

# HRSA Ryan White HIV/AIDS Program (RWHAP) Core Medical Services Waiver Request Attestation Form

This form is to be completed by the Chief Elected Official, Chief Executive Officer, or a designee of either.

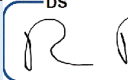
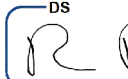

Please initial to attest to meeting each requirement after reading and understanding the explanation.

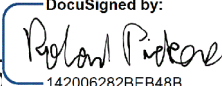
Name of recipient San Francisco Department of Public Health, HIV Health Services

RWHAP Part A recipient  RWHAP Part B recipient  RWHAP Part C recipient

Initial request  Renewal request

Year of request 2024 (for the 2025-2026 year)

REQUIREMENT	EXPLANATION
<b>No ADAP waiting lists</b>	By initialing here and signing this document, you attest there are no AIDS Drug Assistance Program (ADAP) waiting lists in the service area. 
<b>Availability of, and accessibility to core medical services to all eligible individuals</b>	By initialing here and signing this document, you attest to the availability of and access to core medical services for all HRSA RWHAP eligible individuals in the service area within 30 days. Such access is without regard to funding source, and without the need to spend on these services, at least 75 percent of funds remaining from your RWHAP award after reserving statutory permissible amounts for administrative and clinical quality management. You also agree to provide HRSA HAB supportive evidence of meeting this requirement upon request. 
<b>Evidence of a public process</b>	By initialing here and signing this document, you attest to having had a public process during which input related to the availability of core medical services and the decision to request this waiver was sought from impacted communities, including clients and RWHAP funded core medical services providers. You also agree to provide supportive evidence of such process to HRSA HAB upon request. 

DocuSigned by:  
  
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**SIGNATURE OF CHIEF ELECTED OFFICER (OR DESIGNEE)**  
**F EXECUTIVE OFFICER (OR DESIGNEE)**

Grant Colfax, MD

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**PRINT NAME**

Director of Health, San Francisco Department of Public Health

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**TITLE**

August 14, 2024

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**DATE**

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is **0906-0065** and is **valid until 09/30/2024**. Public reporting burden for this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

Expiration Date **09/30/2024**