Registered HIV test sites requesting an HIV Testing MOA with the DOH-Orange: Area 7 Program Office must initially comply with the standards outlined in the FDOH IOP 360-09-17 “Provision of HIV Testing and Linkage” prior to submission of the application.

Potential test sites must complete the DH 1781 Application for Registration and Registration for HIV Testing Programs and return it to the Early Intervention Consultant (EIC). In addition, potential test sites must submit the application for a Memorandum of Agreement/Memorandum of Understanding (MOA/MOU) to the contract manager.

Potential Sites must complete all required fields and submit all required documentation for the application to be revied by the Department. The Department will contact the potential directly regarding the status of the application.

**I. Provider Information**

|  |
| --- |
| Provider Information |
| **Federal ID/EIN Number/Sunbiz** |  |
| **VENDOR NAME** |  |
| **ADDRESS** |  |
| **CITY/STATE/ZIP** |  |
| **CONTACT PERSON (On file with EIN)** |  |
| **CONTACT EMAIL ADDRESS** |  |
| **PHONE NUMBER** |  |

|  |
| --- |
| Primary Contact Person for Daily Business |
| Name: |  |
| Title: |  |
| Organization: |  |
| Mailing Address: |  |
| CITY/STATE/ZIP: |  |
| Telephone/Fax: |  |
| E-mail: |  |

|  |
| --- |
| MOA Signature Authority –Person Who is Authorized to Sign the MOA |
| Name: |  |
| Title: |  |
| Email (Where DocuSign will be sent): |  |

Please indicate if the agency is a **Clinical Location**:

[ ] Yes [ ] No

Is the agency already a pre-existing HIV testing Site?

[ ] Yes [ ] No

If yes, please list the Site-Number(s):

Has the agency ever held a contract or purchase order with the Department?

[ ] Yes [ ] No

If yes, please list the contract or purchase order number(s) and describe the scope of work:

Please indicate how long the agency has been established and have been providing services in Area 7:

Summary of current services provided by the agency:

gdgdg

Please describe the anticipated support of DOH-Orange concerning receiving a MOA:

**II. Provider Attestation**

Has any legal action been taken against the Provider (Agency) within the last 12 month?

[ ] Yes [ ] No

If yes, please explain:

Has any legal action been taken against the medical provider within the last 12 months?

[ ] Yes [ ] No

If yes, please explain:

Does the Provider (Agency) intend to use the executed MOA to attain additional funding? I.e., STD services, 340B, other state grants, etc.

[ ] Yes [ ] No

If yes, please explain:

The Provider certifies that all above information and attached documentation is accurate. Provider understands that any falsification of the provided information will result in an immediate denial of the application for MOA with the Department or termination of executed agreement. Provider also understands that the Department has the right to deny the execution of a MOA for any reason.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Representative Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**III. Supporting Documentation Checklist**

Provider (agency) should ensure that each of the following documents have been attached and submitted with this application:

[ ]  DH Form 1781 Application Registration for HIV Testing Programs including License of certificate or number to practice in the State of Florida

[ ]  CLIA (Clinical Laborites Amendment Act) Certificate/Waiver

[ ]  Biomedical Waste Permit and Biomedical Waste Plan

[ ]  Exposure Control Plan and Needle-stick procedure (OSHA)

[ ]  Policies and Procedures relating to Confidentiality (HIPAA)

[ ]  Standard Operation Procedure (SOP) relating to Quality Assurance

[ ]  Standard Operation Procedure (SOP) relating to participation in the Rapid Start Treatment Program

[ ]  Community Outreach Plan (if applicable)

[ ]  Linkage to Care Plan for new HIV Diagnosis (CBO only)

[ ]  Linkage to PrEP and nPEP Services Plan (CBO only)