

# Department of Health and Human Services

## Substance Abuse and Mental Health

### Services Administration

## Minority AIDS Initiative: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project

(Short Title: Portable Clinical Care Pilot Project)

(Initial Announcement)

Notice of Funding Opportunity (NOFO) No. TI-24-013

Assistance Listing Number: 93.243

### Key Information:

<b>Application Deadline</b>	<b>Applications are due by July 8, 2024.</b>
<b>FY 2024 NOFO Application Guide</b>	Throughout the NOFO there will be references to the FY 2024 NOFO Application Guide ( <a href="#">Application Guide</a> ). 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.
<b>Intergovernmental Review (E.O. 12372)</b>	Applicants must comply with E.O. 12372 if their state(s) participate(s). Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after the application deadline. See <a href="#">Section I</a> of the <i>Application Guide</i> .
<b>Public Health System Impact Statement (PHSIS)/Single State Agency Coordination</b>	Applicants must send the PHSIS to appropriate state and local health agencies by the administrative deadline. Comments from the Single State Agency are due no later than 60 days after the application deadline.

**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* (Application and 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 Minority AIDS Initiative: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project (Short Title: Portable Clinical Care Pilot Project). The purpose of this program is to pilot a portable clinical care approach to underserved populations experiencing unsheltered homelessness by integrating behavioral health, human immunodeficiency virus (HIV) treatment, and prevention services. This approach focuses on literally “meeting people where they are,” such as encampments, with the equitable delivery of integrative services. Recipients will be expected to take a syndemic approach to healthcare delivery through utilization of low barrier substance use disorder (SUD) treatment; HIV and viral hepatitis testing and treatment; HIV prevention including condom, Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) distribution; mental health care; and harm reduction services. With this program, SAMHSA aims to improve the healthcare for people experiencing unsheltered homelessness while learning, through the experience of funded grant recipients, about best practices for SUD, HIV, viral hepatitis, sexually transmitted infections (STIs), mental health, and harm reduction service delivery in a low-barrier, on-site context.

<b>Funding Opportunity Title:</b>	Minority AIDS Initiative: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project (Short Title: Portable Clinical Care Pilot Project)
<b>Funding Opportunity Number:</b>	TI-24-013
<b>Due Date for Applications:</b>	July 8, 2024
<b>Estimated Total Available Funding:</b>	Up to \$2,600,000
<b>Estimated Number of Awards:</b>	Up to 4 (1 award will be made to an applicant serving a rural area, pending sufficient application volume)
<b>Estimated Award Amount:</b>	Up to \$650,000 per year
<b>Cost Sharing/Match Required:</b>	No
<b>Anticipated Project Start Date:</b>	September 30, 2024
<b>Anticipated Award Date:</b>	No later than September 29, 2024

<b>Length of Project Period:</b>	Up to 3 years
<b>Eligible Applicants:</b>	<p>Eligible applicants are States and Territories, including the District of Columbia, political subdivisions of States, Indian tribes, or tribal organizations (as such terms are defined in <a href="#">section 5304 of title 25</a>), community-based public and private non-profit entities, or programs operated by or in accordance with a contract or award with the Indian Health Service, or other public or private non-profit entities, including faith-based organizations, including faith-based organizations.</p> <p>[See <a href="#">Section III-1</a> for complete eligibility information.]</p>
<b>Authorizing Statute:</b>	MAI–Portable Clinical Care Pilot Project awards are authorized under Section 509 of the Public Health Service Act, as amended.

# I. PROGRAM DESCRIPTION

## 1. PURPOSE

The purpose of this program is to pilot an approach to comprehensive healthcare for underserved populations experiencing unsheltered homelessness through the provision of portable clinical care delivered outside, focused on the integration of behavioral health and HIV treatment and prevention services. Unsheltered homelessness includes [persons sleeping in settings not designed for shelter such as cars, encampments, transportation settings, or abandoned buildings.](#)

According to the Centers for Disease Control and Prevention (CDC), people experiencing homelessness are more likely to engage in activities associated with increased risk of HIV/hepatitis C virus (HCV) acquisition or transmission, including substance use, injection drug use, and having multiple sex partners.<sup>1</sup> Compounding these heightened risk factors, unsheltered individuals often do not engage with the healthcare system. The health access disparities for this population exist for a variety of reasons involving cost, medical mistrust, and structural barriers that are notably exacerbated by the stigma associated with homelessness, HIV, and substance use. The U.S. Department of Housing and Urban Development (HUD) estimated that there were over 580,000 people experiencing homelessness in 2022, of which nearly 234,000 are unsheltered.<sup>2</sup> For these unsheltered individuals, their primary nighttime location is a public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for people (for example, the streets, vehicles, or parks).

For people living with HIV, stable housing is closely linked to successful HIV outcomes, while those people living with HIV who lack stable housing are more likely to delay HIV care and are less likely to access HIV care or adhere to their HIV treatment.<sup>3</sup> Unsheltered populations often face several co-occurring conditions, including mental illness, SUD, and infections such as HIV and viral hepatitis, any of which may be barriers to finding and maintaining stable housing.

This pilot project is an opportunity to implement an evidence-based approach addressing the needs of unsheltered populations through a lens of person-centered care. This approach focuses on literally “meeting people where they are,” such as encampments, with the equitable delivery of integrative services for SUD treatment, HIV and viral hepatitis primary care and prevention services, mental health care, and harm reduction services. The aim is that services will be brought to unsheltered populations to improve their overall health and quality of life.<sup>4</sup>

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<sup>1</sup> <https://www.cdc.gov/hiv/policies/data/role-of-housing-in-ending-the-hiv-epidemic.html>

<sup>2</sup> [The 2022 Annual Homelessness Assessment Report \(AHAR to Congress\) Part 1: Point-In-Time Estimates of Homelessness, December 2022 \(huduser.gov\)](#)

<sup>3</sup> <https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/housing-and-health>

<sup>4</sup> <https://www.streetmedicine.org/>

Portable clinical care promotes direct outreach by bringing services and providers out of the clinic and into the places where people are in need of services. Portable clinical care teams provide healthcare directly on the street or in encampments, or other locations where unhoused persons may seek services or shelter, removing access barriers, and preventing medical conditions from deteriorating to the point of needing emergency care. Taking this approach to reaching people experiencing unsheltered homelessness will allow recipients to provide behavioral healthcare services that address many of the reasons unsheltered individuals do not engage with the healthcare system, including fear of theft or destruction of personal property; past trauma; compounded stigma around homelessness, HIV, and substance use; and prior maltreatment in past encounters with the healthcare system.

This pilot program is in alignment with [SAMHSA's Strategic Plan 2023–2026](#), the [National HIV/AIDS Strategy \(NHAS\)](#), [Ending the HIV Epidemic in the U.S. Initiative](#), the [Viral Hepatitis National Strategic Plan](#), the [Sexually Transmitted Infections National Strategic Plan](#), [HHS Overdose Prevention Strategy](#), and [All In: The Federal Strategic Plan to Prevent and End Homelessness](#).

Three (3) awards will be made to applicants serving people experiencing unsheltered homelessness in non-rural areas and one (1) award will be made to an applicant serving people experiencing unsheltered homelessness in a rural area<sup>5</sup> pending sufficient application volume. SAMHSA's grant 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, religion, and sex (including gender identity, sexual orientation, and pregnancy). Recipients must also agree to comply with federal conscience laws, where applicable.

SAMHSA aims to improve the healthcare for people experiencing unsheltered homelessness while learning, through the experience of funded grant recipients, best practices for SUD, HIV, viral hepatitis, STI, mental health, and harm reduction service delivery by providing portable clinical care. The best practices and lessons learned will be disseminated to the public and health providers following the completion of the pilot project.

The Minority AIDS Initiative: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project is authorized under Section 509 of the Public Health Service Act, 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

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<sup>5</sup> Source: HUD [Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness](#)



project. Key personnel and staff selected for the project should reflect the diversity in the geographic catchment area.

**Key personnel for this program are:**

- **Project Director:** Person responsible for oversight of the entire project, including overseeing, monitoring, and managing the award; at least a *25 percent* level of effort is required.
- **Program Coordinator:** Person responsible for the day-to-day operations of the award; *100 percent* level of effort is required; and
- **Program Evaluator:** Person responsible for evaluating the processes and outcomes of the award; at least a *25 percent* level of effort is required.

Award recipients are encouraged to consider hiring people with lived experience with SUD, co-occurring SUDs and mental health conditions, recovery, homelessness and/or experience with unsheltered homelessness, and/or living with HIV in lieu of education as appropriate.

**If you receive an award, 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.

### **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.

**Recipients are required to carry out each of these activities.**

- **Provide basic primary health care services and supplies**
  - Provide basic primary healthcare services such as wound care, including the provision of wound care supplies, such as gloves, bandages, irrigation, dressings, gauze, and antibiotics and screenings for high blood pressure, diabetes, and acute infections with appropriate follow-up care on-site or referral, if necessary.
    - **NOTE:** See Funding Limitations Section for information about the purchase of over the counter and prescription medication using grant funds.
- **Low barrier substance use disorder treatment**
  - Conduct screening and assessment of SUD and co-occurring mental and substance use disorders.

- Develop and implement a low barrier approach that offers SUD services, including U.S. Food and Drug Administration (FDA)-approved medications to treat SUDs including opioid use disorder (OUD), stimulant use disorder, and alcohol use disorder (AUD), and makes 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.).
  - **NOTE:** See Funding Limitations Section for information about the purchase of medication for the treatment of SUD using grant funds.
- Have access to or have the ability to partner with existing licensed Opioid Treatment Programs (OTPs), Office-Based Opioid Treatment programs (OBOTs), and [Certified Community Behavioral Health Clinics \(CCBHCs\)](#) to provide all forms of Medications for Opioid Use Disorder (MOUD) as appropriately clinically indicated and in accordance with clients' individualized treatment goals, and AUD treatment programs. Recipients must ensure that individuals receiving MOUD are not excluded from any other services, including, but not limited to, housing, peer support programs, etc.
- Provide other SUD and mental health treatment or referral and coordination of treatment. These services must be culturally appropriate, trauma-informed, evidence-based or community-defined, and may be provided outside, in-person by the portable clinical care team, and/or through referral to outpatient, intensive outpatient, day treatment, or residential settings based on client needs and collaborative treatment plan. If an evidence-based practice(s) (EBP(s)) exists for the population(s) of focus and types of problems or disorders being addressed (e.g., medications for opioid use disorder as standard of care for opioid use disorder), the expectation is that EBP(s) will be utilized. If one does not exist but there are evidence-informed and/or culturally promising practices that are appropriate or can be adapted, these interventions may be implemented in the delivery of services. Services provided through referral may be delivered in-person or via telemedicine as permissible by state and federal law.
- **Take a [syndemic approach](#) to address infectious diseases and conditions, including HIV/AIDS,<sup>6</sup> STIs, viral hepatitis, monkeypox (Mpox), and tuberculosis, as appropriate.** Note: See Funding Limitation Section for information about the use of grant funds for infectious disease testing, treatment, and prevention.
  - Screen clients and their drug-using and/or sexual partners on-site for HIV, viral hepatitis, STIs, Mpox, and tuberculosis.
  - Provide **HIV** testing, prevention, and treatment using a portable clinical care approach, including:

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<sup>6</sup> [Status neutral approach letter](#).

- On-site preliminary HIV testing, including HIV self-test kits<sup>7</sup> and pre- and post-test counseling.
  - For people who receive a preliminary positive HIV test, provide confirmatory testing on-site (preferred) or by-referral, and if confirmed, provide referral/linkage to HIV treatment on-site (preferred) or by referral as necessary. HIV treatment should begin preferably within hours but not longer than 30 calendar days after diagnosis.
  - For people who receive a preliminary positive HIV test, have a person with a psychological background on-site that can provide emotional support. For people who test HIV-negative but are at increased risk of getting HIV, provide HIV prevention education, including, but not limited to, information about harm reduction, Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP).
  - Provide referral and linkage to PrEP for individuals who are at increased risk of exposure to HIV, preferably within hours but not longer than 30 calendar days.
  - Provide referral and linkage to PEP services for individuals in emergency situations following a possible HIV exposure. PEP must be started within 72 hours of exposure.
    - **Note:** SAMHSA funds cannot be used to pay for PrEP or PEP medications. However, SAMHSA funds can be used to pay for office visits and lab work medically relevant to PrEP or PEP initiation.
- Provide **viral Hepatitis** testing, prevention, and treatment using a portable clinical care approach, including:
- Test all participants with increased likelihood of acquiring viral hepatitis (B and C) either on-site or through referral in accordance with state and local requirements. Hepatitis A testing may also be performed if an outbreak is currently taking place in the recipient's geographic area. People who are vulnerable to HCV include persons who have more than one sex partner; use needles, syringes, or other drug injection equipment; or exchange sex for drugs or money.
  - Provide hepatitis A and B vaccination to participants as necessary.
  - For people who test positive for hepatitis B and/or hepatitis C, provide case management and referral and linkage to treatment for hepatitis B and C. Case management includes comprehensive assessment of the client's needs and development of an individualized service plan, including infectious disease prevention and/or treatment services, as well as helping clients with funding for treatment, including HCV treatment, as necessary.
    - **Note:** SAMHSA funds cannot be used to pay for treatment for hepatitis B or C.

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<sup>7</sup> [SAMHSA Colleague Letter: Oral Fluids](#)

- Use award resources, including funds or staff, for **Mpox** activities conducted in conjunction with SAMHSA supported work as allowable in [SAMHSA's Mpox Dear Colleagues letter](#). Such activities include, but are not limited to, navigating people served by award funds to testing, treatment, and prevention resources identified through collaboration with local health departments and mental health support of individuals with Mpox served by this award or referral/navigation to these services.
- Test participants for **STIs** (gonorrhea, chlamydia, syphilis, and genital herpes) and provide treatment on-site or referral as needed.<sup>8,9</sup> Refer to [SAMHSA's STI's/Syphilis Dear Colleagues Letter](#).
- Screen for symptomatic **tuberculosis** and test participants for latent or active tuberculosis and provide treatment as needed.
- Implement infectious disease testing quality assurance measures following established guidelines.
- Develop Memorandum of Agreements (MOAs) with the following, as appropriate:
  - Primary HIV treatment and care providers, including [Ryan White providers](#), to strengthen integration of care through case management.
  - Treatment providers for referrals and linkages to follow-up care and treatment for individuals with viral hepatitis (B or C).
  - Care providers for referrals and linkages to PrEP.
  - Care providers for referrals and linkage to PEP.
- **Harm reduction services<sup>10</sup>**
  - Provide evidence-based harm reduction education, supplies, and 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 federal, state, and local laws, regulations, and other requirements related to such programs or services.* SAMHSA has discussed harm reduction services in such sources as <https://www.samhsa.gov/find-help/harm-reduction/framework>.
  - Distribute FDA-approved overdose reversal medication, drug supply testing (e.g., fentanyl and xylazine test strips), and overdose prevention education to the populations of focus regarding the use of substances, including but not limited to, opioids and their synthetic analogs.
    - **NOTE:** See funding limitations section for information about using grant funds for the purchase of harm reduction supplies.
- **Mental health care, treatment, and referral**
  - Conduct screening and assessment of mental health conditions and co-occurring mental and substance use disorders.

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<sup>8</sup> [Sexually Transmitted Infections National Strategic Plan \(2021–2025\)](#)

<sup>9</sup> [STI Screening Recommendations \(cdc.gov\)](#)

<sup>10</sup> SAMHSA funds may not be used to purchase syringes to prevent and control the spread of infectious diseases. No federal funding can be used directly or through subsequent reimbursement of grantees to purchase pipes. The grant award will include an explicit prohibition of these federal funds to be used to purchase drug paraphernalia.

- Provide trauma-informed, culturally responsive, client-centered, evidence-based, recovery-oriented, and integrated mental health and substance use services on-site (preferred) or by referral if barriers to on-site delivery exist. For further information on trauma-informed approaches see SAMHSA resources such as <https://store.samhsa.gov/product/practical-guide-implementing-trauma-informed-approach/pep23-06-05-005>.
- Deliver or coordinate any services determined to be necessary to address any identified mental health conditions. Portable clinical team members may deliver medication as clinically indicated for clients' psychiatric needs and as prescribed by an appropriately licensed healthcare practitioner working within their scope of practice.
  - **NOTE:** See Funding Limitations Section for information about the use of grant funds for the purchase of psychotropic/psychiatric medication.
- **Provide care coordination and case management services to address infectious diseases and the social determinants of health, including housing.**
  - Using a multi-disciplinary team approach that includes peers, implement strategies that effectively reach the people who are experiencing unsheltered homelessness (including in encampments) and may need these services.
  - Provide [care coordination](#), [case management](#), and referral/linkage to infectious disease prevention and treatment as necessary based on client's individual needs, including HIV, viral hepatitis A, B, and C, STIs, Mpox, and tuberculosis. This includes comprehensive assessment of the client's needs and development of an individualized service plan, including infectious disease prevention and/or treatment services, as well as helping clients with funding for treatment, including HCV treatment, as necessary.
  - Develop and implement a detailed plan of action with purposeful and documented engagement with sustainable permanent housing options, including collaborating with [HUDs Continuum of Care \(CoCs\)](#) to enroll individuals in the local CoC Coordinated Entry System (CES), as well as the [Housing Opportunities for Persons with AIDS \(HOPWA\)](#) program and other public housing options as appropriate. This plan, as well as applicable MOAs, must be in place before grant activities begin.
  - Provide case management services to coordinate all aspects of care, including behavioral health, primary care, infectious disease prevention and treatment, other supportive services (e.g., housing, benefits, employment), and assist with transitions for returning to the community after any hospitalization or emergency room visit as appropriate, including enrolling eligible individuals in health insurance, Medicaid, Medicare, and other benefit programs (e.g., Social Security Disability Insurance and Supplemental Security Income, Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, prescription assistance programs, etc.), and other human and community-based services as appropriate.
  - Provide peer support services (e.g., peer-led or peer-supported activities) by hiring of staff with lived experience such as peer mentors, peer support

specialists, recovery support specialists, and recovery coaches). Peer support specialists may have lived experience with any of the following as appropriate:

- lived experience with unsheltered homelessness;
- living with HIV/AIDS and taking antiretroviral therapy and are adherent to their treatment;
- HIV-negative but have lived experience with HIV prevention methodologies such as taking or have taken PrEP or participated in other HIV risk reduction behaviors;
- lived experience with treatment and recovery from hepatitis C;
- lived experience with STIs such as syphilis treatment and recovery;
- lived experience with and are in active recovery for SUD, mental health disorders, or co-occurring disorders.

Though the purpose of this pilot is to provide comprehensive care at the point of contact with clients, recipients should have a referral process for clients for instances in which a portable clinical care approach will not address their needs, including through new models of telehealth service delivery. Transportation must be directly provided (i.e., pick-up and drop-off) to and from all referral providers.

- **Document best practices and lessons learned while implementing integrated care using a portable clinical care approach. Disseminate findings from pilot program.**
  - Report to SAMHSA twice per year a narrative progress report documenting best practices, lessons learned, and challenges.
  - Annually, participate in a virtual learning collaborative to share best practices and lessons learned, as well as brainstorm solutions to challenges faced by members of the learning collaborative.
  - Document best practices and lessons learned for the public through either the development of white papers, participation in conference presentations, a guide to be shared with the public about launching their own portable clinical care program, etc. Specifically, pilot program lessons learned should include insight into:
    - How much does this program cost to operate optimally, including budget allocation for services provided, staffing, and supplies?
    - What is the ideal staffing requirement to manage and implement this program using a portable clinical care approach?
    - What kind of supplies are needed? Have these supplies been appropriately accounted for in this program?
    - What are best practices and lessons learned for planning and implementing a portable clinical care comprehensive care program?
    - When are referrals necessary? How are these referrals managed? How is attendance to referrals made tracked?
    - The number of racial, ethnic, sexual and gender minority populations served and their demographic data in the program evaluation.
    - Best practices and lessons learned from serving people experiencing unsheltered homelessness.

#### 4. ALLOWABLE ACTIVITIES

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

- Training/workforce development including but limited to:
  - Training for staff to provide services for mental health or SUD issues and harm reduction strategies.
  - Provide training in evidence-based practices (EBPs) for service providers, such as MOUD and medications for AUD, motivational interviewing, intensive case management (ICM), community reinforcement approach (A-CRA), motivational interviewing, or peer supports.
- Develop and implement tobacco cessation programs, activities, and/or strategies.
- Develop and implement evidence-based contingency management (CM) programs to treat stimulant use disorder and concurrent substance misuse, and to improve retention in care. **Clients may not receive contingencies totaling more than \$75, per budget period.** 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: primary grant recipient staff and if applicable sub-awardee(s) receive appropriate education on CM prior to implementation; describe the role of individuals in delivery and monitoring of CM services; the incentivized behaviors, and the approach to verification; the type of CM services to be offered; the process for monitoring fidelity to evidence-based practices; and oversight of primary grant recipient staff and if applicable sub-awardee(s) CM implementation and operation, as outlined in [Appendix A](#) of this NOFO. The Statement of Certification must be provided in **Attachment 11** of your application.
- Incorporate [Undetectable = Untransmittable \(U=U\)](#) messaging in communication strategies.
- Address the intersection between oral and behavioral health by providing dental kits to promote oral health for individuals experiencing unsheltered homelessness (i.e., dental kits are limited to items such as toothpaste, toothbrush, dental floss, non-alcohol containing mouthwash).
- Distribute over-the-counter medications as needed (i.e., antacids, ibuprofen, antibacterial ointments, etc.).
- Distribute hygiene kits as needed (soap, clean water, clean socks and undergarments, antibacterial ointments, feminine hygiene products, bandages, tissues, hand wipes, sunscreen, lotion, etc.).
- Develop formal partnerships to provide Recovery Support Services (RSS), including peer support services designed to improve access to and retention in care and facilitate long-term recovery.
- Purchase tent or similar other temporary and moveable structure for on-site (e.g., in encampments) that provide appropriate privacy and adequate space to administer and dispense medications, conduct screenings, and provide SUD treatment. The following services may be provided by the portable clinical care team, assuming compliance with all applicable federal, state, and local law:



- Administering and dispensing medications for SUD treatment either initiation or continuation;
- Collecting samples for drug testing or analysis (e.g., Fentanyl and other synthetic drugs);
- Dispensing of prescription and over-the-counter medications;
- Dispensing of medication for infectious disease (i.e., antiretroviral medication, sexually transmitted infection medication, hepatitis C treatment, etc.).
- Distribute safer sex kits, including condoms.
- Provide equipment and supplies to enhance harm reduction<sup>11</sup> efforts, such as
  - Medication lock boxes;
  - FDA-approved overdose reversal medication (nasal and intramuscular formulations permitted, including higher dosage formulations as approved by FDA);
  - Sharps disposal and medication disposal kits;
  - Substance test kits, including test strips for xylazine, fentanyl and other synthetic drugs;
  - Wound care management supplies (e.g., gloves, bandages, irrigation, dressings, gauze and antibiotics, etc.);
  - Distribution of syringes to prevent the spread of infectious disease; ***NOTE: Funds cannot be used to purchase syringes to prevent and control the spread of infectious disease. Funds may be used to purchase syringes to administer intramuscular naloxone.***
- Coordinate and utilize crisis and 988 systems.
- Provide or ensure linkage to and support engagement with recovery support services to improve access to and retention in services and to continue treatment gains [e.g., vocational rehabilitation; childcare, educational, and transportation services; independent living skills (e.g., budgeting, financial education); occupational therapy; and psychosocial rehabilitation services].
- Provide referral and linkage to food assistance programs, including food pantries and meal services.
- A vehicle may be required for the portable clinical care team to reach the population of focus and to transport supplies or provide the required transportation (i.e., pick up and drop off) for those requiring services that cannot be provided on-site by the portable clinical care outreach team. Vehicle purchases are allowable with the agency's prior approval. When approved, vehicles must be purchased within the grant's first year to ensure the grant receives a benefit.
  - In addition, when purchased with grant funds, organizations must remove vehicle depreciation from their federally approved indirect cost rates or de minimis rate to avoid a double recovery. Due to the pilot nature of this program, the purchase, lease, or use of a mobile medical clinic with ensuite medical facilities to provide grant services is not an allowable expense, but rather partnerships can be formed with other organizations including portable

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<sup>11</sup> See the [Harm Reduction Framework](#).



- medical clinics capable of providing specialized medical care via ensuite medical facilities (i.e., mammograms, dental care, showers, etc.).
- Use of telehealth and/or telemedicine services, including audio-only telehealth.
- Implement a communication campaign focused on reducing stigma related to harm reduction, SUD, HIV, other infectious diseases, and homelessness.
- Provide public education on any state “Good Samaritan” laws related to harm reduction.

### **System Capacity Building (optional allowable activity)**

Although awards for the provision of services must be used primarily for direct services, SAMHSA recognizes that system capacity changes may be needed to implement the services or improve their effectiveness. System capacity building encompasses activities that support the direct service expansion of the project and do not include capitalizable costs. Recipients may use grant funds for the types of system capacity building listed below, if necessary, to support the direct service expansion of the project.

**Applicants must describe in Section B of the Project Narrative the use of funds for non-capitalizable system capacity building activities which may include:**

- Developing partnerships with other providers for service delivery and with stakeholders serving the population of focus, including those working with 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, adherence to the Behavioral Health Guide for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, development or revision of credentialing, licensure, or accreditation requirements)<sup>12</sup>

**Capitalizable infrastructure, such as computer systems/software, new buildings, or structural changes to existing facilities (e.g., to the foundation, roof, floor, or**

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<sup>12</sup> 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.

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 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.

All SAMHSA recipients are required to collect and report certain data so that SAMHSA can 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 your Project Narrative in response to [Section E](#): Data Collection and Performance Measurement in Section V of this NOFO

Recipients are required to report performance on the following measures:

- Total number of clients served.
- Client demographic information.
- Number of clients receiving services by service type, client demographics, and service delivery type (i.e., point of care, referral)
  - Primary health care services,
  - Low-barrier SUD treatment services,
  - Infectious disease services, including prevention, testing, and treatment services,
  - Mental healthcare services,
  - Harm reduction services, and
  - Case management and other support services.
- Number of services rendered by service type and service delivery type (i.e., point of care, referral)
  - Primary health care services,
  - Low-barrier SUD treatment services,
  - Infectious disease services, including prevention, testing, and treatment services,
  - Mental healthcare services,
  - Harm reduction services, and
  - Case management and other support services.
- Data on program administration, such as costs, staffing footprint, logistics information, etc.

Recipients will also be required to report to SAMHSA on a semi-annual basis on the number of harm reduction supplies (i.e., overdose reversal medications and drug testing strips), HIV test kits and viral Hepatitis test kits purchased with SAMHSA funds as well as the number of positive HIV and viral Hepatitis tests.

Recipients will also be required to provide data on referrals and linkages to follow-up care. When necessary, recipients will be expected to work with providers with whom they have linkages/partnerships or to whom they make referrals in order to gather this data.

Data are to be submitted on a semi-annual basis (at six months and twelve months of each budget year) within 30 days of the end of each reporting period.

The data you collect allows SAMHSA to report on key outcome measures. Performance measures are also used to show how programs reduce disparities in behavioral health access, increase client retention, expand service use, and improve outcomes. 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.)

In addition, one key part of the performance assessment is determining if your project has or will have the intended impact on behavioral health disparities. You will be expected to collect data to evaluate whether the disparities you identified in your Disparity Impact Statement (DIS) are being effectively addressed.

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.<sup>13</sup> These are part of SAMHSA's core principles, as documented in our strategic plan.

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<sup>13</sup> "[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.

**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;
- *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.

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.

### *Behavioral Health Disparities*

If your application is funded, you must submit a Behavioral Health DIS no later than 60 days after award. See [Section G of the Application Guide](#). Progress and evaluation of DIS activities must be reported in annual progress reports (see [Section VI.3 Reporting Requirements](#)).

The DIS is a data-driven, quality improvement approach to advance equity for all. It is used to identify underserved and historically under-resourced populations at the highest risk for experiencing behavioral health disparities. The purpose of the DIS is to create greater inclusion of underserved populations in SAMHSA's grants.

The DIS aligns with the expectations related to [Executive Order 13985](#).

### *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 and, in some circumstances, 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 first collaborative National Tribal Behavioral Health Agenda (TBHA). Tribal applicants are encouraged to briefly cite the applicable TBHA foundational element(s), priority(ies), and strategies that are addressed by their application. The TBHA can be accessed [here](#). Tribal applicants are encouraged to refer to The Indigenous HIV/AIDS Syndemic Strategy, Weaving Together the National HIV, STI, and Viral Hepatitis Plans, which was released in November 2022 and can be found [here](#). Applicants may also refer to the Tribal Opioid Response Strategic Agenda: Healing Our Nations Together, developed by NIHB and Northwest Portland Area Indian Health Board (NPAIHB), alongside tribal policymakers, national experts, service providers, and community members, which can be found [here](#).

### *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, 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 virtual recipient meetings and expects you to fully participate in these meetings. If SAMHSA elects to hold an in-person meeting, budget revisions may be permitted.

## **II. FEDERAL AWARD INFORMATION**

### **1. GENERAL INFORMATION**

<b>Funding Mechanism:</b>	Cooperative Agreement
<b>Estimated Total Available Funding:</b>	Up to \$2,600,000
<b>Estimated Number of Awards:</b>	Up to 4
<b>Estimated Award Amount:</b>	\$650,000 per year, inclusive of indirect costs
<b>Length of Project Period:</b>	Up to 3 years
<b>Anticipated Start Date</b>	No later than September 30, 2024

**Your annual budget cannot be more than \$650,000 in total costs (direct and indirect) in any year of the project.** 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.

### **2. COOPERATIVE AGREEMENT REQUIREMENTS**

These awards are being made as cooperative agreements because they require substantial post-award federal programmatic participation in the oversight of the project. Under this cooperative agreement, the roles and responsibilities of recipients and SAMHSA staff are:

#### Role of Recipient:

The Recipient must:

- 1) Comply with terms and conditions of the cooperative agreement award, and
- 2) Collaborate with SAMHSA staff in project implementation and monitoring.



In addition, the recipient must (list):

- 1) Comply with the terms of the MAI: Portable Clinical Care Pilot Project, including implementation of all required activities.
- 2) Provide SAMHSA with all required performance data.
- 3) Submit all required forms, data, and reports on a timely basis.
- 4) Participate in monthly/bi-monthly/quarterly conference calls with the Government Project Officer (GPO) and other SAMHSA staff as appropriate.
- 5) Review progress toward meeting goals and objectives of the program. If program shows persistent and substandard performance, the Project Director will work with the GPO to develop a Collaborative Action Plan (CAP). By developing a CAP, the recipient communicates to the GPO an awareness of substandard performance, an intent to improve, and a process for improving.

#### Role of SAMHSA Staff:

The Government Project Officer (GPO) handles programmatic monitoring, including regular calls that may involve the Grants Management Specialist (GMS), and site visits. The GPO will work with you on implementing program and evaluation activities and will make recommendations about program continuance. Your GPO will also oversee the publication of any project results and packaging and dissemination of products and materials to make the findings available to the field. SAMHSA staff will:

- 1) Conduct monthly/bi-monthly/quarterly conference calls with recipient to provide guidance and make recommendations for technical assistance as appropriate.
- 2) Maintain regular communication with recipients throughout program implementation during routine conference calls.
- 3) Review and approve all key personnel.
- 4) Review and approve performance data and progress reports.
- 5) Ongoing review of recipient progress toward meeting goals and objectives of the program, as well as other performance indicators. If recipient shows persistent and substandard performance, work with Project Director to develop a Collaborative Action Plan (CAP), which is a requirement for the recipient to develop and implement a plan to improve performance. If performance does not improve, the GPO may take further action.
- 6) If indicated, provide technical assistance with selection of evidence-based/culturally responsive and/or evidence-informed substance use and HIV interventions.
- 7) Direct the recipients to the Addiction Technology Transfer Center (ATTC) for technical assistance as appropriate.

The GMS is responsible for all business management aspects of negotiation, award, and financial and administrative aspects of the cooperative agreement. The GMS uses information from site visits, reviews of expenditure and audit reports, and other appropriate means to ensure the project operates in compliance with all applicable federal laws, regulations, guidelines, and the terms and conditions of award.

### III. ELIGIBILITY INFORMATION

#### 1. ELIGIBLE APPLICANTS

Eligible applicants are states and territories (Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), including the District of Columbia, political subdivisions of states, Indian tribes, or tribal organizations (as such terms are defined in [section 5304 of title 25](#)), health facilities, or programs operated by or in accordance with a contract or award with the Indian Health Service, or other public or private non-profit entities, including faith-based organizations.

All non-profit entities must provide documentation of their non-profit status in **Attachment 8** of your 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. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the award requirements.

A Urban Indian Organization (UIO) means a nonprofit corporate body situated in an urban center, governed by an urban Indian-controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in [section 1653\(a\)](#) of this title.

Recipients who received funding in FY23 under the Portable Clinical Care Pilot Project NOFO (TI-23-024) are not eligible to apply. Applicants providing services in the following cities: San Francisco, California, Los Angeles, California, and Phoenix, Arizona, which were funded under the FY23 Portable Clinical Care Pilot Project NOFO TI-23-024, are also not eligible to apply.

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

- An organization may submit more than one application; however, each application must focus on a different population of focus or a different geographic/catchment area(s).

- One (1) award will be made to an applicant providing services in a rural area, pending sufficient application volume. To be eligible for this set-aside, applicants must submit information certifying that their project will be implemented in a rural area. In addition, they must submit a list of counties in which their project will be implemented. See instructions for required documentation in **Attachment 9**.
- SAMHSA's goal is to pilot this program in different and distinct geographic areas where the number of people experiencing unsheltered homelessness is high; therefore, if more than one application is received from an eligible entity serving the same geographic catchment area, only the highest scoring application serving that geographic area will be considered for funding.

## 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 to people experiencing homelessness as well as experience providing some or all of the following services: substance use disorder treatment, substance use prevention, mental health, behavioral health—which includes both mental health and substance use 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.
  - Applicants are required to demonstrate with supportive data that they have provided services to people experiencing homelessness, particularly individuals from medically underserved racial and ethnic groups, for a minimum of 2 consecutive years immediately prior to the submission of their application.
2. Each service provider organization (which must include the applicant, as well as any partners) must have a minimum of two consecutive years of experience immediately prior to the submission of their application providing relevant services to people experiencing unsheltered homelessness. Official documents must establish that the organization has provided relevant services for the last

two years immediately prior to the submission of their application. This requirement must be met by the applicant organization.

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 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: 9/29/2027.
  - 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 you are requesting funds for three years in total, enter the requested budget amount for each budget period in columns b and c (i.e., two 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 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. Identification of at least one experienced, credentialed mental health treatment, substance use prevention, substance use disorder treatment, or recovery support provider organization.
2. 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.
3. 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).
4. Statement of Certification—You must provide a written statement certifying that all partnering 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**  
Review information in [Section IV.6](#) and see [Section I](#) of the *Application Guide (Intergovernmental Review)* for detailed information on E.O. 12372 requirements to determine if this applies.
- **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: Documentation of Non-profit Status**  
**Proof of non-profit status must be submitted by private non-profit organizations. Any of the following is acceptable evidence of non-profit status:**
  - A reference to the applicant organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations as described in section 501(c)(3) of the IRS Code.
  - A copy of a current and valid Internal Revenue Service tax exemption certificate.

- A statement from a State taxing body, State Attorney General, or other appropriate state official certifying the applicant organization has non-profit status.
  - A certified copy of the applicant organization's certificate of incorporation or similar document that establishes non-profit status.
  - Any of the above proof for a state or national parent organization and a statement signed by the parent organization that the applicant organization is a local non-profit affiliate.
- **Attachment 9: Statement of Certification (if applicable)**
- One award will be made to applicants that will provide services to individuals experiencing unsheltered homelessness in a rural area. To be eligible, applicants must submit information certifying that their project will be implemented in a rural area, the rural counties they will serve and the estimated number of people experiencing unsheltered homelessness in that area. Applicants that do not submit information certifying that their project will be implemented in a rural area will NOT be considered for this set-aside, even if your project will be implemented in areas that otherwise would qualify. For the purposes of this NOFO, rural area is a county which<sup>14</sup>:
    - (1) Has no part of it within an area designated as a standard metropolitan statistical area by the Office of Management and Budget; or
    - (2) Is within an area designated as a metropolitan statistical area or considered as part of a metropolitan statistical area and at least 75 percent of its population is local on U.S. Census blocks classified as non-urban; or
    - (3) is located in a state that has a population density of less than 30 persons per square mile (as reported in the most recent decennial census), and of which at least 1.25 percent of the total acreage of such State is under Federal jurisdiction, provided that no metropolitan city in such State is the sole beneficiary of the grant amounts awarded under this NOFO. A metropolitan city means a city that was classified as a metropolitan city under section 102(a) of the Housing and Community Development Act of 1974 (42 U.S.C. 5302(a)) for the fiscal year immediately preceding the fiscal year for which Emergency Solutions Grants program funds are made available.
- **Attachment 10: 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.

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<sup>14</sup> Source: HUD [Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness](#)



- **Attachment 11: Contingency Management Statement of Certification**  
If you plan to implement contingency management with Portable Clinical Care Pilot Project 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 A](#) 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 8, 2024.** If you are submitting more than one application, the project title should be different for each application.

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 for individuals receiving SAMHSA funded mental and/or substance use disorder treatment services, not to exceed \$10.00 per person per day.<sup>15</sup>
- Funding may be used to link clients to available housing resources, including recovery housing, but funds from this grant may not be used to pay for housing.
- A vehicle may be required for the portable clinical care team to reach the population of focus and to transport supplies or provide the required transportation (I.e., pick up and drop off) for those requiring services that cannot be provided on-site by the portable clinical care outreach team.
  - Vehicle purchases are allowable with the agency's prior approval. When approved, vehicles must be purchased within the grant's first year to ensure the grant receives a benefit. Also, when purchased with grant funds, organizations must remove vehicle depreciation from their federally approved indirect cost rates or de minimis rate in order to avoid a double recovery.
  - Due to the pilot nature of this grant program, the purchase, lease, or use of a mobile medical clinic with ensuite medical facilities to provide grant services is not an allowable expense, but rather, partnerships can be formed with other organizations including portable medical clinics capable of providing specialized medical care via ensuite medical facilities (i.e., mammograms, dental care, showers, etc.).
- Funds may be used to pay for Food and Drug Administration (FDA) approved medications for the treatment of SUDs (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium, etc.) as part of a comprehensive treatment plan when the client has no other source of funds to do so.

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<sup>15</sup> *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.*

- SAMHSA should be the payer-of-last resort for FDA-approved medications, as well as for harm reduction supplies, such as support for overdose reversal, including the purchase of naloxone kits, substance test kits, including test strips for fentanyl and other synthetic drugs.
- 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 amount may be subject to change.**

- Grant funds may not be used for the purchase of pipes/pipettes, syringes for the prevention and control of infectious diseases, or other drug paraphernalia. However, other supplies related to harm reduction<sup>16</sup> are an allowable expense, such as:
  - Medication lock boxes;
  - FDA-approved overdose reversal medication (nasal and intramuscular formulations permitted, including higher dosage formulations as approved by FDA);
  - Sharps disposal and medication disposal kits;
  - Substance test kits, including test strips for xylazine, fentanyl and other synthetic drugs; and
  - Wound care management supplies (e.g., gloves, bandages, irrigation, dressings, gauze and antibiotics, etc.);
  - Distribution of syringes to prevent the spread of infectious disease;

***NOTE: Funds cannot be used to purchase syringes to prevent and control the spread of infectious disease. Funds may be used to purchase syringes to administer intramuscular naloxone.***
- Grant funds may not be used to purchase medications for the treatment of HIV; viral hepatitis treatment; Mpox testing, vaccination, or treatment; PrEP or PEP.
- Funds may be used to purchase generic psychotropic/psychiatric medication or for infectious disease testing, vaccination, and treatment resources, including purchase and administration (Note that SAMHSA grant funds are the payer-of-last resort):

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<sup>16</sup> See SAMHSA's [harm reduction](#) website and SAMHSA's [Harm Reduction Framework](#).

- Over-the-counter medications (i.e., antacids, ibuprofen, antibacterial ointments, etc.);
- Purchase of test kits for infectious diseases including HIV, viral hepatitis, STI's, and tuberculosis, and other required supplies (e.g., gloves, biohazardous waste containers, etc.);
- HIV preliminary and confirmatory testing, including HIV self-test kits;
- Viral Hepatitis B and C (antibody and confirmatory) testing;
- Viral Hepatitis A and B vaccination.
- STI testing and treatment (chlamydia, gonorrhea, and syphilis);
- Tuberculosis testing and treatment;
- Human papillomavirus (HPV) vaccination;
- Generic antibiotics for the treatment of infection;
- Generic psychotropic/psychiatric medication, to be used in a gap filling capacity whilst clients in need receives Medicaid or other coverage. Psychiatric medication purchased using grant funds may not be used to provide maintenance medication for clients.
- NOTE: Dispensing medication other than those purchased by the grant as prescribed by a licensed medical prescriber is allowable.

**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 (20 points–  
approximately 1 page)**

1. Identify and describe your population of focus, which must include exclusively people experiencing unsheltered homelessness, that your program will serve and the geographic catchment area where you will deliver services. The geographic catchment area you describe must align with meeting people experiencing unsheltered homelessness where they are (i.e., in encampments, parks, under bridges, etc.).
2. 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.
3. 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 people experiencing unsheltered homelessness and the syndemic of HIV, substance use disorder, and mental illness (i.e., current prevalence rates or incidence data) for people experiencing unsheltered homelessness 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	Total

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 **3** 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, Program Coordinator, and Project Evaluator) 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 (10 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.
- Three (3) awards will be made to applicants providing services in non-rural areas and one (1) award will be made to an applicant providing services in a rural area pending sufficient application volume.
- Recipients who received funding in FY23 under the Portable Clinical Care Pilot Project NOFO (TI-23-024) are not eligible to apply. Applicants serving in the following cities: San Francisco, California, Los Angeles, California, and Phoenix, Arizona, which were funded under the FY23 Portable Clinical Care Pilot Project NOFO TI-23-024, are also not eligible to apply.
- SAMHSA's goal is to pilot this program in different and distinct geographic areas where the number of people experiencing unsheltered homelessness is especially high. Therefore, if more than one application is received from an eligible entity serving the same catchment geographic area, only the highest scoring application serving that geographic area will be considered for funding.
- SAMHSA may select awards for funding that best reach underserved communities and/or populations.
- 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**

You will be required to submit a programmatic progress report semi-annually (at six months and twelve months of the reporting period). The semi-annual report will be due within 30 days of the end of the second quarter and the annual report will be due within 30 days of the end of the 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.

- Progress and efforts made to achieve the goal(s) of the DIS, including qualitative and quantitative data and any updates, changes, or adjustments as part of a quality improvement plan.

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:

Kirk E. James, MD  
Center for Substance Abuse Treatment  
Substance Abuse and Mental Health Services Administration  
(240) 276-1617  
[TCE-HIV@samhsa.hhs.gov](mailto:TCE-HIV@samhsa.hhs.gov)

Kristin Roha, MS, MPH  
Center for Substance Abuse Treatment  
Substance Abuse and Mental Health Services Administration  
(240) 276-0586  
[TCE-HIV@samhsa.hhs.gov](mailto:TCE-HIV@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](mailto:FOACSAT@samhsa.hhs.gov)

For review process and application status questions, contact:

Samantha Dock Herbster  
Office of Financial Resources, Division of Grant Review  
Substance Abuse and Mental Health Services Administration  
(240) 276-0405  
[samantha.dockherbster@samhsa.hhs.gov](mailto:samantha.dockherbster@samhsa.hhs.gov)

## **Appendix A – 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 principals 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; and,
- Duration reinforcement(s) will be 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, 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 90 days of grant award, you must submit your plan to ensure: (1) primary grant recipient staff and sub-awardee(s), if applicable, receive appropriate education on contingency management prior to implementation; and (2) oversight of contingency management implementation and operation for primary grant recipient staff and sub-awardee(s), if applicable.

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.