Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

FY 2024

State Opioid Response Grants

(Short Title: SOR)

(Initial Announcement)

Notice of Funding Opportunity (NOFO) No. TI-24-008

Assistance Listing Number: 93.788

Key Information:

Application Deadline	**Applications are due by July 1, 2024.**
FY 2024 NOFO Application Guide	Throughout the NOFO there will be references to the FY 2024 NOFO Application Guide (Application Guide). The Application Guide provides detailed instructions on preparing and submitting your application. Please review each section of the Application Guide for important information on the grant application process, including the registration requirements, required attachments, and budget.

Electronic Grant Application Submission Requirements	**You must complete three (3) registration processes**: 1. System for Award Management (SAM); 2. Grants.gov; and 3. eRA Commons. See ***Section A of the Application Guide*** (Registration and Application Submission Requirements) to begin this process.

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for the fiscal year (FY) 2024 cohort of the State Opioid Response (SOR) program. The purpose of this program is to address the public health crisis caused by escalating opioid misuse, opioid use disorder (OUD), and opioid-related overdose across the nation. States and territories are expected to use the resources to: (1) increase access to U.S. Food and Drug Administration (FDA)-approved medications for the treatment of opioid use disorder (MOUD); (2) support the continuum of prevention, harm reduction, treatment, and recovery support services for OUD and other concurrent substance use disorders; and (3) support the continuum of care for stimulant misuse and use disorders, including those involving cocaine and methamphetamine. With this program, SAMHSA aims to enhance the development of comprehensive strategies related to opioid and stimulant use/misuse and to reduce overdose deaths across America.

Funding Opportunity Title:	State Opioid Response Grants (Short Title: SOR)
Funding Opportunity Number:	TI-24-008
Due Date for Applications:	July 1, 2024
Estimated Total Available Funding:	$1,480,500,000
Estimated Number of Awards:	Up to 59
Estimated Award Amount:	See Appendix A for estimated award amounts.
Cost Sharing/Match Required:	No
Anticipated Project Start Date:	September 30, 2024
Anticipated Award Date:	No later than September 29, 2024
Length of Project Period:	Up to 3 years

Eligible Applicants:	Eligibility is limited to Single State Agencies (SSAs) and territories. Note: Tribes are eligible to apply under a separate announcement. [See Section III-1 for complete eligibility information.]
Authorizing Statute:	SOR awards are authorized under the Further Consolidated Appropriations Act, 2024, Division D, Title II, [Public Law 118-47] and section 1003 of the 21st Century Cures Act [Public Law 114-255] (42 USC 290ee–3 note), as amended.

I. PROGRAM DESCRIPTION

1. PURPOSE

The purpose of this program is to address the overdose crisis, driven primarily by illicitly manufactured fentanyl, by providing resources to states and territories for increasing access to U.S. Food and Drug Administration (FDA)-approved medications for the treatment of opioid use disorder (MOUD), and for supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders. The State Opioid Response (SOR) program also supports the continuum of care for stimulant misuse and use disorders, including those involving cocaine and methamphetamine.

According to the Centers for Disease Control and Prevention (CDC), provisional data indicate there were 106,363 drug overdose deaths in the United States during the 12-month period ending in August 2023. Of the drug overdose deaths, 80,609 involved opioids. Illicitly manufactured fentanyl continues to drive the majority of deaths, but mortality rates due to cocaine and psychostimulants such as methamphetamine have also increased. Overdose deaths involving stimulants increased by 6 percent from 2022 to 2023. These deaths are likely linked to co-use or mixing, by illicit producers, of cocaine or methamphetamine with fentanyl or heroin. As in other areas, the COVID-19 years saw an exacerbation of health disparities in overdoses.

The SOR program provides resources for evidence-based treatments, practices, and interventions for OUD and stimulant use disorders. SAMHSA requires that MOUD is made available to those diagnosed with OUD. MOUD includes FDA-approved treatments such as methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, and injectable extended-release naltrexone.

SAMHSA does not recognize medically managed withdrawal, when done in isolation, as an evidence-based practice for OUD. Medically managed withdrawal (the updated term for detoxification) is not the standard of care for OUD and is associated with a very high relapse rate, while also significantly increasing an individual's risk for opioid overdose and death if opioid use is resumed.[1] If medically managed withdrawal services are provided by SOR recipients or sub-recipients, it must be accompanied by the offer and provision of injectable extended-release naltrexone to protect such individuals from

[1] Substance Abuse and Mental Health Services Administration. (2021). *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63 Publication No. PEP21-02-01-002. Rockville, MD: Substance Abuse and Mental Health Services Administration.

opioid-related overdose in case of return to use and to improve treatment and recovery outcomes.

In addition to these treatment services, recipients must implement effective prevention,[2] harm reduction,[3] and recovery support services.[4]

SAMHSA encourages grant recipients to address the diverse behavioral health needs of underserved communities as defined by Executive Order 13985. Recipients must also serve all individuals equitably and administer programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age, religion, and sex (including gender identity, sexual orientation, and pregnancy). Recipients must also agree to comply with federal conscience laws, where applicable.

SOR awards are authorized under the Further Consolidated Appropriations Act, 2024, Division D, Title II, [Public Law 118-47] and section 1003 of the 21st Century Cures Act [Public Law 114-255] (42 USC 290ee–3 note), as amended.

2. KEY PERSONNEL

Key personnel are staff members who must be part of the project, whether or not they receive a salary from the project. Key personnel must make a major contribution to the project. Key personnel and staff selected for the project should reflect the diversity in the geographic catchment area.

Key personnel for this program are the Project Director, Project Coordinator, and Data Coordinator. The Project Director, Project Coordinator, and Data Coordinator cannot be the same person. No more than two people can share a position.

- The **Project Director** is responsible for oversight of the entire project, including overseeing, monitoring, and managing the award, with a level of effort of 100% (1.0 FTE).
- The **Project Coordinator** is responsible for the day-to-day operations of the project, with a level of effort of 100% (1.0 FTE).
- The **Data Coordinator** is responsible for all aspects of data collection and reporting, ensuring complete, accurate, and timely data entry into SPARS and/or other data systems as directed by SAMHSA. The Data Coordinator is also

[2] Substance Abuse and Mental Health Services Administration. Prevention of Substance Use and Mental Disorders. https://www.samhsa.gov/find-help/prevention

[3] Substance Abuse and Mental Health Services Administration. Harm Reduction. https://www.samhsa.gov/find-help/harm-reduction

[4] Substance Abuse and Mental Health Services Administration. Recovery and Recovery Support. https://www.samhsa.gov/find-help/recovery

responsible for monitoring client-level intake and follow-up rates, to ensure that recipients are meeting the target numbers reported in the application. The level of effort is 100% (1.0 FTE) for all awards $4 million and above, and 50% (0.5 FTE) for all awards less than $4 million.

You will be notified if the individuals designated for these positions have been approved. If you need to replace Key Personnel during the project period, SAMHSA will review the credentials and job description before approving the replacement.

Key personnel or other grant-supported staff may not exceed 100% level of effort across all federal and non-federal funding sources.

In addition to the key personnel referenced above, in Section D of the Project Narrative, you **must** identify a **Point of Contact (POC)** for financial management matters who is knowledgeable of all federal financial management requirements and the fiscal/budgetary requirements specific to the SOR program. As noted in Section H of the NOFO Application Guide, *Standards for Financial Management and Standard Funding Restrictions,* this position may not be directly charged to the award. As a result, use of an indirect cost rate is the most effective mechanism to recover these costs and not violate federal financial requirements of consistency, allocability, and allowability.

3. REQUIRED ACTIVITIES

You are expected to begin the delivery of services by the fourth month of the award. You are expected to serve the unduplicated number of individuals proposed in the Project Narrative (B.1).

You must provide a description in B.2. of the Project Narrative of how you plan to implement all the required activities listed below.

- Applicants are expected to update the needs assessment that was submitted with the FY 2022 SOR application using the most current statewide epidemiological data. As applicable, work with the local, state, or tribal epidemiological outcomes workgroups to inform this needs assessment. The updated needs assessment must be included in **Attachment 9** of your application and must identify/include:

    - The scope of OUD and substance use disorders and overdose mortality in your state or territory.
    - The strengths, unmet service needs, and critical gaps in your service system across underserved populations, including sexual and gender minorities, geographic, and other racial and ethnic demographic groups.
    - Areas where opioid and stimulant misuse, substance use disorder, use of emergency medical resources for substance use, such as hospitalization and overdose, are the most prevalent.

- The number and location of opioid treatment providers in the state or territory, including Opioid Treatment Programs (OTPs).
- All existing activities and their funding sources in the state or territory that address opioid and stimulant use prevention, harm reduction (e.g., drug checking technologies, including fentanyl test strips), treatment, and recovery support service activities and remaining gaps in these activities.
- An updated naloxone distribution and saturation plan particularly focused on areas within your state or territory with high rates of overdose mortality. Naloxone and other opioid overdose reversal medications are an important tool in preventing overdose deaths and many studies have demonstrated the value of naloxone distribution and that increased saturation in communities reduces overdose deaths.[5,6] This plan must include:
    - The data and data sources your state or territory is using to estimate saturation and the approach you are taking to generate saturation estimates for your state or territory;
    - The estimated gap in your current supply of naloxone and other opioid overdose reversal medications, including a description of particular populations or communities where the gap is the greatest;[7]
    - A targeted distribution strategy to get the appropriate type of naloxone and other opioid overdose reversal medications into the hands of those most likely to witness an overdose and in the locations where they are most likely to occur;
    - A communications plan to address overdoses in the areas where there is high risk of fatal and non-fatal overdoses. This should include a strategy to ensure communication to people who use drugs, in a manner that is easy for them to accept and ensures trust that leads to effective and efficient distribution of naloxone and other opioid overdose reversal medications in the areas they frequent;
    - Partnerships with existing public and private efforts and funding sources external to SOR, such as through other federal grants (e.g., OD2A, FR-CARA, etc.), Medicaid, "buyers' clubs," and recent opioid-related court settlements;

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[5] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., Ruiz, S., & Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *BMJ*, 2013 Jan 30;346: f174. https://doi.org/10.1136/bmj.f174

[6] Irvine, M. A., Oller, D., Boggis, J., Bishop, B., Coombs, D., Wheeler, E., Doe-Simkins, M., Walley, A. Y., Marshall, B. D. L., Bratberg, J., & Green, T.C. (2022).Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: A modelling study. *Lancet Public Health*, 2022 Feb 10: S2468–2667(21)00304-2. Epub ahead of print. https://doi.org/10.1016/s2468-2667(21)00304-2

[7] FRED (A Framework for Reconstructing Epidemiological Dynamics) FRED Web (pitt.edu) provides a helpful resource for some states and counties to plan for their naloxone saturation needs.

- A budget that includes the cost of the naloxone and other opioid overdose reversal medications, and other operational requirements; and
- A timeline for implementation of plan activities over the project period.

- Provide a description of progress made on implementation of the comprehensive state strategic plan that was submitted with the FY 2022 SOR application. Update and submit the FY 2022 state strategic plan to address the gaps in prevention, harm reduction, treatment, and recovery services related to opioids and stimulants identified in the updated needs assessment. The description of progress and updated strategic plan must be included in **Attachment 10** and address:

  - The needs of underserved communities as defined in Executive Order 13985 (e.g., racial/ethnic minorities and LGBTQI+) and older adults with targeted interventions, when appropriate.
  - Strategies and activities that address behavioral health disparities and the social determinants of health.
  - Outreach efforts to engage tribes, tribal organizations, and urban Indian organizations to ensure that strategies are implemented to meet their needs.

  When updating the strategic plan, applicants may consider interventions described in the practice guides from the HEALing Communities Studies:

  - Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide: https://www.samhsa.gov/resource/ebp/opioid-overdose-reduction-continuum-care-approach-orcca-practice-guide-2023
  - Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide: https://www.samhsa.gov/resource/ebp/engaging-community-coalitions-decrease-opioid-overdose-deaths-practice-guide-2023

Recipients and sub-awardees **must** use SAMHSA funds primarily to support direct services. This includes the following activities:

- Implement service delivery models that enable the full spectrum of treatment and recovery support services that facilitate positive treatment outcomes and long-term recovery from opioid and stimulant use disorders. Models for evidence-based treatment include, but are not limited to:

  - Hub and spoke/center of excellence models in which patients with OUD and stimulant use disorder are stabilized in a specialized treatment setting focused on the care and treatment of OUD and stimulants, and associated conditions such as mental illness, physical illness, including infectious diseases, and other substance use disorders. Once stabilization has occurred, they are transferred to community-based providers, including primary care practitioners.

- Treatment in SAMHSA-certified OTPs.
- Addiction specialty care programs that either directly provide or support use of MOUD in addition to psychosocial services such as drug counseling, psychoeducation, toxicology testing, individual, group, and/or family therapy, vocational/educational resources, case management, and recovery support services, including community-based services that provide peer supports, address housing needs and issues of families (e.g., reunification of children who may be in foster care while a parent[s] receive treatment); this may include outpatient, intensive outpatient, or partial hospital levels of care.
- Non-specialty settings, such as emergency departments, urgent care centers, and, in some cases, pharmacies that also support appropriate MOUD and recovery support services.
- Inpatient/residential programs that provide intensive treatment services to those meeting medical necessity criteria and which offer MOUD provided the care continuum includes a connection to MOUD in the community once individuals are discharged from the inpatient/residential program.
- Primary care or other clinical practice settings, including certified community behavioral health clinics, where MOUD is provided and linkages to psychosocial services and recovery support services centered on patient needs related to the provision of comprehensive treatment of OUD.
- Programs that address the multi-faceted and complex needs of individuals with stimulant use disorder (e.g., polysubstance use, psychosis, violence, co-occurring stimulant use and mental disorders).
- Low barrier MOUD treatment programs that provide medications for treatment and other supportive services but do so without any preconditions to access. Low barrier models of care provide person-centered care and make minimal requirements of patients, thus removing or reducing barriers to treatment and meeting the individual where they are. For more information on low barrier models of care, see: https://store.samhsa.gov/product/advisory-low-barrier-models-care-substance-use-disorders/pep23-02-00-005
- Innovative telehealth strategies in rural and underserved areas to increase the capacity of communities to support OUD/stimulant use disorder prevention, treatment, and recovery.
- Care coordination and case management services, as appropriate, to ensure the provision of the full spectrum of treatment and recovery support services.

- Support the full continuum of prevention, harm reduction, treatment, and recovery support services for transitional aged youth and young adults (ages 16–25). Possible services and approaches include:

  - Increasing access and removing barriers to MOUD among youth.
  - Funding behavioral health services for transitional aged youth and young adults with substance use disorders, including treatment and recovery supports.

- Supporting family-based treatment and recovery support services for youth and young adults with, or at risk for, opioid misuse, stimulant misuse, opioid and/or stimulant use disorder and other substance misuse and use disorders.
- Supporting the use of naloxone and other opioid overdose reversal medications for all ages it is approved for provided State and local laws are followed.
- Training school staff in substance misuse prevention, including how to implement evidence-based interventions to fidelity.
- Supporting recovery high schools and collegiate recovery programs.

- Implement recovery support services, including but not limited to:

  - Recovery coaching,
  - Vocational training,
  - Employment support,
  - Transportation,
  - Childcare,
  - Linkages to legal services,*
  - Recovery Community Organizations,
  - Temporary housing supports (i.e., application fees, deposits, rental assistance, utility deposits, and utility assistance),
  - Hygiene kits,
  - Dental kits to promote oral health for individuals with OUD enrolled in treatment with buprenorphine (i.e., dental kits are limited to items such as toothpaste, toothbrush, dental floss, non-alcohol–containing mouthwash, and educational information related to accessing dental care), and
  - Recovery Housing.

  *Recipients may not pay for legal services with grant funds.

  Note: Recovery Housing is one component of the substance use disorders treatment and recovery continuum of care. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Individuals in recovery should have a meaningful role in developing the service array used in their recovery plan. Recovery houses are safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. Substance-free does not prohibit prescribed medications taken as directed by a licensed practitioner, such as pharmacotherapies specifically approved by FDA for treatment of OUD, as well as other medications with FDA-approved indications for the treatment of co-occurring health conditions. Recipients must describe the mechanism(s) in place in their jurisdiction to ensure that a recovery housing facility to receive these funds supports and provides clients access to evidence-based treatment, including all forms of MOUD, in a safe and appropriate

setting. Recipients must also describe how recovery housing supported under this award is in an appropriate and legitimate facility (e.g., state or other credentialing or certification or an established or recognized model). For more information on recovery housing, see: https://store.samhsa.gov/product/best-practices-recovery-housing/pep23-10-00-002.

- Implement prevention and education services including:
    - Training of peers, first responders, and other key community sectors on the recognition of opioid overdose and appropriate use of naloxone and other opioid overdose reversal medications.
    - Developing evidence-based community prevention efforts, such as strategic messaging on the consequences of opioid and stimulant misuse, particularly focused on the dangers of counterfeit fentanyl pills targeted to youth.
    - Implementing evidence-based universal prevention interventions, involving schools, parents, and community programs; and
    - Purchasing and distributing naloxone and other opioid overdose reversal medications based on the naloxone distribution and saturation plan.

- Provide harm reduction services, either through the support of integrated harm reduction services singly within treatment settings, treatment providers collaborating with community-based harm reduction organizations, or through the support of syringe service programs.[8] Harm reduction services funded under this award must adhere to federal, state, and local laws, regulations, and other requirements related to such programs or services.[9,10] For information on SAMHSA's Harm Reduction Framework and allowable harm reduction supplies and services, see https://www.samhsa.gov/find-help/harm-reduction/framework and https://www.samhsa.gov/find-help/harm-reduction.

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[8] Consolidated Appropriations Act, 2023 (Public Law 117-328) Section 526, notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug. Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law.

[9] 21 U.S.C. §863(a) states:
[I]t is unlawful for any person to sell or offer for sale drug paraphernalia; to use the mails or any other facility of interstate commerce to transport drug paraphernalia; or to import or export drug paraphernalia." The term "drug paraphernalia" is defined as "any equipment, product, or material of any kind which is primarily intended or designed for use in manufacturing, compounding, converting, concealing, producing, processing, preparing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance, possession of which is unlawful under this subchapter." 21 U.S.C. §863(d).

[10] The Consolidated Appropriations Act, 2023 (2022), Section 1261 [Public Law 117-328] provides: "Notwithstanding any provision of this title and the amendments made by this title, no funds made available to carry out this title or any amendment made by this title shall be used to purchase, procure, or distribute pipes or cylindrical objects intended to be used to smoke or inhale illegal scheduled substances."

- Engage with correctional institutions, sheriffs' associations, and law enforcement to provide and/or expand MOUD treatment to incarcerated individuals. For more information on implementing MOUD services in correctional settings, see: https://www.samhsa.gov/resource/ebp/medication-assisted-treatment-mat-opioid-use-disorder-jails-prisons-planning.

- Provide treatment transition, recovery support services, and coverage for individuals reentering communities from criminal justice settings or other rehabilitative settings.

- Make use of the SAMHSA-funded SOR/Tribal Opioid Response (TOR) Technical Assistance/Training (TA/T) resources to assist in providing training and technical assistance on evidence-based practices to healthcare providers and others in your state or territory who will render services to individuals with OUD and/or stimulant use disorders.

- Ensure that all qualified practitioners who serve clients with substance use disorders and are employed by an organization receiving funding through SOR meet the MATE Act Training Requirements as delineated in Section 1263 of the Consolidated Appropriations Act, 2023. For more information on the training requirements and related resources, see https://www.samhsa.gov/medications-substance-use-disorders/training-requirements-mate-act-resources and https://www.deadiversion.usdoj.gov/faq/MATE_Act_faq.html.

- Provide testing for HIV, viral hepatitis, and sexually transmitted infections (STIs) (e.g., syphilis) as clinically indicated and warm hand-off referrals to appropriate treatment to those testing positive.

- When there are no other sources of funding available, and as clinically indicated, provide testing for potential complications of OUD or stimulant use disorder. These tests include a complete blood count (CBC), international normalized ratio (INR), and a comprehensive metabolic panel (CMP).

- As clinically indicated, provide vaccinations for hepatitis A and B, or appropriate referrals. Where the individual has not already received the recommended vaccinations below, provide and/or refer to vaccination services. Recommended vaccinations include, but are not limited to:

    - Hepatitis A;
    - Hepatitis B;
    - Human papillomavirus (HPV) (for those up to age 26);
    - Meningococcal;

- Pneumococcal (pneumonia);
- Tetanus, diphtheria, and pertussis (TDaP); and
- Zoster (shingles) (for those ages 18 and older).

4. ALLOWABLE ACTIVITIES

Allowable activities are not required. Applicants may propose to use funds for the following activities after ensuring that they can carry out all of the required activities:

- Develop and implement culturally adapted or informed, evidence-based prevention, harm reduction, treatment, and recovery support services to address stimulant misuse and use disorders, including those involving cocaine and methamphetamine. Clinical treatment may include outpatient, intensive outpatient, day treatment, partial hospitalization, or inpatient/residential levels of care.

- Purchase and/or implement mobile and/or non-mobile medication units that provide appropriate privacy and adequate space to administer and dispense medications for OUD treatment in accordance with federal regulations.[11] The following services may be provided in mobile medication units, assuming compliance with all applicable federal, state, and local law:

  - Administering and dispensing medications for OUD treatment;
  - Collecting samples for drug testing or analysis;
  - Dispensing take-home medications;
  - Conducting intake/initial psychosocial and appropriate medical assessments, with a full physical examination to be completed or provided within 14 days of admission, in units that provide appropriate privacy and adequate space;
  - Initiating methadone or buprenorphine after an appropriate medical assessment has been performed, including through telehealth services as allowable by federal and state laws; and
  - Counseling and other services, in units with appropriate privacy and with adequate space, may be provided directly or when permissible through use of telehealth services. Non-mobile medication units may also offer the above services where space allows for quality patient care and are consistent with state and local laws and regulations.

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[11] Letter to OTP Directors, SOTAs, and State Directors from Kimberly Nelson, Acting Director of CSAT https://www.samhsa.gov/sites/default/files/2021-letter-mobile-component.pdf
Letter to State Substance Abuse Directors on the adoption of mobile medication units from Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use https://www.samhsa.gov/sites/default/files/2021-letter-state-authorities- mobile.pdf

- Purchase and distribution of drug checking technologies, including fentanyl and xylazine test strips, as guided by SAMHSA.

- Develop and implement evidence-based contingency management (CM) programs to treat stimulant use disorder and concurrent substance misuse, and to improve retention in care. If you plan to implement CM programs, you must certify that you will comply with all applicable conditions and training requirements, as well as provide a plan, within **90 days of grant award**, to ensure: (1) sub-awardees receive appropriate education on CM prior to implementation; and (2) oversight of sub-awardee CM implementation and operation, as outlined in **Appendix B** of this NOFO. This Statement of Certification must be provided in **Attachment 11** of your application.

- Implement transportation programs and models that increase access to care and service delivery in rural communities/areas. Possible program models include:

    - Working with existing public transit systems to expand services beyond the traditional "fixed route system" to include a variety of other models, such as ridesharing, volunteer models, and mobility management models.
    - Voucher models, sometimes called "taxi vouchers," using tickets or coupons that eligible riders can offer to participating transportation providers in exchange for a ride.
    - Coordinated Services Models – agencies working together to share resources.
    - Mobility on Demand – integrating and connecting pre-existing modes of transportation.

    For more information on the models mentioned above, see: https://www.ruralhealthinfo.org/.

- Collaborate with TOR recipients and other SAMHSA and federal agency award and/or contract recipients.

- Provide training and activities to enhance and expand the diverse substance use and co-occurring substance use and mental disorder workforce (prevention, treatment, harm reduction, and recovery support services). Note: Although workforce development is an allowable use of award funds, SAMHSA expects that priority will be given to the provision of treatment and recovery support services across the full continuum of care and to prevention and harm reduction activities. Recipients will be expected to utilize the training and education resources that SAMHSA provides at no cost to the award.

- Develop and implement tobacco cessation programs, activities, and/or strategies.

- Provide activities that address behavioral health disparities and the social determinants of health.

Capacity Building

Capacity building involves strengthening the ability of an organization to meet identified goals so that it can sustain or improve the delivery of services. Capacity-building activities may include, but are not limited to, training, education, and technical assistance; expansion of partnerships; and the development of program materials. SAMHSA recognizes that you may need to implement capacity-building activities to provide or expand direct services or improve their effectiveness. In B.2 of the Project Narrative, applicants must describe the use of funds for capacity building, such as:

- Developing partnerships with other providers for service delivery and with stakeholders serving the population of focus, including underserved and diverse populations.

- Policy development to support needed service system improvements (e.g., rate-setting activities, establishment of standards of care, development or revision of credentialing, licensure, or accreditation requirements).[12]

Capitalizable infrastructure, such as computer systems/software, new buildings, or structural changes to existing facilities (e.g., to the foundation, roof, floor, or exterior or loadbearing walls of a facility, or extension of existing facility) are recoverable as depreciation through an approved negotiated indirect cost rate or 10% de minimis rate in accordance with your organization's existing capitalization/amortization policies.

5. USING EVIDENCE-BASED PRACTICES, ADAPTED, AND COMMUNITY-DEFINED EVIDENCE PRACTICES

You should use SAMHSA's funds to provide services or practices that have a proven evidence base and are appropriate for the population(s) of focus. Evidence-based practices are interventions that promote individual-level or population-level outcomes. They are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the people receiving the services. See SAMHSA's Evidence-Based Practices Resource Center and the National Network to Eliminate

[12] For purposes of this NOFO, efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders ("legislation and other orders") proposed or pending before the Congress or any State government, State legislature, or local legislature or legislative body, and recipients may not use federal funds for such activities. This restriction extends to both grassroots lobbying efforts and direct lobbying. However, for state, local, and other governmental recipients, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

Disparities in Behavioral Health to identify evidence-informed and culturally appropriate mental illness and substance use prevention, treatment, and recovery practices that can be used in your project.

An ***evidence-based practice*** (EBP) is a practice that has been documented with research data to show its effectiveness. A ***culturally adapted practice*** refers to the systematic modification of an EBP that considers language, culture, and context in a way that is compatible with the clients' cultural patterns, meaning, and values. ***Community-defined evidence practices*** (CDEPs) are practices that communities have shown to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community.

Both researchers and practitioners recognize that EBPs, culturally adapted practices, and CDEPs are essential to improving the effectiveness of treatment and prevention services. While SAMHSA realizes that EBPs have not been developed for all populations and/or service settings, application reviewers will closely examine proposed interventions for evidence base and appropriateness for the population of focus. If an EBP(s) exists for the population(s) of focus and types of problems or disorders being addressed, it is expected you will use that/those EBP(s). If one does not exist but there are culturally adapted practices, CDEPs, and/or culturally promising practices that are appropriate, you may implement these interventions.

In Section C of your Project Narrative, identify the practice(s) from the above categories that are appropriate or can be adapted to meet the needs of your specific population(s) of focus. You must discuss the population(s) for which the practice(s) has (have) been shown to be effective and document that it is (they are) appropriate for your population(s) of focus. You must also address how these interventions will improve outcomes and how you will monitor and ensure fidelity to the practice. For information about monitoring fidelity, see the Fidelity Monitoring Checklist. In situations where an EBP is appropriate but requires additional culturally informed practices, discuss this in C.1.

6. DATA COLLECTION/PERFORMANCE MEASUREMENT AND PROJECT PERFORMANCE ASSESSMENT

Data Collection/Performance Measurement

You must collect and report data for SAMHSA to meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your plan for data collection and reporting in Section E of the Project Narrative.

This information will be gathered using a uniform data collection tool provided by SAMHSA. Recipients are required to submit data via SAMHSA's Performance

Accountability and Reporting System (SPARS) or other data reporting systems as directed by SAMHSA; and access will be provided upon award. An example of a tool is the GPRA Client Outcome Measures for Discretionary Programs. This tool collects data on program participants and the services provided during the program. Data will be collected at three points: intake to SAMHSA-funded services, six months post intake, and discharge from the SAMHSA-funded services. Recipients will be expected to do an intake interview with all clients in their specified unduplicated target number and are also expected to achieve a six-month follow-up rate of 80 percent.

Training and technical assistance on SPARS data collection and reporting will be provided after award.

Recipients should enter their data within 1 day, but no later than 7 days, after the intake interview is conducted. This guidance applies to recipients who manually enter their data and batch upload their data.

The data you submit allows SAMHSA to report on key outcome measures, such as abstinence, employment, education, and stability in housing. Performance measures are also used to show how programs are reducing disparities in behavioral health access, increasing client retention, expanding service use, and improving outcomes. As a result, SAMHSA may add additional or modify existing reporting measures throughout the reporting period to meet these needs.

Recipients will also be required to report program-level data on a quarterly basis in SPARS. The SOR/TOR Program Instrument currently collects the following measures:

- Purchase and distribution of naloxone
- Overdose reversals
- Fentanyl test strips purchase and distribution
- Education of school-aged children, first responders, and key community sectors on opioid and/or stimulant misuse
- Outreach activities that focus on underserved and/or diverse populations.

Performance data will be reported to the public as part of SAMHSA's Congressional Budget Justification.

A cross-site evaluation may be required to build the evidence base for this program. This may include collecting additional supporting data by the evaluation team, staff and client participation in focus groups, site visits, and/or submission of documents for review. Recipients, including their subrecipients, staff, or contractors, as applicable, must participate in all aspects of the evaluation if selected as part of the evaluation design. You will be provided with details on the evaluation upon award, including the type of evaluation and research questions, and expectations for selected grants.

Project Performance Assessment

Recipients must periodically review their performance data to assess their progress and use this information to improve the management of the project. The project performance assessment allows recipients to determine whether their goals, objectives, and outcomes are being achieved and if changes need to be made to the project. This information is included in your Programmatic Progress Report (See Section VI.3 for a description of reporting requirements).

For more information, see the *Application Guide, Section D - Developing Goals and Measurable Objectives and Section E - Developing the Plan for Data Collection and Performance Measurement.*

7. OTHER EXPECTATIONS

SAMHSA Values That Promote Positive Behavioral Health

SAMHSA expects recipients to use funds to implement high-quality programs, practices, and policies that are recovery-oriented, trauma-informed, and equity-based to improve behavioral health.[13] These are part of SAMHSA's core principles, as documented in our strategic plan.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recipients promote partnerships with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster:

- *Health*—managing one's illnesses or symptoms and making informed, healthy choices that support physical and emotional well-being;
- *Home*—having a stable and safe place to live;
- *Purpose*—conducting meaningful daily activities, such as a job or school; and
- *Community*—having supportive relationships with families, friends, and peers.

Recovery-oriented systems of care embrace recovery as:

- emerging from hope;
- person-driven, occurring via many pathways;
- holistic, supported by peers and allies;
- culturally-based and informed;
- supported through relationship and social networks;
- involving individual, family, and community strengths and responsibility;

[13] "Behavioral health" means the promotion of mental health, resilience and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

- supported by addressing trauma; and based on respect.

Trauma-informed approaches recognize and intentionally respond to the lasting adverse effects of experiencing traumatic events. SAMHSA defines a trauma-informed approach through six key principles:

- *Safety*: participants and staff feel physically and psychologically safe;
- *Peer Support:* peer support and mutual self-help are vehicles for establishing safety and hope, building trust, enhancing collaboration, and using lived experience to promote recovery and healing;
- *Trustworthiness and Transparency*: organizational decisions are conducted to build and maintain trust with participants and staff;
- C*ollaboration and Mutuality:* importance is placed on partnering and leveling power differences between staff and service participants;
- *Cultural, Historical, and Gender Issues*: culture- and gender-responsive services are offered while moving beyond stereotypes/biases;
- *Empowerment, Voice, and Choice*: organizations foster a belief in the primacy of the people who are served to heal and promote recovery from trauma.

It is critical for recipients to promote the linkage to recovery and resilience for individuals and families affected by trauma.

Behavioral health equity is the right to access high-quality and affordable health care services and supports for all populations, regardless of the individual's race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. By improving access to behavioral health care, promoting quality behavioral health programs and practices, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further reduced by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity.

Language Access Provision

Per Title VI of the Civil Rights Act of 1964, recipients of federal financial assistance must take reasonable steps to make their programs, services, and activities accessible to eligible persons with limited English proficiency. Recipients must administer their programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). (See the Application Guide *Section J - Administrative and National Policy Requirements*.)

Tobacco and Nicotine-free Policy

You are encouraged to adopt a tobacco/nicotine inhalation (vaping) product-free facility/grounds policy and to promote abstinence from all tobacco products (except accepted tribal traditions and practices).

Reimbursements for the Provision of Services

Recipients must first use revenue from third-party payments (such as Medicare or Medicaid) from providing services to pay for uninsured or underinsured individuals. Recipients must implement policies and procedures that ensure other sources of funding (such as Medicare, Medicaid, private insurance, etc.) are used first when available for that individual. Grant award funds for payment of services may be used for individuals who are not covered by public or other health insurance programs. Each recipient must have policies and procedures in place to determine affordability and insurance coverage for individuals seeking services. Program income revenue generated from providing services must first be used to pay for programmatic expenses related to the proposed grant activities.

Recipients must also assist eligible uninsured clients with applying for health insurance. If appropriate, consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health Administration or senior services).

Inclusion of People with Lived Experience Policy

SAMHSA recognizes that people with lived experience are fundamental to improving mental health and substance use services and should be meaningfully involved in the planning, delivery, administration, evaluation, and policy development of services and supports to improve processes and outcomes.

Behavioral Health for Military Service Members and Veterans

Recipients are encouraged to address the behavioral health needs of active-duty military service members, national guard and reserve service members, returning veterans, and military families in designing and implementing their programs. Where appropriate, consider prioritizing this population for services.

Behavioral Health for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex (LGBTQI+) Individuals

In line with the Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals and the behavioral health disparities that the LGBTQI+ population faces, all recipients are encouraged to address the behavioral health needs of this population in designing and implementing their programs.

Behavioral Health Crisis and Suicide Prevention

Recipients are encouraged to develop policies and procedures that identify individuals at risk of suicide/crisis; and utilize or promote SAMHSA national resources, such as the 988 Suicide & Crisis Lifeline, the SAMHSA Helpline/Treatment Locator, and FindSupport.gov.

8. RECIPIENT MEETINGS

SAMHSA will hold an in-person meeting in year one of the award. You must send a maximum of two people, including the Project Director, to this recipient meeting. You must submit a detailed budget and narrative for this travel. These meetings are usually held in the Washington, D.C., metropolitan area for 2 days. If SAMHSA elects to hold a virtual meeting, budget revisions may be permitted.

II. FEDERAL AWARD INFORMATION

1. GENERAL INFORMATION

Funding Mechanism:	Grant Award
Estimated Total Available Funding:	$1,480,500,000
Estimated Number of Awards:	Up to 59
Estimated Award Amount:	**See Appendix A for estimated award amounts**
Length of Project Period:	Up to 3 years
Anticipated Start Date	September 30, 2024

SOR grants are awarded via a formula. Each State, as well as the District of Columbia, will receive not less than $4,000,000. Each territory will receive not less than $500,000.

Annual continuation awards will depend on the availability of funds, progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are the Single State Agencies for Substance Use Services in the 50 states, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia.

Tribes/Tribal Nations are eligible to apply for opioid response funding under a separate announcement.

For general information on eligibility for federal awards, see https://www.grants.gov/learn-grants/grant-eligibility.

2. COST SHARING AND MATCHING REQUIREMENTS

Cost sharing/match is not required in this program.

3. OTHER REQUIREMENTS

Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with an established record of service delivery and expertise will be able to provide the required services quickly and effectively. Applicants are encouraged to include appropriately credentialed organizations that provide services to underserved, diverse populations. All required activities must be provided by applicants directly, by subrecipients, or through referrals to partner agencies. In **Attachment 1**, applicants must submit evidence that three additional requirements related to the provision of services have been met.

The three requirements are:

1. A provider organization for direct client services (mental health/substance use disorder prevention, treatment, and recovery supports) appropriate to the award must be involved in the project. The provider may be the applicant or another organization. More than one provider organization may be involved.

2. Each mental health/substance use disorder prevention, treatment, and recovery support provider organization (which may include the applicant and any partners) must have at least two years of experience (as of the due date of the application) providing relevant services. Official documents must establish that the organization has provided relevant services for the last two years.

3. Each mental health/substance use disorder prevention, treatment, or recovery support provider organization must be in compliance with all applicable local (city, county) and state licensing, accreditation, and certification requirements, as of the due date of the application.

The above requirements apply to all service provider organizations. If the state licensure requirements are not met by the organization, an individual's license cannot be used instead of the state requirement. Eligible tribes and tribal organization mental health/substance use disorder prevention, treatment, recovery support providers must be in compliance with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the

application. In Attachment 1, you must include a statement certifying that the service provider organizations will meet these requirements.

Following the review of your application, if the score is in the fundable range, the Government Project Officer (GPO) may request that you submit additional documentation or verify that the documentation submitted is complete. **If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.**

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

The application forms package can be found at Grants.gov Workspace or eRA ASSIST. Due to potential difficulties with internet access, SAMHSA understands that applicants may need to request paper copies of materials, including forms and required documents. See *Section A of the Application Guide* for more information on obtaining an application package.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

REQUIRED APPLICATION COMPONENTS:

You must submit the standard and supporting documents outlined below and in *Section A - 2.2 of the Application Guide (Required Application Components).* All files uploaded must be in Adobe PDF file format. See *Section B of the Application Guide* for formatting and validation requirements.

SAMHSA will not accept paper applications except under special circumstances. If you need special consideration, the waiver of this requirement must be approved in advance. See *Section A - 3.2 of the Application Guide (Waiver of Electronic Submission)*.

- **SF-424** – Fill out all Sections of the SF-424.
  - In **Line 4** (Applicant Identifier), enter the eRA Commons Username of the PD/PI.
  - In **Line 8f**, enter the name and contact information of the Project Director identified in the budget and in Line 4 (eRA Commons Username).
  - In **Line 17** (Proposed Project Date) enter: a. Start Date: 9/30/2024; b. End Date: 9/29/2027).
  - **In Line 18** (Estimated Funding), enter the amount requested or to be contributed for the first budget/funding period only by each contributor.
  - **Line 21** is the authorized official and should not be the same individual as the Project Director in Line 8f.

It is recommended new applicants review the sample of a completed SF-424.

- **SF-424A BUDGET INFORMATION FORM –** Fill out all Sections of the SF-424A using the instructions below. **The totals in Sections A, B, and D must match.**

  - **Section A –** Budget Summary: If cost sharing/match is **not required,** use the first row only (Line 1) to report the total federal funds (e) and non-federal funds (f) requested for the **first year** of your project only. If cost sharing/match **is required,** use the **second row** (Line 2) to report the total non-federal funds (f) for the **first year** of your project only.

  - **Section B –** Budget Categories: If cost sharing/match is **not required,** use the first column only (Column 1) to report the budget category breakouts (Lines 6a through 6h) and indirect charges (Line 6j) for the total funding requested for the **first year** of your project only. If cost sharing/match is required, use the second column (Column 2) to report the budget category breakouts for the **first year** of your project only.

  - **Section C –** If cost sharing/match is **not required,** leave this section blank. If cost sharing/match **is required,** use the second row (line 9) to report non-federal match for the **first year** only.

  - **Section D –** Forecasted Cash Needs: Enter the total funds requested, broken down by quarter, only for **Year 1** of the project period. Use the first row for federal funds and the second row (Line 14) for **non-federal** funds.

  - **Section E –** Budget Estimates of Federal Funds Needed for the Balance of the Project: Enter the total funds requested for the out years (e.g., Year 2 and Year 3). For example, if funds are being requested for three years total, enter the requested budget amount for each budget period in columns b and c (i.e., 2 out years). — (b) First column is the budget for the second budget period; (c) Second column is the budget for the third budget period. Use Line 16 for federal funds and Line 17 for non-federal funds.

See *Section B of the Application Guide* to review common errors in completing the SF-424 and the SF-424A. These errors will prevent your application from being successfully submitted.

See instructions on completing the SF-424A form at:

- Sample SF-424A (No Match Required)

It is highly recommended you use the Budget Template on the SAMHSA website.

- **PROJECT NARRATIVE – (Maximum 25 pages total)**
  The Project Narrative describes your project. It consists of Sections A through E. (Remember that if your Project Narrative starts on page 5 and ends on page 25, it is 26 pages long, not 25 pages.) Instructions for completing each section of the Project Narrative are provided in Section V.1 – Application Review Information.

- **BUDGET JUSTIFICATION AND NARRATIVE**
  You must submit the budget justification and narrative as a file entitled "BNF" (Budget Narrative Form). (*See Section A – 2.2 of the Application Guide - Required Application Components*.)

- **ATTACHMENTS 1 THROUGH 11**

  Except for Attachment 4 (Project Timeline), do not include any attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider these attachments.

  To upload the attachments, use the:
  - Other Attachment Form if applying with Grants.gov Workspace.
  - Other Narrative Attachments if applying with eRA ASSIST.

  - ***Attachment 1: Service Providers/Evidence of Experience and Credentials***
    Statement of Certification — You must provide a written statement certifying that all partnering service provider organizations will meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements.

  - ***Attachment 2: Data Collection Instruments/Interview Protocols***
    You do not need to include standardized data collection instruments/interview protocols in your application. If the data collection instrument(s) or interview protocol(s) is/are not standardized, submit a copy. Provide a publicly available web link to the appropriate instrument/protocol.

  - ***Attachment 3: Sample Consent Forms***
    Include, as appropriate, informed consent forms for:
    - service intervention;
    - exchange of information, such as for releasing or requesting confidential information.

  - ***Attachment 4: Project Timeline***
    Reviewers will assess this attachment when scoring Section B of your Project Narrative. The timeline cannot be more than two pages. See instructions in Section V, B.3.

- ***Attachment 5: Biographical Sketches and Position Descriptions***
  See *Section F of the Application Guide - Biographical Sketches and Position Descriptions* for information on completing biographical sketches and position descriptions. Position descriptions should be no longer than one page each and biographical sketches should be two pages in total.

- ***Attachment 6: Letter to the State Point of Contact***
  Not applicable for this NOFO.

- ***Attachment 7: Confidentiality and SAMHSA Participant Protection/ Human Subjects Guidelines***
  This **required** attachment is in response to *Section C of the Application Guide* and reviewers will assess the response.

- ***Attachment 8: Form SMA 170 – Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations***
  You must complete Form SMA 170 if your project is providing substance use prevention or treatment services.

- ***Attachment 9: Needs Assessment***
  This attachment is in response to Section I-1.3, Required Activities of this NOFO, and will be scored by reviewers (see Section V, A.2). The updated Needs Assessment must include a Naloxone Distribution and Saturation Plan. The needs assessment should identify:

  - The scope of OUD and substance use disorders and overdose mortality in your state or territory.
  - The strengths, unmet service needs, and critical gaps in your service system across underserved populations, including sexual and gender minorities, geographic, and other racial and ethnic demographic groups.
  - Areas where opioid and stimulant misuse, substance use disorder, and use of emergency medical resources for substance use, such as hospitalization and overdose are the most prevalent.
  - The number and location of opioid treatment providers in the state or territory, including Opioid Treatment Programs (OTPs).
  - All existing activities and their funding sources in the state or territory that address opioid and stimulant use prevention, harm reduction (e.g., drug-checking technologies, including fentanyl test strips), treatment, and recovery support service activities and remaining gaps in these activities.

- ***Attachment 10: Strategic Plan***
  This attachment is in response to Section I-1.3, Required Activities of this NOFO, and will be scored by reviewers (see Section V, B.1). The Strategic Plan must address the gaps in prevention, harm reduction, treatment, and recovery services related to opioids and stimulants identified in the updated

needs assessment. **Note: Attachments 8 and 9 combined are limited to a maximum of 10 pages.**

- ***Attachment 11: Contingency Management Statement of Certification***
  If you plan to implement contingency management with SOR funds, you must provide a written statement certifying that you will comply with the conditions and training requirements for contingency management as outlined in **Appendix B** of this NOFO.

3. UNIQUE ENTITY IDENTIFIER AND SYSTEM FOR AWARD MANAGEMENT

*Section A of t*he Appli*cation Guide has information about the* three registration processes you must complete including obtaining a Unique Entity Identifier and registering with the System for Award Management (SAM). You must maintain an active SAM registration throughout the time your organization has an active federal award or an application under consideration by an agency. This does not apply if you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110.

4. APPLICATION SUBMISSION REQUIREMENTS

Submit your application no later than 11:59 PM (Eastern Time) on **July 1, 2024.**

If you have been granted permission to submit a paper copy, the application must be received by the above date and time. Refer to *Section A of the Application Guide* for information on how to apply.

All applicants MUST be registered with NIH's eRA Commons, Grants.gov, and the System for Award Management (**SAM.gov**) **in order to submit this application.** The process could take up to six weeks**.** (See *Section A of the Application Guide* for all registration requirements).

If an applicant is not currently registered with the eRA Commons, Grants.gov, and/or SAM.gov, the registration process MUST be started immediately. If an applicant is already registered in these systems, confirm the SAM registration is still active and the Grants.gov and eRA Commons accounts can be accessed.

WARNING: BY THE DEADLINE FOR THIS NOFO, THE FOLLOWING TASKS MUST BE COMPLETED TO SUBMIT AN APPLICATION:

- **The applicant organization MUST be registered in NIH's eRA Commons;**

  AND

- **The Project Director MUST have an active eRA Commons account (with the PI role) affiliated with the organization in eRA Commons.**

No exceptions will be made.

DO NOT WAIT UNTIL THE LAST MINUTE TO SUBMIT THE APPLICATION. Waiting until the last minute may result in the application not being received without errors by the deadline.

5. FUNDING LIMITATIONS/RESTRICTIONS

The funding restrictions for this project must be identified in your budget for the following:

- Food can be included as a necessary expense[14] for individuals receiving SAMHSA-funded mental and/or substance use disorder prevention, harm reduction, treatment, and recovery support services, not to exceed $10.00 per person per day.

- Only medications approved by the U.S. Food and Drug Administration (FDA) for treatment of opioid use disorder and/or opioid overdose can be purchased with SOR funds.

- Funds may not be expended through the award or a subaward by any agency which would deny any eligible client, patient, or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone; buprenorphine products, including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations; naltrexone products, including extended-release and oral formulations; or long-acting products, such as extended release injectable or buprenorphine.). Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a practitioner who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's OUD. Similarly, medications available by prescription or office-based injection must be permitted if it is appropriately authorized through prescription or administration by a licensed prescriber or provider. In all cases, MOUD must be permitted to be continued for as long as the prescriber or treatment provider, in conjunction with

[14] Appropriated funds can be used for an expenditure that bears a logical relationship to the specific program, makes a direct contribution, and be reasonably necessary to accomplish specific program outcomes established in the grant award or cooperative agreement. The expenditure cannot be justified merely because of some social purpose and must be more than merely desirable or even important. The expenditure must neither be prohibited by law nor provided for through other appropriated funding.

the patient, determines that the medication is clinically beneficial. Recipients must ensure that clients will not be compelled to no longer use MOUD as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

- Funds may not be used to make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services (See 42 U.S.C. § 1320a-7b).

  Note: A recipient or treatment or prevention provider may provide up to $30 noncash incentive to individuals to participate in required data collection follow-up. This amount may be paid for participation in each required follow-up interview. For programs including contingency management as a component of the treatment program, clients may not receive contingencies totaling more than $75 per budget period. The incentive amounts may be subject to change.

Recipients must also comply with SAMHSA's Standards for Financial Management and Standard Funding Restrictions in *Section H of the Application Guide.*

6. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

All SAMHSA programs are covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (HHS) regulation at 45 CFR Part 100. Under this Order, states may design their own processes for reviewing and commenting on proposed federal assistance under covered programs. See the Application Guide, *Section I - Intergovernmental Review* for additional information on these requirements, as well as requirements for the Public Health System Impact Statement (PHSIS).

7. OTHER SUBMISSION REQUIREMENTS

See *Section A of the Application Guide* for specific information about submitting the application.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes your plan for implementing the project. It includes the Evaluation Criteria in Sections A–E below. The application will be reviewed and scored according to your response to the evaluation criteria.

In developing the Project Narrative, use these instructions:

- The Project Narrative (Sections A–E) may be no longer than **25 pages**.

- You must use the five sections/headings listed below in developing your Project Narrative.

- **Before the response to each criterion, you must indicate the section letter and number**, **i.e**., **"A.1," "A.2," etc.** You do not need to type the full criterion in each section.

- Do not combine two or more criteria or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.1. **Reviewers will only consider information included in the appropriate numbered criterion.**

- Your application will be scored based on how well you address the criteria in each section.

- The number of points after each heading is the maximum number of points a review committee may assign to that section. Although scoring weights are not assigned to individual criterion, each criterion is assessed in determining the overall section score.

- Any cost-sharing in your application will not be a factor in the evaluation of your response to the Evaluation Criteria.

SECTION A: Population of Focus and Statement of Need (10 points – approximately 3 pages [not including Attachment 8 - Needs Assessment])

1. Identify and describe your population(s) of focus and the geographic catchment area where you will deliver services that align with the intended population of focus. Provide a demographic profile of the population of focus to include the following: race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status.

2. Based on your needs assessment, describe the extent of the problem in the catchment area, including service gaps and disparities experienced by underserved and historically under-resourced populations. Document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus identified in A.1. Identify the source of the data (for example, the National Survey on Drug Use and Health (NSDUH), County Health Rankings & Roadmaps, Social Vulnerability Index, etc.).

3. In **Attachment 9*,** provide your Needs Assessment. It must include the required elements for the Needs Assessment outlined in Section I-1.3- Required Activities.

***Note: Attachments 9 and 10 combined must not exceed 10 pages.**

SECTION B: Proposed Implementation Approach (30 points – approximately 12 pages [not including Attachment 10 – Strategic Plan and Attachment 4 – Project Timeline])

1. Describe the goals and measurable objectives of your project and align them with the Statement of Need described in A.2. (See the Application Guide, *Section D - Developing Goals and Measurable Objectives*) for information of how to write SMART objectives – Specific, Measurable, Achievable, Relevant, and Time-bound). Provide the following table for the three-year project period.

Number of Unduplicated Individuals to be Served with Award Funds				
	Year 1	Year 2	Year 3	**Total**
Prevention Services				
Treatment Services**				
Recovery Support Services**				
GPRA/SPARS Target**				

****Note: Of those individuals receiving treatment and recovery support services, applicants must indicate the total number of individuals who will complete the CSAT Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs Tool each year; the total receiving treatment and recovery support services will be the applicant's GPRA target in SPARS.**

2. Describe how you will implement all Required Activities in Section I, which should be incorporated in your Strategic Plan. In **Attachment 10*,** provide your Strategic Plan.

   ***Note: Attachments 9 and 10 combined must not exceed 10 pages.**

3. In **Attachment 4**, provide no more than a two-page chart or graph depicting a realistic timeline for the entire three years of the project period showing dates, key activities, and responsible staff. The key activities must include the required activities outlined in Section I [**NOTE:** Be sure to show that the project can be

implemented, and service delivery can begin as soon as possible and no later than four months after the award]. **The timeline does not count towards the page limit for the Program Narrative.**

SECTION C: Proposed Evidence-based, Adapted, or Community defined Evidence Service/Practices (25 points — approximately 5 pages)

1. Identify the EBPs, culturally adapted practices, or CDEPs that you will use. Discuss how each intervention chosen is appropriate for your population(s) of focus and the intended outcomes you will achieve. Describe any modifications (e.g., cultural) you will make to the EBP(s)/CDEP(s) and the reasons the modifications are necessary. If you are not proposing to make any modifications, indicate so in your response.

2. Describe the monitoring process you will use to ensure the fidelity of the EBPs/CDEP(s), evidence-informed and/or promising practices that will be implemented. (See information on fidelity monitoring in Section I.5.)

SECTION D: Staff and Organizational Experience (15 points – approximately 2 pages)

1. Demonstrate the experience of the state/territory with similar projects and/or providing services to the population(s) of focus, including underserved and historically under-resourced populations.

2. Identify other organization(s) that you will partner with in the project. Describe their experience providing services to the population(s) of focus and their specific roles and responsibilities for this project. Describe the diversity of partnerships.

3. Provide a complete list of staff positions for the project, including the Key Personnel (Project Director, Project Coordinator, and Data Coordinator) and other significant personnel. For each staff member, describe their:
    - Role;
    - Level of Effort (stated as a percentage full-time employment, such as 1.0 (full-time) or 0.5 (half-time) and not number of hours); and
    - Qualifications, including their experience providing services to the population of focus, familiarity with the culture(s) and language(s) of this population, and working with underserved and historically under-resourced populations.

4. Provide a Point of Contact for the financial management and oversight of the award.

SECTION E: Data Collection and Performance Measurement (20 points – approximately 3 pages)

1. Describe how you will collect the required data for this program and how such data will be used to manage, monitor, and enhance the program (See the *Application Guide, Section E – Developing the Plan for Data Collection and Performance Measurement*).

2. BUDGET JUSTIFICATION, EXISTING RESOURCES, OTHER SUPPORT (Other federal and non-federal sources)

You must provide a narrative justification of the items included in your budget. In addition, if applicable, you must provide a description of existing resources and other support you expect to receive for the project as a result of cost matching. Other support is defined as funds or resources, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions, or non-federal means. (This should correspond to Item #18 on your SF-424, Estimated Funding.) Other sources of funds may be used for unallowable costs, e.g., sporting events, entertainment.

See the *Application Guide, Section E - Budget and Justification* for information on the SAMHSA Budget Template. **It is highly recommended that you use the template.** Your budget must reflect the funding limitations/restrictions noted in Section IV-5. **Identify the items associated with these costs in your budget.**

3. REVIEW AND SELECTION PROCESS

Applications are peer-reviewed according to the evaluation criteria listed above.

Award decisions are based on the strengths and weaknesses of your application as identified by peer reviewers. Note the peer review results are advisory and there are other factors SAMHSA might consider when making awards.

The program office and approving official make the final decision for funding based on the following:

- Approval by the Center for Substance Abuse Treatment National Advisory Council (NAC), when the individual award is over $250,000
- Availability of funds.
- Submission of any required documentation that must be received prior to making an award.
- SAMHSA is required to review and consider any Responsibility/Qualification (R/Q) information about your organization in SAM.gov. In accordance with 45 CFR 75.212, SAMHSA reserves the right not to make an award to an entity if that entity does not meet the minimum qualification standards as described in section 75.205(a)(2). You may include in your proposal any comments on any

information entered into the R/Q section in SAM.gov about your organization that a federal awarding agency previously entered. SAMHSA will consider your comments, in addition to other information in R/Q, in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

VI. FEDERAL AWARD ADMINISTRATION INFORMATION

1. FEDERAL AWARD NOTICES

You will receive an email from eRA Commons that will describe how you can access the results of the review of your application, including the score that your application received.

If your application is approved for funding, a Notice of Award (NoA) will be emailed to the following: 1) the Signing Official identified on page 3 of the SF-424 (Authorized Representative section); and 2) the Project Director identified on page 1 of the SF-424 (8f). The NoA is the sole obligating document that allows recipients to receive federal funding for the project.

If your application is not funded, an email will be sent from eRA Commons.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

If your application is funded, you must comply with all terms and conditions of the NoA. See information on standard terms and conditions. See the Application Guide, *Section J - Administrative and National Policy Requirements* for specific information about these requirements. You must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS 690). To learn more, see the HHS Office for Civil Rights website.

In addition, if you receive an award, HHS may terminate it if any of the conditions in CFR § 200.340 (a)(1)-(4) are met. No other termination conditions apply.

3. REPORTING REQUIREMENTS

Recipients are required to submit Programmatic Progress Reports at 6 months and 12 months. The six-month reports are due no later than 30 days after the end of the second quarter. The twelve-month reports are due within 90 days of the end of the budget period. The reports must include:

- Updates on key personnel, budget, or project changes (as applicable).
- Progress achieving goals and objectives and implementing evaluation activities.
- Progress implementing required activities, including accomplishments, challenges and barriers, and adjustments made to address these challenges.

- Problems encountered serving the populations of focus and efforts to overcome them.
- Progress achieved in addressing the needs of underserved, diverse populations (e.g., racial/ethnic minorities, LGBTQI+, older adults) and implementation of targeted interventions to promote behavioral health equity.

You must submit a final performance report within 120 days after the end of the project period. This report must be cumulative and include all activities during the entire project period.

Management of Award:

Recipients must also comply with standard award management reporting requirements, unless otherwise noted in the NOFO or NoA.

VII. AGENCY CONTACTS

For program and eligibility questions, contact:

Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
(240) 276-0300
OPIOIDSOR@samhsa.hhs.gov

For fiscal/budget questions, contact:

Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
(240) 276-1940
OPIOIDSOR@samhsa.hhs.gov

For review process and application status questions, contact:

Toni Davidson
Office of Financial Resources, Division of Grant Review
Substance Abuse and Mental Health Services Administration
(240) 276-2571
toni.davidson@samhsa.hhs.gov

Appendix A – FY 2024 Allocations

FY 2024 Annual Formula Based Allocation of State Opioid Response Grants

Note: If all states/territories do not apply, funds remaining will be redistributed to all recipients. The "Annual Award Amount" column displays the MAXIMUM dollar amount PER YEAR for which a state/territory can apply. The project period is three years. Funding availability and allocations for the second and third years are contingent upon Congressional appropriations and direction.

In the Further Consolidated Appropriations Act, 2024 [P. L. 118-47], Congress mandated that the HHS Secretary make SOR funding allocations pursuant to the requirements of section 1003 of the 21st Century Cures Act [Public Law 114-255] (42 USC 290ee–3 note), as amended, which directs the HHS Secretary to leverage a formula that uses national survey results that the Secretary determines are the most objective and reliable measures of drug use and drug-related deaths. The formula must avoid a significant cliff between States with similar overdose mortality rates to prevent unusually large funding changes in States when compared to prior year allocations. The formula must also distribute a 15 percent set-aside to States with the highest mortality rate related to opioid use disorders.

In FY 2024, SAMHSA revised its formula to better meet this statutory requirement. Specifically, the formula continues to leverage data estimating drug overdose deaths and opioid misuse per state. Each state and the District of Columbia receives a minimum award of $4M. Each territory receives a minimum award of $500K.

Additionally, the 15 percent set-aside was distributed among the 25 states with the highest overdose mortality rates. For the FY 2024 allocation, the following states were included in the set-aside: AK, AZ, CT, DE, DC, FL, IN, KY, LA, ME, MD, MA, MO, NH, NJ, NM, NC, OH, PA, RI, SC, TN, VT, WV, WI.

State	FY 2024 Annual Award Amount
ALABAMA	$16,176,149
ALASKA	$5,989,474
AMERICAN SAMOA	$500,000
ARIZONA	$34,788,112
ARKANSAS	$10,647,596
CALIFORNIA	$105,640,843
COLORADO	$20,798,725
CONNECTICUT	$15,021,882
DELAWARE	$38,795,579
DISTRICT OF COLUMBIA	$25,158,059

FLORIDA	$104,258,643
GEORGIA	$28,949,840
GUAM	$500,000
HAWAII	$4,000,000
IDAHO	$7,832,433
ILLINOIS	$36,702,359
INDIANA	$30,264,193
IOWA	$8,962,591
KANSAS	$8,323,394
KENTUCKY	$37,207,506
LOUISIANA	$17,995,265
MAINE	$9,790,828
MARSHALL ISLANDS	$500,000
MARYLAND	$53,133,365
MASSACHUSETTS	$59,506,350
MICHIGAN	$36,363,911
MICRONESIA	$500,000
MINNESOTA	$11,293,373
MISSISSIPPI	$7,097,094
MISSOURI	$26,338,560
MONTANA	$4,342,525
NEBRASKA	$4,588,329
NEVADA	$16,629,170
NEW HAMPSHIRE	$29,880,604
NEW JERSEY	$68,764,571
NEW MEXICO	$11,786,253
NEW YORK	$56,116,176
NORTH CAROLINA	$36,604,318
NORTH DAKOTA	$4,000,000
NORTHERN MARIANA ISLANDS	$500,000
OHIO	$100,192,260
OKLAHOMA	$15,795,312
OREGON	$15,271,666
PALAU	$500,000
PENNSYLVANIA	$83,123,161
PUERTO RICO	$12,537,000
RHODE ISLAND	$11,359,101
SOUTH CAROLINA	$18,791,695
SOUTH DAKOTA	$4,068,870
TENNESSEE	$31,349,498
TEXAS	$52,083,706
UTAH	$10,698,472

VERMONT	$5,989,474
VIRGIN ISLANDS	$500,000
VIRGINIA	$27,332,465
WASHINGTON	$27,116,364
WEST VIRGINIA	$45,758,863
WISCONSIN	$17,784,023
WYOMING	$4,000,000

Appendix B – Contingency Management

To mitigate the risk of fraud and abuse, while also promoting evidence-based practice, recipients who plan to implement contingency management (CM) interventions as part of their SAMHSA grant award will be required to comply with the following conditions:

1. The type of CM model chosen will be consistent with the needs of the population of focus.

2. To ensure fidelity to evidence-based practice, staff who will implement, administer, and supervise CM interventions are required to undergo CM-specific training prior to implementing CM. Training should be delivered by an advanced degree holder who is experienced in the implementation of evidence-based contingency management activities. Training should be easily accessible, and it can be delivered live or through pre-recorded training sessions. When participants receive training through pre-recorded sessions, they should have an opportunity to pose questions and to receive responses in a timely manner.

   Education must include the following elements:

   o The core principals of contingency management
   o Target behavior;
   o The population of focus;
   o Type of reinforcer (incentive);
   o Magnitude (or amount) of reinforcer;
   o Frequency of reinforcement distribution;
   o Timing of reinforcement distribution; and,
   o Duration reinforcement(s) will be used;
   o How to describe contingency management to eligible and ineligible patients;
   o Evidence-based models of contingency management and protocols to ensure continued adherence to evidence-based principles;
   o The importance of evidence-based practice on patient outcomes;
   o Testing methods and protocols for target substance use disorders and/or behaviors;
   o Allowable incentives, appropriate selection of incentives, storage of incentives, the distribution of incentives, and immediacy of awards o Integration of contingency management into comprehensive clinical activities and program design. Contingency management should be integrated into services, counseling and treatment activities that provide ongoing support to the clients;
   o Documentation standards;
   o Roles and responsibilities, including the role of the supervisor, decision maker, and direct care staff; and
   o Techniques for supervisors to provide on-going oversight and coaching.

Within **90 days of grant award**, you must submit your plan to ensure: (1) that sub-awardees receive appropriate education on contingency management prior to implementation; and (2) oversight of sub-awardee contingency management implementation and operation.

The CM Incentive is offered or furnished pursuant to an evidence-based CM intervention.

3. The recipient's organization must maintain written documentation in the patient's medical record that includes:

   I. The type of CM model and incentives offered that are recommended by the client's licensed health care professional;

   II. A description of the CM incentive furnished;

   III. An explanation of the health outcome or target behavior achieved; and

   IV. A tally of incentive values received by the patient to confirm that per incentive and total incentive caps are observed.

4. Receipt of the CM Incentive is contingent upon achievement of a specified target behavior, consistent with the beneficiary's treatment plan that has been verified with objective evidence.

5. The CM Incentive is recommended by the client's treating clinician, who is licensed under applicable state law.

6. The CM Incentive is not cash, but may be tangible items, vouchers, or payment of bills that are of equivalent value to the individual's total or accrued incentive earnings. Incentives must be consistent with recovery and should not allow purchase of weapons, intoxicants, tobacco or pornography. Further, incentives should not allow purchase of lottery tickets, or promote gambling.

7. No person markets the availability of a CM Incentive to induce a patient to receive federally reimbursable items or services or to receive such items and services from a particular provider or supplier.