

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

Catherine Fine

Associate Bureau Director

HIV/STI Services Division

Boston Public Health Commission

AGENDA

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HIV/STI Services Division Team



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Purpose of This RFP



Reduce incidence of HIV, STIs, mpox, and HCV



Focus on highest-risk populations in the city of Boston



Strengthen community-based prevention systems

What We're Looking For



COMMUNITY-
CENTERED
APPROACHES



STRONG LINKAGE
TO CARE



INTEGRATION OF
BIOMEDICAL
PREVENTION



REALISTIC,
MEASURABLE
OUTCOMES

Priority Populations

- MSM (especially MSM of color)
- Women of color
- Transgender individuals
- People who use substances
- Non-US born individuals

Why This Works Matters

Esete Fenta

Senior Program Coordinator

HIV

352

New HIV diagnoses
2022–2024

50%

of new HIV cases
among Black NH

31%

of new cases among
Hispanic/Latinx

53%

of new cases among non-US born
individuals

Key Data Points:

- 50 % of new HIV cases are among Black individuals
- 31% of new HIV cases are among Hispanic/Latinx individuals
- 53% of new HIV diagnoses are among non-US born individuals
- Most common exposure: MSM (39% of new HIV diagnoses)
- Highest rates: Mattapan, South End, Dorchester and Roxbury

STIs

5,734

average annual chlamydia cases
2022–2024

2,533

average annual gonorrhea cases
2022–2024

356

average annual syphilis cases
2022–2024

31%

of cases among Hispanic/Latinx
individual

Key Data Points:

- Chlamydia remains high; gonorrhea and syphilis are increasing
- Highest burden among young adults (ages 20–39)
- Black and Hispanic/Latinx communities are disproportionately impacted
- Dorchester accounts for a large share of STI cases in Boston, but rates of each STI vary by neighborhood

MPOX

115

Cases identified during
2022 outbreak



Recent increase in reported cases
2025 - 2026

52%

of new cases among
Black and Hispanic/Latinx

68%

of new cases among
unvaccinated individuals

Key Data Points:

- Transmission occurs through close or sexual contact
- Primarily impacts MSM communities
- Vaccination remains a key prevention strategy
- Continued need for outreach, education, and early identification

HEPATITIS C (HCV)

2970

Confirmed cases
2017–2025

211

Reported cases in
2025

66.5%

of cases among males

82.9%

Linked to injection drug use

Key Data Points:

- Strong link between HCV and injection drug use
- Cases have declined but transmission continues
- Racial and ethnic disparities persist
- Ongoing need for testing, linkage to care, and harm reduction services

Guiding Principles

Iyiola (Ola) Faturiyele

HIV/STI Services Division Director

Guiding Principles

Health Equity

- Focus on disparities across race/ethnicity, geography, gender identity, immigration status, and socioeconomic status
- Engage communities in program design and delivery
- Address structural and social determinants of health
- Support equitable access to care

What this looks like in practice:

Designing outreach specifically for a priority population and delivering it in their language and cultural context in trusted community settings

Guiding Principles

Evidence-Based Activities

- Base education and outreach efforts on the best available science
- Describe the evidence supporting proposed interventions
- Adapt interventions to meet the needs of the target population

What this looks like in practice:

Using a proven HIV education model and adapting it culturally for the community you serve.

Guiding Principles

Prevention Strategies

- Promote behavior change and long-term engagement in care
- Include healthcare engagement such as testing and treatment adherence
- Link behavioral strategies to biomedical interventions

What this looks like in practice:

Providing education while actively connecting participants to testing, PrEP, or treatment services

Guiding Principles

Compliance and Transparency

- Adhere to all programmatic and fiscal requirements
- Submission of a proposal indicates agreement to comply
- Funded activities and funding are considered public information

What this looks like in practice:

Submitting required reports and invoices on time and following the approved scope of work and budget. Commit to understanding HRSA standards as applicable.

Guiding Principles

Collaborations and Partnerships

- Clearly describe relationships among organizations
- Define roles, responsibilities, and communication
- Ensure coordination across community-based and clinical providers
- Demonstrate how partnerships and collaborations support service delivery

For the Purpose of this RFP

Partnerships (Formal Structure)

- Apply jointly under one proposal
- One lead agency serves as fiscal conduit
- Shared scope of work and responsibilities
- Included in budget and program implementation
- Stablished MOU

Collaborations (Coordination)

- Work with other organizations to support services
- No shared funding or contractual relationship
- Support referrals, outreach, and access to care

What this Looks Like in Practice

Partnerships (Formal Structure)

Health Equity For All (lead agency) and Movement for Change apply jointly under one proposal. Health Equity For All manages the contract and budget, while Movement for Change delivers a defined portion of outreach and education activities. Both organizations have clearly outlined roles, share responsibility for implementation, and have a formal agreement in place.

Collaborations (Coordination)

Health Equity For All (single applicant) works with Safe Neighborhood Health Center and East Boston Community Outreach to support referrals and community engagement. The clinic accepts referrals for testing and prevention services, while the community organization supports outreach and provides space for activities, helping improve access to services for the target population.

Guiding Principles

Quality Assurance

- Ensure services are delivered with quality, consistency, and responsiveness
- Use approaches such as staff training, protocols, and participant feedback
- Monitor service delivery regularly

What this looks like in practice:

Training staff and using standard materials to ensure services are delivered consistently across all activities

Guiding Principles

Process and Outcome Measures

- Measure program activities (process measures)
- Measure results and changes (outcome measures)
- Use practical and feasible data collection methods

What this looks like in practice:

Tracking how many people were reached and how many were successfully linked to care or services

Guiding Principles

Quality Improvement

- Use a deliberate process to improve services and outcomes
- Identify problems and implement corrective actions
- Monitor the effectiveness of improvements over time

What this looks like in practice:

Adjusting program strategies when participation or outcomes are lower than expected

Guiding Principles

Accessibility

- Address linguistic, cultural, and disability-related barriers
- Ensure materials and communications are accessible
- Align with ADA, WCAG, and Section 508 standards

What this looks like in practice:

Providing materials in multiple languages and formats that are accessible to individuals with disabilities

Guiding Principles

Syndemic Approach

- Recognize overlapping impacts of racism, homophobia, transphobia, xenophobia, and other forms of oppression
- Address multiple, interconnected risks across infectious diseases

What this looks like in practice:

Integrating prevention efforts with referrals to services such as substance use treatment or behavioral health support

Guiding Principles

Sex Positivity

- Use a sex-positive framework
- Recognize healthy sexuality, consent, and relationship well-being
- Abstinence-only approaches will not be considered

What this looks like in practice:

Providing non-judgmental sexual health education that supports informed and respectful decision-making

Guiding Principles

Trauma-Informed Care

- Recognize the needs of individuals with experiences of trauma
- Build safety, trust, empowerment, and self-determination
- Design services to respond to these needs

What this looks like in practice:

Creating a service environment where participants feel safe, respected, and supported

Guiding Principles

Anti-Stigma Approach

- Address stigma related to HIV, STIs, mpox, HCV, and intersecting factors
- Recognize stigma as a barrier to prevention, testing, and care
- Incorporate anti-stigma approaches into program design and delivery

What this looks like in practice:

Training staff to provide inclusive, non-judgmental services that reduce barriers to care.

Allowable Interventions, Settings and Funding

Sandra Vasquez

Program Director

ALLOWABLE INTERVENTIONS & SETTINGS

Interventions

- Outreach & Community Engagement
- Individual & Group Education/Health Promotion
- Materials Distribution (safer sex/use supplies)
- HIV/STI/HCV Testing
- Facilitated Access to PrEP, PEP, Vaccination
- Supported Referrals to Care & Services
- Peer-Led Programs
- Incentives (non-cash; gift cards allowed)

Settings

- Clinical & Community-Based Organizations
- Community Health Centers
- Bars, Clubs, Barbershops, Beauty Salons
- Faith-Based & Civic Organizations
- Health Fairs & Community Events
- Online Platforms & Mobile Apps
- Shelters & Housing Settings
- Recovery/SUD Treatment Programs
- Correctional Settings

Funding Overview

Up to \$1.4 Million Available

Budget Period: July 1, 2026 – June 30, 2027

Award Range

\$100,000 – \$300,000
No awards below
\$100,000

Renewable Through June 30, 2030

Based on available
funding and
performance

2 Ways to Apply

1. Single Agency
2. In Partnership (Same funding range applies)

For the Purpose of this RFP

Partnerships

- One organization serves as the lead agency and fiscal conduit
- Shared scope of work, roles, and responsibilities
- Includes a formal agreement (e.g., MOU)
- Partners are included in the budget and program implementation

Collaborations

- Work with other organizations to support service delivery
- No shared funding or contractual relationship
- Collaborators are not subcontractors or formal partners
- Focus on coordination, referrals, and access to services
- May include clinical or community-based organizations

PROGRAM RULES & FISCAL HIGHLIGHTS

Program Requirements

- Biannual progress reports (Jan 15 & Jul 15)
- Monthly data via E2Education&Outreach by 15th of every month
- Participate in monitoring calls with BPHC
- BPHC logo on all funded materials (prior approval required)
- Submit materials for review 2 weeks prior
- At least one site visit per budget period
- Attend best practices & learning meetings

Fiscal Requirements

- Cost reimbursement basis; no advance payments
- Invoices due monthly within 15 days of month-end
- Use BPHC standard invoice template
- Fringe rate: agency's audited rate, max 62%
- Indirect/admin costs capped at 15% of direct costs
- No cash incentives; store gift cards OK with policy on file
- Budget revisions not accepted after April 1, 2027

ELIGIBILITY & APPLICATION PROCESS

Eligibility Requirements

- Must be a 501(c)(3) nonprofit organization
- Must be based in Boston
- Must primarily serve Boston residents
- Lead agency must meet all criteria in partnerships
- Non-501(c)(3) may participate as sub-partner only

Application Must Include

- Narrative (max 20 pages, 12pt, double-spaced)
- Budget & Justification (Excel format)
- All required tables (do not count toward 20-pg)
- Cover Page, 501(c)(3) cert., SAM.gov status
- Key staff resumes
- MOU (if applying as partnership)

Proposal Scoring Criteria:

Section	Points
Target Population & Need	15
Organizational Capacity	15
Program Description	35
Quality Assurance Plan	10
Process & Outcome Measures	15
Budget & Justification	10

Prevention RFP Application

Idalin Andrades

Director of Prevention and Early Intervention

BOSTON PUBLIC HEALTH COMMISSION

Writing a Successful FY2027 Prevention RFP Application

A Step-by-Step Guide for Community Organizations | Health Equity Centered

-
- Covers all 7 application sections
 - Includes strong-answer examples throughout
 - Designed for first-time applicants

WHAT REVIEWERS ARE LOOKING FOR

Understanding the review lens before you write

Every section is scored on one central question:

"Does this proposal show a deep, data-grounded understanding of health inequity in Boston, and a clear, realistic plan to address it?"

Community Connection

- Do you know your community?
- Do they trust you?
- Are they reflected in your team?

Health Equity Focus

- Which disparities will you reduce?
- How does racism shape risk?
- Who is hardest to reach — and why?

Realistic & Specific

- Are numbers achievable?
- Is the timeline credible?
- Does the budget match the work?

Evidence + Experience

- What works for this population?
- Have you done this before?
- Are partners named and real?

SECTION 1: COVER PAGE & ORGANIZATIONAL INFO

Simple — but get it right. Reviewers notice gaps here.

What You Must Include

- Organization legal name & address
- Contact person (name, title, email, phone)
- Executive Director contact info
- Federal ID Number (FIN/EIN)
- 501(c)(3) verification document
- SAM.gov active registration status
- Partner organization names (if applicable)
- Lead agency designation (if partnership)
- Authorized signature
- Cover Page
- Table 1: Organization Diversity Form
- Certificate of Authority (provided in RFP)
- Verification of SAM.gov registration status

✓ Health Equity Tip for Section 1

The Organization Diversity Form (Table 1) is your first chance to tell BPHC who you are. If your organization is Minority-owned, Women-owned, LGBTQ+-owned, or Veteran-owned — say so clearly. BPHC actively encourages proposals from organizations that reflect the communities they serve. This matters in the review.

💡 Pro Tip

Register on SAM.gov NOW if you haven't — it can take 7–10 business days to activate. Without it, you cannot receive federal pass-through funding. Go to sam.gov and create a free account.

⚠️ Common Mistake

Using an outdated address or leaving the Executive Director section blank. Reviewers cannot contact you if information is wrong or missing.

SECTION 2: TARGET POPULATION & NEED (Part 1 of 2)

15 points • Show you know your community deeply

This section asks: WHO will you serve, WHERE, and WHY does it matter for health equity?

✓ STRONG ANSWER — Target Population

"Our program will serve Black and Latinx MSM ages 18–45 living in Mattapan and Roxbury, with a focus on non-US born individuals. We expect to reach approximately 200 unduplicated participants annually. Black residents of Mattapan have the highest HIV incidence in Boston at 44 per 100,000 — more than twice the city average — yet our community assessment found 68% of our target population had not been tested in the past year due to fear of stigma and distrust of clinical settings."

✗ WEAK ANSWER — Too Vague

"We will serve at-risk individuals in Boston who need HIV prevention services. We expect to reach many participants and will work across several neighborhoods."

Why the strong answer scores higher:

- Names specific race/ethnicity + age + neighborhood
- Gives a real number (200 participants)
- Ties to BPHC epidemiological data (44/100k)
- Explains the equity barrier (stigma + distrust)

SECTION 2: TARGET POPULATION & NEED (Part 2 of 2)

15 points • Name the barriers. Explain how you respond to them.

Reviewers want to see that you understand WHY your population faces higher risk — and that structural racism, not individual behavior, is the root cause.

Structural Barriers

- Lack of health insurance
- No PrEP-prescribing clinics nearby
- Language barriers at clinical sites
- Immigration fear preventing care-seeking

Social/Community Barriers

- HIV stigma in faith communities
- Homophobia & transphobia
- Distrust of health systems due to racism
- Isolation due to housing instability

Individual Access Barriers

- No transportation to testing sites
- Inconsistent work schedules
- Mental health or substance use needs
- Low health literacy in primary language

✓ **STRONG language for the barriers section:**

"The structural racism embedded in Boston's healthcare system has resulted in Black residents experiencing higher rates of uninsurance, less access to PrEP-prescribing providers, and greater exposure to HIV-related stigma. Our community health workers — who are themselves from Mattapan — build trust where clinical providers have not."

SECTION 3: ORGANIZATIONAL CAPACITY

15 points • Prove you can do this work — not just describe it

This section asks: Why is YOUR organization the right one to serve this population? Show your track record.

Track Record

Name specific programs you have run. Use numbers.

✓ "Over the past 3 years, we have tested 1,200 Black and Latinx residents for HIV through our mobile unit in Dorchester, achieving a 94% linkage-to-care rate for reactive results."

Staff Capacity

Name key roles. Attach resumes.

✓ "Our Program Director has 8 years of HIV prevention experience. Our 4 CHWs are bilingual in Spanish/Haitian Creole and certified in motivational interviewing."

Community Trust

Describe your roots in the community.

✓ "Founded in 2010 by formerly incarcerated Black men, our organization has deep trust in the Roxbury re-entry community. 85% of our staff were born in the neighborhoods we serve."

Partners & Collaborations

Name clinical partners. Show MOUs exist.

✓ "We have an active MOU with Fenway Health for PrEP navigation and with Codman Square Health Center for HCV treatment referrals, both renewed in 2025."

Pro Tip

BPHC prioritizes organizations owned or led by people from the communities most affected — Black, Latinx, LGBTQ+, people with lived experience of HIV/substance use. State this explicitly if it applies to your organization. It strengthens your proposal.

SECTION 4A: PROGRAM DESCRIPTION — INTERVENTIONS

35 points total for Section 4 • The most important section

Name your interventions clearly. Explain why each one fits your specific population. Every intervention must connect to biomedical prevention (testing, PrEP, vaccination, or treatment).

✓ STRONG — Naming Interventions with Equity Rationale

"We will use a combination of three interventions: (1) Peer-led group education using the evidence-based CONNECT intervention, adapted for Black MSM ages 18–35 with Haitian Creole-language materials; (2) Community-based HIV and syphilis rapid testing at 2 Dorchester barbershops bi-weekly; and (3) PrEP navigation with hands-on support for insurance enrollment, appointment scheduling, and transportation to Fenway Health. These are evidence-based approaches that have proven effective in communities with high structural barriers to clinical care. All testing-positive individuals will be linked to care within 72 hours."

✗ WEAK — Vague and disconnected

"We will do outreach and education about HIV prevention. We will refer people to testing and PrEP if needed."

Every proposal MUST show how it connects participants to at least one biomedical prevention strategy:

HIV/STI/HCV
Testing

PrEP or
PEP Access

Mpox
Vaccination

Doxy PEP
Referral

HCV
Treatment

SECTION 4B: GOALS, OBJECTIVES & ACTIVITIES

35 points (Section 4 total) • Be specific. Use numbers.

Goals describe the change you want to create. Objectives are measurable milestones. Activities are what you actually do.

GOAL

The big change you're working toward

✓ Example:

"Reduce HIV transmission among Black MSM in Mattapan by increasing regular testing rates and PrEP uptake."

OBJECTIVE

Specific, measurable, time-bound targets

✓ Example:

"By June 30, 2027, provide HIV/STI testing to 200 unduplicated individuals, with 90% receiving results same-day."

ACTIVITY

The specific things you do

✓ Example:

"CHW will conduct 2 testing events per month at Partner Barbershop, Dorchester, on Tuesday evenings 5–8 PM."

⚠ Don't over-promise: 200 well-served participants is stronger than 2,000 with no explanation of how. Reviewers check whether numbers match your staffing, budget, and hours of operation.

SECTION 4C: PARTNERSHIPS & COLLABORATIONS

35 points (Section 4) • Show you don't work in a silo

BPHC requires ALL funded programs to have written collaborative agreements with at least one clinical provider for testing, PrEP/PEP, vaccination, and treatment.

FORMAL PARTNERSHIP (apply together)

- One lead agency holds the contract & funds
- Partners are subcontractors — each needs a budget
- MOU required — outline each partner's role & scope
- One partner can be non-501(c)(3) as a sub
- Lead agency must have 501(c)(3) status

COLLABORATION (coordination only)

- No fiscal relationship — no subcontracts
- Agree to work together toward shared goals
- Examples: referring clients, co-hosting events
- Written agreement (letter, MOU) strongly encouraged
- Still name them — reviewers want to see real networks

✓ STRONG — Partnership description

"Health Equity For All (lead) and Movement for Change (sub) will co-deliver this program. Movement for Change will conduct all Spanish-language outreach and education in East Boston (40% of total activities), with a dedicated budget of \$75,000. A signed MOU is included as Attachment F. PrEP navigation will be provided in collaboration with Safe Neighborhood Health Center, which has agreed to offer same-week PrEP appointments for all our referrals (letter of support attached)."

✓ STRONG — Collaboration description

"Health Equity For All will collaborate with Safe Neighborhood Health Center and East Boston Community Outreach to support access to prevention and care services. Safe Neighborhood Health Center will accept referrals for HIV/STI testing and PrEP services and provide timely appointments for referred clients. East Boston Community Outreach will support community engagement through outreach events and provide space for group education sessions. These collaborations will strengthen access to services and improve linkage to care for the target population."

SECTION 5: QUALITY ASSURANCE PLAN

10 points • Show how you ensure services are delivered well

QA is not about perfection — it's about having a system to catch problems early and fix them. Reviewers want to see that you take service quality seriously.

Staff Training

Name specific trainings.

✓ "All CHWs will complete a 3-day BPHC-approved harm reduction training before program launch and attend monthly supervision with the Program Director."

Supervision & Oversight

Describe how work is reviewed.

✓ "Program Director will conduct bi-weekly 1:1s with each CHW, review encounter notes monthly, and accompany CHWs on at least 2 community sessions per quarter."

Participant Feedback

Explain how you hear from clients.

✓ "We will administer a 5-question anonymous satisfaction survey at every group session. Results reviewed monthly and shared with staff at team meetings."

Data Review

Show how data drives improvement.

✓ "Program Director reviews monthly service data within 7 days of submission. If testing numbers fall below 85% of target, a corrective action plan is developed within 2 weeks."

Pro Tip

Health equity QA tip: Include how you will monitor whether services are reaching identified target population participants (e.g., undocumented individuals, people experiencing homelessness). If numbers show underrepresentation, your QA plan should describe how you respond.

SECTION 6: PROCESS & OUTCOME MEASURES

15 points • Show you can track and learn from your work

Process measures = what you did. Outcome measures = what changed. **You need both.**

Measure Type	Example Measure	How You Track It	Tool / Method
Process	# individuals reached via outreach	CHW tally sheets, reviewed weekly	E2 data platform (BPHC system)
Process	# HIV tests conducted, by type	Test log with date, site, result	E2 platform + paper log backup
Outcome	% reactive results linked to care within 72 hrs	Follow-up calls logged per client	Navigation tracking spreadsheet
Outcome	# newly enrolled in PrEP	Navigator confirms enrollment with clinic	Care coordination log
Outcome	Change in HIV knowledge score	Pre/post survey at group sessions	5-question paper survey, results tallied monthly

 **Pro Tip**

You must submit monthly data to BPHC via the E2Education&Outreach platform by the 15th of each month. BPHC will train all funded agencies on the platform before the contract starts.

SECTION 7: BUDGET & BUDGET JUSTIFICATION (Part 1 of 2)

10 points • Every dollar must connect to your program work

Use the Excel template provided. Budgets are cost reimbursement — you spend first, then invoice BPHC. No advance payments.

PERSONNEL	OTHER DIRECT COSTS	INDIRECT / ADMIN
<ul style="list-style-type: none">● List every position by title & name● Show FTE (e.g., 0.5 = 50% time on this grant)● Annual = (Salary ÷ 12) × FTE × Months● Fringe rate = your audited rate, max 62%● Enter 'TBH' if position not yet filled	<ul style="list-style-type: none">● Be specific: 'Office supplies' not 'Supplies'● Incentives: list cost/person, policy must exist● No cash incentives — store gift cards only● Travel: IRS mileage rate, Boston only● Meals must link to a program event; include sign-in sheets	<ul style="list-style-type: none">● Capped at 15% of total direct costs● Must use HHS-negotiated rate OR de minimis rate● If using de minimis, no itemized admin costs needed● Itemize all admin costs in the budget (if agency does not have a negotiated rate)● Cannot use negotiated rates AND admin costs together.

Award range: \$100,000 – \$300,000 | No awards below \$100,000 | Contracts renewed annually pending performance through June 30, 2030

SECTION 7: BUDGET JUSTIFICATION (Part 2 of 2)

For every line item, explain WHAT it is, WHY it's needed, and HOW you calculated it

The justification is where you tell the story behind each number. Reviewers reject budgets where they can't see the connection to program work.

✓ STRONG — Personnel justification example

"Program Coordinator (Adelina Santosh, 0.75 FTE, 12 months): \$45,000 annually \times 0.75 FTE = \$33,750. Ms. Santosh is responsible for scheduling all testing events, managing CHW timesheets, submitting monthly data to E2, and coordinating with clinical partners. She brings 5 years of HIV navigation experience. Fringe at 32% = \$10,800. Personnel subtotal: \$44,550."

✓ STRONG — Incentives justification example

"Participant Incentives: \$25 gift card \times 200 participants = \$5,000. Gift cards will be distributed to participants completing HIV testing. Our agency incentive policy (attached) requires a receipt with client initials (**no client identifiable information**) from each participant. Gift cards are purchased from CVS and tracked in a log reviewed monthly by the fiscal officer."

✗ WEAK — Budget narrative that will be returned

"Incentives: \$5,000 — needed to encourage participation. Personnel: \$60,000 — for staff who will work on the program."

⚠ Budget revisions will NOT be accepted after April 1, 2027. Budget carefully upfront — spend 25% per quarter or risk contract reduction.

CENTERING HEALTH EQUITY IN EVERY SECTION

Health equity is not a separate section — it runs through your entire proposal.

Section 2

Name the specific race/ethnicity, neighborhood, and documented disparity you will address. Cite BPHC data. Explain how structural racism — not behavior — creates the disparity.

Section 3

State if your organization is led by or founded by community members. Name the % of staff who share lived experience with the target population.

Section 4

Explain how each intervention was chosen for this specific community. Show cultural/linguistic adaptation. Name peer staff roles. Link every activity to biomedical prevention.

Section 5

Describe how your QA plan monitors whether the hardest-to-reach participants are actually being served. Build in an equity check at every reporting cycle.

Section 6

Include outcome measures that track equity — e.g., % of participants who are Black/Latinx, % who are non-US born, % who were uninsured before enrollment.

Section 7

Budget for interpretation/translation services, transportation support, and community health worker salaries that reflect community wages — these are health equity investments.

SUBMISSION CHECKLIST & KEY REMINDERS

Before you hit submit — verify every item below

NARRATIVE (PDF)

- Cover Page (signed)
- Check List (signed)
- Section 1: Org Info complete
- Section 2: Target Population
- Section 3: Org Capacity
- Section 4: Program Description
- Section 5: QA Plan
- Section 6: Process/Outcome Measures
- Section 7: Budget Narrative
- ≤ 20 pages, 12pt, double-spaced

TABLES & BUDGET (Excel)

- Table 1: Organization Diversity Form
- Tables 2.1–2.3: Target Population
- Table 3: Partnership/Collaboration
- Budget Template (Excel format)
- Budget calculations checked
- Fringe rate documented
- Incentive policy on file
- Indirect rate documented (if used)

ATTACHMENTS

- Certificate of Authority
- 501(c)(3) verification
- SAM.gov registration status
- Key staff resumes
- MOU (if applying as partnership)
- Budget Justification
- Letters of support (recommended)

DEADLINE: May 22, 2026 at 5:00 PM | Submit electronically to BPHC @ CommunityPrevention@bphc.org | NO EXCEPTIONS

NEXT STEPS & WHERE TO GET HELP

1

Today

All documents are there — budget templates, tables, LOI template

Download the full RFP from the BPHC website

2

By May 11

Not binding — but strongly encouraged. Shows BPHC you plan to apply

Submit your Letter of Intent (LOI)

3

By May 14

Email: communityprevention@bphc.org • Answers posted May 20

Submit written questions to BPHC – Answers will be posted on same RFP link

4

Now–May 22

Start with Section 2 (population) and Section 4 (program) — they are worth 50 of 100 points

Write your proposal using this guidance

5

May 22, 5PM

Submit electronically per BPHC instructions

Submit final proposal — no late submissions accepted

Questions: communityprevention@bphc.org | Program Director: Idalin Andrades

You have the expertise. This funding is here to support your community. We look forward to your proposal.