IHS or pass-through entity all violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award.

Submission is required for all applicants and recipients, in writing, to the IHS and to the HHS Office of Inspector General all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. 45 CFR 75.113.

Disclosures must be sent in writing to: U.S. Department of Health and Human Services, Indian Health Service, Division of Grants Management, ATTN: Mr. Robert Tarwater, Director, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857 (Include ''Mandatory Grant Disclosures'' in subject line), Office: (301) 443–5204, Fax: (301) 594–0899, Email: *Robert.Tarwater@ihs.gov.*

And,

U.S. Department of Health and Human Services, Office of Inspector General, ATTN: Mandatory Grant Disclosures, Intake Coordinator, 330 Independence Avenue SW, Cohen Building, Room 5527, Washington, DC 20201, URL: *https://oig.hhs.gov/fraud/report-fraud/*, (Include ''Mandatory Grant Disclosures'' in subject line), Fax: (202) 205–0604 (Include ''Mandatory Grant Disclosures'' in subject line) or Email: *MandatoryGranteeDisclosures@oig.hhs.gov.*

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to: Ms. Lisa C. Neel, Public Health Advisor, Office of Public Health Support, Division of Epidemiology & Disease Prevention, Indian Health Service, 5600 Fishers Lane, Mailstop: 09E17B, Rockville, MD 20857, Phone: (301) 443–4305, Email: *Lisa.Neel@ihs.gov.*

2. Questions on grants management and fiscal matters may be directed to: Mr. John Hoffman, Senior Grants Management Specialist, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2116, Fax: (301) 594–0899, Email: *John.Hoffman@ihs.gov.*

3. Questions on systems matters may be directed to: Mr. Paul Gettys, Grant Systems Coordinator, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2114; or the DGM main line (301) 443–5204, Fax: (301) 594–0899, Email: *Paul.Gettys@ihs.gov.*

VIII. Other Information

The Public Health Service strongly encourages all grant, cooperative agreement and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

Dated: July 31, 2019.

Michael D. Weahkee,

Assistant Surgeon General, U.S. Public Health Service, Principal Deputy Director, Indian Health Service.

[FR Doc. 2019–16760 Filed 8–5–19; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Division of Epidemiology and Disease Prevention; Epidemiology Program for American Indian/Alaska Native Tribes and Urban Indian Communities Ending the HIV Epidemic in Indian Country

Announcement Type: Competing Supplement.

Funding Announcement Number: HHS–2019–IHS–EPI–0002.

Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.231.

Key Dates

Application Deadline Date: September 5, 2019.

Earliest Anticipated Start Date: September 30, 2019.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) Office of Public Health Support, Division of Epidemiology and Disease Prevention (DEDP), in partnership with the IHS Office of Clinical and Preventive Services (OCPS) National Human Immunodeficiency Virus (HIV) & Viral Hepatitis C (HCV) Program and the U.S. Department of Health and Human Services (HHS) Minority HIV/AIDS Fund (MHAF) is accepting applications for competitive supplemental funds to enhance activities in the Epidemiology Program for American Indian/Alaska Native (AI/AN) Tribes and Urban Indian communities. This program is funded by the Office of the Assistant Secretary, HHS, is authorized under the statutory earmark for minority AIDS prevention and treatment activities, and is to be carried out pursuant to Title III of the Public Service Act. The funding is being made available through an intra-Departmental Delegation of Authority (IDDA) to award specific funding for fiscal year (FY) 2019. This program is described in the Assistance Listings located at *https://beta.sam.gov* (formerly known as Catalog of Federal Domestic Assistance) under 93.231.

Background

The Tribal Epidemiology Center (TEC) program was authorized by Congress in 1996 as a way to provide public health support to multiple Tribes and Urban Indian communities in each of the IHS Areas. Only current TEC grantees are eligible to apply for the competing supplemental funding under this announcement and must demonstrate that they have complied with previous terms and conditions of the TEC program.

The Office of Infectious Disease and HIV/AIDS Policy (OIDP) is located within the Office of the Assistant Secretary for Health HHS. The OIDP has directed the IHS to make awards to conduct projects and activities in support of the Ending the HIV Epidemic: A Plan for America initiative (EHE). The purpose of MHAF is to reduce new HIV infections, improve HIV-related health outcomes, and to reduce HIV-related health disparities for racial and ethnic minority communities by supporting innovation, collaboration, and the integration of best practices, effective strategies, and promising emerging models in the response to HIV among minority communities.

Current data on the burden of HIV in the United States (U.S.) tells us where HIV transmission occurs more frequently than other jurisdictions. In 2016 and 2017, more than 50% of new HIV diagnoses occurred in 48 counties and the jurisdictions of Washington, District of Columbia (DC) and San Juan, Puerto Rico. In addition, seven states have a substantial rural burden reflecting more than 75 cases and 10% or more of their diagnoses in rural areas.

Our national investments in HIV for nearly four decades have shown remarkable results in preventing new infections, improving health outcomes, and reducing deaths in hundreds of thousands of Americans. Despite this, progress has plateaued and additional

effort is needed to ensure that all affected groups derive benefit equally. Some groups, like American Indian/Alaska Native, African American and Latino gay and bisexual men, transgender individuals, or people living in the South, have a higher burden of HIV and experience health disparities at each stage of the HIV care continuum. Southern states today account for an estimated 44% of all people living with an HIV diagnosis in the U.S.,[1] despite having only about one-third (37%) of the overall U.S. population.[2] Diagnosis rates for people in the South are higher than for Americans overall. Eight of the 10 states and all 10 metropolitan statistical areas with the highest rates of new HIV diagnoses are in the South. In addition to the severe burden in the South, nationally there is a high incidence of HIV among transgender individuals, high-risk heterosexuals, and persons who inject drugs.[3]

As recognized by the President during the February 2019 State of the Union address, we have an unprecedented opportunity to end the HIV epidemic in America. We have access to the most powerful HIV prevention and treatment tools in history and new technology that allows us to pinpoint where infections are spreading most rapidly. By effectively equipping all at-risk communities with these tools, we can end the HIV epidemic in America. The EHE acts boldly on this unprecedented opportunity by providing the hardest hit communities with the additional expertise, technology, and resources required to address the HIV epidemic in their communities. Phase One of the EHE focuses on the areas of the nation that comprised more than 50% of the new HIV diagnoses in 2016 and 2017, including 7 states with marked rural HIV burden, 48 individual counties among other states and the jurisdictions of Washington, DC, and San Juan, Puerto Rico. See *https://www.hiv.gov* and *https://files.hiv.gov/s3fs-public/Ending-the-HIV-Epidemic-Counties-and-Territories.pdf* for more information about the EHE and its Phase One focus jurisdictions. The utilization of the MHAF for this funding announcement given its mission and goals, is a critical building block in this effort and reflects our decision to act now.

HHS recently developed a set of critical health priorities for the nation known as ''Leading Health Indicators'' (or LHIs) that are a call to action in critical public health areas. HHS will use the LHIs to assess the health of the U.S. population over the next decade, to facilitate collaboration among diverse groups, and to motivate individuals and communities to take action to improve their health. The following LHIs also will be used by policymakers and public health professionals to track progress in local communities as they work toward meeting these key national health goals:

(1) Diagnose 95 percent of persons aged 13 years and older living with HIV who are aware of their HIV infection by 2025, working from a baseline of 85.8 percent in 2016.

(2) Treat 95 percent of persons aged 13 years and older via linkage to appropriate care within one month of diagnosis by 2025, working from a baseline of 78.3 percent in 2017.

(3) Treat 95 percent of persons aged 13 years and older diagnosed with HIV via sufficient viral suppression (viral load, 200 copies/ml) by 2025, working from a baseline of 61.5 percent in 2016.

(4) Prevent new HIV infections by achieving 50–60 percent PrEP coverage among those for whom PrEP was indicated by 2025.

There are notable concerns in new HIV diagnoses in AI/AN populations compared to some other race/ethnicities: (1) New HIV diagnoses among AI/AN people increased by 70% from 2011 to 2016; (2) AI/AN patients have the lowest three-year survival rates of any race/ethnicity after an AIDS diagnosis; and (3) both male and female AI/AN people had the highest percent of estimated diagnoses of HIV infection attributed to injection drug use.[4] Mortality data also found that AI/AN individuals have significantly higher death rates from HIV/AIDS than whites, which could be attributable to later diagnosis, lack of linkage to care, difficulty accessing care, challenges to treatment adherence, or other factors or combination of factors.

Another common co-morbidity for bloodborne HIV infection is Hepatitis C Virus (HCV) infection. In 2009, approximately 21% of HIV-infected adults who were tested for past or present HCV infection tested positive, although co-infection prevalence varies substantially according to HIV-infected risk group (*e.g.,* men who have sex with men (MSM), high-risk heterosexuals, and persons who inject drugs).[5] [6] [7] As HCV is a bloodborne virus primarily transmitted through direct contact with the blood of an infected person, coinfection with HIV and HCV is common (62–80%) among HIV-infected injection-drug users.[8] [9] [10] Although transmission via injection drug use remains the most common mode of HCV acquisition in the U.S.,[9] sexual transmission is an important mode of acquisition among certain groups, including HIV-infected MSM with certain risk factors.[11] Data have shown that HCV disproportionately affects AI/AN people, with HCV-related mortality more than double the national rate.[12] In a recent IHS survey, almost 50% of the AI/AN individuals diagnosed with HCV were born after 1965 and younger than the targeted birth cohort for HCV screening campaigns (1945–1965, 'Baby Boomers'). Untreated HCV can lead to a myriad of extrahepatic manifestations and cirrhosis with complications such as portal hypertension, end stage liver disease, and hepatocellular carcinoma (HCC). Early diagnosis and treatment of

[1] Centers for Disease Control and Prevention (CDC). HIV Surveillance Report, 2014; vol. 26. Available at *https://www.cdc.gov/hiv/library/reports/surveillance/*. Published December 2015.

[2] U.S. Census Bureau. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014. Available at *http://factfine.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&src=pt.* Accessed November 13, 2015.

[3] Department of Health and Human Services, Centers for Disease Control and Prevention. HIV in the United States and dependent areas. *https://www.cdc.gov/hiv/statistics/overview/ataglance.html.* Updated January 29, 2019. Accessed February 5, 2019.

[4] *https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf.*

[5] Garg S, Brooks J, Luo Q, Skarbinski J. Prevalence of and Factors Associated with Hepatitis C Virus (HCV) Testing and Infection Among HIV-infected Adults Receiving Medical Care in the United States. Infectious Disease Society of America (IDSA). Philadelphia, PA, 2014.

[6] Yehia BR, Herati RS, Fleishman JA, Gallant JE, Agwu AL, Berry SA, et al. Hepatitis C virus testing in adults living with HIV: A need for improved screening efforts. PLoS ONE 2014;9(7):e102766. *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0102766.*

[7] Spradling PR, Richardson JT, Buchacz K. Trends in hepatitis C virus infection among patients in the HIV Outpatient Study, 1996–2007. J Acquir Immune Defic Syndr 2010;53:388–396.

[8] Yehia BR, Herati RS, Fleishman JA, Gallant JE, Agwu AL, Berry SA, et al. Hepatitis C virus testing in adults living with HIV: a need for improved screening efforts. PLoS ONE 2014;9(7):e102766. *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0102766.*

[9] Spradling PR, Richardson JT, Buchacz K. Trends in hepatitis C virus infection among patients in the HIV Outpatient Study, 1996–2007. J Acquir Immune Defic Syndr 2010;53:388–396

[10] Centers for Disease Control and Prevention. *https://www.cdc.gov/hepatitis/statistics/2015surveillance/commentary.htm.* Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2017.

[11] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at *https://www.ncbi.nlm.nih.gov/pubmed/19357635* July 6, 2018.

[12] *https://aspe.hhs.gov/system/files/pdf/260026/HepC.pdf.*

HCV infection prevents the development of extrahepatic manifestations, and progressive liver disease including cirrhosis. Recently developed treatments for HCV are more accessible and highly effective at greatly reducing HCV- and HCC-related mortality. Treatment for HCV can be highly successful at the primary care level with appropriate planning and support.

Data also show that Sexually Transmitted Infection (STI) rates remain elevated in Indian Country. Recurrent STIs can increase the likelihood of HIV transmission. Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis, particularly among MSM. The latest Indian Health Surveillance Report: Sexually Transmitted Diseases 2015 [13] showed that AI/AN people have 3.8 times the incidence rate of whites for chlamydia and 4.4 times the rate of whites for gonorrhea. Compared to other races/ethnicities, AI/AN people have the second highest rates for both chlamydia and gonorrhea. Gonorrhea rates have continued to increase drastically since 2011. Regional differences in STI incidence in Indian Country are also observed. There is a disparate and increased STI burden among AI/AN youth and AI/AN women, particularly women of reproductive age. In addition, recent outbreaks of syphilis have been observed among AI/AN communities. Some of these outbreaks are connected to the use of injection drugs and methamphetamines, all known risk factors for HIV transmission.

Finally, treatment for substance use disorders can be difficult to access in IHS catchment areas, as the appropriated budget includes fewer dollars per patient compared to other federal direct-care networks. Untreated substance use disorders can exacerbate risk-taking behavior and reduce adherence to treatment.

Confronting these intersecting epidemics requires collaboration across sectors and disciplines and the use of existing public health and clinical infrastructures. Lasting changes to these trends for HIV and related comorbidities among AI/AN people will also require innovative new approaches, incorporating existing and new data sources, all driven by community input.

Purpose

The purpose of this IHS competitive supplement is to support communities in reducing new HIV infections and relevant co-morbidities, specifically STI and HCV infections, improve HIV-, STI- and HCV-related health outcomes, and to reduce HIV-, STI- and HCV-related health disparities among AI/AN people.

The MHAF is funding IHS grantees to meet the four strategies of EHE—diagnose, treat, protect, and respond. Our goal is ambitious and the pathway is clear—employ strategic practices in Indian Country to: (1) Diagnose all people with HIV as early as possible after infection; (2) treat the infection rapidly and effectively to achieve sustained viral suppression; (3) respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections and (4) establish local teams committed to the success of the initiative in each jurisdiction.

To reach the EHE goal of 75% reduction in new HIV infections in 5 years and at least 90% reduction in 10 years, the IHS, through an IDDA to obligate specific amounts from MHAF, is offering this funding opportunity to the TECs to support activities across Indian Country within the *Community Planning Domain.*

Developing the Foundation for Phase 1 of EHE: the Community Planning Domain

Each application must address the *Community Planning Domain* of the EHE. Aspects to include are listed below and are priority areas for this Notice of Funding Opportunity (NOFO). However, applications may include other aspects of the community planning domain not specifically mentioned below. Proposed activities should focus on HIV but should also include opportunities to address relevant STIs and HCV.

Limited Competition Justification

The IHS enters into cooperative agreements with TECs under the authority of Section 214(a)(1) of the Indian Health Care Improvement Act, Public Law 94–437, as amended by Public Law 102–573. The TECs carry out a variety of functions specified in statute. These functions include data collection and analysis; evaluation of existing delivery systems, data systems, and other systems that impact the improvement of Indian health; making recommendations for the targeting of services; and provision of requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations [25 U.S.C. 1621m(b)]. Other organizations do not have the capacity to provide this support. With respect to access to information, TECs are treated as public health authorities for the purposes of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191). Unlike their counterparts, they have no or little funding from their jurisdictional governments to perform these public functions.

This limited-eligibility NOFO will allow the TECs to directly support the communities they serve in their HIV/HCV/STI diagnosis, prevention, treatment, and response efforts. The TECs already possess technical expertise in program management, community-based interventions and educational tool development. The TECs must have demonstrated their ability to methodically and effectively reach Tribal members and efficiently work with AI/AN populations on their public health capacity building. Selected organizations that have previous experience working effectively with Tribal governments will help ensure that interventions and infrastructure are culturally appropriate and locally-minded.

II. Award Information

Funding Instrument Cooperative Agreement

Estimated Funds Available

The total funding identified for FY 2019 is approximately $1,900,000. Individual award amounts for the first budget year are anticipated to be between $250,000 and $275,000. The funding available for competing and subsequent continuation awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. The IHS is under no obligation to make awards that are selected for funding under this announcement.

The TEC sites serving areas that include the Phase One priority jurisdictions are eligible to apply for the funding under this announcement.

Anticipated Number of Awards

Approximately seven awards will be issued under this program announcement.

Period of Performance

The period of performance is for two years.

Cooperative Agreement

Cooperative agreements awarded by the HHS are administered under the same policies as a grant. However, the funding agency (IHS) is anticipated to have substantial programmatic involvement in the project during the entire award segment. Below is a detailed description of the level of involvement required for IHS.

[13] *https://www.ihs.gov/epi/includes/themes/responsive2017/display_objects/documents/std/Indian_Health_Surveillance_Report_STD_2015.pdf.*

Substantial Involvement Description for Cooperative Agreement

(1) The IHS Office of Public Health Support (OPHS) Division of Epidemiology and Disease Prevention (DEDP) and the IHS Office of Clinical and Preventive Services (OCPS), Division of Clinical and Community Services (DCCS) will provide ongoing consultation and technical assistance to plan, implement, and evaluate each component as described under Recipient Activities.

(2) The IHS will conduct site visits to TECs and/or coordinate TEC visits to IHS and other federal, state, county, or AI/AN-serving agencies to assess work plans and ensure data security, confirm compliance with applicable laws and regulations, assess program activities, and to mutually resolve problems, as needed.

(3) The IHS OPHS/DEDP and OCPS/DCCS will provide a forum for outreach and education to advance the goals of this program through existing and new partnerships. The IHS will facilitate TECs' participation in the IHS National AI/AN STD Prevention workgroup, a forum that includes approximately 150 participants from clinical, public health, advocacy and education sectors working in HIV/STI control.

(4) The IHS OPHS/DEDP and OCPS/DCCS will coordinate reporting and technical assistance as required.

III. Eligibility Information

1. Eligibility

Only current TEC awardees are eligible to apply for the competing supplemental funding under this announcement and must demonstrate that they have complied with previous terms and conditions of the TEC program.

TEC sites serving areas that include the Phase One priority jurisdictions are eligible to apply for the funding under this announcement.

Note: Please refer to Section IV.2 (Application and Submission Information/Subsection 2, Content and Form of Application Submission) for additional proof of applicant status documents required, such as Tribal resolutions, proof of non-profit status, etc.

2. Cost Sharing or Matching

The IHS does not require matching funds or cost sharing for grants or cooperative agreements.

3. Other Requirements

Applications with budget requests that exceed the highest dollar amount outlined under the Award Information, Estimated Funds Available section, or exceed the Period of Performance outlined under the Award Information, Period of Performance section will be considered not responsive and will not be reviewed. The Division of Grants Management (DGM) will notify the applicant.

IV. Application and Submission Information

1. Obtaining Application Materials

The application package and detailed instructions for this announcement are hosted on *https://www.Grants.gov*.

Please direct questions regarding the application process to Mr. Paul Gettys at (301) 443–2114 or (301) 443–5204.

2. Content and Form Application Submission

The applicant must include the project narrative as an attachment to the application package. Mandatory documents for all applicants include:

- Abstract (one page) summarizing the project.
- Application forms:
  - SF–424, Application for Federal Assistance.
  - SF–424A, Budget Information—Non-Construction Programs.
  - SF–424B, Assurances—Non-Construction Programs.
- Project Narrative (not to exceed 10 pages). See IV.2.A Project Narrative for instructions.
  - Background information on the organization.
  - Proposed goals, specific, measurable, achievable, realistic and time-bound) (SMART) objectives (see *https://www.cdc.gov/tb/programs/Evaluation/Guide/PDF/b_write_objective.pdf,* for more information), scope of work, and activities (to be included in a one-page timeframe chart) that provide a description of what the applicant plans to accomplish.
- Budget Justification and Narrative (not to exceed 5 pages). See IV.2.B Budget Narrative for instructions.
- One-page Timeframe Chart.
- Glossary of terms and acronyms used in the application.
- Letters of Support from organization's Board of Directors (optional).
- Biographical sketches for all Key Personnel.
- Contractor/Consultant resumes or qualifications and scope of work.
- Disclosure of Lobbying Activities (SF–LLL).
- Certification Regarding Lobbying (GG-Lobbying Form).
- Copy of current Negotiated Indirect Cost rate (IDC) agreement (required in order to receive IDC).
- Organizational Chart.
- Documentation of current Office of Management and Budget (OMB) Financial Audit (if applicable).

Acceptable forms of documentation include:

- Email confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or
- Face sheets from audit reports. Applicants can find these on the FAC website: *https://harvester.census.gov/facdissem/Main.aspx*

Public Policy Requirements

All federal public policies apply to IHS grants and cooperative agreements with the exception of the Discrimination Policy.

Requirements for Project and Budget Narratives

A. Project Narrative: This narrative should be a separate document that is no more than 10 pages and must: (1) Have consecutively numbered pages; (2) use black font 12 points or larger; (3) be single-spaced; (4) and be formatted to fit standard letter paper (8-1/2 x 11 inches).

Be sure to succinctly answer all questions listed under the evaluation criteria (refer to Section V.1, Evaluation Criteria) and place all responses and required information in the correct section noted below or they will not be considered or scored. If the narrative exceeds the page limit, the application will be considered not responsive and not be reviewed. The 10-page limit for the narrative does not include the work plan, standard forms, Tribal resolutions, budget, budget justifications, narratives, and/or other appendix items.

There are three parts to the narrative: Part 1—Program Information; Part 2—Program Planning and Evaluation; and Part 3—Program Report. See below for additional details about what must be included in the narrative. The page limits below are for each narrative and budget submitted.

Part 1: Program Information (limit—3 pages)

Section 1: Needs.

Describe the TEC's current health program activities, how long it has been operating, and what programs or services are currently being provided by the organization. Describe how the Tribal Organization has determined it has the administrative infrastructure to support the activities proposed.

Part 2: Program Planning and Evaluation (limit—3 pages)

Section 1: Program Plans.

Describe fully and clearly the activities the TEC plans to conduct this work.

Section 2: Program Evaluation.

Describe fully and clearly the improvements that will be made by the TEC to meet the public health needs of the community in the context of the funding requirements.

Part 3: Program Report (limit—4 pages)

Section 1: Describe your organization's significant program activities and accomplishments over the past five years associated with the goals of this announcement.

Please identify and describe significant program activities and achievements associated with the proposed activities. Provide a comparison of the actual accomplishments to the goals established for the project period, or if applicable, provide justification for the lack of progress.

B. Budget Narrative (limit—5 pages)

Provide a budget narrative that explains the amounts requested for each line of the budget. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Be very careful about showing how each item in the ''other'' category is justified. For subsequent budget years, the narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the period of performance. Do NOT use the budget narrative to expand the project narrative.

3. Submission Dates and Times

Applications must be submitted through *Grants.gov* by 11:59 p.m. Eastern Daylight Time (EDT) on the Application Deadline Date. Any application received after the application deadline will not be accepted for review. *Grants.gov* will notify the applicant via email if the application is rejected.

If technical challenges arise and assistance is required with the application process, contact *Grants.gov* Customer Support (see contact information at *https://www.grants.gov*). If problems persist, contact Mr. Paul Gettys (*Paul.Gettys@ihs.gov*), DGM Grant Systems Coordinator, by telephone at (301) 443–2114 or (301) 443–5204. Please be sure to contact Mr. Gettys at least 10 days prior to the application deadline. Please do not contact the DGM until you have received a *Grants.gov* tracking number. In the event you are not able to obtain a tracking number, call the DGM as soon as possible.

The IHS will not acknowledge receipt of applications.

4. Intergovernmental Review

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions

- Pre-award costs are allowable up to 90 days before the start date of the award provided the costs are otherwise allowable if awarded. Pre-award costs are incurred at the risk of the applicant.
- The available funds are inclusive of direct and indirect costs.
- Only one supplement will be awarded per applicant.

6. Electronic Submission Requirements

All applications must be submitted via *Grants.gov*. Please use the *https://www.Grants.gov* website to submit an application. Find the application by selecting the ''Search Grants'' link on the homepage. Follow the instructions for submitting an application under the Package tab. No other method of application submission is acceptable.

If the applicant cannot submit an application through *Grants.gov*, a waiver must be requested. Prior approval must be requested and obtained from Mr. Robert Tarwater, Director, DGM. A written waiver request must be sent to *GrantsPolicy@ihs.gov* with a copy to *Robert.Tarwater@ihs.gov*. The waiver must: (1) Be documented in writing (emails are acceptable) before submitting an application by some other method, and (2) include clear justification for the need to deviate from the required application submission process.

Once the waiver request has been approved, the applicant will receive a confirmation of approval email containing submission instructions. A copy of the written approval must be included with the application that is submitted to the DGM. Applications that are submitted without a copy of the signed waiver from the Director of the DGM will not be reviewed. The Grants Management Officer of the DGM will notify the applicant via email of this decision. Applications submitted under waiver must be received by the DGM no later than 5:00 p.m., EDT, on the Application Deadline Date. Late applications will not be accepted for processing. Applicants that do not register for both the System for Award Management (SAM) and *Grants.gov* and/or fail to request timely assistance with technical issues will not be considered for a waiver to submit an application via alternative method.

Please be aware of the following:

- Please search for the application package in *https://www.Grants.gov* by entering the Assistance Listing (CFDA) number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- If you experience technical challenges while submitting your application, please contact *Grants.gov* Customer Support (see contact information at *https://www.grants.gov*).
- Upon contacting *Grants.gov*, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.
- Applicants are strongly encouraged not to wait until the deadline date to begin the application process through *Grants.gov* as the registration process for SAM and *Grants.gov* could take up to 20 working days.
- Please follow the instructions on *Grants.gov* to include additional documentation that may be requested by this funding announcement.
- Applicants must comply with any page limits described in this funding announcement.
- After submitting the application, the applicant will receive an automatic acknowledgment from *Grants.gov* that contains a *Grants.gov* tracking number. The IHS will not notify the applicant that the application has been received.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS)

Applicants and grantee organizations are required to obtain a DUNS number and maintain an active registration in the SAM database. The DUNS number is a unique nine-digit identification number provided by D&B that uniquely identifies each entity. The DUNS number is site specific; therefore, each distinct performance site may be assigned a DUNS number. Obtaining a DUNS number is easy, and there is no charge. To obtain a DUNS number, please access the request service through *https://fedgov.dnb.com/webform,* or call (866) 705–5711.

The Federal Funding Accountability and Transparency Act of 2006, as amended (''Transparency Act''), requires all HHS recipients to report information on sub-awards. Accordingly, all IHS grantees must notify potential first-tier sub-recipients that no entity may receive a first-tier sub-award unless the entity has provided its DUNS number to the prime grantee organization. This requirement ensures the use of a universal identifier to enhance the quality of information available to the public pursuant to the Transparency Act.

System for Award Management (SAM)

Organizations that are not registered with SAM will need to obtain a DUNS number first and then access the SAM online registration through the SAM home page at *https://www.sam.gov* (U.S. organizations will also need to provide an Employer Identification Number from the Internal Revenue Service that may take an additional 2–5 weeks to become active). Please see *SAM.gov* for details on the registration process and timeline. Registration with the SAM is free of charge, but can take several weeks to process. Applicants may register online at *https://www.sam.gov.*

Additional information on implementing the Transparency Act, including the specific requirements for DUNS and SAM, are available on the DGM Grants Management, Policy Topics website: *https://www.ihs.gov/dgm/policytopics/.*

V. Application Review Information

Weights assigned to each section are noted in parentheses. The 10-page project narrative should include only the first year of activities; information for multi-year projects should be included as an appendix. See ''Multi-year Project Requirements'' at the end of this section for more information. The narrative section should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the applicant. It should be well organized, succinct, and contain all information necessary for reviewers to understand the project fully. Points will be assigned to each evaluation criteria adding up to a total of 100 possible points. Points are assigned as follows:

1. Criteria

A. Introduction and Need for Assistance (10 Points)

Must include the applicant's background information, a description of epidemiological service, epidemiologic capacity and history of support for such activities. Applicants need to include current public health activities, what program services are currently being provided, and interactions with other public health authorities in the region (state, local, or Tribal).

Please describe how the TEC will make improvements in capacity to address IHS, Tribal and Urban (I/T/U), local-level, and/or Area-level HIV/HCV/STI burden. In order to significantly reduce transmission of HIV/HCV/STI, I/T/U need baseline and annual measurements of HIV/HCV/STI diagnoses, linkage to care, and viral load measurements, as applicable. The TECs will also help evaluate geographies with higher burden of HIV/HCV/STI and assist communities in targeting interventions.

B. Project Objective(s), Work Plan and Approach (25 Points)

a. Clearly identify the operational strategies to be addressed by the TEC. Activities in at least two of the EHE's key operational strategies should be planned for completion within the program period (indicate these two activities in bold).

b. Applicants will outline their approach for addressing the operational strategies in the work plan or logic model. Outline overarching activities, short-term and long-term outcomes. Make note of proposed timelines and partners who will be involved in each activity.

Activities

Applications must include the following activities:

1. Coordination Operational Strategy

i. Grantees will send at least one representative to the annual HIV Coordination meeting, scheduled in September of each year to coincide with the U.S. Conference on AIDS. Budget should include travel and associated costs for participation.

ii. Grantees will participate in the IHS National AI/AN STI Prevention workgroup.

2. Diagnosis Operational Strategy

The TECs will provide technical assistance and/or disease surveillance support to communities by developing analytical reports to examine the burden of HIV and other relevant comorbidities such as STIs and HCV in Tribal communities.

3. Treatment Operational Strategy

The TECs will provide support to communities in the development of enhanced activities and expanded capacity to better identify people who are not in care, including those who were never linked to care following an HIV, STI, or HCV diagnosis and those who have fallen out of care.

4. Respond Operational Strategy

Respond rapidly to detect and characterize growing HIV, STI, or HCV clusters and prevent new infections. TECs will provide technical assistance and/or direct support to communities on the following activities:

i. Develop or accelerate the development of community plans that are customized for AI/AN communities. Extensive community engagement in this process will help ensure that community-specific social norms and unique epidemic attributes are addressed. Initial community-specific plans will be requested by May 31, 2020. Planning should reflect the time-sensitive nature of this activity.

ii. Develop collaborative partnerships among Tribal, state, and local health departments, the clinical community, and community-based organizations to expand and routinize HIV diagnosis, treatment, prevention and response.

Further Activities

Applications are required to address the above activities, and must propose activities addressing at least two of the additional below operational strategies.

1. Diagnosis Operational Strategy

Diagnose all people with HIV, STIs, and HCV as early as possible after infection and connect them to immediate treatment. The TECs will provide technical assistance and/or direct support to AI/AN communities on the following activities:

i. Implementing HIV testing recommendations through the rapid replication of proven or innovative HIV screening models;

ii. Developing and implementing innovative testing and health care engagement strategies focused on meeting the needs of groups at higher risk, including MSM, transgender individuals, high-risk heterosexuals, and persons who inject drugs.

2. Protection Operational Strategy

Protect people at risk for HIV using potent and proven prevention interventions, including Pre-Exposure Prophylaxis (PrEP), a medication that can prevent new HIV infections. The TECs will provide technical assistance and/or direct support to communities on the following activities:

PrEP

i. Support efforts to increase the awareness of, access to, and utilization of PrEP among identified populations;

ii. Support efforts to incentivize providers and community-based healthcare organizations to integrate HIV testing, linkage, and referral to care, and linkage or referral to medical prevention (*i.e.,* PrEP) services into primary care services, particularly for their higher-risk patients;

TasP/U=U

i. Raise awareness about the prevention benefits of ''Treatment as Prevention'' (TasP) and ''Undetectable = Untransmittable'' (U=U) among providers, people living with and at risk for HIV, and the general population;

Opioids and Substance Misuse

i. As an entry point to recovery services and overdose and infection prevention, support the development, expansion, implementation, and evaluation of harm-reduction services for people who inject drugs.

a. Evaluate the local acceptability and opportunities for establishing or increasing syringe services programs (SSPs): including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.

STIs other than HIV

i. Promote early identification of individuals with recurrent STI events with focus on Chlamydia, gonorrhea, and syphilis through analysis of clinical or other locally available data.

ii. Promote linkage to care including PrEP or other appropriate services to aid the prevention of HIV and other infectious disease transmission, especially for those diagnosed with STIs.

iii. Promote and support Expedited Partner Therapy (EPT) for individuals diagnosed with chlamydia and gonorrhea to control transmission.

iv. Promote enhanced STI screening among youth and MSM and engage providers in adopting best practices, such as obtaining a thorough sexual history and promoting an adolescent-friendly clinic environment.

3. Respond Operational Strategy

Respond rapidly to detect and characterize growing HIV, STI, or Viral hepatitis clusters and prevent new infections. The TECs will provide technical assistance and/or public health surveillance support to communities on the following activities:

i. Establish and support boots-on-the-ground public health workforce capacity that is culturally competent and committed to ensuring implementation of community-based HIV, STI, and/or Viral hepatitis control plans, including facilitating and troubleshooting collaborative community-wide disease control efforts;

ii. Develop or expand the capacity to detect and respond to all established or emerging HIV, STI, and/or Viral hepatitis clusters to reduce disease transmission.

C. Program Evaluation (30 Points)

a. Clearly identify plans for program evaluation to ensure that objectives of the program are met at the conclusion of the funding period.

b. Include (SMART) evaluation criteria.

c. Evaluation should minimally include summaries of activities in each of the proposed key operational strategies.

D. Organizational Capabilities, Key Personnel and Qualifications (30 Points)

a. Include an organizational capacity statement which demonstrates the ability to execute program strategies within the program period.

b. Project management and staffing plan. Detail that the organization has the current staffing and expertise to address each of the program activities. If current capacity does not exist please describe the actions that the TEC will take to fulfill this gap within a specified timeline.

c. Demonstrate local partners' willingness to work with TEC on proposed efforts. Applicants are particularly encouraged to collaborate with other federally-funded organizations such as their local health departments and Ryan White HIV/AIDS Program awardees.

d. Demonstrate that the TEC has previous successful experience providing technical or programmatic support to Tribal communities.

E. Categorical Budget and Budget Justification (5 Points)

a. Provide a detailed budget and accompanying narrative to explain the activities being considered and how they are related to proposed program objectives.

Multi-Year Project Requirements

Applications must include a brief project narrative and budget (one additional page per year) addressing the developmental plans for each additional year of the project. This attachment will not count as part of the project narrative or the budget narrative.

Additional documents can be uploaded as Appendix Items in *Grants.gov*

- Work plan, logic model and/or time line for proposed objectives.
- Position descriptions for key staff.
- Resumes of key staff that reflect current duties.
- Consultant or contractor proposed scope of work and letter of commitment (if applicable).
- Current Indirect Cost Rate Agreement.
- Organizational chart.
- Map of area identifying project location(s).
- Glossary of terms and acronyms used in the application.
- Additional documents to support narrative (*i.e.* data tables, key news articles, etc.).

2. Review and Selection

Each application will be prescreened for eligibility and completeness as outlined in the funding announcement. Applications that meet the eligibility criteria shall be reviewed for merit by the Objective Review Committee (ORC) based on evaluation criteria. Incomplete applications and applications that are not responsive to the administrative thresholds will not be referred to the ORC and will not be funded. The applicant will be notified of this determination.

Applicants must address all program requirements and provide all required documentation.

3. Notifications of Disposition

All applicants will receive an Executive Summary Statement from the IHS OPHS within 30 days of the conclusion of the ORC outlining the strengths and weaknesses of their application. The summary statement will be sent to the Authorizing Official identified on the face page (SF–424) of the application.

A. Award Notices for Funded Applications

The Notice of Award (NoA) is the authorizing document for which funds are dispersed to the approved entities and reflects the amount of federal funds awarded, the purpose of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period. Each entity approved for funding must have a user account in GrantSolutions in order to retrieve the NoA. Please see the Agency Contacts list in Section VII for the systems contact information.

B. Approved but Unfunded Applications

Approved applications not funded due to lack of available funds will be held for one year. If funding becomes available during the course of the year, the application may be reconsidered.

Note: Any correspondence other than the official NoA executed by an IHS grants management official announcing to the project director that an award has been made to their organization is not an authorization to implement their program on behalf of the IHS.

VI. Award Administration Information

1. Administrative Requirements

Cooperative agreements are administered in accordance with the following regulations and policies:

A. The criteria as outlined in this program announcement.

B. Administrative Regulations for Grants:

- Uniform Administrative Requirements for HHS Awards, located at 45 CFR part 75.

C. Grants Policy:

- HHS Grants Policy Statement, Revised 01/07.

D. Cost Principles:

- Uniform Administrative Requirements for HHS Awards, ''Cost Principles,'' located at 45 CFR part 75, subpart E.

E. Audit Requirements:

- Uniform Administrative Requirements for HHS Awards, ''Audit Requirements,'' located at 45 CFR part 75, subpart F.

2. Indirect Costs

This section applies to all recipients that request reimbursement of indirect costs (IDC) in their application budget. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to obtain a current IDC rate agreement prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate agreement is not on file with the DGM at the time of award, the IDC portion of the budget will be restricted. The restrictions remain in place until the current rate agreement is provided to the DGM.

Generally, IDC rates for IHS grantees are negotiated with the Division of Cost Allocation *https://rates.psc.gov/* and the Department of Interior (Interior Business Center) *https://www.doi.gov/ibc/services/finance/indirect-Cost-Services/indian-tribes.* For questions regarding the indirect cost policy, please call the Grants Management Specialist listed under ''Agency Contacts'' or the main DGM office at (301) 443–5204.

3. Reporting Requirements

The grantee must submit required reports consistent with the applicable deadlines. Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This requirement applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports. Per DGM policy, all reports are required to be submitted electronically by attaching them as a ''Grant Note'' in GrantSolutions. Personnel responsible for submitting reports will be required to obtain a login and password for GrantSolutions. Please see the Agency Contacts list in section VII for the systems contact information.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required semi-annually within 30 days after the budget period ends. These reports must include a brief comparison of actual accomplishments to the goals established for the period, a summary of progress to date or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required.

Additional quarterly reports and quarterly calls discussing progress on a standardized form are required for this funding. Post-award, the standard form will be disseminated to all funded programs.

Special attention should be devoted to reporting on the development of community plans required under the Respond Operational Strategy.

A final report must be submitted within 90 days of expiration of the period of performance.

B. Financial Reports

Federal Financial Report (FFR or SF–425), Cash Transaction Reports are due 30 days after the close of every calendar quarter to the Payment Management Services, HHS at *https://pms.psc.gov.* The applicant is also requested to upload a copy of the FFR (SF–425) into our grants management system, GrantSolutions. Failure to submit timely reports may result in adverse award actions blocking access to funds.

Grantees are responsible and accountable for accurate information being reported on all required reports: the Progress Reports and Federal Financial Report.

C. Data Collection and Reporting

The TEC must report annually (by their respective IHS Area or Tribal health board) the progress towards EHE goals via a standardized form.

The TEC will participate in quarterly calls with the program office.

D. Federal Sub-award Reporting System (FSRS)

This award may be subject to the Transparency Act sub-award and executive compensation reporting requirements of 2 CFR part 170.

The Transparency Act requires the OMB to establish a single searchable database, accessible to the public, with information on financial assistance awards made by federal agencies. The Transparency Act also includes a requirement for recipients of federal grants to report information about first-tier sub-awards and executive compensation under federal assistance awards.

The IHS has implemented a Term of Award into all IHS Standard Terms and Conditions, NoAs and funding announcements regarding the FSRS reporting requirement. This IHS Term of Award is applicable to all IHS grant and cooperative agreements issued on or after October 1, 2010, with a $25,000 sub-award obligation dollar threshold met for any specific reporting period. Additionally, all new (discretionary) IHS awards (where the period of performance is made up of more than one budget period) and where: (1) The period of performance start date was October 1, 2010 or after, and (2) the primary awardee will have a $25,000 sub-award obligation dollar threshold during any specific reporting period will be required to address the FSRS reporting.

For the full IHS award term implementing this requirement and additional award applicability information, visit the DGM Grants Policy website at *https://www.ihs.gov/dgm/policytopics/.*

E. Compliance with Executive Order 13166 Implementation of Services Accessibility Provisions for All Grant Application Packages and Funding Opportunity Announcements

Recipients of federal financial assistance (FFA) from the HHS must administer their programs in compliance with federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age and, in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. The HHS provides guidance to recipients of FFA on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. Please see *https://www.hhs.gov/civil-rights/for-*

individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/.

The HHS Office for Civil Rights (OCR) also provides guidance on complying with civil rights laws enforced by HHS. Please see *https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html;* and *https://www.hhs.gov/civil-rights/index.html.* Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see *https://www.hhs.gov/civil-rights/for-individuals/disability/index.html.* Please contact the HHS OCR for more information about obligations and prohibitions under federal civil rights laws at *https://www.hhs.gov/ocr/about-us/contact-us/index.html* or call (800) 368–1019 or TDD (800) 537–7697. Also note it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at *https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.*

Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for benefits and services from the IHS.

Recipients will be required to sign the HHS–690 Assurance of Compliance form which can be obtained from the following website: *https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf,* and send it directly to the: U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, DC 20201.

F. Federal Awardee Performance and Integrity Information System (FAPIIS)

The IHS is required to review and consider any information about the applicant that is in the Federal Awardee Performance and Integrity Information System (FAPIIS), at *https://www.fapiis.gov,* before making any award in excess of the simplified acquisition threshold (currently $150,000) over the period of performance. An applicant may review and comment on any information about itself that a federal awarding agency previously entered. IHS will consider any comments by the applicant, in addition to other information in FAPIIS in making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in 45 CFR 75.205.

As required by 45 CFR part 75 Appendix XII of the Uniform Guidance, non-federal entities (NFEs) are required to disclose in FAPIIS any information about criminal, civil, and administrative proceedings, and/or affirm that there is no new information to provide. This applies to NFEs that receive federal awards (currently active grants, cooperative agreements, and procurement contracts) greater than $10,000,000 for any period of time during the period of performance of an award/project.

Mandatory Disclosure Requirements

As required by 2 CFR part 200 of the Uniform Guidance, and the HHS implementing regulations at 45 CFR part 75, effective January 1, 2016, the IHS must require a non-federal entity or an applicant for a federal award to disclose, in a timely manner, in writing to the IHS or pass-through entity all violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award.

Submission is required for all applicants and recipients, in writing, to the IHS and to the HHS Office of Inspector General all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. 45 CFR 75.113.

Disclosures must be sent in writing to:

U.S. Department of Health and Human Services, Indian Health Service, Division of Grants Management, ATTN: Mr. Robert Tarwater, Director, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857. (Include ''Mandatory Grant Disclosures'' in subject line.)
Office: (301) 443–5204
Fax: (301) 594–0899
Email: Robert.Tarwater@ihs.gov.

AND

U.S. Department of Health and Human Services, Office of Inspector General, ATTN: Mandatory Grant Disclosures, Intake Coordinator, 330 Independence Avenue SW, Cohen Building, Room 5527, Washington, DC 20201.
URL: https://oig.hhs.gov/fraud/report-fraud/. (Include ''Mandatory Grant Disclosures'' in subject line.)
Fax: (202) 205–0604 (Include ''Mandatory Grant Disclosures'' in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to: Ms. Lisa C. Neel, Public Health Advisor, Office of Public Health Support, Division of Epidemiology & Disease Prevention, Indian Health Service, 5600 Fishers Lane, Mailstop: 09E17B, Rockville, MD 20857, Phone: (301) 443–4305, E-Mail: *Lisa.Neel@ihs.gov.*

2. Questions on grants management and fiscal matters may be directed to: Mr. John Hoffman, Senior Grants Management Specialist, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2116, Fax: (301) 594–0899, Email: *John.Hoffman@ihs.gov.*

3. Questions on systems matters may be directed to: Mr. Paul Gettys, Grant Systems Coordinator, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2114; or the DGM main line (301) 443–5204, Fax: (301) 594–0899, E-Mail: *Paul.Gettys@ihs.gov.*

VIII. Other Information

The Public Health Service strongly encourages all grant, cooperative agreement and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

Dated: July 31, 2019.

Michael D. Weahkee,

Assistant Surgeon General, U.S. Public Health Service, Principal Deputy Director, Indian Health Service.

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