Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

FY24 Tribal Opioid Response Grants

(Short Title: TOR)

(Initial Announcement)

Notice of Funding Opportunity (NOFO) No. TI-24-009

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), in collaboration with SAMHSA's Office of Tribal Affairs and Policy (OTAP), is accepting applications for the fiscal year (FY) 2024 Tribal Opioid Response grant (Short Title: TOR) program. The purpose of this program is to assist in addressing the opioid overdose crisis in Tribal communities by increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD), and supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and co-occurring substance use disorders. Recipients are expected to implement activities to support prevention, harm reduction, treatment, and recovery support services for stimulant misuse and use disorders, including those involving cocaine and methamphetamine. With this program, SAMHSA aims to increase the number of individuals receiving MOUD and/or other substance use disorder (SUD) treatment, increase access to naloxone and other opioid overdose reversal medications, decrease mortality from drug overdoses, and promote education of school-aged children, first responders, and key community sectors on opioid and/or stimulant misuse.

Funding Opportunity Title:	Tribal Opioid Response Grants (TOR)
Funding Opportunity Number:	TI-24-009
Due Date for Applications:	July 1, 2024
Estimated Total Available Funding:	Up to $63,000,000
Estimated Number of Awards:	Up to 130
Estimated Award Amount:	See Appendix A and Appendix B for distribution
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 5 years

Eligible Applicants:	Eligibility is limited to federally recognized American Indian or Alaska Native Tribe or tribal organizations. Tribes and tribal organizations may apply individually, as a consortium, or in partnership with an Urban Indian Organization [See Section III-1 for complete eligibility information.]
Authorizing Statute:	The TOR program is 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 the TOR program is to assist in addressing the overdose crisis in Tribal communities by increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD), and supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and co-occurring substance use disorders, and stimulant misuse and use disorders, including those involving cocaine and methamphetamine. This program also supports the National Tribal Behavioral Health Agenda's (TBHA) Cultural Wisdom Declaration (CWD) and inclusion of ancestral cultural knowledge, wisdom, ceremony, and practices of American Indian and Alaska Native tribes into the award application.

Between 2018 and 2021, American Indians and Alaska Natives had the highest drug overdose death rate from fentanyl and other synthetic opioids, excluding methadone.[1] Data from the 2022 National Survey on Drug Use and Health indicate that American Indians and Alaska Natives have the highest rate of opioid and prescription pain reliever misuse among any race or ethnicity.[2]

SAMHSA aims to increase the number of individuals receiving MOUD and/or other SUD treatment, increase access to naloxone and other opioid overdose reversal medications, decrease mortality from drug overdoses, and promote education of school-aged children, first responders, and key community sectors on opioid and/or stimulant misuse. SAMHSA requires that MOUD be made available to those diagnosed with OUD. MOUD includes methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, and injectable extended-release naltrexone.

Medically managed withdrawal or "detox" alone is not the standard of care for OUD; it is associated with a very high relapse rate, significantly increasing an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medically managed withdrawal when done in isolation is not an evidence-based practice for OUD. If medically managed withdrawal is provided, it must be accompanied by injectable

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[1] Han B, Einstein EB, Jones CM, Cotto J, Compton WM, Volkow ND. Racial and Ethnic Disparities in Drug Overdose Deaths in the US During the COVID-19 Pandemic. *JAMA Netw Open.* 2022;5(9):e2232314. doi:10.1001/jamanetworkopen.2022.32314

[2] Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report.

extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes.

In addition to these treatment services, recipients may employ culturally appropriate effective treatment, prevention, harm reduction, and recovery support services to ensure that individuals are receiving a comprehensive array of services across the spectrum of prevention, treatment, harm reduction, and recovery. Tribal entities are also encouraged to incorporate TBHA foundational elements, priorities, and strategies as appropriate.

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 their programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age and, in some circumstances, religion, and sex (including gender identity, sexual orientation, and pregnancy). Recipients must also agree to comply with federal conscience laws, where applicable.

The TOR program is 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 is the Project Director at a minimum of 0.25 FTE (25 percent level of effort).

- The Project Director is responsible for oversight of the project.

If you receive an award, you will be notified if the individual designated for this position has 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.

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 the required activities listed below.

Recipients are required to select one or more activities from the treatment, recovery support services, prevention or harm reduction activities listed below. Recipients are not required to choose an activity from all four of the service areas but should choose the most appropriate set of activities to make OUD treatment, recovery support, prevention, and harm reduction services available in their community.

- **TREATMENT:** Implement service delivery models that enable the full spectrum of trauma-informed treatment and recovery support services that facilitate positive treatment outcomes and long-term recovery from opioid and stimulant use disorders. Evidence-based models for treating OUD 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 and then transferred to community-based providers once stabilization has occurred.
    - Treatment in federally and state-regulated Opioid Treatment Programs.
    - Addiction specialty care programs that either directly provide or support use of MOUD in addition to psychosocial services, such as drug counseling, psychoeducation, toxicology screening, individual, group, and/or family therapy, vocational/educational resources, case management, and recovery support services including community-based services. These services may include peer supports, address housing needs, and focus on family issues (e.g., reunification of children who may be in foster care while a parent(s) receives treatment) and may be provided in outpatient, intensive outpatient, or partial hospital levels of care. Treatment programs may be culturally-driven and include culturally-specific interventions.
    - Non-specialty settings such as emergency departments, crisis units, urgent care centers, certified community behavioral health clinics and community mental health centers, and pharmacies that also support appropriate MOUD and recovery support services.
    - Residential programs that provide intensive services to those meeting medical necessity criteria and which offer MOUD provided the care continuum includes a connection to MOUD in the community once discharged from the residential program. This may include specialty residential programs such as those that provide services to pregnant women, or individuals with young children.
    - Primary care or other clinical practice settings 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 such as federally qualified health centers.

    - Programs that address the multi-faceted and complex needs of individuals with stimulant use disorder (e.g., polydrug use, psychosis, violence, co-occurring stimulant use and mental disorders, etc.).
    - Low-threshold MOUD treatment programs that offer services and make minimal requirements of patients, thus removing or reducing barriers to treatment and expanding access to care (i.e., barriers relating to transportation, cost, appointment adherence requirements, concurrent substance use, psychosocial service adherence, criminal legal history, client's stage of change, etc.).
    - Programs that use innovative telehealth strategies in rural and underserved areas to increase the capacity of communities to support OUD/stimulant use disorder prevention, treatment, and recovery, including audio-only telehealth as permissible by federal and state law.

- **RECOVERY:** Recovery support includes a broad range of services to assist individuals and families to initiate, stabilize, and maintain long-term SUD recovery. Award recipients may implement recovery support services including:
    - Training peer recovery specialists and/or recovery coaches following the guidelines required in each state or jurisdiction. Certification requirements for peers may include those developed by State Certification entities, Tribes and Tribal organizations, and SAMHSA's National Model Standards for Peer Support Certification.
    - Hiring or contracting with peer recovery specialists and/or recovery coaches, including those working towards certification, to provide services such as recovery coaching, telephone recovery check-ups, warmlines, and other supports.
    - Providing recovery housing: Recovery housing is one component of the SUD 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 the Food and Drug Administration (FDA) for treatment of opioid use disorder 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 (or if there is no mechanism in place, adherence to the national standards) in their jurisdiction to assure 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).

    Funds can be used for:
        - Paying bed fees for program participants; and
        - Paying fees related to state certification.

    - Promoting client job training and education. Award recipients may pay for or provide logistical assistance to clients to access peer recovery training, provide assistance with soft skills development, and connect clients to job fairs and other events to network and find career opportunities.
    - Creating Recovery Supportive Communities, such as facilitating recovery events or by designating space to support recovery group meetings and social gatherings.
    - Creating and expanding programs to support recovery for those currently incarcerated and for those preparing for and experiencing re-entry after incarceration. Programs that provide peer support, MOUD, supportive housing, job placement, and community/cultural connections in these settings are encouraged.

- **PREVENTION:** Implement prevention and education services including:
    - Developing culturally-informed and responsive evidence-based community prevention efforts, such as strategic communications messaging on the consequences of stigma, opioid and stimulant misuse, and implementing school-based prevention programs, elder education, and outreach.
    - Enhancing community-wide policies and procedures to incorporate trauma-informed practices that acknowledge the impact of historical and generational trauma.
    - Training Tribal staff (e.g., behavioral health providers, school staff, housing personnel, youth workers, etc.) in reducing Adverse Childhood Experiences (ACEs) and promoting positive Social Determinants of Health (SDOH).
    - Providing psychosocial educational activities that address behavioral health disparities and the social determinants of health.
    - Providing support to individuals impacted by SUDs, including screening, case management, referrals, and warm hand-offs to resources and psychosocial supports. SAMHSA encourages award recipients to raise awareness of the 988 Suicide and Crisis Lifeline (https://samhsa.gov/find-help/988) and other crisis services available to anyone in the Tribe.

- **HARM PREVENTION/REDUCTION:** Implement harm prevention/reduction services including:
  - Training peers, first responders, other healthcare workers, school personnel, human services personnel, and other key Tribal members on the recognition of opioid overdose and appropriate use of opioid overdose reversal medications such as naloxone.
  - Purchasing and distributing naloxone and other opioid overdose reversal medications to reduce the incidence of fatal overdoses.
    - Recipients may consider purchasing naloxone vending machines or emergency naloxone cabinets as a means of increasing access to naloxone and other opioid overdose reversal medications.
  - Conducting naloxone saturation mapping and assessment to identify areas of unmet need for distribution of and access to naloxone and other opioid overdose reversal medications.
  - Purchasing and distributing drug checking supplies, including fentanyl and Xylazine testing strips, as guided by SAMHSA.
  - Purchasing and distributing other supplies to enhance harm reduction efforts. A list of allowable harm reduction supplies and services can be found on the SAMHSA website.
  - Providing harm reduction services on-site, either singularly or in collaboration with a community-based harm reduction organization. Harm reduction services funded under this award must adhere to applicable federal, state, Tribal, and local laws, regulations, and other requirements related to such programs or services.
  - Hiring and training staff to effectively deliver comprehensive harm reduction services, including, but not limited to, mobile outreach, motivational interviewing techniques, and trauma-informed care.
  - Providing support services for individuals receiving harm reduction services, including, but not limited to, screening, referral, linkage to care, and warm handoffs to partner services focused on SUD treatment, infectious disease, mental health services, primary care, housing, and other psychosocial needs.

4. ALLOWABLE ACTIVITIES

Allowable activities are not required. Applicants may propose to use funds for the following activities:

- Completing a community readiness or needs assessment, and a comprehensive strategic plan, based on the most current epidemiological data for the Tribe to address the gaps in prevention, treatment, and recovery support services identified by the Tribe. Tribes may also use funds to update existing plans.

- Implementing workforce development activities to ensure that individuals working in tribal communities are well versed in strategies to prevent and treat opioid misuse and use disorders.

- Incorporating culturally appropriate and traditional practices into the program design and implementation.

- 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 **180 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 C** of this NOFO. This Statement of Certification must be provided in **Attachment 10** of your application.

- Providing assistance to patients with treatment costs and developing other strategies to eliminate or reduce treatment costs for under- and uninsured patients. Award recipients may provide cost assistance to clients for transportation, childcare, and other supportive services. They may also provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings.

- Purchasing and/or implementing 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. 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 opioid use disorder 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.
  - Counseling and other services, in units that provide appropriate privacy and have 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.

- Supporting education, screening, care coordination, risk reduction interventions, testing, and counseling for HIV/AIDS, hepatitis, and other infectious diseases.

- Supporting innovative telehealth strategies to increase the capacity of tribal communities to support OUD/stimulant use disorder prevention, treatment, and

recovery. Strategies may include providing a subscription for mobile services for phones or devices (or cell phone plan) to allow clients to access telehealth.

- Award recipients may purchase a comprehensive plan that includes data, text, and minutes for a new phone or data and phone minutes that can be uploaded and used by clients with existing phones/mobile devices.
- Award recipients that purchase mobile plans for clients must also provide direct client-level treatment and/or recovery support services with TOR funds and the recipients of the mobile plans must be actively participating in those services.
- Award recipients must have a system for documenting:
    - That clients are not eligible for other resources for mobile phone plans, including the Federal Lifeline Assistance Program; and
    - If a client is eligible for other resources, it is determined those resources are insufficient to meet an individual's care needs in terms of the quality of the services/technology or there are competing household needs for that service.

Note: TOR funds may not be used to purchase mobile phones or other mobile devices for clients. Award recipients may, however, take advantage of subscription plans that offer free devices with their service. The use of mobile services should be encouraged to enable access to treatment, recovery, and other related services. Clients will not be allowed to accrue additional charges with TOR funds for mobile applications and mobile other content that is not related to their treatment and recovery services.

- Developing and implementing tobacco/nicotine product (e.g., vaping) cessation programs, activities, and/or strategies.

- Assessing the impact of the award. (Consider working with Tribal Epidemiology Centers or an Evaluator to implement this activity. However, including an Evaluator in the staffing component is not required).

- Providing 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.

- Training/workforce development to help your staff or other providers in the community identify mental health or substance use issues or provide effective culturally and linguistically competent services consistent with the purpose of the program.

- 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)[3]

- Implementing, acquiring, or upgrading health information technology.

- Providing cultural competency and implicit bias reduction training to service providers to increase awareness and acknowledgment of differences in language, age, culture, socio-economic status, political and religious beliefs, sexual orientation and gender identity, and life experiences.

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 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.

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[3] 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.

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.

Data will be gathered using uniform data collection tools provided by SAMHSA. Recipients are required to submit data via SAMHSA's Performance Accountability and Reporting System (SPARS); and access will be provided upon award.

The two data collection tools used in the TOR program include:

1. 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, 6-months post intake, and discharge from the SAMHSA funded services. 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 GPRA 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 reporting measures throughout the reporting period to meet these needs.

2. The SOR/TOR Program Instrument. This tool collects data on program-level outcomes and is submitted on a quarterly basis in SPARS. The SOR/TOR – Program Instrument will collect the following measures:

   - Naloxone and other opioid overdose reversal medications purchase and distribution
   - Overdose reversals
   - Drug checking supplies
   - Education of school-aged children, first responders, and key community sectors on opioid and/or stimulant misuse

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

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.[4] 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;
- 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;

[4] "Behavioral health" means the promotion of mental health, resilience and wellbeing; 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.

- *Collaboration 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.[5]

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*)

Tribal Behavioral Health Agenda

SAMHSA, working with tribes, the Indian Health Service, and National Indian Health Board, developed the National Tribal Behavioral Health Agenda (TBHA). Tribal applicants are encouraged to briefly cite the applicable TBHA foundational element(s), priority(ies), and strategies their application addresses.

[5] https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

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 years one, three, and five of the project. You must include this travel in your submitted budget narrative. You may budget for up to two people, including the Project Director. 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:	Up to $63,000,000
Estimated Number of Awards:	Up to 130 awards
Estimated Award Amount:	See Appendix A and Appendix B for distribution
Length of Project Period:	Up to 5 years
Anticipated Start Date	September 30, 2024

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

Eligibility is statutorily limited to Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, and consortia of tribes or tribal organizations. Tribes and tribal organizations may only be included in one award application.

A tribal organization is the recognized body of any AI/AN tribe; any legally established organization of AI/ANs controlled, sanctioned, or chartered by such governing body, or is democratically elected by the adult members of the Indian community to be served by such organization and includes the maximum participation of AI/ANs in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval with a signed letter. A single tribe or Tribal organization in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the award requirements.

For general information on eligibility for federal awards, see https://www.grants.gov/applicants/applicant-eligibility.html.

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 services appropriate to the award must be involved in the project. The provider may be the applicant or another organization committed to the project as demonstrated by a Letter of Commitment (LOC). More than one provider organization may be involved.

2. Applicants must submit official documentation that all participating Tribal mental health/substance abuse treatment provider organizations: 1) comply with all applicable Tribal requirements for licensing, accreditation, and certification; OR 2) provide documentation from the Tribe or other tribal governmental unit that licensing, accreditation, and certification requirements do not exist.

3. Non-tribal mental health/substance use disorder treatment provider organizations 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). Non-tribal mental health/substance use disorder treatment provider organizations must

comply 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. 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 meet these requirements.

Following the review of your application, if the score is in the fundable range, the 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: 9/29/2029).
- **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, Year 3, Year 4, and Year 5). For example, if funds are being requested for five years total, enter the requested budget amount for each budget period in columns b, c, d, and e (i.e., 4 out years). — (b) First column is the budget for the second budget period; (c) Second column is the budget for the third budget period; (d) Third column is the budget for the fourth budget period; (e) Fourth column is the budget for the fifth 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 https://www.samhsa.gov/grants/how-to-apply/budget-and-narrative**on the SAMHSA website.**

- **PROJECT NARRATIVE – (Maximum 10 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 15, it is 11 pages long, not 10 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 10**

  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: Letters of Commitment/Service Providers/Evidence of Experience and Credentials***
    1. A list of all direct service provider organizations that will partner in the project, including the applicant agency if it is a service provider organization.
    2. Letters of Commitment from these direct service provider organizations; **(Do not include any letters of support. Reviewers will not consider them.** A letter of support describes general support of the project while a Letter of Commitment outlines the specific contributions an organization will make in the project.) Tribes and Tribal organizations applying as a consortium must include signed letters from each participating entity.

3. Statement of Certification — You must provide a written statement certifying that all partnering non-Tribal service provider organizations listed in this application 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: IHS User Population Estimate Information and Need-Based Supplement Award Eligibility.*** You must complete and submit the table listed in Appendix A using the information provided in Appendix A – Annual Base Award Allocation of Tribal Opioid Response Grants and

Appendix B – List of Highest Overdose Mortality Counties for Need-Based Supplement Eligibility.

- ***Attachment 10: Contingency Management and Statement of Certification.*** If you plan to implement CM with TOR funds, you must provide a written statement certifying that you will comply with the conditions and training requirements for CM as outlined in Appendix C of this NOFO.

3. UNIQUE ENTITY IDENTIFIER AND SYSTEM FOR AWARD MANAGEMENT

Section A of the Application 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[6] 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 TOR 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 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

[6] 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 conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

- Recovery housing is an allowable cost. Funds may not be used to pay for non-recovery housing, housing application fees, or housing security deposits.
- 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 offered under contingency management services may be subject to change.

You 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 **10 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 1 page)

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. Specify your current user population estimate and the county or counties you plan to serve with TOR funds. 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. 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, Social Vulnerability Index, etc.).

SECTION B: Proposed Implementation Approach (30 points – approximately 5 pages, not including 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:

Number of Unduplicated Individuals to be Served with Award Funds						
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Treatment Services*						
Recovery Support Services*						
Prevention Services						
Harm Reduction 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 for each award year; the total receiving treatment and applicable recovery support services will be the applicant's GPRA target in SPARS.

2. Describe how you will implement all Required Activities in Section I. **If funds will be used for capacity-building, describe how those funds will be used.**

3. In **Attachment 4**, provide no more than a two-page chart or graph depicting a realistic timeline for the entire five 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 2 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 1 page)

1. Demonstrate the experience of your organization 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. If applicable, include Letters of Commitment from each partner in **Attachment 1.** If you are not partnering with any other organization(s), indicate so in your response.

3. Provide a complete list of staff positions for the project, including the Key Personnel (Project Director) 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.

SECTION E: Data Collection and Performance Measurement (20 points – approximately 1 page)

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 K - 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 semi-annual Programmatic Progress Reports (at 6 months and 12 months). The six-month report is due no later than 30 days after the end of the second quarter. The annual progress report is due within 90 days of the end of each budget period.

The report must discuss:

- 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

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:

William Longinetti
Office of Tribal Affairs and Policy
Substance Abuse and Mental Health Services Administration
(240) 276-1190
william.longinetti@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
FOACSAT@samhsa.hhs.gov

For review process and application status questions, contact:

Sara Fleming
Office of Financial Resources, Division of Grant Review
Substance Abuse and Mental Health Services Administration
(240) 276-1693
Sara.Fleming@samhsa.hhs.gov

Appendix A – Annual Base Award Allocation of Tribal Opioid Response Grants

Grant awards will consist of base awards and need-based supplement awards for eligible applicants. Funds for base awards will be distributed based on the FY2023 Indian Health Service user population estimate data and the values provided below. Dollar amounts are based on user population of Tribes. If a Tribe elects to partner with another Tribe to apply, base award amounts of each Tribe in the application may be summed for the total application budget. The first column shown represents the Tribe's user population. The second column shows the **maximum** base award amount for which the Tribe may apply **per year**. Applicants may elect to apply for less than the amount shown; however, applicants may not apply for more than the annual amount shown in any year of the grant.

IHS User Population	Base Award Per Year
1-10,000	$250,000
10,001-20,000	$425,000
20,001-40,000	$750,000
40,001+	$1,750,000

Applicants should complete the table below and submit in Attachment 9. Applicants should refer to the IHS user population estimate dataset (IHS Headquarters Publications | Division of Program Statistics) and indicate their most current user population estimate and the specific service unit within the dataset representing their user population. If an application includes partnering tribes, a table should be completed for each partnering tribe.

Name of Tribe	[Insert the name of Tribe]
IHS User Population Estimate	[Insert FY2023 user population estimate here]
Service Unit	[Insert service unit here]
Need-Based Supplement Eligible Counties	[Insert any counties you will serve from Appendix B]

Appendix B – List of Highest Overdose Mortality Counties for Need-Based Supplement Eligibility[7]

Applicants who plan to serve one or more of the counties listed in the table below will be eligible for additional need-based supplemental grant funds. Applicants should complete the table in Appendix A and indicate which county or counties they plan to serve with the TOR grant. The exact amount of supplemental funds available will be determined after application submission.

STATE	COUNTY
Alaska	Anchorage Municipality
Alaska	Fairbanks North Star Borough
Alaska	Juneau City and Borough
Alaska	Kodiak Island Borough
Alaska	Matanuska-Susitna Borough
Arizona	Apache County
Arizona	Coconino County
Arizona	Maricopa County
Arizona	Navajo County
Arizona	Pima County
Arizona	Pinal County
California	Humboldt County
California	Kern County
California	Lake County
California	Mendocino County
California	San Francisco County
California	Sonoma County
Colorado	Denver County
Idaho	Bannock County
Maine	Penobscot County
Maine	Washington County
Michigan	Isabella County

[7] The TOR formula need-based supplement was devised in order to quantify American Indian/Alaskan Native (AI/AN) opioid mortality burden at the county level. The data for the need-based supplement was taken from the most currently available National Vital Statistics System (NVSS) restricted use files: Detailed Mortality all counties 2019-2021. The formula need-based supplement components include decile rankings of (1) mean county-level AI/AN overdose mortality (counts) over 3 years, (2) mean county-level AI/AN overdose death rate over three years by total population, (3) mean county-level AI/AN overdose death rate over three years by AI/AN population, (4) total AI/AN population per county, and (5) total county-level AI/AN overdose deaths summed over three years. By combining rates and counts, the formula strikes a balance of addressing the needs of both smaller and larger Tribes.

Minnesota	Becker County
Minnesota	Beltrami County
Minnesota	Carlton County
Minnesota	Cass County
Minnesota	Hennepin County
Minnesota	Mahnomen County
Minnesota	Mille Lacs County
Minnesota	Ramsey County
Minnesota	St. Louis County
Montana	Cascade County
Montana	Hill County
Montana	Lake County
Montana	Roosevelt County
Montana	Rosebud County
Montana	Yellowstone County
Nevada	Washoe County
New Mexico	Bernalillo County
New Mexico	McKinley County
New Mexico	Otero County
New Mexico	Rio Arriba County
New Mexico	San Juan County
New Mexico	Sandoval County
New York	Erie County
North Carolina	Cumberland County
North Carolina	Hoke County
North Carolina	Jackson County
North Carolina	Robeson County
North Carolina	Scotland County
North Carolina	Swain County
North Dakota	Benson County
North Dakota	Burleigh County
North Dakota	Cass County
North Dakota	McKenzie County
North Dakota	Mountrail County
North Dakota	Sioux County
North Dakota	Ward County
Oklahoma	Adair County
Oklahoma	Caddo County
Oklahoma	Muskogee County
Oklahoma	Oklahoma County
Oklahoma	Pittsburg County
Oklahoma	Pontotoc County

Oklahoma	Sequoyah County
Oklahoma	Tulsa County
Oregon	Klamath County
Oregon	Multnomah County
South Dakota	Pennington County
South Dakota	Roberts County
Washington	Clallam County
Washington	Grays Harbor County
Washington	King County
Washington	Kitsap County
Washington	Mason County
Washington	Pierce County
Washington	Snohomish County
Washington	Spokane County
Washington	Thurston County
Washington	Whatcom County
Washington	Yakima County
Wisconsin	Ashland County
Wisconsin	Brown County
Wisconsin	Milwaukee County
Wisconsin	Sawyer County
Wisconsin	Shawano County
Wyoming	Fremont County

Appendix C – 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:

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

Within **180 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 ticket 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.