan submitted with your application for this RFA should be for the period 1/1/11 through 12/31/11. Note Modification to the RFA above: It is expected that contracts resulting from this RFA will have an initial contract year of 1/1/11-12/31/11. In place of annual renewals for Years 2-5, the Department may instead elect to establish a single four-year contract for Years 2-5 of this initiative. Should this occur, awardees will be provided with additional guidance at that time."

**241. Question:** Is the budget to be submitted for Component B a one year budget or five year budget.

**Answer:** The budget submitted with your application for this RFA should be for the period 1/1/11 to 12/31/11. Note above Modifications to the RFA: It is expected that contracts resulting from this RFA will have an initial contract year of 1/1/11-12/31/11. In place of annual renewals for Years 2-5, the Department may instead elect to establish a single four-year contract for Years 2-5 of this initiative. Should this occur, awardees will be provided with additional guidance at that time."

### **Work Scope**

**242. Question:** What is the precise role of the NYSDOH in the project?

**Answer:** The NYSDOH will assist the successful applicant in identifying specific adolescent topics for professional education through feedback from healthcare providers or other youth serving systems on emerging adolescent issues. The NYSDOH will approve any training provided by the successful applicant. The NYSDOH will also have general contractual oversight of this project.

**243. Question:** What role will the COE play to support the state-wide training initiative?

**244. Question:** What is the role of the DOH funded Center of Excellence? What activities/services would the DOH funded Center of Excellence lend?

**245. Question:** The RFA states that the DOH funded Center of Excellence contract provides NYSDOH access to “leading national adolescent medicine experts and a growing collaborative network of additional adolescent specialists across New York State and nationally” (see page 27). Does this mean that the DOH funded Center of Excellence have a network of health care providers who could serve as trainers for the proposed project? Does the DOH funded Center of Excellence has a network of state-wide providers that could serve as a pool of participants for the proposed training (as trainers?) or would these physicians be likely to have good knowledge of adolescent friendly sexual health services?

**246. Question:** Component B – The RFA states that the COE contract provides NYSDOH access to leading national adolescent medicine experts and a growing collaborative network of additional adolescent specialists across New York State and nationally. Can a potential grantee tap into the experts to identify trainers? Or are those experts available to identify healthcare providers for training?

**Answer to questions 243, 244, 245, & 246:** The DOH funded Center of Excellence is recognized for a high level of expertise and leadership in the areas of adolescent health and youth development and can assist in identifying emerging adolescent issues; has affiliations with various adolescent professionals who are potential resources to develop professional education and who could potentially serve as trainers. Costs associated with professional education will be the responsibility of the successful applicant for Component B.

**247. Question:** If you have trainers through your own organization that could do training, you don’t need to contract outside of the organization for training?

**Answer:** Correct.

**248. Question:** Can the NYSDOH provide any more specifics about who these “adolescent experts” are? The DOH funded Center of Excellence website site reveals many Cornell development specialists, sociologists, etc, while adolescent medicine doctors seem to be from Rochester.

**Answer:** Through the various projects completed by the DOH funded Center of Excellence and the professional, research and academic affiliations of the professionals with the Center include state, national and international experts.

**249. Question:** Do grant applicants need to demonstrate their ability to identify and attract targeted health care providers to the proposed training programs?

**Answer:** Yes, as described on page 31, applicants should include this information.

**250. Question:** The RFA asks us to identify the health disparities related to race, ethnicity, disability, socioeconomic status and/or geography and how these disparities will be addressed with community health care providers (see **Page 29**). Does the state already have data on this?

**251. Question:** Component B question (page 29)—It says in the RFA that we are to identify health disparities regarding race and ethnicity, socio-economic status and geography and we wondering if the State already has data on this and would give guidance on this?

**Answer to questions 250 & 251:** Data are available on the Department of Health's website ([www.nyhealth.gov](http://www.nyhealth.gov)). Applicants are asked to describe how these disparities will be addressed specifically through their work with community health care providers.

**252. Question:** Will the providers that are targeted and served by Component B be directly connected to the projects in Component A or is Component B expected to reach beyond those involved in Component A scope of work?

**253. Question:** On **Page 8** of the RFA, under a section focusing on the purpose of the Component A CAPP Community-Based initiative, it says that one of the Core Strategies of the Component A-funded projects is to “Ensure access to comprehensive reproductive healthcare and family planning services for adolescents.” Would the NYSDOH like to see collaboration between the projects that are funded under Component A and the training initiative is funded under Component B?

**254. Question:** What are the expectations for how the Component A grantees will interface with the clinics in their communities? What is the expectation of Component B interfacing with component A grantees and providers in their communities?

**Answer to questions 252, 253 & 254:** Component B is generally independent of Component A. Component A grantees need to implement a comprehensive program that includes activities in all four core strategies described on pages 13 to 17 of the RFA, including activities under Core Strategy 2 to ensure access to comprehensive reproductive health care and family planning services for adolescents. Component A applicants that are not approved under Article 28 of the Public Health Law to provide family planning services must provide a letter from one or more family planning provider serving the targeted community stating their intent to collaborate with the CAPP applicant organization/agency. The letter needs to indicate the provider’s willingness to accept referrals, including referrals of Medicaid clients; appropriate assessment and referral; ability to provide a full range of medical family planning services; and follow-up agreements.

For Component B grantees, as stated in the CAPP RFA Section III. B, page 27, the initiative will serve New York State practicing pediatricians, family practitioners, obstetrician/gynecologists, nurse practitioners, physician assistants and other health professionals that provide healthcare for adolescents and young adults. Work done by Component A grantees to identify barriers to

adolescent access to comprehensive reproductive health care services may inform the work of the Component B grantee.

**255. Question:** Is it the intent that the Component B grantee provide training & TA to all providers (listed on pg. 27 of RFP) throughout NYS?

**Answer:** The intent of the initiative is to make training available state- wide.

**256. Question:** For Component B, will any curriculum or resource development be allowed or be expected or is Component B primarily managing the scheduling of professional education meetings and using training curricula & resources that are already in existence?

**Answer:** Both, as stated in the CAPP RFA Section III D, page 28-29, the selected applicant will be responsible for the logistics, development and coordination of state-wide and regional in-person professional trainings and other resources for community healthcare providers and others interested in these content areas through teleconferencing, DVD/CD-ROM, website and newsletter.

**257. Question:** Who sets the content of the training? Will there be existing policies, procedures, recommendations, guidelines that the training content is supposed to follow or does the grantee do this based on their expertise and experience?

**Answer:** We would expect that the grantee would have a certain level of expertise and also expertise in delivering trainings. The Department will work with the awardee to determine the significant health issues needed that to be addressed and approve training(s).

### **Review and Award Process**

**258. Question:** The RFA indicates that the state plans to provide a one-year award with four annual renewals depending on performance and availability of funding. Is the state committed to this longer-term vision given the truly ambitious scope of the proposed project? Can we create a program that is meant to serve as the foundation for a longer-term and more in-depth project?

**Answer:** New York State has had a longstanding commitment to adolescent pregnancy prevention. Despite the significant reductions in adolescent pregnancy and birth, it remains a significant public health problem facing New York State today. As noted above under modifications to the RFA, it is expected that contracts resulting from this RFA will have an initial contract year of 1/1/11-12/31/11. In place of annual renewals for Years 2-5, the Department may elect to establish a single four-year contract for Years 2-5 of this initiative. Should this occur, awardees will be provided with additional guidance at that time.