ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration for Children and Families	
	1. Log No: ACF-ACYF-FVPSA-IM- 22-03	**2. Issuance Date:** September 19, 2022
	3. Originating Offices: Administration on Children, Youth and Families; Family and Youth Services Bureau, Division of Family Violence Prevention and Services	
	4. Key Words: Domestic Violence; Healthcare; Health Care Services Reimbursement; Medical Advocacy; Health Care Advocacy; Domestic Violence Screening/Assessment in Healthcare Settings; Preventive Care; Affordable Care Act; ACA	

TO: Family Violence Prevention and Services Act (FVPSA) State/Territory Administrators, Tribes, State/Territory Domestic Violence Coalitions, and FVPSA Subrecipients (e.g., Domestic Violence Service Providers)

SUBJECT: Provision of Medical Advocacy

PURPOSE: The purpose of this information memorandum (IM) is to provide guidance to Family Violence Prevention and Services Act (FVPSA) grant recipients and subrecipients (e.g., domestic violence and sexual assault service providers) regarding the definition of medical advocacy, which is a reimbursable expense under the FVPSA statute (42 U.S.C. § 10408(b)(1)(G)(iii)) and to address a set of questions that may arise in the context of providing medical advocacy. The IM also provides guidance regarding access to the Health Insurance Marketplace Special Enrollment Periods for Domestic Violence Survivors.

LEGAL REFERENCES: Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 1001, 42 U.S.C. § 300gg-13 (amending § 2713 of the Public Health Services Act); the Family Violence Prevention and Services Act (FVPSA), 42 U.S.C. § 10401 *et seq*.; the FVPSA Regulations, 45 CFR § 1370.

INFORMATION

Every day, thousands of domestic violence service providers use the Family Violence Prevention and Services Act (FVPSA) funds to provide safety, supportive services, and to increase access to health and behavioral health services for domestic violence, dating violence, and family violence survivors and their dependents. Expanding access to and availability of medical advocacy and

supportive services increases survivor safety, as well as strengthens the health and well-being of the 1.3 million survivors served by the FVPSA funded programs every year.

This information memorandum (IM) provides guidance to FVPSA grant recipients and subrecipients (.e.g., domestic violence, dating violence, family violence, and sexual assault service providers) regarding the definition of medical advocacy, as referenced in the FVPSA statute (42 U.S.C. § 10408(b)(1)(G)(iii)) and addresses a set of questions that may arise in the context of providing medical advocacy.

The FVPSA statute allows FVPSA subrecipients to receive reimbursement[1] for medical advocacy with FVPSA funds, and specifically lists reimbursable expenses to include *medical advocacy, including provision of referrals for appropriate health care services (including mental health, alcohol, and drug abuse treatment)* (42 U.S.C. § 10408(b)(1)(G)(iii)). The IM also provides guidance regarding access to the Health Insurance Marketplace Special Enrollment Periods for Domestic Violence Survivors.

The provision of medical advocacy includes health referrals and coordination of health care services, including reproductive and maternal health care services, physical health, behavioral health, and substance use treatment, to address injuries and the harmful health effects of violence, trauma, and abuse; helping people safety plan to manage a chronic health condition while surviving abuse; providing trauma-informed health advocacy to help survivors talk with healthcare providers about how domestic violence is impacting their health; helping health care providers safely implement domestic violence screening, assessment, and referrals with patients; or helping survivors access treatment for a traumatic brain injury, aligns with allowable services identified in the FVPSA statute (42 U.S.C. 10408(b)(1)(A)-(H)) and also the FVPSA regulation definition of supportive services and preventive services (45 CFR § 1370.2).

I. Background

The impact of experiencing domestic violence has lifelong, health-related consequences for survivors, including chronic pain, traumatic brain injury, digestive problems, reproductive and maternal health concerns, and the potential loss of access to health care providers. Housing instability and homelessness exacerbate this problem. Health care providers, working in partnership with states, territories, domestic violence service providers, tribes, and culturally specific organizations, represent important opportunities to respond to the physical and behavioral health needs of survivors of domestic violence, including mitigating the spread of COVID-19, through integrated health and community-based supports for families that face particular barriers at the intersection of domestic violence, homelessness, and health care. Domestic violence is a significant public health issue that is preventable, and the provision of medical advocacy by

[1] See ACF-ACYF-FVPSA-IM- 22-02 for guidance regarding how to receive payment(s) from health programs or other third-party payers, including reimbursement through Medicaid and health insurance plans, for the provision of domestic violence related medical advocacy that is not otherwise funded through FVPSA.

domestic violence service providers is an important service component when working to prevent or respond to domestic violence across communities.

Additionally, the Affordable Care Act (ACA) includes coverage, without cost sharing under non-grandfathered plans, of an annual well-woman preventive care visit. Screening and brief counseling for domestic violence and IPV for all adolescent and adult women is one of the eight additional recommended preventive services.[i]

1. *Screening* may consist of a few, brief, open-ended questions, and may include the use of brochures, forms, or other assessment tools including chart prompts.

2. *Counseling* provides basic information, including how a patient's health concerns may relate to violence and referrals to local DV support agencies when patients disclose abuse.[ii]

II. Provision of Medical Advocacy and Health Advocacy Services

The FVPSA statute allows FVPSA subrecipients to receive reimbursement for *medical advocacy* using FVPSA funds, and specifically lists reimbursable expenses to include the *provision of referrals for appropriate health care services (including mental health, alcohol, and drug abuse treatment)* (42 U.S.C. § 10408(b)(1)(G)(iii)).[2] The FVPSA regulation provides additional context to the provision of medical advocacy in the definitions of both *supportive services* and *secondary prevention*:

> *Supportive services* means services for adult and youth victims of family violence, domestic violence, or dating violence, and their dependents that are designed to meet the needs of such victims and their dependents for short-term, transitional, or long-term safety and recovery. Supportive services include but are not limited to: direct and/or referral-based advocacy on behalf of victims and their dependents; counseling; case management; employment services; referrals; transportation services; legal advocacy or assistance; childcare services; **health, behavioral health, and preventive health services**; culturally and linguistically appropriate services; and other services that assist victims or their dependents in recovering from the effects of the violence. (45 CFR § 1370.2). To the extent not already described in this definition, supportive services also include but are not limited to other services identified in FVPSA at 42 U.S.C. § 10408(b)(1)(A)-(H).
>
> **Supportive services may be directly provided by FVPSA grant recipients or subrecipients and/or by providing advocacy or referrals to assist survivors in accessing such services.**
>
> *Secondary prevention* is identifying risk factors or problems that may lead to future family violence, domestic violence, or dating violence and taking the necessary actions to eliminate the risk factors and the potential problem, and may include, but are not limited to, healing services for children and youth who have been exposed to domestic violence or

[2] See ACF-ACYF-FVPSA-IM- 22-02 for guidance regarding how to receive payment(s) from health programs or other third-party payers, including reimbursement through Medicaid and health insurance plans, for the provision of domestic violence related medical advocacy that is not otherwise funded through FVPSA.

dating violence, home visiting programs for high-risk families, and **screening programs in health care settings**. (45 CFR § 1370.2).

Within the medical community, *health advocacy* relates to ensuring access to care, navigating the health care system, mobilizing resources, addressing health inequities, influencing health policy and creating system change.[iii] For the purposes of this guidance, *medical advocacy*, which is the term used within the FVPSA statute, is inclusive of health advocacy and/or health services which are often terms more frequently used in the medical community, and refers to the provision of universal education on healthy and unhealthy relationships, screening and brief counseling, including providing basic information, referrals, tools, safety plans, and provider education tools. Medical advocacy also refers to the provision of health referrals and coordination of health care services, including reproductive and maternal health, physical health, behavioral health, and substance use treatment services to address injuries and the harmful health effects of violence, trauma, and abuse; helping people safety plan to manage a chronic health condition while surviving abuse; providing trauma-informed health advocacy to help survivors talk with healthcare providers about how domestic violence is impacting their health; helping health care providers safely implement domestic violence screening/assessment and referrals with patients; and helping survivors access treatment for a traumatic brain injury. This guidance is not intended to address medical advocacy of a clinical nature, including that which relates to child abuse and sexual assault services, forensic examinations, pediatrician examinations, etc.

High-quality training and technical assistance at the intersections of survivor advocacy and health care provision is vital to providing universal education about domestic violence and healthy relationship behaviors, providing knowledgeable referrals, and preventing future incidents of harm. Medical advocacy can include providing advocacy services at a health care provider location, receiving referrals from a community health center, clinic, or other provider who has identified a survivor, and/or offering health assessments with survivors in advocacy settings and providing referrals to a community health center, clinic, or health care provider for reproductive health, physical health, and behavioral health services or any other health related services that survivors and their children may need to treat injuries or the health effects of violence, trauma, and abuse.

Listed below are scenarios that illustrate how FVPSA grant recipients and subrecipients can implement and receive payment, both by using FVPSA funding or a third-party funding source, for medical advocacy. These examples are not all-inclusive or exhaustive.

- Scenario #1: The FVPSA grant recipient/subrecipient leveraged their relationship with a hospital in their region. Together, they created a bi-directional referral system and implemented cross-training, including health training for advocacy staff. As a result of their mutually beneficial relationship, the hospital funded the program with over $50,000 annually to support their continued collaboration and health advocacy efforts. The hospital gained full trust in the program to provide quality domestic violence support services onsite, as well as referrals. Preventative healthcare utilization increased, and the hospital was able to document a cost savings. Ultimately, they were able to make the case for additional funding to fully support their health advocate who is co-located between the

domestic violence program and the hospital. The subrecipient would report this additional funding as program income.

- Scenario #2: The FVPSA grant recipient/subrecipient had a survivor living with type 2 diabetes who was trying to self-manage her symptoms without medical care. Upon accessing DV advocacy services, she was immediately connected to a health care provider, assisted with enrolling in health coverage, and assigned to a skilled physician. The survivor was able to receive necessary medical attention, better manage living with the condition, and learned to advocate for her own health. The FVPSA grant recipient/subrecipient was able to bill for the advocate's time for completing this medical advocacy using existing FVPSA grant funds.

- Scenario #3: The FVPSA grant recipient/subrecipient is a licensed Medicaid provider with the state. Their domestic violence advocate(s) provide direct services covered by the client's (i.e., survivor's) insurance. The reimbursable services provided by the DV advocate include brief counseling and care coordination either at the community health center, clinic, other health care provider location, or at the subrecipient site. The subrecipient bills the health insurance plan directly for the pre-negotiated rate, and the health insurance plan reimburses the subrecipient.

- Scenario #4: The FVPSA grant recipient/subrecipient has a formal, contractual relationship with a health care provider that pays the subrecipient a monthly retainer to be "on call" to provide a specific scope of services (e.g., care coordination; screening and brief counseling; bi-directional referrals).

- Scenario #5: A healthcare provider employs a FVPSA grant recipient to be on site at the health care location and pays the FVPSA grant recipient for the time that the domestic violence advocate is onsite to provide medical advocacy at the health care provider's location.

- Scenario #6: The FVPSA grant recipient contracts with a health care or behavioral health provider to deliver services at the domestic violence shelter or program. The health care provider is not on staff with the FVPSA grant recipient; they operate independently. The health care provider delivers reimbursable health care services (e.g., counseling) and bills the client's (i.e., survivor's) insurance. The health insurance company directly reimburses the health care provider and the health care provider shares a percentage of the revenue with the FVPSA grant recipient.

Within the context of providing medical advocacy, the following questions may arise:

- **If the referring health entity requires or requests information about the acceptance of a named referral by the subrecipient, does that violate victim confidentiality given the information may be linked to personally identifiable health records?** – Yes, unless the victim signs an informed, time-limited release of information (ROI). Upon provision of medical advocacy, regardless of how the survivor-initiated contact, the FVPSA-funded

program has the legal responsibility to protect the confidentiality and privacy of victims and their dependents (45 CFR § 1370.4). Survivors should be offered the option, and have the right to allow a DV program to communicate with the referring entity or bill their insurance for medical advocacy, or to consent to sharing Personally Identifying Information (PII) via informed, written, reasonably time-limited consent. The program may not share information without such consent. The purpose of the consent should be to benefit the victim, and not merely assist the healthy entity or the victim service provider, such as for reporting purposes. Survivors also must be informed that they have the right to refuse to consent to the sharing of PII or to communication with the referring entity or their insurance provider, and should be informed that their refusal to consent will not impede their ability to access services at the FVPSA-funded program. Protection of electronic health records does exist under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[iv], although FVPSA/VAWA/VOCA requirements are generally considered to provide more stringent protection.[v] Nonetheless, the survivor should be informed of the protections and limitations of both FVPSA/VAWA/VOCA and HIPAA when engaging in medical advocacy services and how to provide consent, if desired, for PII to be shared with Medicaid or other payers.

- **Can a FVPSA funded domestic violence service provider accept a referral of a named person from a health care provider or health system?** – Yes. This would be similar to accepting bi-directional/warm referrals/hand-offs from any other social service agency, community health center, or community partner such as child welfare services, parenting programs, public benefits caseworkers, health programs, etc.

  However, as noted above, survivor privacy and confidentiality must be protected, and it should be communicated to the referring organization that services funded through the FVPSA are statutorily mandated to be voluntary (42 U.S.C. § 10408(d)(2)). This means that the receipt of shelter or supportive services cannot be conditioned on participation in other services including, but not limited to, counseling, parenting classes, mental health or substance use disorders treatment, pursuit of specific legal remedies, or life skill classes, etc. (45 CFR § 1370.10(b)(10)). Furthermore, the individual referred must initiate contact with the local DV service provider—the subrecipient cannot directly reach out to the individual.

- **Is there appropriate language that can be used to obtain survivor consent that would not violate individual privacy and confidentiality?** – See this article published by the National Network to End Domestic Violence (NNEDV), *Connecting the Dots: Advocates' Responsibilities for Increasing Privacy, Upholding Confidentiality, and Promoting Safety* (http://nnedv.org/latest_update/connecting-dots_confidentiality/) which includes an analysis of survivor rights, federal statutes, informed consent, and links to model confidentiality templates.

- **Is participation in medical advocacy or health services mandatory for survivors? -** No, in accordance with the FVPSA statute and regulations, shelter services, and supportive services must be provided on a voluntary basis and no condition may be applied for the

receipt of emergency shelter (42 U.S.C. 10408(d)(2) and 45 CFR 1370.10(b)(10)). FVPSA recipients/subrecipients cannot impose conditions for admission to shelter by applying inappropriate screening methods (45 CFR 1370.10(b)(10)).

- **Can FVPSA grant funds be used to meet the basic needs of survivors?** Yes, the FVPSA grant funds can be used to meet the basic needs of survivors of domestic violence. The FVPSA funds can be used to support the operation and administration of culturally specific domestic violence programs as well as to provide supportive services to ensure that survivors receive the shelter, reproductive and maternal, physical, and/or behavioral, health care, support and services they may need to heal. This includes the following:
    - Staffing
    - Utilities
    - Food and toiletries
    - Rental costs of the facility
    - Safe homes
    - Hotel or motel vouchers
    - Emergency and immediate shelter, including temporary refuge or lodging in individual units such as apartments that are not required to be owned, operated or leased by the program
    - Supplies for the DV program, such as but not limited to: Clothing, Toiletries, and Personal Protection Equipment (PPE), etc.
    - Transportation to access shelter, health services, social services, court appointments, employment, or childcare, etc.
    - Developing safety plans
    - Individual and group counseling and peer support groups
    - Training, technical assistance, prevention, and outreach to increase awareness of domestic violence services and culturally specific services
    - Culturally specific and linguistically appropriate services
    - Language accesses services and supports
    - Services for children and youth
    - Advocacy, case management services, and information and referral services

III. ACA Health Insurance Marketplace Special Enrollment Periods for Domestic Violence Survivors.

For many survivors of domestic and sexual violence, access to health care is a vital part of healing and self-determination to recover from abuse. However, domestic violence survivors experience many barriers to accessing health insurance and health services. The FVPSA Program, the National Health Resource Center on Domestic Violence, state domestic violence and sexual assault coalitions and domestic violence and sexual assault services programs are working with advocates and health providers to help survivors across the country access the trauma-informed care and coverage they need.

Survivors of domestic abuse or those who have experienced spousal abandonment, who are already enrolled in health coverage, and need to enroll in coverage separate from the perpetrator of the abuse or abandonment, can enroll in health insurance coverage through the Marketplace at any time throughout the year via a Special Enrollment Period (SEP). They do not need to wait for the annual Open Enrollment Period. Many consumers will qualify for substantial financial assistance to purchase Marketplace coverage based on their income.

For states that use the HealthCare.gov platform, survivors of domestic violence and their dependents may switch their health coverage to the Marketplace at any point during the year by starting a new application with the Marketplace Call Center and asking for an SEP. They must say that they are a "victim of domestic violence." This is done through self-attestation and no documentation is needed to prove domestic violence. The consumer must enroll in coverage within 60 days after the SEP is granted. This SEP is only available to consumers who are already enrolled in coverage and want to enroll in a plan separate from the perpetrator of the abuse or abandonment.

For purposes of the premium tax credit that is available to help consumers purchase health insurance through the Marketplace, survivors of domestic violence and abandoned spouses who are legally married but who are living apart from their spouse at the time of filing an income tax return, and who are unable to file a joint return as a result of domestic abuse, are eligible for financial help through the Marketplace and permitted to claim a premium tax credit while filing a tax return with a filing status of married filing separately. Furthermore, the survivors in this scenario are not required to count the spouse's income towards their household income. This means that survivors are able to qualify for financial help based on their own salary—making needed health insurance much more affordable to survivors and their children.

After the application has been completed, consumers will be able to see what financial help they are eligible for based only on their attested income (as well as any countable income for any dependents they list on the application). Survivors then can choose a plan that best meets their needs and enroll.

Consumers in states that operate their own Marketplace platforms should contact their state's Marketplace. Consumers can find contact information for their Marketplace by visiting http://www.healthcare.gov/get-coverage/.

Screening and counseling for domestic violence are now benefits that health plans are required to cover. Insurance companies are **prohibited from denying coverage to victims of domestic violence as a preexisting condition**.

Survivors and their dependents may also qualify for Medicaid or the Children's Health Insurance Program (CHIP) based on their income or other factors. When applying at HealthCare.gov, if it looks like anyone in the household qualifies for Medicaid or CHIP, the Marketplace will send the application information to the state Medicaid or CHIP agency, who will then contact the applicants about next steps. Medicaid/CHIP enrollment is year-round and anyone who may be eligible for

coverage through Medicaid/CHIP should submit an application through the Marketplace or with their state agency.

IV. Conclusion

Through the implementation of the FVPSA grant funds and American Rescue Plan (ARP) supplemental funding, states, territories, tribes, coalitions, DV shelters, DV programs, rape crisis centers and sexual assault services programs, and culturally specific organizations have access to over $1 billion in funding to provide shelter and supportive services including medical advocacy, health advocacy, and health care services for millions of survivors and their children, http://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/fvpsa-arp-grants-portal/arp-grants-program.

The FVPSA statute allows FVPSA subrecipients to use FVPSA funding for many important services, including the provision of medical advocacy, and specifically lists reimbursable expenses to include *medical advocacy, including provision of referrals for appropriate health care services (including mental health, alcohol, and drug abuse treatment)* (42 U.S.C. § 10408(b)(1)(G)(iii)).

The provision of medical advocacy, to include health referrals and coordination of health care services, including to reproductive health, physical health, behavioral health, and substance use treatment, to address injuries and the harmful health effects of violence, trauma, and abuse; helping people safety plan to manage a chronic health condition while surviving abuse; providing trauma-informed health advocacy to help survivors talk with healthcare providers about how domestic violence is impacting their health; helping health care providers safely implement domestic violence screening, assessment, and referrals with patients; or helping survivors access treatment for a traumatic brain injury, aligns with allowable services identified in the FVPSA statute (42 U.S.C. 10408(b)(1)(A)-(H)) and also the FVPSA regulation definition of supportive services and preventive services (45 CFR § 1370.2).

RESOURCES

Confidentiality Technical Assistance

National Network to End Domestic Violence
http://nnedv.org/
The National Network to End Domestic Violence (NNEDV) is a social change organization dedicated to creating a social, political, and economic environment in which violence against women no longer exists. NNEDV provides training and assistance to the statewide and territorial coalitions against domestic violence. It also furthers public awareness of domestic violence and changes beliefs that condone intimate partner violence. Find your State/Territorial DV Coalition at: http://nnedv.org/content/state-u-s-territory-coalitions/. NNEDV's Safety Net project focuses on the intersection of technology and domestic and sexual violence and works to address how it impacts the safety, privacy, accessibility, and civil rights of victims.

Online Toolkit

Confidentiality Toolkit

http://www.techsafety.org/confidentiality

This toolkit provides information on the confidentiality and privacy obligations for programs that receive federal grants that serve victims of domestic violence, sexual assault, dating violence, and stalking. The toolkit was created to assist non-profit victim service organizations and programs, co-located partnerships, coordinated community response teams, and innovative partnerships of victim service providers working to address domestic and dating violence, sexual assault, and stalking and to understand and follow the confidentiality obligations mandated by the funding they receive through the Violence Against Women Act (VAWA), Family Violence Prevention and Services Act (FVPSA), Victims of Crime Act (VOCA), and related state and federal privacy laws.

Health Care Enrollment and Special Enrollment Period Resources for Advocates and Survivors, https://www.healthcare.gov/glossary/special-enrollment-period/

Top 5 Ways Advocates Can Promote Healthcare Access

This National Health Resource Center on Domestic Violence resource helps advocates learn more about the important role of helping survivors navigate what can be an overwhelming and complicated healthcare enrollment process. Build a relationship with the "assisters" (sometimes called "navigators") in your area, the people who are trained to help people sign up for healthcare in each state, http://www.futureswithoutviolence.org/wp-content/uploads/Top-5-Open-Enrollment-1.pdf.

Health Partnerships

A consortium of community partners and health care providers enables domestic violence programs, culturally specific organizations, tribes and rural communities to support the safety and health needs of domestic violence survivors and increases health supports to mitigate the spread of COVID-19. The following resources provide examples of and guidance regarding partnerships between domestic violence organizations and health care providers.

- CDC Community coalition-based COVID-19 Prevention and Response provides guidance on using a whole-community approach to prepare for COVID-19 among people experiencing homelessness, http://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html#coalition.
- The FVPSA-funded National Health Resource Center on Domestic Violence has developed two resources that can help states, territories, tribes, shelters, domestic violence and sexual assault services programs, and health care providers build and sustain strong partnerships.
    1. A step-by-step online guide for community health centers on building partnerships with Domestic Violence (DV) and Sexual Assault (SA) advocacy, addressing violence in health centers, and promoting prevention: IPVHealthPartners.org.

2. An online toolkit for health care providers and DV advocates to prepare a clinical practice to address domestic and sexual violence, including screening instruments, sample scripts for providers, patient and provider educational resources: IPVHealth.org.

These partnerships may include entities such as:

- Community-based organizations (including faith-based organizations and social service organizations),
- Local chapters of national medical/health associations,
- Local health departments,
- Indian Health Services,
- Health Resources and Services Administration (HRSA)-funded health centers,
- Health centers and other community-based health providers,
- Culturally specific community-based organizations,
- Tribes and tribal organizations,
- Philanthropic organizations,
- Local municipal entities, such as fire departments and Emergency Medical Services,
- Social service providers (e.g., food banks, community transportation, childcare),
- Runaway and homeless youth programs, and
- Community Action Coalitions, Chambers of Commerce, Health Equity Councils, and other community groups.

Partnering with Health Departments

Health departments can facilitate the development of important partnerships with health care providers and officials to increase COVID-19 health services coordination. The CDC has contact information on state and territorial health departments that can be accessed through the following website link, http://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html.

Partnering with Indian Health Service (IHS) Facilities and Tribal Health Programs

IHS, an agency within the U.S. Department of Health and Human Services, provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states.

IHS continues to work closely with our tribal and urban Indian organization partners, as well as state and local public health officials, to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. For more on the federal response in Indian Country, visit http://www.ihs.gov/coronavirus.

Grant recipients, subrecipients, and partners must comply with HHS grant regulations and HHS and ACF policies, as well as the terms and conditions of the supplemental grant award.

American Rescue Plan (ARP) FVPSA Funding Resources

- FVPSA Grantee Success Stories, which includes a series of eight podcasts that highlights ways FVPSA grantees are using ARP funding to meet the health and safety needs of survivors: http://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/fvpsa-arp-grants-portal/fvpsa-multimedia.
- Relevant news articles and stories about the positive impact of ARP funding to meet the health and safety needs of survivors:
    - The Massachusetts FVPSA state administrator success story of supporting shelters in implementing expanded medical advocacy and supportive services: http://www.acf.hhs.gov/fysb/news/crisis-response-catalyst-innovation
    - FVPSA funded Stronghearts Native Helpline inspirational story: http://www.acf.hhs.gov/fysb/news/fvpsa-arp-funding-catalyst-stronghearts-expansion
    - Vermont LGBTQ pride inspirational story: http://www.acf.hhs.gov/fysb/news/vermont-advocates-provide-safespace-lgbtqi-community
    - Asian and Pacific Institute on Gender-Based Violence (API-GBV) ARP success story about supporting the mental health and wellbeing of advocates: http://www.acf.hhs.gov/fysb/success-story/fvpsa-apigbv-healing-advocates

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[i] HHS Family Violence Prevention and Services Act fact sheet, *The Affordable Care Act & Women's Health* (December 2013). https://www.acf.hhs.gov/sites/default/files/fysb/aca_fvpsa_20131211.pdf; https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/partner-violence.html#aca

[ii] Centers for Medicare and Medicaid Services, *Affordable Care Act Implementation FAQs – Set 12*. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12

[iii] Hubinette M, Dobson S, Scott I, Sherbino J. Health advocacy. *Med Teach*. 2017;39(2):128-135. DOI: 10.1080/0142159X.2017.1245853

[iv] https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

[v] National Network to End Domestic Violence, Frequently Asked Questions about U.S Federal Laws & Confidentiality for Survivors. https://www.techsafety.org/faq-federal-laws