# Community Collaborative for Reimagining HIV Care

Call for Proposals

MERCK Foundation

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## 1. Overview

The Merck Foundation (the "Foundation") is pleased to announce the launch of the *Community Collaborative for Reimagining HIV Care* (the *"Collaborative"*), a five-year national initiative to improve timely access to and continuity of high-quality, person-centered care for people living with HIV in under-resourced communities across the United States.

Through this Call for Proposals, the Foundation will select eligible organizations to implement innovative, community-centered programs that address the evolving needs of people living with HIV. Eligible organizations must be designated as a qualified 501(c)(3) nonprofit organization in the United States. Please refer to Section 7 for a complete list of eligibility criteria.

**Interested applicants should submit a Letter of Intent (LOI), of no more than 5 pages, by August 26, 2026 for consideration. Please see Section 11 for LOI submission instructions.**

Following a review of LOIs, the Foundation will invite a select number of organizations to submit a full proposal. The Foundation anticipates announcing grant awards in the first quarter of 2027. Please see Section 10 for the application timeline.

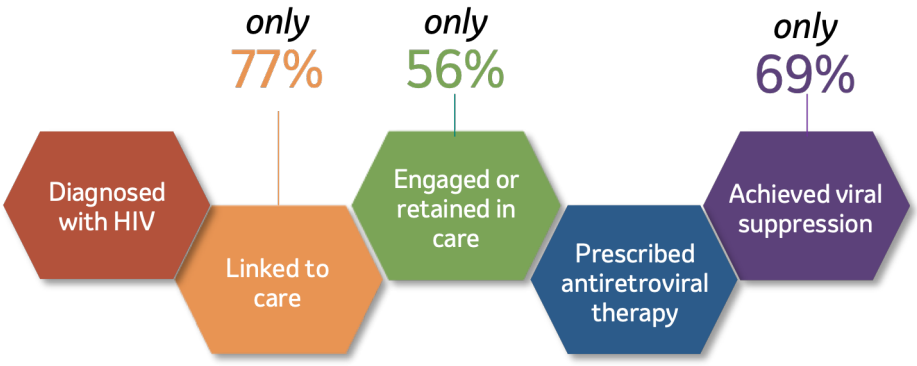
## 2. Intent of the *Community Collaborative for Reimagining HIV Care*

### Background

An estimated 1.2 million people in the United States (U.S.) are living with HIV.[1] Although overall incidence has declined, HIV disproportionately affects certain geographic regions. For example, the South accounts for more than half of all new HIV diagnoses each year.[1]

Additionally, the age of people living with HIV in the U.S. is shifting. Young people ages 25-34 represent the largest proportion of those newly diagnosed with HIV.[1] At the same time, half of all people living with HIV are now over age 50[1] – a population often managing HIV alongside chronic and behavioral health conditions and managing care across multiple providers and care systems.[2]

**Among people diagnosed with HIV in the United States:**




*Source: CDC Core Indicators for Monitoring the Ending the HIV Epidemic Initiative, Preliminary Data Through December 2025*

HIV is now a manageable chronic condition for many individuals who are connected to HIV care and treatment and remain engaged in care. For others, there are significant gaps along the HIV care continuum that have a serious effect on health outcomes.[1]

A variety of nonclinical factors – including unstable housing, food insecurity, transportation barriers, lack of insurance, HIV-related stigma, fragmented service systems – as well as mental and behavioral health needs can influence whether someone newly diagnosed with HIV is promptly linked to care and treatment and remains engaged in care over time.[3,4,5]

Persistent gaps in linkage to and retention in HIV care are evident across urban centers – where structural barriers and fragmented health services compound challenges in accessing care.[6,7] Rural communities face access challenges often due to provider shortages, travel distances and stigma that can delay diagnosis and treatment and disrupt sustained engagement in care.[8,9,10]

### A New Initiative to Advance Equitable Access to Holistic, Person-Centered HIV Care

The *Collaborative* will help improve timely access to and continuity of high-quality care for people living with HIV in under-resourced communities in the United States. The Foundation is committing $20 million over five years (2027-2031) to support this national, multi-site initiative.

The *Collaborative* aims to:

1. **Catalyze innovation in HIV care** by promoting **holistic approaches** to address the medical and social needs of people living with HIV;
2. **Improve health outcomes and quality of life** for people living with HIV through a person-centered, culturally responsive approach;
3. **Build sustainable community partnerships** to overcome barriers to access and engagement in care; and
4. Disseminate lessons learned and best practices to **advance innovative HIV care models**.

Program grantees will convene regularly to share best practices, challenges and lessons learned and participate in a variety of leadership, evaluation and data collection activities.

## 3. Expected Core Elements of Program Development

Core elements for program development are described in Sections 3.1 through 3.9. Applicants should address all elements in their proposals. In working toward achieving the *Collaborative's* goals, program grantees are expected to include the following elements in their proposed program.

### 3.1. Transform the Delivery of HIV Care

Program grantees are expected to implement a holistic, multidisciplinary, person-centered, and culturally responsive approach to HIV care delivery that addresses the complex medical, behavioral, and social needs of people living with HIV.

A **holistic approach** recognizes that HIV outcomes are connected to or influenced by the broader aspects of one's health and life.[11] People living with HIV may also have co-occurring chronic conditions (e.g., cardiovascular disease), mental and behavioral health needs, substance use disorders, unstable housing, food insecurity, transportation barriers, insurance challenges, and the cumulative effects of stigma and social isolation.[5]

**Multidisciplinary care** is characterized by the engagement of multiple health care professionals that work across clinical, behavioral, and social dimensions of health in the planning and delivery of care. This approach moves away from siloed, fragmented care models and instead emphasizes shared decision-making, clear communication, mutual respect, and a unified commitment to individuals' well-being.[12]

A **person-centered, culturally responsive approach** reflects how holistic care is delivered. Care should be tailored to individual needs, preferences, schedules, languages and lived experience, and should engage individuals as partners in their own care. [13,14] Care should also be delivered in a manner that is responsive to and respectful of an individual's cultural beliefs and practices.

*Applicants should describe their proposed approach to implementing holistic, multidisciplinary, person-centered, and culturally responsive care as steps to foster the transformation of HIV care. Section 4 provides additional guidance on related interventions.*

### 3.2. Implement Multi-Level Health Care Interventions

The *Collaborative* is built on a **multi-level model of HIV care continuity**. Decades of research and practice point to a consistent conclusion: People living with HIV stay in care when interventions reinforce one another across the levels that shape their care experience.[15,16] Single-level interventions, however well-designed, are rarely sufficient on their own.

Programs should work effectively across **all three of the following levels**: (1) individual and peer support; (2) care providers and care teams; (3) organizational processes and systems.

*Applicants should describe how their proposed interventions function across every level to create a cohesive approach to HIV care. Section 4 provides additional guidance on multi-level strategies.*

## 3.3. Collaborate with Organizations Outside the Health Care Sector to Address Social Care Needs

Cross-sectoral collaborations will enable program grantees to address nonclinical barriers to care, extend reach to underserved populations and increase capacity to enhance the array of services offered to people living with HIV.

Program grantees are expected to collaborate with organizations in various sectors outside of health care – such as food, housing, recreation/parks districts, education, public health and social services – to develop and implement effective and sustainable interventions that meet the needs of underserved populations.

*Applicants should demonstrate how they will develop and maintain collaborations with other sectors, including how they will define roles and responsibilities and how the collaboration will address relevant nonclinical barriers to care for the selected population(s). Additional guidance on cross-sectoral collaborations can be found in Section 4.4. Note: Collaborating organizations must meet the eligibility criteria outlined in Section 7.*

## 3.4. Engage the Community in Program Development and Implementation

The Foundation is interested in proposals designed in partnership with, or led by, **community-based organizations and other trusted local partners** — reflecting the belief that durable improvements in care often come from organizations accountable to the people and places they serve.

Programs will begin with a 6-month planning period during which program grantees are expected to engage members of their community and collaborating organizations in program development. Involving the community from the outset and throughout program implementation helps ensure that the program is tailored to local needs, addresses nonclinical barriers to care and is respectful and responsive to the health beliefs, practices and cultural and linguistic needs of the focus population(s).

Program grantees should implement activities that create authentic and equitable opportunities for community participation. **Appendix C provides resources for approaches to encourage community input in program development**.

*Applicants should describe the process for engaging community members and/or organizations – for example, through community advisory councils and/or focus groups – to obtain input for the program. Applicants should demonstrate how they will develop and maintain partnerships and ensure meaningful and ongoing participation and engagement with community members and/or organizations.*

### 3.5. Expand and Strengthen Existing Efforts

The *Collaborative* aims to build on and strengthen applicants' existing programs, organizational capacity, and partnerships, rather than create entirely new, stand-alone efforts. Applicants should present evaluation findings or other documentation of program successes (see Section 3.6).

Applicants should describe how they will use grant funding to build on existing programs or efforts relevant to the proposed work. For example, applicants may propose to expand successful approaches by (a) extending them to additional populations or settings, (b) adding intervention components, (c) enhancing collaborations with current partners, (d) collaborating with new partners or (e) combining components of their approaches in various ways.

*Applicants should describe their current work relevant to this initiative, including (a) work to improve HIV care delivery and health outcomes in under-resourced communities and (b) multi-level health care approaches and cross-sectoral collaborations to address medical, behavioral, and social needs of people living with HIV.*

### 3.6. Use Evidence-Informed and Practice-Based Approaches to Meet Local Needs

Program grantees are expected to implement approaches based on existing evidence or, in cases of newer approaches that have not yet been fully evaluated, based on promising practices from the field and local experience that are relevant to their communities. In developing their intervention(s), program grantees should strive to balance local innovation and knowledge with existing evidence to meet the needs of the focus population(s).

*Applicants should present evidence supporting proposed intervention approaches, such as published findings, recognized best practices, recommendations and guidelines, or preliminary evaluation findings that support the effectiveness of the proposed interventions. In developing their interventions, applicants should aim to balance innovation with existing evidence and promising practices. Applicants should demonstrate how these interventions respond to local community need, clearly describing the population(s) to be served – including relevant demographic, clinical, and contextual characteristics – with a rationale grounded in identified local gaps in care.*

### 3.7. Demonstrate Program Feasibility

Program grantees are expected to implement interventions that are feasible within the parameters of the grant (e.g., time frame, funding available) and the existing infrastructure of the applicant organization and its partners (e.g., staff capacity, resources).

*Applicants should describe the feasibility of the proposed program, including how staff and other resources will be allocated to implement the program effectively and in a timely manner. Applicants should identify potential challenges to implementing the proposed program and offer potential solutions to address them. Applicants should demonstrate organizational and partner capacity to carry out the proposed program.*

## 3.8. Plan for Sustainability

Program grantees will implement interventions that have the potential to be sustained and scaled beyond the grant funding period. Sustainability may be achieved through activities such as:

- Engaging with local, regional or national policy makers*
- Engaging payers to develop innovative cost-sharing or payment reform models
- Experimenting with revenue-generating models so that programs can self-sustain
- Securing opportunities to unlock additional funding from other funders to scale programs

**Although Foundation funds cannot be used to support legislative advocacy, we recognize the importance of engaging with policy stakeholders to identify avenues for program sustainability and communicate strategic goals of the Collaborative.*

*Applicants should present a realistic plan for sustainability and/or scalability of the program considering the local context and capacity. Plans should demonstrate how organizational infrastructure, staffing and resources can support the intervention after the grant funding ends. Applicants should describe how the program could be sustained beyond the grant period, including potential funding, policy or operational pathways to sustain successful components.*

## 3.9. Participate in a Community of Practice

Grantees will be supported through a structured peer-learning community designed to accelerate knowledge exchange, strengthen program implementation, and build the foundation for long-term sustainability. This resource includes:

- Regular convenings or virtual learning sessions with other grantees
- Peer exchange and discussion of implementation challenges, emerging lessons, and promising practices
- Opportunities to share tools, models, and implementation examples across sites

Through these activities, grantees will build relationships with peer organizations, access diverse perspectives and solutions, and establish connections with one another that extend beyond the grant funding period.

# 4. Interventions

Program grantees will be expected to implement complementary interventions that strengthen timely access to holistic, multidisciplinary, person-centered, culturally responsive HIV care and improve continuity of care over time. Interventions should be designed to address barriers to care across the following domains:

- Strengthening individual-level support
- Strengthening care delivery and workforce capacity
- Advancing system and workflow integration
- Strengthening community-based and cross-sectoral collaboration

Applicants are required to propose integrated, practical approaches that combine multiple strategies rather than rely on a single intervention. Applicants should tailor their proposed interventions to the specific context of the focus population and avoid a one-size-fits-all approach.

## 4.1. Strengthening Individual-Level Support

Programs should include strategies that directly support individuals in accessing, navigating, and remaining engaged in HIV care.

Examples include:

- Care navigation and coordination, including support with appointment scheduling, referrals, and follow-up
- Peer support models, including peer navigators, mentors, community health workers or support groups
- Rapid linkage to care
- Outreach and re-engagement strategies for individuals who have fallen out of care
- Support for addressing barriers to care, such as transportation, benefits navigation, or connection to social services
- Education and coaching to support engagement in care and self-management

*Applicants should describe how individual-level supports are tailored to the needs of the populations served and how they will contribute to improved continuity of care.*

## 4.2. Strengthening Care Delivery and Workforce Capacity

Programs should include strategies to strengthen how care is delivered and how providers and care teams support individuals over time.

Examples include:

- Multidisciplinary, team-based care models that incorporate a range of roles (e.g., clinicians, nurses, social workers, community health workers, peer navigators)

- Integration of behavioral health, mental health, and other supportive services into HIV care delivery
- Training and capacity building for primary care providers, HIV specialists, and care teams to support person-centered, coordinated care for people living with HIV—particularly for providers who may be newer to HIV care or supporting older adults with complex comorbidities
- Approaches to improve communication and coordination across care teams

*Applicants should describe how these strategies will improve the delivery of holistic, person-centered HIV care and support continuity of care.*

### 4.3. Advancing System and Workflow Integration

Programs should include strategies that strengthen systems integration and care coordination to improve continuity of care for people living with HIV.

People living with HIV often receive care and support across multiple settings, providers, and service systems. Gaps in communication, referral follow-through, care transitions, and coordination across organizations can disrupt continuity of care. Programs should aim to reduce fragmentation and strengthen the systems, workflows, and partnerships needed to support sustainable, comprehensive, person-centered HIV care.

Examples include:

- Strengthening coordination between HIV care providers and other clinical services, such as primary care, behavioral health, pharmacy, or specialty care
- Developing or improving referral pathways and closed-loop referral systems across clinical and community-based partners
- Establishing processes to support timely connection to care and reduce drop-off between services
- Improving workflows, communication protocols and shared accountability across care teams and partner organizations
- Using data systems, registries, case management platforms, or other tools to identify care gaps, support follow-up, and monitor continuity of care
- Creating or strengthening partnerships and operating structures that enable better coordination across organizations involved in supporting people living with HIV

*Applicants should describe how these strategies will improve communication and coordination across providers, teams, and organizations as well as support timely linkage, re-engagement, and retention in care.*

### 4.4. Strengthening Community-Based and Cross-Sectoral Collaboration

This initiative requires collaboration with organizations outside the health care sector to address the health-related social needs of people living with HIV. Program grantees should

establish or strengthen partnerships with groups that are addressing the nonclinical barriers to care that are most relevant to their focus population(s). Collaborators may include nonprofit organizations, community groups, faith-based organizations, health departments, social service agencies and other organizations that offer services relevant to the proposed interventions or can facilitate outreach to and communication with the communities that the program grantees will serve.

Examples include:

- Partnerships with community-based organizations to provide navigation, outreach, and supportive services
- Collaboration with organizations addressing housing, food access, transportation, behavioral health, or other social needs
- Community-based outreach and engagement strategies to build trust and connect individuals to care

*Applicants should describe how community-based and cross-sector partnerships are integrated into the program and how they contribute to improved access to and continuity of care.*

# 5. Monitoring and Evaluation

## 5.1. Cross-Site Program Evaluation

To assess the impact of the *Collaborative,* a designated evaluation team will support a cross-site evaluation involving all program grantees. The evaluation will provide evidence of the *Collaborative's* impact and support grantees' efforts to achieve sustainability and scale. The evaluation will assess improvements in HIV care delivery and HIV-related health outcomes.

The *Collaborative's* evaluation team will lead the cross-site evaluation and engage program grantees in a 6-month planning period to develop the evaluation plan, core outcomes for each program grantee to measure, and standard data collection methods and instruments that are feasible and appropriate across sites. Program grantees are expected to actively participate in evaluation design, including harmonization of cross-site metrics, and site-specific data collection efforts. Program grantees will then be responsible for collecting and reporting on data using the selected data collection instruments (further details appear in the sections below).

The cross-site evaluation will include both a **process evaluation** to examine how the interventions were implemented and an **outcome evaluation** to measure results.

The **process evaluation** will examine the following:

- How interventions were implemented
- Facilitators and barriers to implementation
- Fidelity of program implementation and reasons for changes (if any)

- Systems-level changes that occurred as a result of the *Collaborative*
- Partnerships developed or enhanced as part of the *Collaborative*
- Implementation of the sustainability plan, including barriers and facilitators to sustainability

The **outcome evaluation** will examine the impact of the *Collaborative* on key outcomes. Anticipated required core measures to be captured across all program grantees include the following (aligned to Health Resources and Services Administration Ryan White HIV/AIDS Program performance measures)[17,18]:

- **Linkage to care:** Percentage of newly referred/diagnosed clients attending first HIV medical visit within 30 days (1 month) of diagnosis
- **Retention in care:** Percentage of active clients with ≥ 2 visits ≥ 90 days apart in 12 months (1 year)
- **Missed visit rate:** Percentage of scheduled HIV appointments not attended (no-show rate)
- **Viral suppression:** Percentage of active clients with most recent viral load <200 copies/mL
- **Closed-loop referral completion:** Percentage of clients with identified need who receive documented referral + confirmed service connection within 60 days
- **Annual social needs screening:** Percentage of active clients screened annually using standardized social needs screening tool

Final updates to core measures and definitions will be established during the 6-month planning period in collaboration with grantees and the evaluation team.

## 5.2. Program Grantee-Level Data Collection and Monitoring Requirements

### 5.2.1. Cross-Site Reporting and Evaluation

All program grantees are expected to actively support the cross-site evaluation. The evaluation team will engage grantees during the 6-month planning period to finalize the evaluation plan, align on core outcome definitions, and establish standard data collection methods and instruments. Following the planning period, all grantees will be required to:

- **Report on implementation progress.** Provide regular reports on program activities, highlighting what is working, challenges encountered, adaptations made, and key lessons learned.
- **Collect and report core quantitative measures.** Collect and submit data on the standardized, required core measures to enable cross-site tracking of program reach, implementation, and outcomes, in addition to any other relevant site-specific measures.
- **Contribute qualitative documentation.** Provide observations and insights on implementation with illustrative examples (e.g., case vignettes, quotes, photos) and client stories that capture how change occurs in practice and provide context beyond quantitative data.

- **Participate in cross-site learning.** Actively engage in convenings and virtual learning sessions to facilitate peer exchange, shared problem-solving, and collective learning.

### 5.2.2. Site-Level Monitoring Plan

In addition to the cross-site data requirements described in Section 5.1, grantees are expected to develop and implement a **site-level data collection and monitoring plan** to guide day-to-day program management. This plan should enable each grantee to track implementation progress, identify challenges early, and make timely course corrections. Grantees are encouraged to leverage existing data systems and reporting infrastructure wherever possible, rather than create parallel systems.

In addition to the required core measures, grantees should identify site-specific indicators relevant to their proposed program and population. These may include shorter-term process and reach measures, patient-reported health outcomes and experience with care, health care utilization and clinical outcomes, and measures tied to locally identified barriers or program-specific activities.

*Applicants should describe their proposed approach to site-level monitoring, including planned data collection methods, how data will be gathered from collaborating organizations, and how monitoring findings will inform program management and improvement.*

*Applicants invited to submit a full proposal will also be required to include a programmatic logic model as part of their proposal. The logic model should outline planned inputs, activities, short-term outcomes and long-term outcomes aligned with the goals of the Collaborative. Further instructions on the logic model are presented in Section 11.2.1 and Appendix B.*

## 6. Dissemination of Findings

To help advance innovative HIV care models, program grantees will share the findings and lessons learned from their programs throughout the five-year initiative and at the end of the funding period. Potential approaches for disseminating findings include conference abstracts, peer-reviewed articles, op-eds or other articles and presentations to key stakeholders.

*Applicants should provide an overview of how program results will be shared widely to promote best practices in transforming HIV care to improve access to timely, high-quality, culturally responsive care for people living with HIV in under-resourced communities.*

## 7. Eligible Organizations

An eligible organization is one that the United States Internal Revenue Service has designated as a qualified 501(c)(3) nonprofit organization in the United States. Given that the *Collaborative* aims to meet both the medical and social needs of people living with HIV in under-resourced communities, applicants must demonstrate active involvement in

community-focused HIV programming and/or meaningful collaboration with local community-based organizations.

The Foundation expects the proposed program to be led by or co-led in partnership with a community-based organization (CBO), with the partnership formally established prior to application submission. For grantees that are not CBOs, the lead CBO partner must serve as a program co-director, with no less than 20% of total program funding allocated to the partner organization. The CBO partner would be bound by the same allowable and unallowable use of funds as the prime grantee and is jointly responsible for performance monitoring, evaluation, and reporting.

**Eligible organizations may include the following:**

- Health care organizations, including, but not limited to, Federally Qualified Health Centers, community health centers or clinics, integrated health systems, hospitals and other health care organizations (***Note:*** *For academic medical centers, applicants must have affiliated community-based health center(s) and clearly demonstrate active involvement of community-based health centers in the development of the application and proposed program*)
- Community-based or nongovernmental organizations
- Units of state or local government

**Organizations that are not eligible for support through the *Collaborative* include the following:**

- For-profit entities or organizations
- Political organizations
- Fraternal, labor, or veterans' organizations and activities
- Religious organizations or groups whose activities are primarily sectarian in purpose
- Organizations that discriminate on the basis of race, color, gender, sexual orientation, gender identity, marital status, religion, age, national origin, veterans' status or disability

Program grantees are encouraged to partner with other organizations in their geographic area to develop and implement locally relevant and community-informed programs and may identify additional partners as subcontractors. Subcontractors must meet the eligibility criteria outlined above.

## 8. Funding Available

The Foundation may provide an eligible organization with a maximum grant not to exceed $1,500,000 over a five-year period. Annual budgets for the proposed programs cannot exceed $300,000 in any single year. Grant funds cannot be used to displace existing funding for ongoing programs.

The indirect rate for general organizational administrative and operating costs cannot exceed 15% of the total annual grant amount of up to $300,000. Any equipment should be specifically outlined in the budget – it is not considered a general administrative cost.

***Note:*** *Grants are intended to support HIV care programs, not clinical research or other research studies.*

## 9. Allowable and Unallowable Uses of Funds

**Grant funds may be used for the following purposes:**

- Project staff salaries and fringe benefits (***Note:*** *Grant funding is not expected to provide full staff support*)
- Project consultants, such as data collection or communications support
- Other essential direct costs, including educational and training materials, limited equipment, general office materials and supplies, printing and copying, telephone and computer costs, postage and delivery and data processing
- Travel to program activities, including an annual program grantee meeting
- Subcontracts (same allowable and unallowable use of funds apply)

**Grant funds may <u>not</u> be used for the following purposes:**

- Direct clinical care, social services, or other reimbursable services such as medical care, food or housing
- Medical screening or testing
- HIV prevention, including pre- and post-exposure prophylaxis (PrEP and PEP, respectively)
- Purchase of or discounts on medications, vaccines, medical devices, or biologics
- Basic or clinical research projects, including epidemiological studies, clinical trials, outcomes research, or other pharmaceutical studies
- Unrestricted general operating support
- Financial support for political candidates, lobbying, or legislative advocacy
- Fellowship/tuition support intended for a specific individual or institution
- Endowments, including for academic chairs
- Media products that are not an integral part of the program
- Meetings, conferences, or symposia that are not integral parts of the program
- Fundraising events
- Capital or building campaigns, including new construction or renovation of facilities or health information technology installation or improvement
- Grants to one organization to be passed to another, except under specific approved subcontracting arrangements
- Programs that directly support the marketing or sales objectives of Merck & Co., Inc., Rahway, NJ, USA

***Note**: Program grantees can use funds to catalyze change at local, state or regional levels, with the aim of producing results that improve population health. However, program grantees cannot use funds to advocate for legislation at any level; to pay for direct or other reimbursable services, such as medical care, food or housing; or to supplant existing funding sources for programming.*

# 10. Project Milestones and Timeline

## 10.1. Application Timeline

| Deadline | Application Activity |
|---|---|
| **August 26, 2026** | Deadline for eligible organizations to submit a LOI |
| **September 30, 2026** | Applicants are notified whether they are invited to submit a full proposal |
| **November 23, 2026** | Deadline for invited applicants to submit full proposals |
| **Q1 2027** | Anticipate that awards will be announced |

## 10.2. Project Timeline

Proposals will include a project timeline that outlines a 6-month planning period and program implementation activities across the five-year grant period. The timeline should also note potential points when the program grantee plans to disseminate program updates or impact and any activities key to executing the programs' sustainability plan and/or promoting scalability of the program.

# 11. How to Apply

Instructions for submitting a proposal through the two-step application process are outlined below. All questions regarding the application process can be directed to hivcollaborative@rabinmartin.com.

## 11.1. Letter of Intent

The first step in the application process is to submit a Letter of Intent (LOI) by August 26, 2026 to hivcollaborative@rabinmartin.com. **The LOI should be no longer than five pages** (1.5 line spaced, minimum 10-point font size) and include:

**Cover Page**

- Program director information (name, title, affiliation, mailing/shipping address, telephone number and e-mail address)
- Contact person information (if different from program director)
- Communications contact person's information

**Organization overview** (approximately 0.25 page)

- Organization's mission and core values

- Current services and programs offered

**Section 1: Program focus** (approximately 0.5 page)

- Program goals and objectives
- Description of barriers to HIV care and HIV disparities in the local community to be addressed through the program
- Description of population(s) and communities served, including relevant demographic (e.g., age range, race or ethnicity, gender, gender identity, socioeconomic status, etc.), clinical, and social context — and the circumstances that shape their engagement in HIV care
- Geographic area for programs and population statistics for the area, specifically, total population of geographic area and population(s) to be served

**Section 2: Proposed program** (approximately 3 pages)

- Overview of proposed interventions focused on improving timely access to and continuity of HIV care through a holistic, person-centered and culturally responsive approach. Interventions should include multi-level strategies addressing individual-level support, provider and workforce capacity, and system and workflow integration
- Overview of proposed cross-sectoral collaborations, including how they will address nonclinical barriers to HIV care (e.g., health-related social needs)
- Discussion of how proposed interventions build on current programs and successes in the community
- Potential impact on improving access to timely high-quality, person-centered care and maintaining continuity of care for people living with HIV
- Overview of proposed plan to monitor successful program implementation
- ***Note:*** **LOIs should not reference any medicines manufactured by Merck or any other company.**

**Section 3: Capabilities and Experience** (approximately 1 page)

- Capabilities and experience of the organization, the program director, co-directors and other key staff (e.g., data manager, communications staff) as they relate to the program goals and interventions
- Qualifications of key staff in collaborating organizations and any subcontractors or consultants
- Experience of program partners related to addressing barriers to care in their communities
- Evidence of authentic community engagement through prior or current collaborations with community stakeholders, partners and organizations beyond letters of support; evidence may include joint grant proposals, co-authored publications and documented program collaborations with previous or current partners.

The Foundation will review the LOIs and invite selected applicants to submit full proposals. All applicants will be notified whether they have been selected by **September 30, 2026**.

## 11.2. Invited Full Proposals

Invited applicants will submit a full proposal by **November 23, 2026**. The full proposal should include three sections as separate documents:

- **Section I:** Proposal narrative including Cover Page, Table of Contents, Program Plans, Data Collection Plans, Organizational Capabilities and Experience and Key Personnel and Staffing Plan (see Exhibit A.)
- **Section II:** Appendices
- **Section III:** Detailed budget and narrative budget justification

Invitations for full proposals will include instructions and the URL for uploading proposal documents to the Foundation's online grants management system.

### 11.2.1. Section I

The specifications for this section should include a header on each page that details the name of the program director and consecutive page numbers covering all of Section I. Section I should not exceed 20 pages. Please use 1-inch margins, type font no smaller than Arial 11 point and set for one-sided printing. ***Note:*** **Proposals should not reference any medicines manufactured by Merck or any other company.**

**Exhibit A.: Overview of Section I – Proposal narrative sections and content**

| | |
|---|---|
| **1.** Cover page | • Program title<br>• Program director information (name, title, affiliation, and contact information)<br>• Contact person, if different from the program director<br>• Person responsible for grant and budget administration, if different from the program director<br>• Website<br>• Proposed grant period<br>• Total amount of funding requested (not to exceed $1,500,000 over five years) |
| **2.** Table of Contents | • Limit to one page |
| **3.** Project Plan | |
| 3.1. Project goals and objectives | • Statement of goals and objectives of the proposed program<br>• Discussion on how program will transform the delivery of HIV care by promoting person-centered approaches to meet the medical and social needs of people living with HIV through:<br>  ○ Holistic approaches to care<br>  ○ Tailored and culturally responsive care<br>  ○ Multidisciplinary, coordinated, team-based care<br>  ○ Cross-sectoral collaboration with community-based organizations<br>• Anticipated impact of the program, including estimated number of people to be reached over the 5-year period |
| 3.2. Implementation context | • Disparities in HIV care and health outcomes in the local community to be addressed |

| | |
|---|---|
| | • Barriers related to health-related social needs (housing, transportation, food security, stigma, etc.)<br>• Geographic area for program and population level statistics for the area, specifically: total population of geographic area and population(s) to be served by the program (including race and ethnicity, age range, gender, gender identity, socioeconomic status) and rationale for focusing on a specific group(s) and/or geographic area(s) (e.g., access to high-quality care, disparities in morbidity, mortality)<br>• Description of organization's access to and experience with the identified population(s) |
| 3.3. Intervention strategies | • Description of proposed multi-level intervention strategies at individual, provider/workforce, and system levels<br>• Description of cross-sectoral collaborations and how they will address medical and social needs to transform HIV care through holistic, multidisciplinary, person-centered care<br>• Evidence to support proposed intervention strategies<br>• Description of how the proposed intervention strategies will build on, strengthen and/or expand existing programs, and prior successes<br>• Description of how the proposed interventions will help to achieve the initiative's goals and the local program goals and objectives<br>• Description of anticipated challenges and proposed strategies to address them |
| 3.4. Cross-sectoral collaborations | • Description of how program is led by or co-led in partnership with community-based organizations<br>• Description of community and cross-sector collaborator(s), including type of organization, mission, population(s) served and relevant capabilities<br>• Evidence of strong community connection and partnership with trusted local partners<br>• Roles and responsibilities of community-based and cross-sector collaborators<br>• Description of how collaborations will be developed and maintained throughout implementation |
| 3.5. Engage the community in program planning | • Discussion of how people living with HIV and community members will be meaningfully engaged during the program planning period and implementation (e.g., through a community advisory board) and how community involvement will be developed and maintained |
| 3.6. Feasibility | • Description of how staff and resources, including collaborating organizations, will be allocated within the budget and timeframe of the *Collaborative*<br>• Description of potential challenges with program implementation and solutions to address them |
| 3.7. Sustainability | • Description of options to sustain and scale the program or specific elements beyond the grant period, including how staffing and other program costs will be supported<br>• Identification of potential challenges to program sustainability and scalability and strategies for addressing them |

| | |
|---|---|
| 3.8. Overall project timeline | • Project planning and implementation timeline with specific milestones, including 6-month planning period |
| **4.** Data collection | |
| 4.1. Program logic model and impact metrics | • Logic model outlining the key components of the proposed program and the relationship between the outcomes expected in the short-, intermediate- and long-term and the proposed inputs and activities, including illustrative programmatic metrics to assess impact. More details can be found in Appendix B. |
| 4.2. Data collection methods | • Proposed data collection methods, including how data will be collected from collaborating organizations. ***Note:*** *grantees are encouraged to leverage existing data systems and reporting infrastructure wherever possible, rather than create parallel systems.*<br>• Description of local program monitoring plan |
| 4.3. Dissemination of findings | • Identification of potential approaches to share findings and program results |
| **5.** Organizational Capabilities and Experience | • Existing programs, activities, staffing, and resources in the areas of the proposed project<br>• Detail of similar information for subcontractor(s)<br>• Key accomplishments, evaluation findings and lessons learned from previously and currently funded relevant projects and, if appropriate, how ongoing projects will be integrated with the currently proposed project<br>• Capabilities to implement monitoring and evaluation activities (may be through arrangement with external evaluation organization), including to collect patient outcomes and track health care utilization<br>• Description of prior experience, if any, participating in a multi-site initiative and convening with peers as part of a cohort to share best practices, challenges and lessons learned<br>• Past and current community collaborations and relationship to the currently proposed project<br>• Description of experience and past success with sustainability planning<br>• Pending funding from the Ryan White HIV/AIDS Program (including amount) and other sources (including potential funding sources and amounts) for projects similar to the proposed project |
| **6.** Key Personnel and Staffing Plan | • Titles, affiliations, experience, and qualifications of program director, co-directors, program manager, and other key staff<br>• Roles and responsibilities for program director and other key staff, lines of authority (include an organizational chart)<br>• Percentage of time on program anticipated for program director and other key staff<br>• Role of subcontractor(s) staff, if any |

### 11.2.2. Section II

Proposals may include a limited number of appendices:

- Resumes for the program director and other key staff (limited to two pages each)
- Documentation of 2-3 relevant community partnership commitments outlining evidence of prior collaboration beyond letters of support

### 11.2.3. Section III

The budget should include sufficient detail on labor and other costs for reviewers to assess how program activities will be supported and the adequacy of proposed staffing. The budget should be submitted in Excel format with (1) a summary worksheet for all 5 years, and (2) separate summary worksheets for each year of funding requested. The summary worksheets should present the following information:

- **Salary and fringe benefits.** List personnel individually by title. Include annual salary, percentage of time on the project, and fringe benefits in accordance with applicant's personnel policies.
- **Travel and transportation.** State the number of trips and specify the origin and destination for proposed trips, mode and duration of travel, and number of individuals traveling. Travel expenses should be based on the applicant's standard travel policies.
- **Equipment.** Include a breakdown of equipment by type, including unit cost and quantity.
- **Supplies.** Include a breakdown of supplies by type, including unit cost and quantity.
- **Trainings or workshops.** Break down by type of training or workshop, including number of participants and days.
- **Subcontracts.** List any goods and services procured through a contract mechanism, including subgrants and consultants. Show each contract separately and provide a breakdown of costs included, such as a daily rate and number of days for consultants.
- **Other direct costs.** Include costs associated with communications, printing, report preparation, telephone and computer, data processing, and so on.
- **Indirect costs.** Indirect rates shall not exceed 15%.
- **In-kind contributions.** Includes in-kind support from applicant and/or collaborating organizations, if any, for the program

A detailed narrative budget justification should be prepared in Microsoft Word to address the following:

- Amount and duration of requested funding
- Explanation and justification for all budget line items

## 12. Full Proposal Review and Evaluation Criteria

The Foundation will review invited proposals, with input from a panel of external experts, including the review criteria outlined below in Exhibit B. The Foundation cannot return proposals or provide individual technical critiques.

**Exhibit B. Technical evaluation weights for invited full proposals**

| Review Criteria | Points |
|---|---|
| **Potential impact of the program,** including the significance of program goals as they relate to transforming HIV care through holistic, person-centered, multidisciplinary approaches and reducing barriers related to health-related social needs among the population(s) to be served. Impact will also be assessed based on the proposed program logic model and potential scale and reach of the interventions. | 20 |
| **Evidence-informed innovation** and strength of intervention approaches that build on scientific evidence and offer innovative, multi-level, integrated and locally adapted approaches. | 20 |
| **Cross-sectoral collaboration,** including the diversity of organizations and how collaborations will expand the reach and effectiveness of the program and address barriers related to health-related social needs. | 15 |
| **Qualifications and experience** of the organization, program director, co-directors, and other key staff. | 15 |
| **Demonstrated community standing and track record** within the HIV communities the organization serves. | 10 |
| **Sustainability plan** for proposed interventions and cross-sectoral community collaborations. | 10 |
| **Data collection plan and capabilities,** including demonstrated capabilities to contribute to the cross-site evaluation. | 10 |
| Total | 100 |

## Appendix A: References


[1] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (U.S.). Division of HIV/AIDS Prevention. "Core Indicators for Monitoring the Ending the HIV Epidemic Initiative, Preliminary Data Through December 2025 [Tables]." CDC Stacks. May 7, 2025. https://stacks.cdc.gov/view/cdc/256157

[2] National Institutes of Health. "HIV and Specific Populations: HIV and Older People." April 21, 2026. HIVinfo.nih.gov. Accessed May 4, 2026. https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-older-people

[3] Health Resources and Services Administration (HRSA). Ryan White HIV/AIDS Program Annual Data Report. 2024. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/2024-ryan-white-annual-data-report.pdf

[4] Moitra, Ethan, Paola Jiménez Muñoz, Johanna Ramirez, and Megan M. Pinkston. "Barriers and Pathways to Re-Engage People with HIV and Substance Use in Medical Care: A Qualitative Study among Persons with Lived Experience." *AIDS Research and Therapy* 22 (October 21, 2025): 106. https://doi.org/10.1186/s12981-025-00803-y

[5] Dawson, Lindsey and Jennifer Kates. "What Do We Know About People with HIV Who Are Not Engaged In Regular HIV Care?". KFF, June 22, 2023. https://www.kff.org/hiv-aids/what-do-we-know-about-people-with-hiv-who-are-not-engaged-in-regular-hiv-care/

[6] Dombrowski, Julia C., Maria A. Corcorran, Tara Carney, Miłosz Parczewski, and Monica Gandhi. "The Impact of Homelessness and Housing Insecurity on HIV." *The Lancet HIV* 12, no. 6 (2025): e449–58. https://doi.org/10.1016/S2352-3018(25)00048-7

[7] O'Grady, Thomas, Marlene Eisenberg, Stephen Weinberg, Ainur Kussainova, James Tesoriero, and Shu-Yin John Leung. "Housing Instability as a Barrier to HIV Viral Suppression: Evidence from a U.S. Systematic Review and Meta-Analysis." *AIDS and Behavior*, ahead of print, May 22, 2026. https://doi.org/10.1007/s10461-026-05177-4

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[9] Tao, Jun, Mofan Gu, S. Alexandra Marshall, et al. "Engagement and Retention in HIV Care in Rural Southern U.S. Using an All-Payer Claims Database." *PLOS One* 20, no. 12 (2025): e0339520. https://doi.org/10.1371/journal.pone.0339520

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[13] AIDS Education and Training Center National HIV Curriculum. "Cultural Humility and Patient-Centered Care." Accessed June 9, 2026. https://aidsetc.org/topic/patient-centered

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## Appendix B: Program Logic Model Template

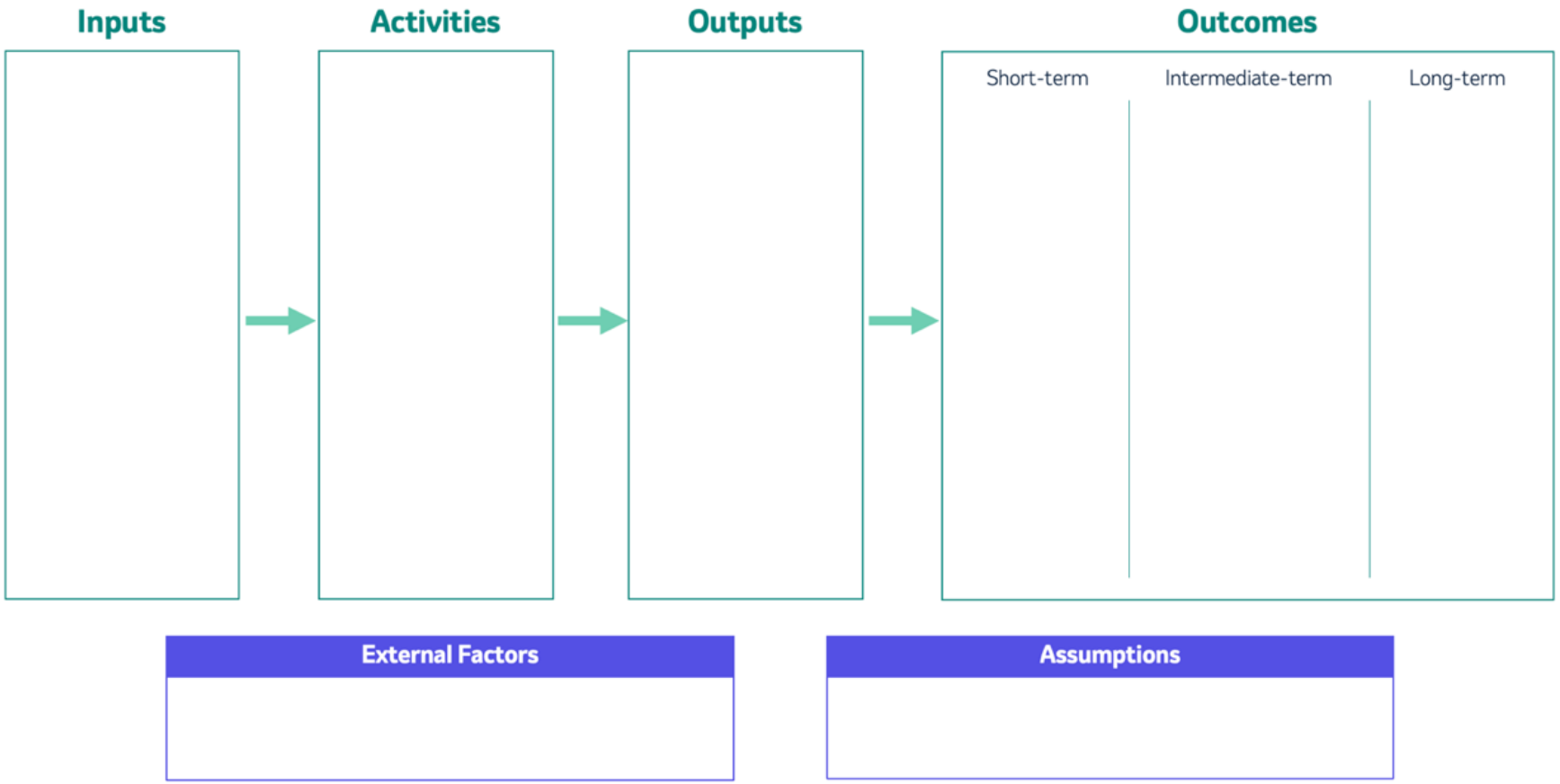
Applicants invited to submit a full proposal are required to submit a logic model outlining the key components of the proposed program and relationship between the outcomes expected in the short-, intermediate-, and long-term and the proposed inputs and activities.

A logic model template is provided on the next page. Applicants should develop their own logic models in Microsoft Word and include it in the appendices of the full proposal submission.

Applicants are welcome to approach the logic model as they see fit, but we recommend including the below elements:

- **Inputs:** The resources (e.g., financial, human, and technological) required to conduct the activities proposed
- **Activities:** The specific changes or action that will occur to produce the outputs and outcomes proposed
- **Outputs:** The quantifiable deliverables that are a result of the proposed activities that take place
- **Outcomes:** The impact you expect the inputs, activities, and outputs will have for the focus population and wider community
- **External Factors:** The elements outside of one's control that can affect the success of the program or intervention (e.g., economic environment, climate, and conflict).
- **Assumptions:** The aspects, situations, or components that may help or hinder the success of the intervention or program

## Program Logic Model Template:



# Appendix C: Additional Resources for Applicants

## HIV Care Transformation

### Person-Centered Care

- Cultural Humility and Patient-Centered Care, National AETC Support Center (NASC) (link)
- Adherence to the Continuum of Care: Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV, U.S. Department of Health and Human Services (link)

### Coordinated, Team-Based Care

- Primary Care Guidance for Providers Who Care for Persons With HIV: 2024 Update by the HIV Medicine Association of the Infectious Diseases Society of America (HIVMA/IDSA), Clinical Infectious Diseases (link)
- Building a Medical Home for HIV-Positive, Multiply Diagnosed Homeless Populations, American Journal of Public Health (link)
- Integrating Community Health Workers into HIV Care Clinics: A Qualitative Study with Health System Leaders and Clinicians in the Southern United States, BMC Health Services Research (link)

### Differentiated Service Delivery (DSD)

- A Systems Level Approach to Innovative HIV Care and Treatment Models in the United States: Street Medicine and Differentiated Service Delivery: White Paper, HIV Medicine Association (link)
- Differentiated Service Delivery for HIV Treatment and Prevention – Online Training Course. International AIDS Society (link)

### Low-Barrier, Walk-In, and Wraparound Care Models

- Implementation of Low-Barrier Human Immunodeficiency Virus Care: Lessons Learned From the Max Clinic in Seattle. Clinical Infectious Diseases (link)
- Telehealth Challenges, Opportunities, and Policy Recommendations for Rural Older Adults Living with HIV in the United States. Journal of Aging & Social Policy (link)

### Rapid ART Initiation

- Rapid ART Initiation, New York State Department of Health AIDS Institute Clinical Guidelines Program (link)
- Initiation of Antiretroviral Therapy, Clinical Info, U.S. Department of Health and Human Services (link)
- Essential Elements of and Challenges to Rapid ART Implementation: A Qualitative Study of Three Programs in the United States, BMC Infectious Diseases (link)

**Individual**

- A Scoping Review of Peer Navigation Programs for People Living with HIV: Form, Function and Effects, AIDS and Behavior (link)
- Outcomes and Costs of Publicly Funded Patient Navigation Interventions to Enhance HIV Care Continuum Outcomes in the United States: A Before and After Study, PLOS Medicine (link)
- Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention — Linkage to, Retention in, and Re-engagement in HIV Care, Centers for Disease Control and Prevention (link)

**Provider**

- HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review, Centers for Disease Control and Prevention (link)
- HIV Stigma and Health Care Discrimination Experienced by Hispanic or Latino Persons with HIV — United States, 2018–2020, Morbidity and Mortality Weekly Report (link)
- HIV Related Stigma among Healthcare Providers: Opportunities for Education and Training, AIDS Patient Care and STDs (link)
- Cultural Competence and Humility in Infectious Diseases Clinical Practice and Research, Journal of Infectious Diseases (link)

**Health Care Teams**

- A Community Health Worker Approach for Ending the HIV Epidemic, American Journal of Preventive Medicine (link)
- Using Community Health Workers to Improve Clinical Outcomes Among People Living with HIV: A Randomized Controlled Trial, AIDS Behavior (link)

**Health Care Organizations and Systems**

- Effective Interventions by EHE Pillar, Centers for Disease Control and Prevention (link)
- HIV Data to Care—Using Public Health Data to Improve HIV Care and Prevention, Journal of Acquired Immune Deficiency Syndromes (JAIDS) (link)
- HIV/AIDS Value Based Payment Arrangement Fact Sheet, New York State Department of Health Medicaid Redesign (link)
- Impact of a Medical Home Model on Costs and Utilization Among Comorbid HIV-Positive Medicaid Patients, American Journal of Managed Care (link)

## Cross-Sectoral Collaborations and Interventions

- Housing Opportunities for Persons With AIDS (HOPWA) Program, U.S. Department of Housing and Urban Development (link)
- Housing and Health, HIV.gov, U.S. Department of Health and Human Services (link)

- Food Is Medicine for Human Immunodeficiency Virus: Improved Health and Hospitalizations in the Changing Health Through Food Support (CHEFS-HIV) Pragmatic Randomized Trial, The Journal of Infectious Diseases (link)
- Comprehensive and Medically Appropriate Food Support Is Associated with Improved HIV and Diabetes Health, Journal of Urban Health (link)
- Southern States Manifesto 2024, Southern AIDS Coalition (cross-sector policy and program priorities for the South) (link)

## Aging with HIV and Comorbidity Management

- Special Populations: HIV and the Older Person, Clinical Info, U.S. Department of Health and Human Services (link)
- Guidance: Addressing the Needs of Older Patients in HIV Care, New York State Department of Health AIDS Institute Clinical Guidelines Program (link)
- Comprehensive Geriatric Assessment in Older Persons With HIV, Open Forum Infectious Diseases (link)
- Aging with HIV, HIV.gov, U.S. Department of Health and Human Services (link)