Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

PPHF- 2014 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (PPHF-2014)

(Short Title: State/Tribal Youth Suicide Prevention Cooperative Agreements)

(Initial Announcement)

Request for Applications (RFA) No. SM-14-008

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

Key Dates:

Application Deadline	**Applications are due by May 19, 2014.**
Intergovernmental Review (E.O. 12372)	**Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**Applicants must send the PHSIS to appropriate state and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.**

Table of Contents

EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2014 PPHF-2014 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (Short Title: State/Tribal Youth Suicide Prevention Cooperative Agreements) (PPHF-2014). The purpose of this program is to support states and tribes (including Alaska Villages and urban Indian organizations) in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

Funding Opportunity Title:	State/Tribal Youth Suicide Prevention Grants
Funding Opportunity Number:	SM-14-008
Due Date for Applications:	May 19, 2014
Anticipated Total Available Funding:	$17,707,000
Estimated Number of Awards:	24
Estimated Award Amount:	Up to $736,000 per year
Cost Sharing/Match Required	No
Length of Project Period:	Up to 5 years
Eligible Applicants:	Eligible applicants are states, federally recognized tribes/tribal organizations and private/non-profit organizations designated by the state and/or tribe/tribal organization. See Section III-1 of this RFA for complete eligibility information.

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) PPHF- 2014 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (Short Title: State/Tribal Youth Suicide Prevention Cooperative Agreements) (PPHF-2014). The purpose of this program is to support states and tribes (including Alaska Villages and urban Indian organizations) in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

As a result of the State/Tribal Youth Suicide Prevention Cooperative Agreements, states, tribes, and communities will:

- Increase the number of persons in youth-serving organizations such as schools, foster care systems, and juvenile justice programs, trained to identify and refer youth at risk for suicide.
- Increase the number of clinical service providers (including those working in health, mental health, and substance abuse) trained to assess, manage, and treat youth at risk for suicide.
- Improve continuity of care and follow-up of youth identified at risk for suicide discharged from emergency department and inpatient psychiatric units.
- Increase the identification of risk, referral and utilization of behavioral health care services.
- Increase the promotion and utilization of the National Suicide Prevention Lifeline.
- Comprehensively implement applicable sections of the 2012 *National Strategy for Suicide Prevention* to reduce rates of suicidal ideation, suicide attempts, and suicide deaths in their communities.

SAMHSA has demonstrated that behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the nation's health. To continue to improve the delivery and financing of prevention, treatment and recovery support services, SAMHSA has identified eight Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. The State and Tribal Youth Suicide Prevention grants closely align with SAMHSA's Prevention of Substance Abuse and

Mental Illness Strategic Initiative. More information is available at the SAMHSA website: http://beta.samhsa.gov/about-us. The State/Tribal Youth Suicide Prevention Grant program will address the prevention of suicides and attempted suicides among populations at high risk, especially military families, youth, and AI/AN, as well as the expected impact on behavioral health disparities. (See Appendix J: Addressing Behavioral Health Disparities).

The Garrett Lee Smith State/Tribal Youth Suicide Prevention Grants are authorized under Section 520E of the Public Health Service Act, as amended and are financed in part by 2014 Prevention and Public Health funds (PPHF-2014). This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD.

The State/Tribal Youth Suicide Prevention Cooperative Agreements Program is one of SAMHSA's services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the 4th month of the project at the latest. SAMHSA expects grantees to work collaboratively with the Suicide Prevention Resource Center.

2. EXPECTATIONS

SAMHSA expects states and tribes are committed to making suicide prevention a core priority in statewide or tribal youth and young adult serving systems, and are paired with at least one intensive community-based effort. Efforts must include linkage with behavioral health care programs/systems committed to making suicide prevention a core priority through implementation of Goals 8 and 9 of the 2012 National Strategy for Suicide Prevention.

In addition, SAMHSA also expects applicants to address the needs of youth at high-risk identified by the National Action Alliance for Suicide Prevention (NAASP) and utilize materials from applicable NAASP Task Forces; populations include, but are not limited to LGBTQ youth, American Indians and Alaska Natives (AI/AN), youth in contact with juvenile justice, military family members, and veterans. Other high-risk groups might include Latina youth, older adults, individuals with disabilities, survivors of suicide attempts and of suicide loss, youth involved in the juvenile justice system, and youth with serious mental illness. Applicants are also expected to consider to what degree their proposed activities can coordinate with other streams of prevention funding/programs (such as substance abuse prevention, violence prevention, etc.) in the community as well as with current SAMHSA suicide prevention-funded university campuses in the state/tribe. Grantees are encouraged to visit http://www.findyouthinfo.gov to locate potential program partners.

You must use SAMHSA's services grant funds primarily to support allowable direct services. This includes the following types of activities:

- Providing outreach and other engagement strategies to increase participation in, and access to, treatment or prevention services for diverse populations. If you are proposing to provide only outreach and other strategies to increase access, you must show that there are treatment services available and your organization has the ability to connect individuals with those services.

- Providing direct treatment (including screening, assessment, and care management) or prevention services for diverse populations at risk. Treatment services must be provided in outpatient, day treatment (including outreach-based services) or intensive outpatient, or residential programs.

- Providing "wrap-around"/recovery support services (e.g., child care, vocational, educational, and transportation services) designed to improve access and retention. [Note: Grant funds may be used to purchase such services from another provider.]

- Provide and implement system-wide suicide prevention training in schools, educational institutions, juvenile justice systems**,** substance abuse programs, primary care, mental health programs, foster care systems, and other child and youth support organizations. All training must be evidence-based or a promising practice.

- Develop and implement state-sponsored statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems**,** substance abuse programs, primary care, mental health programs, foster care systems, and other child and youth support organizations. Support public and private nonprofit organizations actively involved in the development and continuation of state-sponsored statewide or tribal youth suicide early intervention and prevention strategies.

- Provide support to institutions of higher education to coordinate or implement state-sponsored youth suicide early intervention and prevention strategies.

- Collect and analyze data on state-sponsored statewide or tribal youth suicide early intervention and prevention services that can be used to monitor the effectiveness of such services and to advance research, technical assistance, and policy development. Assist eligible entities, through state-sponsored statewide or tribal youth suicide early intervention and prevention strategies, to achieve targets for youth suicide reductions under Title V of the Social Security Act

- Conduct and/or monitor local surveillance on non-lethal suicide attempts and deaths by suicide.

- Provide a plan for assuring that suicide prevention activities within youth-serving systems are sustained post-grant cycle.

- Incorporate suicide prevention activities across the entire 10-24 age range set by statue, including efforts to reduce risk factors and prevent youth from becoming suicidal; activities that identify, refer, and monitor youth with suicide ideation; and the provision of intervention and follow-up with youth who have made suicide attempts.
- Form or participate in an existing public/private coalition of youth-serving institutions and agencies, which advises, participates in, and supports grant activities. Membership should include schools and other educational institutions, foster care systems, juvenile justice systems, childcare systems, health, mental health and substance abuse agencies, and other child- and youth-supporting organizations, youth, and suicide loss and suicide attempt survivors.
- Grrantees and sub-recipients of grant funds shall obtain prior written, informed voluntary consent from each child's parent or legal guardian for assessment services, school sponsored programs and treatment involving medication related to youth suicide conducted in elementary and secondary schools except:
    - In an emergency, where it is necessary to protect the immediate health and safety of the student or other students, or
    - In other instances, as defined by the state or tribe, where parental consent cannot be reasonably obtained.

    Note: These requirements do not supersede section 444 of the General Education Provisions Act, including the requirement of prior voluntary parental consent for the disclosure of any educational records. These requirements also do not modify or affect parental notification requirements for programs authorized under the Elementary or Secondary Education Act of 1965 (as amended by the No Child Left Behind Act of 2001).
- Suicide assessment, early intervention, and treatment services may not be provided for youth whose parents or legal guardians object based on their religious beliefs or moral objections.
- School personnel may not require that a student obtain any medication as a condition of attending school or receiving services.

Applicants must meet the following requirements:

- At least 85 percent of grant funds must be used for direct services, of which at least 5 percent must be given to institutions of higher learning to coordinate suicide prevention efforts among campuses across the state, or to implement, or evaluate youth suicide early intervention or prevention strategies.

- Are required to submit and follow a statewide or tribal suicide prevention plan submitted in Attachment 4 of your application. This suicide prevention plan should incorporate the 2012 *National Strategy for Suicide Prevention* (available online at http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/.

- Grant-funded initiatives do not have to be proposed for every locality in a state or tribe. Some applicants may develop programs that do address every locality, but others may choose to focus on specific geographical areas or populations. Those who do the latter must target areas, regions, or populations with rates of youth suicide attempts or suicide that exceed the national average as determined by the Centers for Disease Control and Prevention surveillance systems. In providing assistance to entities within the state, grantees must give preference to public organizations, private nonprofit organizations, political subdivisions, institutions of higher education, and tribal organizations actively involved with the state-sponsored statewide or tribal youth suicide early intervention and prevention strategy that:

    - Provide early intervention and assessment services to youth who are at risk for mental or emotional disorders, substance abuse disorders, and co-occurring mental and substance abuse disorders that may lead to suicide or a suicide attempt, and that are integrated with school systems, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems and other child and youth support organizations.
    - Demonstrate collaboration among early intervention and prevention services or certify that the grantee will engage in future collaboration.
    - Employ or include a commitment to evaluate youth suicide early intervention and prevention practices and strategies adapted to the local community.
    - Provide timely referrals and decrease wait time over the course of the grant for appropriate community mental health care and treatment to youth who are at risk for suicide or suicide attempts.

- Provide immediate support and information resources to families of youth who are at risk for suicide, such as families of youth who have attempted suicide.
- Offer access to services and care to youth with diverse linguistic and cultural backgrounds.
- Offer appropriate intervention services, care, and information to families, friends, schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems, and other child and youth support organizations of youth who recently died by suicide.
- Ensure that educators, foster care, juvenile justice, childcare professionals and community care providers are properly trained to effectively identify youth who are at risk for suicide.
- Provide ongoing training for those individuals on effective youth suicide early intervention and prevention services, practices, and strategies. Ensure that health, mental health, and substance abuse professionals are properly trained on an ongoing basis to effectively identify, assess, and manage youth who are at risk for suicide.
- Ensure that training and public awareness campaigns are up to date, connected to action items (e.g., what to do if you are worried about a friend) and part of a more comprehensive suicide prevention plan.

Applicants who screen for suicide risk must screen and assess youth for the presence of co-occurring substance use (abuse and dependence) and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

Serious mental illness is a significant risk factor for suicide. More than 60% of suicide deaths occur among individuals with mood disorders, particularly among those suffering with bipolar disorders or acute episodes of major depression. (NSSP, 2012). Almost 5% of those diagnosed with schizophrenia will die by suicide during their lifetimes, usually near the onset of their illness (2005). [1]

Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors to suicide. State/Tribal Suicide Prevention applicants are

---

[1] The lifetime risk of suicide in schizophrenia: a reexamination. Palmer BA, Pankratz VS, Bostwick JM. Arch Gen Psychiatry, 2005 Mar;62(3):247-53.

encouraged to target improved access to suicide prevention services for young persons who are either at risk for serious mental illness, are experiencing their first episode of psychosis, or have received a diagnosis of schizophrenia or a psychotic mood disorder.

Applicants must comprehensively implement strategies from applicable sections of the 2012 *National Strategy for Suicide Prevention*. Applicants are required to implement the following activities:

- Utilize timely surveillance data of youth suicide deaths and non-fatal suicide attempts at both the start of their grant to target efforts, during the grant to modify their efforts as needed, and at the end of their grant to demonstrate the impact of their grant activities.
- Require crisis response plans to be developed/adjusted, implemented, and monitored within systems receiving grant funding.
- Link specifically with emergency departments and inpatient psychiatric units to ensure continuity of care and follow-up of youth identified at risk for suicide.
- Incorporate efforts to reduce access to lethal means among youth with identified suicide risk.
- Provide a protocol for response to suicide clusters.
- Ensure that all public awareness initiatives, including social media outreach and awareness efforts, are tied to the grantee's larger strategic plan, with a specific target audience and a specific goal. Communication campaigns should contain messages that are action-oriented and must be grounded in the concepts of safe messaging. (See "Safe and Effective Messaging for Suicide Prevention" at http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf).
- Involve youth though mechanisms such as Youth Councils to encourage their input and feedback.
- Encourage the involvement, input of, and feedback from suicide loss and suicide attempt survivors.
- Utilize feedback and involvement from suicide loss and suicide attempt survivors.
- Utilize appropriate materials targeting specific populations produced by National Action Alliance for Suicide Prevention Task Forces (e.g., Clinical Workforce Preparedness, and Youth in Contact with the Juvenile Justice System).
- With adequate justification, applicants may elect to implement strategies from additional sections of the 2012 *National Strategy for Suicide Prevention* as relevant to youth suicide prevention in your area.

Grantees must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are ineligible for public or commercial health insurance programs, individuals for whom

coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Grantees are also expected to facilitate the health insurance application and enrollment process for eligible uninsured youth. Grantees should also consider other systems from which a potential service recipient may be eligible for services (for example, the Department of Veterans Affairs), if appropriate for and desired by that individual to meet his/her needs. In addition, grantees are required to implement policies and procedures that ensure other sources of funding are secured first when available for that individual.
Recovery from mental disorders and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition is intended to advance recovery opportunities for all Americans, particularly in the context of health reform, and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition is to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition and principles of recovery into their programs to the greatest extent possible.

Over 2 million men and women have been deployed to serve in support of overseas contingency operations, including Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. Individuals returning from Iraq and Afghanistan are at increased risk for suffering post-traumatic stress and other related disorders. Experts estimate that up to one-third of returning veterans will need mental health and/or substance abuse treatment and related services. In addition, the family members of returning veterans have an increased need for related support services. To address these concerns, SAMHSA strongly encourages all applicants to consider the unique needs of returning veterans and their families in developing their proposed project and consider prioritizing this population for services where appropriate.

The Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act place strong emphasis on the widespread adoption

and implementation of electronic health record (EHR) technology. Accordingly, all SAMHSA grantees who provide services to individuals are encouraged to demonstrate ongoing clinical use of a certified electronic health record (EHR) system in each year of their SAMHSA grant. A certified EHR is an electronic health record system that has been tested and certified by an approved Office of National Coordinator's (ONC) certifying body.

In Section F: Electronic Health Record Technology (EHR), of the Project Narrative, applicants are asked either to:

- Indicate that this section is not-applicable if no clinical services will be provided through these grant funds.
- Identify the certified, EHR system that you, or the primary provider of clinical services associated with the grant (i.e., the grantee, sub-awardee or sub-contractor that is expected to deliver clinical services to the most patients during the term of the grant), have adopted to manage client-level clinical information (include a copy of your signed, executed EHR vendor contract in Attachment 6 of your application); ***or***
- Describe the plan for the primary provider of clinical services to acquire a certified EHR system. This plan should include staffing, training, budget requirements and a timeline for implementation. Alternatively, if you have an EHR system that is not currently certified by an ONC approved certifying body, you may include a letter of commitment from your vendor and associated plan to achieve certification. This should include a timeline.
- The EHR must explicitly include suicide prevention.

For more information and resources on EHRs, see Appendix K.

This activity is considered infrastructure development; not more than 15% of the total grant award may be used for infrastructure development activities.

If your application is funded, you will be expected to develop a health disparities impact statement. This statement consists of three parts: (1) proposed number of individuals to be served by subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to health disparities; (2) proposed quality improvement plan to decrease the differences in **access, service use** and **outcomes** among those subpopulations; and (3) the quality improvement plan should include alignment with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (See Appendix J: Addressing Behavioral Health Disparities.)

In Section G: Applicants are to provide a State or Tribal Suicide Prevention Plan.

In Section H: Applicants are to provide a recent Community Readiness Assessment. The Community Readiness Model provides communities, organizations, and social

networks with the stages of readiness for the development of appropriate strategies that are more successful and cost effective. The Model has nine stages of readiness, and it measures six dimensions (or aspects) of a community. Each dimension has a stage of readiness associated with it, and each readiness stage has specific interventions that work most effectively for that stage. Culture is integrated into the prevention process. Over the past 18 years, the Community Readiness Model has been used in more than 2,500 communities to prevent suicide, substance abuse, intimate partner violence, and other problems.

It is well known that the effects of substance abuse are cumulative, and contribute significantly to costly social, physical, mental, and public health problems and issues. These include: teenage pregnancy; HIV/AIDS; other sexually transmitted diseases (STDs); domestic violence; child abuse; motor vehicle crashes; physical fights; homicide; and suicide. National Survey on Drug Use and Health data also indicate that individuals who experience mental illness or use illegal drugs have higher suicide attempts and suicide death rates.

Grantees are encouraged to consider these substance abuse-related effects carefully as they: 1) assess the demographics and problems in their particular high need communities; and 2) plan together with these communities to implement effective strategies to address their problems. Grantees will be required to work with youth substance abuse prevention and substance abuse treatment programs.

SAMHSA strongly encourages all grantees to provide a tobacco-free workplace and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

2.1 Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An evidence-based practice (EBP) refers to approaches to prevention or treatment that are validated by some form of documented research evidence. In Section B of your project narrative, you will need to:

- Identify the evidence-based practice(s) you propose to implement for the specific population(s) of focus.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective for the specific population(s) of focus.
- If you are proposing to use more than one evidence-based practice, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.

- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus.

[Note: Please see Appendix F, Funding Restrictions, regarding allowable costs for EBPs.]

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See Appendix C for additional information about using EBPs.

2.2 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report performance data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your ability to collect and report the required data in "Section E: Data Collection and Performance Measurement" of your application. Grantees will be required to report performance on the following performance measures quarterly:

- The number of people in the mental health and related workforce training in specific mental health-related practices/activities as a result of the grant.
- The number of organizations that entered in formal written inter/intra-organizational agreements (such as MOUs, MOAs, etc.) to improve mental health-related practices/activities as a result of the grant.
- The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.
- The number of individuals exposed to mental health awareness messages.
- The number of individuals who have received training in prevention or mental health promotion.
- The number of individuals screened for mental health or related interventions.
- The number of individuals referred to mental health or related services.
- The number and percentage of individuals receiving mental health or related services after referral.
- The number of policy changes completed as a result of the grant.
- The number of organizations or communities that demonstrate improved readiness to change their systems in order to implement mental health-related practices that are consistent with the goals of the grant.
- The number of organizations that regularly obtain, analyze, and use mental-health related data as a result of the grant.
- The number of communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery as a result of the grant.
- The number and percentage of work group/advisory group/council members who are consumers/family members.

- The number of individuals contacted through program outreach efforts.
- The total number of contacts made through program outreach efforts.
- The number of programs/organizations/communities that implemented specific-mental health related practices/activities that are consistent with the goals of the grant.
- The number of programs/organizations/communities that implement specific mental health related practices as a result of the grant.

This information will be gathered using the CMHS Transformation Accountability (TRAC) system, which can be found at: https://www.cmhs-gpra.samhsa.gov along with instructions for completing it. Technical assistance for the web-based data entry, fiscal and annual report generation is available. CMHS grantees will be given training and ongoing technical assistance to perform data collection requirements through a separate information technology contract. Applicants should be aware that the TRAC reporting system will migrate to the Common Data Platform (CDP) during the life of the grant.

The collection of these data will enable CMHS to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to mental health. In addition to the NOMs, data collected by grantees will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use, and outcomes nationwide. If you have an electronic health records (EHR) system to collect and manage most or all client-level clinical information, you should use the EHR to automate GPRA reporting.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

In addition to the performance measures mentioned above, grantees will also be required to utilize timely data on youth suicide deaths and non-fatal suicide attempts to measure outcomes.

2.3 Program Evaluation

Grantees are required to evaluate their projects at the local level. In addition grantees are required to submit an evaluation within 18 months of receiving a grant award, as describe in the Sec. 520E(g)(1) of the Public Health Service Act, as amended. This evaluation will address the effectiveness of the activities carried out under the grant.

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help you determine whether you are achieving the goals, objectives, and outcomes you intend to achieve and whether adjustments need to be made to your project. Performance

assessments also should be used to determine whether your project is having /will have the intended impact on behavioral health disparities. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

In developing their local evaluation plans, grantees may wish to consider outcome and process questions such as the following:

Outcome Questions

- What were the effects of the interventions on participants?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/sexual identity (sexual orientation/gender identity)?
- How durable were the effects?
- How sustainable were the activities?

Process Questions

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What types of changes were made to address disparities in access, services, use, and outcomes across subpopulations, including the use of the National CLAS Standards?
- What led to the changes in the original plan?
- What effect did the changes have on the planned interventions and capacity to achieve desired outcomes?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

National Evaluation

In addition to SAMHSA TRAC measures, grantees must collect and report findings for the Congressionally-mandated national evaluation which will be conducted under a separate SAMHSA evaluation contract. The national evaluation will focus on demonstrating the impact of the State/Tribal Suicide Prevention program on suicidal behavior among youth and young adults. Participation in the national evaluation is required, and will involve participation in either the initial national evaluation approach or a revised alternative approach. To support implementation of the national evaluation, grantees will receive training and technical assistance from the Suicide Prevention Evaluation Contractor. Applicants must state their commitment to cooperate with the Suicide Prevention Evaluation Contractor in their applications. Participation in the

national evaluation will likely entail participation in training visits, completing data reports/inventories, data entry, applying for and receiving Institutional Review Board Clearance when appropriate, respondent identification and utilizing a Web-based database developed in consultation with the contractor. Data will be collected quarterly and are to be entered into a web system created by the national evaluation contractor or included in written progress reports. SAMHSA is interested in assessing the extent to which strategies employed by the grantees are consistent with the *National Strategy for Suicide Prevention*, assessing the feasibility of implementing the NSSP in real-world settings, and determining the outcomes associated with implementation. Enhanced evaluation questions may also be required of some grantees to address these key evaluation goals.

At least 10 percent but no more than 15 percent of the total grant award may be used for data collection, performance measurement, and evaluation, e.g., activities required in Sections I-2.2 and 2.3 above.

Infrastructure Development (maximum 15 percent of total grant award)

Although services grant funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use no more than 15 percent of the total services grant award for the following types of infrastructure development, if necessary to support the direct service expansion of the grant project, such as:

- Developing partnerships with other service providers for service delivery.
- Adopting and/or enhancing your computer system, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care process, integration with related support services, and outcomes.

2.4 Grantee Meetings

Grantees must plan to send a minimum of three to five representatives (including the Project Director, evaluator, and if possible, at least one member of the program's public-private coalition) to at least one joint grantee meeting every other year of the grant program. You must include a detailed budget and narrative for this travel to the Washington, D.C. area in your budget. At these meetings, grantees will present the results of their projects and federal staff will provide technical assistance. Each meeting will be up to 3 days.

II. AWARD INFORMATION

Proposed budgets cannot exceed $736,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award. This program is financed in part by 2014 Prevention and Public Health Funds (PPHF-2014).

These awards will be made as cooperative agreements.

Cooperative Agreement

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

Role of Grantee:

The role of the grantee is to comply with the terms of the award and all cooperative agreement rules and regulations, and satisfactorily perform activities to achieve the goals described below:

- Seek SAMHSA approval for key positions to be filled. Key positions include, but are not limited to, project director and evaluation director;
- Consult with and accept guidance from SAMHSA staff on performance of programmatic and data collection activities to achieve goals of the cooperative agreement;
- Maintain ongoing communication with SAMHSA, including a minimum of one call per month, keeping federal program staff informed of emerging issues, developments, and problems, as appropriate;
- Include the GPO on policy, steering, advisory or other task forces;
- Maintain ongoing collaboration with SAMHSA's Evaluation Contractor, the Suicide Prevention Resource Center, and the National Suicide Prevention Lifeline;
- Participate in data/program performance assessment efforts explained in Section I-2.2 and I-2.3 of this RFA.

Role of SAMHSA Staff:

- Approve proposed key positions/personnel;

- Facilitate linkages to other SAMHSA/federal government resources and help grantees access appropriate technical assistance;
- Coordinate cross-site evaluation participation of grantee and staff required conference calls;
- Assure that state/tribe's youth suicide prevention and early intervention projects are responsive to SAMHSA's mission, including implementation of the 2012 *National Strategy for Suicide Prevention*;
- Promote collaboration with other SAMHSA and federal health and behavioral health initiatives, including the Community Mental Health Services and the Substance Abuse Prevention and Treatment Block Grant programs; and the National Action Alliance for Suicide Prevention; and
- Provide technical assistance on sustainability issues.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are:

- States (Including D.C. and the territories)
- Federally recognized Indian tribes, tribal organizations (as defined in the Indian Self-Determination and Educational Assistance Act), or urban Indian organizations (as defined in the Indian Health Care Improvement Act) that are actively involved in the development and continuation of a tribal youth suicide early intervention and prevention strategy
- Public or private non-profit organizations designated by a state, federally recognized Indian tribe, tribal organization, or urban Indian organization, to develop or direct the state/tribal-sponsored youth suicide prevention and early intervention strategy

No single state agency is mandated to be the lead for State/Tribal Youth Suicide Prevention Program grants, as states differ in which state agency has taken the lead for suicide prevention (e.g., Department of Health, Department of Mental Health). Where states have a plan that designates a lead agency, that agency should act as the lead or should designate an alternative lead for State/Tribal Youth Suicide Prevention Grant Program. If the state plan does not designate a lead agency, justify the selection of the lead agency for this application. Although only one agency should be the lead, inclusion of all youth-serving agencies is expected.

The statutory authority for this program prohibits grants to for-profit agencies.

States and/or tribes who have been previous recipients of the State/Tribal Youth Suicide Prevention Program award who do not currently have a grant are eligible but are required to address how this grant award will build on and/or expand the work of the earlier grant awards and not simply continue what was done previously.

The statutory authority for this program prohibits grants to for-profit agencies.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

3. OTHER

3.1 Additional Eligibility Requirements

You must comply with the following three requirements, or your application will be screened out and will not be reviewed:

1. Use of the SF-424 application form; Budget Information form SF-424A; Project/Performance Site Location(s) form; Disclosure of Lobbying Activities, if applicable; and Checklist.

2. Application submission requirements in Section IV-3 of this document; and

3. Formatting requirements provided in Appendix A of this document.

3.2 Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client (e.g., substance abuse treatment, substance abuse prevention, mental health) services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved but all providers involved must make suicide prevention a core priority;

- Each mental health/substance abuse treatment provider organization must have at least 2 years experience (as of the due date of the application) providing relevant services in the geographic area(s) in which services are to

be provided (official documents must establish that the organization has provided relevant services for the last 2 years); and

- Each mental health/substance abuse treatment provider organization must comply with all applicable local (city, county) and state licensing, accreditation, and certification requirements, as of the due date of the application.

[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license. Eligible tribes and tribal organization mental health/substance abuse treatment providers must comply with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application. See Appendix D, Statement of Assurance.]

Following application review, if your application's score is within the funding range, the GPO may contact you to request that the following documentation be sent by overnight mail, or to verify that the documentation you submitted is complete:

- A letter of commitment from every mental health/substance abuse treatment provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided. All provider organizations must agree to make suicide prevention a core priority;

- Official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which the services are to be provided; and

- Official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable local (city, county) and state requirements for licensing, accreditation, and certification; **OR** 2) official documentation from the appropriate agency of the applicable state, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist.[2]

- For tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation, and certification; **OR** 2) documentation from the tribe or other tribal

[2] Tribes and tribal organizations are exempt from these requirements.

governmental unit that licensing, accreditation, and certification requirements do not exist.

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. CONTENT AND GRANT APPLICATION SUBMISSION

You must go to both Grants.gov (http://www.Grants.gov) and the SAMHSA website (http://beta.samhsa.gov/Grants/apply.aspx) to download the required documents you will need to apply for a SAMHSA grant.

Grants.gov

How to Download Forms from Grants.gov (see Appendix B for information on applying through Grants.gov)

To view and/or download the required application forms, you must first search for the appropriate funding announcement number (called the opportunity number).

On the Grants.gov site (http://www.Grants.gov), select the Apply for Grants option from the Applicants Tab at top of the screen. Under STEP 1, click on the red button labeled: 'Download a Grant Application Package'. Enter either the Funding Opportunity Number (SAMHSA's Funding Announcement #) or the Catalogue of Federal Domestic Assistance (CFDA) Number exactly as they appear on the cover page of this RFA, then click the Download Package button. In the Instructions column, click the Download link.

You can view, print or save all of these forms. You can complete the forms for electronic submission to Grants.gov. Completed forms can also be saved and printed for your records. These required forms include:

- Application for Federal Assistance (SF-424);
- Budget Information – Non-Construction Programs (SF-424A);
- Project/Performance Site Location(s) Form;
- Disclosure of Lobbying Activities; and
- Checklist.

Applications that do not include these required forms will be screened out and will not be reviewed.

SAMHSA's Grants Website

You will find additional materials you will need to complete your application on SAMHSA's website (http://beta.samhsa.gov/Grants/apply.aspx). These include:

- Request for Applications (RFA) – Provides a description of the program, specific information about the availability of funds, and instructions for completing the grant application. This document is the RFA;
- Assurances – Non-Construction Programs;
- Certifications;
- Charitable Choice Form SMA 170;
- Pre-Application Webinar Notification; and
- A link to additional vital materials on the Suicide Prevention Resource Center's website, including
    - Information about the 2012 *National Strategy for Suicide Prevention*, including special reference to follow-up in Goal 8 (Promote suicide prevention as a core component of health care services) and Goal 9 (Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors).
    - Information from National Action Alliance for Suicide Prevention Task Forces, including information about the Zero Suicide Toolkit and Juvenile Justice materials.

See Section IV-1.1-Assurances of this RFA to determine if you are required to submit Charitable Choice Form SMA 170. If you are, you can upload this form to Grants.gov when you submit your application.

Be sure to check the SAMHSA website periodically for any updates on this program.

1.1 Required Application Components

Applications must include the following 12 required application components:

- **Application for Federal Assistance (SF-424)** – This form must be completed by applicants for all SAMHSA grants. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or

cooperative agreement from the federal government. SAMHSA applicants are required to provide their DUNS number on the first page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet website at http://www.dnb.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a federal grant application. In addition, you must be registered in the new System for Award Management (SAM). The former Central Contractor Registration (CCR) transitioned to the SAM on July 30, 2012. **SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients).** Once you update your record in SAM, it will take 48 to 72 hours to complete the validation processes. **Grants.gov will reject submissions from applicants who are not registered in SAM or those with expired SAM registrations (Entity Registrations). The DUNS number you use on your application must be registered and active in the SAM. To Create a user account, Register/Update entity and/or Search Records from CCR, go to** https://www.sam.gov.]

- **Abstract** – Your total abstract must not be longer than 35 lines. It should include the project name, population(s) to be served (demographics and clinical characteristics), strategies/interventions, project goals and measurable objectives, including the number of people to be served annually and throughout the lifetime of the project, etc. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reports to Congress, or press releases.

- **Table of Contents** – Include page numbers for each of the major sections of your application and for each attachment.

- **Budget Information Form** – Use SF-424A. Fill out Sections B, C, and E of the SF-424A. A sample budget and justification is included in Appendix H of this document**.**

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through H. Sections A-H together may not be longer than 30 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V – Application Review Information" of this document.

  The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be

provided immediately following your Project Narrative in Sections I through K. There are no page limits for these sections, except for Section J, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation." Supporting documentation should be submitted in black and white (no color).

- **Attachments 1 through 5** – Use only the attachments listed below. If your application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1 and 3 combined. There are no page limitations for Attachments 2, 4, and 5. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.

  - **Attachment 1**: (1) Identification of at least one experienced, licensed mental health/substance abuse treatment provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) letters of commitment from these direct service provider organizations; (4) the Statement of Assurance (provided in Appendix D of this announcement) signed by the authorized representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited, and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time.

  - **Attachment 2**: Data Collection Instruments/Interview Protocols – if you are using standardized data collection instruments/interview protocols, you do not need to include these in your application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or interview protocol(s) is/are not standardized, you must include a copy in Attachment 2.

  - **Attachment 3**: Sample Consent Forms

  - **Attachment 4**: A copy of the state or tribe suicide prevention plan or Community Readiness plan that incorporates the 2012 National Strategy for Suicide Prevention.

  - **Attachment 5:** A copy of the signed, executed EHR vendor contract, if you have an existing EHR system.

- **Project/Performance Site Location(s) Form** – The purpose of this form is to collect location information on the site(s) where work funded under this grant announcement will be performed. This form will be posted on SAMHSA's website with the RFA.

- **Assurances** – Non-Construction Programs. You must read the list of assurances provided on the SAMHSA website and **check the box marked 'I Agree'** before signing the first page (SF-424) of the application. You are also required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form will be posted on SAMHSA's website with the RFA and provided in the application package.

- **Certifications** – You must read the list of certifications provided on the SAMHSA website and **check the box marked 'I Agree'** before signing the first page (SF-424) of the application.

- **Disclosure of Lobbying Activities** – Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or state legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. You must sign and submit this form, if applicable.

- **Checklist** – The Checklist ensures that you have obtained the proper signatures, assurances and certifications. **You must complete the entire form**, including the top portion, "Type of Application", indicating if this is a new, noncompeting continuation, competing continuation or supplemental application, as well as Parts A through D.

- **Documentation of nonprofit status** as required in the Checklist.

1.2 Application Formatting Requirements

Please refer to Appendix A, *Checklist for Formatting Requirements and Screen-out Criteria for SAMHSA Grant Applications*, for SAMHSA's basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on May 19, 2014.

Your application must be submitted through http://www.Grants.gov**.** Please refer to Appendix B, "Guidance for Electronic Submission of Applications."

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

This grant program is covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) 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 Appendix E for additional information on these requirements as well as requirements for the Public Health Impact Statement.

4. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at http://www.samhsa.gov/grants/management.aspx.

- Educational Institutions: 2 CFR Part 220 and OMB Circular A-21
- State, Local and Indian Tribal Governments: 2 CFR Part 225 (OMB Circular A-87)
- Nonprofit Organizations: 2 CFR Part 230 (OMB Circular A-122)
- Hospitals: 45 CFR Part 74, Appendix E

In addition, SAMHSA's **State/Tribal Youth Suicide Cooperative Agreement** grant recipients must comply with the following funding restrictions:

- No more than 15 percent of the total grant award may be used for developing the infrastructure necessary for expansion of services, data collection, performance measurement and performance assessment, including incentives for participating in the required data collection follow-up.

Be sure to identify these expenses in your proposed budget.

SAMHSA grantees also must comply with SAMHSA's standard funding restrictions, which are included in Appendix F.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-H below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-H.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program.
- The Project Narrative (Sections A-H) together may be no longer than 30 pages.
- You must use the eight sections/headings listed below in developing your Project Narrative. You must place the required information in the correct section, **or it will not be considered**. Your application will be scored according to how well you address the requirements for each section of the Project Narrative.
- The Budget Justification and Supporting Documentation you provide in Sections I-K and Attachments 1-5 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.
- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Population of Focus and Statement of Need (10 points)

- With respect to the primary purpose and goals of the grant program, provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic characteristics, sexual identity (sexual orientation, gender identity) and other relevant factors, such as literacy, substance abuse, or serious mental illness.
- Discuss the relationship of your population of focus, including sub-populations, to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your provided services citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of your program and intent of the RFA.

- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data for suicide ideation, attempts, or deaths by suicide) for the population(s) of focus based on data. This statement of need should include a clearly established baseline for the project including suicide deaths and non-fatal suicide attempts among youth and young adults between 10-24 years old. Provide sufficient information on the source of the data and how the data were collected so reviewers can assess the reliability and validity of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., state needs assessments, SAMHSA's National Survey on Drug Use and Health [NSDUH]), and/or national data (e.g., NSDUH, National Center for Health Statistics/Centers for Disease Control and Prevention reports, and U.S. Census data). Examples of data sources for the qualitative data that could be used include Community Readiness Assessments performed within the previous 18 months.

- Applicants must show that needs are consistent with priorities of the tribe, tribal organization, state, or county that has primary responsibility for the service delivery system. Include a description of how your state or tribe will ensure that suicide prevention a core priority in youth/young adult-serving systems (e.g., prioritize surveillance, training, early identification, and appropriate care transitions).

- Applicants should discuss how the proposed project will address needs identified in the state or tribe's suicide prevention plan and provide a copy of the plan in **Attachment 4** of your application. The state or tribal suicide prevention plan must incorporate the 2012 *National Strategy for Suicide Prevention*.

Section B: Proposed Evidence-Based Service/Practice (20 points)

- Describe the purpose of the proposed project, including its goals and objectives. These must relate to the intent of the RFA and performance measures you identify in Section E: Data Collection and Performance Measurement.

- Describe the Evidence-Based Practice(s) (EBP) that will be used and justify its use for your population of focus, your proposed program, and the intent of this RFA. Describe how the proposed practice will address the following issues in the population(s) of focus, while retaining fidelity to the chosen practice: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual

orientation, gender identity); and disability. [See Appendix C: Using Evidence-Based Practices (EBPs).]

- Document that the EBP(s) you have chosen is (are) appropriate for the outcomes you want to achieve.

- Explain how your choice of an EBP will help you address disparities in subpopulations.

- Describe any modifications that will be made (or have already been made), the reasons the modifications are necessary, and the implications of these modifications to the fidelity of the EBP. Also describe why you believe the changes will improve program outcomes.

- If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP. Best practices that are not evidence-based, but have been judged as likely to be effective, can be found in Section 3 of the Suicide Prevention Resource Center's Best Practices Registry (BPR) (http://www.sprc.org/bpr). The BPR's Section 1 contains all suicide prevention EBPs in SAMHSA's NREPP (Section 1—programs that have produced positive outcomes related to suicide prevention). The BPR's Section 3 includes programs, practices, policies, protocols, and informational materials whose *content* is accurate and adheres to accepted standards, although effectiveness has not been demonstrated. Best practices supported by the *National Strategy for Suicide Prevention* can be found on the National Action Alliance for Suicide Prevention web site (e.g., http://zerosuicide.actionallianceforsuicideprevention.org/zero-suicide-tool-kit), http://actionallianceforsuicideprevention.org/task-force/juvenilejustice). The Suicide Prevention Center has a range of other informational materials that can assist applicants in selecting appropriate tools for their programs.

- Provide a logic model that links need, the services or practice to be implemented, and outcomes. See Appendix L for a sample logic model.

- Include a statement indicating your intention to work collaboratively with, and utilize resources from, the Suicide Prevention Resource Center and how you will partner with other prevention and/or health/wellness related programs including other State/Tribal Youth Suicide Prevention grantees or other SAMHSA grantees in your area.

- Include a statement indicating your intention to, and how you will, follow-up after discharge from an emergency department or inpatient unit after a non-fatal suicide attempt.

Section C: Proposed Implementation Approach (30 points)

- Describe the purpose of the proposed project, including a clear statement of its goals and objectives. These must relate to the performance measures you identify in Section E, Performance Assessment and Data.

- Describe how achievement of the goals will produce meaningful and relevant results for your community (e.g., increase access, availability, prevention, outreach, pre-services, treatment, and/or intervention) and support SAMHSA's goals for the program. Describe and provide a rationale for the anticipated impact the proposed project will have on your community and your ability to do the intensive community work required to make the anticipated impact.

- One of your goals must be promoting state or tribal systems-level change. Describe that system and the proposed impact, and your ability to do the intensive community work required to make the anticipated impact.

- If your state or tribe has previously been awarded a State/Tribal Suicide Prevention Grant, please describe how the new grant award will enhance but not duplicate what was started in the previous grant.

- Describe how the community(s) were selected or the process that will be used in making the selection(s).

- Describe the organizations that will be assisted through grant and how preference will be given to public organizations, private nonprofit organizations, political subdivisions, institutions of higher education, and tribal organizations that are actively involved in the state-sponsored statewide or tribal youth suicide early intervention and prevention strategy.

- Using a mix of universal, selective, and indicated prevention strategies, describe how the proposed strategies, service(s), and/or practice(s) will be implemented, and how they fit into your proposed approach. Provide a chart or graph depicting a realistic timeline for the entire project period showing key activities, milestones, and responsible staff. These key activities should include the requirements outlined in Section 1-2: Expectations. Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than 4 months after grant award. [NOTE: The

timeline should be part of the Project Narrative. It should not be placed in an attachment.]

- Describe how program components will be embedded within the existing service delivery system, including other SAMHSA-funded projects including substance abuse prevention and treatment, if applicable.

- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.

- When screening for suicide risk, describe how you will also screen and assess clients for the presence of substance abuse and serious mental illness, and how you will use the information obtained from the screening and assessment to develop appropriate treatment approaches.

- Describe how you will identify, recruit and retain the population(s) of focus. Using your knowledge of the language, beliefs, norms, values and socioeconomic factors of the population(s) of focus, discuss how the proposed approach addresses these issues in outreaching, engaging and delivering programs to this population (e.g., collaborating with community gatekeepers).

- Describe how you will ensure the input of consumers, survivors of loss, survivors of suicide attempts, youth, and families in assessing, planning, and implementing your project.

- Identify any other organization(s) that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. At least one organization must focus on substance use/abuse prevention or treatment. Include letters of commitment from these organizations in **Attachment 1** of your application.

- State the unduplicated number of individuals you propose to serve, including sub-populations, (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes. You are required to estimate the numbers to be served by race, ethnicity, gender, and sexual orientation.

- Describe your plan to continue the project after the funding period ends. Include a description of how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.

- Explain how your project will reach youth at risk for suicide or suicide attempts, such as, but not limited to AI/AN youth; Native Hawaiian and other Pacific Islander youth; Latina adolescents; justice-involved youth; youth in the foster care system; trauma survivors; youth who have abused substances; school drop outs and unemployed young people; returning veterans and their families; LGBTQ youth; youth who have already attempted suicide (and are thus at heightened risk for a further attempt or death by suicide) or have been seen in emergency departments; and youth with serious mental illness.

- Describe plans for ensuring how access to emergency care will be assured for youth identified as being at immediate risk for suicide or suicide attempts and how follow up after emergency care will be promoted.

- Describe plans for facilitating and monitoring cross-system referrals and continuity of care for youth at risk**,** including follow up of youth who have attempted suicide.

- Describe how parental consent will be obtained and family involvement promoted. The Garrett Lee Smith Memorial Act requires that states, tribes, and entities receiving funding under this Act shall obtain prior, written informed consent from the child's parent or legal guardian for assessment services, school-sponsored programs, and treatment involving medication related to youth suicide conducted in elementary and secondary schools. This requirement does not apply:

    - In an emergency, when it is necessary to protect the immediate health and safety of the student or other students; or

    - Other instances, as defined by the state, where parental consent cannot reasonably be obtained.

- Describe how you will incorporate suicide prevention activities across the entire 10-24 year statutory age range including efforts to reduce risk factors and prevent youth from becoming suicidal. These efforts may include activities that attempt to prevent youth from becoming suicidal; that identify, refer, and monitor youth with suicide ideation; and provide interventions and follow-up with youth who have made suicide attempts.

Section D: Staff and Organizational Experience (10 points)

- Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations. Demonstrate that the applicant organization and other participating organizations have linkages to the population(s) of focus and ties to grassroots/community-based

organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.

- Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications.

- Discuss how key staff have demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s).

- Discuss the experience of the applicant organization or working with public/private suicide prevention coalitions who can help advise the project and that includes youth and young adult serving organizations as described in Section I.1.

- Discuss experience or capability of the applicant organization and staff to effectively a) promote system-level change, b) perform intensive community work, c) incorporate substance abuse prevention and treatment providers, and d) follow-up with in-patient and emergency department discharges for suicide attempts.

Section E: Data Collection and Performance Measurement (15 points)

- Document your ability to collect and report on the required performance measures as specified in Section I-2.2 of this RFA. Describe your plan for data collection, management, analysis and reporting. Specify and justify any additional measures or instruments you plan to use for your grant project.

- Describe the data-driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed, and reduced.

- Describe your plan for conducting the local performance assessment as specified in Section I-2.3 of this RFA and document your ability to conduct the assessment, including the identification of data sources which can be used to assess impact on youth suicide deaths and non-fatal suicide attempts. Describe your plan for demonstrating linkages between program activities and improved outcomes.

- Document your ability to participate in the national evaluation as specified in Section I-2.3 of this RFA. Describe your plan for participation in training visits, completing data reports/inventories, data entry, applying for and receiving Institutional Review Board Clearance when appropriate, respondent identification and utilizing a web-based database developed in consultation with the Contractor. Describe your plan for data management and reporting quarterly and your ability to produce written progress reports.

Section F: Electronic Health Record (EHR) Technology (5 points)

- If no clinical services (i.e., screening and assessment, case management, outreach, crisis intervention, etc.) will be provided through these grant funds, indicate that this section is not-applicable to your proposed project. (No points will be awarded for this section.)

- If you or the primary provider of clinical services (i.e., screening and assessment, case management, outreach, crisis intervention, etc.) do not have an existing EHR system and do not plan on acquiring one, indicate that this section is not-applicable to your proposed project. (No points will be awarded for this section.)

- If you currently have an existing EHR system, identify the EHR system that you, or the primary provider of clinical services associated with the grant (i.e., the grantee, sub-awardee or sub-contractor that is expected to deliver clinical services to the most patients during the term of the grant), have adopted to manage client-level clinical information for your proposed project. Include a copy of your EHR vendor contract in **Attachment 5** of your application.

- If you or the primary provider of clinical services do not currently have an existing EHR system, describe the plan to acquire an EHR system. This plan should include staffing, training, budget requirements (including additional resources for funding), and a time line for implementation. Be sure to include these costs in your budget. Alternatively, if you have an EHR system that is not currently certified by an ONC approved certifying body; you may include a letter of commitment from your vendor and associated plan to achieve certification. This should include a time line.

- If you or the primary provider of clinical services will be utilizing or acquiring an EHR system over the course of the grant, indicate how this system will be used and/or modified to enhance suicide prevention efforts through grant activities. SAMHSA strongly recommends integrating into the EHR system suicide screening and risk assessment, ability to monitor patient progress and transition through analytics, ability to identify at-risk patients for all providers engaged in treatment with the patient, and the ability to create and share safety plans between the provider and the patient. Points will only be awarded if suicide prevention components are embedded and utilized within EHR systems. Describe in detail how your proposal will meet this criteria. Behavioral healthcare providers should be in compliance with federal confidentiality regulations including HIPPA and 42CRF Part 2.

- In order to receive these 5 points, the EHR must <u>explicitly</u> include suicide prevention.

Section G: State or Tribal Suicide Prevention Plan (5 points)

- Provide evidence or documentation that the 2012 *National Strategy for Suicide Prevention* has been used to update your state or tribal suicide prevention plans.

Section H: Community Readiness Assessment (5 points)

- Demonstrate the completion of a Community Readiness Assessment which must have been **conducted during the past 18 months** and it must have been **on the topic of suicide prevention.**

- Submit a suicide prevention Community Readiness Assessment with your application, you must include the following tools from the CRA manual:
    - Community Readiness Scoring sheet;
    - Community Readiness Assessment Graph + Stage;
    - Record of Community Strengths, Concerns and Resources;
    - Record of Community Interventions and Strategies: Action Plan.

To download the manual or for more information about the Community Readiness Assessment approach, visit the National Center for Community and Organizational Readiness at Colorado State University: http://www.nccr.colostate.edu/index.html.

NOTE: Although the budget for the proposed project is not a scored review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

Budget Justification, Existing Resources, Other Support (other federal and non-federal sources)

You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Other support is defined as funds or resources, whether federal, 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., meals, sporting events, entertainment.

Be sure to show that no more than 15 percent of the total grant award will be used for either infrastructure development or for data collection, performance measurement and performance assessment. Note that surveillance and training are considered direct prevention services. **Specifically identify the items associated with these costs in your budget**. An illustration of a budget and narrative justification is included in Appendix H, Sample Budget and Justification, of this document.

The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See Appendix B, Guidance for Electronic Submission of Applications.)

SUPPORTING DOCUMENTATION

Section I: Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

Section J: Biographical Sketches and Job Descriptions.

- Include position descriptions for the Project Director and all key personnel. Position descriptions should be no longer than 1 page each. If the person has not been hired, include a position description and/or letter of commitment with a current biographical sketch from the individual.

- For staff who have been identified, include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. Reviewers will not consider information past page 2.

- Information on what you should include in your biographical sketches and job descriptions can be found in Appendix G of this document.

Section K: Confidentiality and SAMHSA Participant Protection/Human Subjects: You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section E of your application. See Appendix I for guidelines on these requirements.

2. REVIEW AND SELECTION PROCESS

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

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers;

- when the individual award is over $150,000, approval by the Center for Mental Health Services' National Advisory Council;

- availability of funds; and

- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size.

VI. ADMINISTRATION INFORMATION

1. AWARD NOTICES

You will receive a letter from SAMHSA through postal mail that describes the general results of the review of your application, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice through postal mail, the Notice of Award (NoA), signed by SAMHSA's Grants Management Officer. The Notice of Award is the sole obligating document that allows you to receive federal funding for work on the grant project.

If you are not funded, you will receive notification from SAMHSA.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- If your application is funded, you must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA website at http://www.samhsa.gov/grants/management.aspx.

- If your application is funded, you must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA website (http://www.samhsa.gov/grants/management.aspx).

- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you prior to grant award. These may include, for example:

    - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;

    - requirements relating to additional data collection and reporting;

    - requirements relating to participation in a cross-site evaluation;

    - requirements to address problems identified in review of the application; or

    - revised budget and narrative justification.

- If your application is funded, you will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual

recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

- If your application is funded, you must comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. You may assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html.

- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a federal grant.

3. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.2, grantees must comply with the reporting requirements listed on the SAMHSA website at http://beta.samhsa.gov/grants/applying/reporting-requirements. Recipients are responsible for contacting their HHS grant/program managers for any need clarifications.

Responsibilities for Informing Sub-recipients:

- Recipients agree to separately identify to each sub-recipient and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, any special CFDA number assigned for 2014 PPHF fund purposes, and amount of PPHF funds.

Reporting Requirements under Sections 218 and 219 in the LHHS Division of the Consolidated Appropriations Act, 2014.

This award requires the recipient to complete projects or activities which are funded under the 2014 PPHF and to report on use of PPHF funds provided through this award. Information from these reports will be made available to the public.

VII. AGENCY CONTACTS

For questions about program issues contact:

Michelle Carnes, Ph.D.
Center for Mental Health Services; Division of Prevention, Traumatic Stress, and Special Programs; Suicide Prevention Branch
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 6-1074
Rockville, Maryland 20857
(240) 276-1869
michelle.carnes@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Gwendolyn Simpson
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1091
Rockville, Maryland 20857
(240) 276-1408
gwendolyn.simpson@samhsa.hhs.gov

Appendix A – Checklist for Formatting Requirements and Screen-out Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. **If you do not adhere to these requirements, your application will be screened out and returned to you without review.**

- Use the SF-424 Application form; Budget Information form SF-424A; Project/Performance Site Location(s) form; Disclosure of Lobbying Activities, if applicable; and Checklist.

- Applications must be received by the application due date and time, as detailed in Section IV-3 of this grant announcement.

- You must be registered in the System Award Management (SAM) prior to submitting your application. The DUNS number used on your application must be registered and active in the SAM prior to submitting your application.

- Information provided must be sufficient for review.

- Text must be legible. Pages must be typed in black, single-spaced, using a font of Times New Roman 12, with all margins (left, right, top, bottom) at least one inch each. **You may use Times New Roman 10 only for charts or tables**. (See additional requirements in Appendix B, "Guidance for Electronic Submission of Applications.")

- To ensure equity among applications, page limits for the Project Narrative cannot be exceeded.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- Applications should comply with the following requirements:

    - Provisions relating to confidentiality and participant protection/human subjects specified in Appendix I of this announcement

    - Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement

- Documentation of nonprofit status as required in the Checklist.

- Black print should be used throughout your application, including charts and graphs (no color). **Materials with printing on both sides will be excluded from the application and not sent to peer reviewers.**

- Pages should be numbered consecutively from beginning to end so that information can be located easily during review of the application. The abstract page should be page 1, the table of contents should be page 2, etc. The four pages of the SF-424 are not to be numbered. Attachments should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- The page limits for Attachments stated in Section IV-2.2 of this announcement should not be exceeded.

Appendix B – Guidance for Electronic Submission of Applications

SAMHSA discretionary grant applications must be submitted electronically through Grants.gov. **SAMHSA will not accept paper applications**, except when a waiver of this requirement is approved by SAMHSA. The process for applying for a waiver is described later in this appendix.

If this is the first time you have submitted an application through Grants.gov, you must complete **three separate registration processes** before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are:

1. DUNS Number registration:

   The DUNS number you use on your application must be registered and active in the SAM.

2. System for Award Management (SAM) registration:

   The **System for Award Management** (SAM) is a federal government owned and operated free website that replaces capabilities of the former Central Contractor Registry (CCR) system, as well as EPLS. Future phases of SAM will add the capabilities of other systems used in federal awards processes.

   SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). Once you update your record in SAM, it will take 48 to 72 hours to complete the validation processes. **Grants.gov will reject electronic submissions from applicants with expired registrations. To Create a user account, Register/Update entity and/or Search Records from CCR, go to** https://www.sam.gov.

   You will find a ***Quick Start Guide for Entities Interested in Being Eligible for Grants through SAM*** *at* https://www.sam.gov/sam/transcript/Quick_Guide_for_Grants_Registrations.pdf.

3. Grants.gov Registration (get username and password):

   Be sure the person submitting your application is properly registered with Grants.gov as the Authorized Organization Representative (AOR) for the specific DUNS number cited on the SF-424 (first page). See the Organization Registration User Guide for details at the following Grants.gov link: http://www.grants.gov/web/grants/applicants/organization-registration.html.

You can find additional information about the Grants.gov process at http://www.grants.gov/web/grants/outreach/grantsgov-training.html.

To submit your application electronically, you may search http://www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the funding announcement number and CFDA number on the cover page of this funding announcement.

You must follow the instructions in the User Guide available at the http://www.Grants.gov apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for technical (IT) help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Grants.gov Contact Center is available 24 hours a day, 7 days a week, excluding federal holidays.

Please allow sufficient time to enter your application into Grants.gov. When you submit your application, you will receive a notice that your application is being processed and that you will receive two e-mails from Grants.gov within the next 24-48 hours. One will confirm receipt of the application in Grants.gov, and the other will indicate that the application was either successfully validated by the system (with a tracking number) or rejected due to errors. It will also provide instructions that if you do not receive a receipt confirmation **and** a validation confirmation or a rejection e-mail within 48 hours, you must contact Grants.gov directly. It is important that you retain this tracking number. **Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.** Please note that it is incumbent on the applicant to monitor your application to ensure that it is successfully received and validated by Grants.gov. **If your application is not successfully validated by Grants.gov, it will not be forwarded to SAMHSA as the receiving institution.**

If you experience issues/problems with electronic submission of your application through Grants.gov, contact the Grants.gov helpdesk by email at support@grants.gov or by phone at 1-800-518-4726 (1-800-518-GRANTS). **Make sure you get a case/ticket/reference number that documents the issues/problems with Grants.gov.** It is critical that you initiate electronic submission in sufficient time to resolve any issues/problems that may prevent the electronic submission of your application. Grants.gov will reject applications submitted after 11:59 PM on the application due date.

SAMHSA highly recommends that you submit your application 24-48 hours before the submission deadline. Many submission issues can be fixed within that time and you can

attempt to re-submit. However, if you have not completed your Grants.gov, SAM, and DUNS registration at least 2 weeks prior to the submission deadline, it is highly unlikely that these issues will be resolved in time to successfully submit an electronic application.

It is strongly recommended that you prepare your Project Narrative and other attached documents in Adobe PDF format. If you do not have access to Adobe software, you may submit in Microsoft Office 2007 products (e.g., Microsoft Word 2007, Microsoft Excel 2007, etc.). Directions for creating PDF files can be found on the Grants.gov website. Use of file formats other than Adobe PDF or Microsoft Office 2007 may result in your file being unreadable by our staff.

The Abstract, Table of Contents, Project Narrative, Supporting Documentation, Budget Justification, and Attachments must be combined into 4 separate files in the electronic submission. **If the number of files exceeds 4, only the four files will be downloaded and considered in the peer review of applications.**

Formatting requirements for SAMHSA e-Grant application files are as follows:

- Project Narrative File (PNF): The PNF consists of the Abstract, Table of Contents, and Project Narrative (Sections A-H) in this order and numbered consecutively.
- Budget Narrative File (BNF): The BNF consists of only the budget justification narrative.
- Other Attachment File 1: The first Other Attachment file will consist of the Supporting Documentation (Sections I-K) in this order and lettered consecutively.
- Other Attachment File 2: The second Other Attachment file will consist of the Attachments (Attachments 1-5) in this order and numbered consecutively.

If you have documentation that does not pertain to any of the 4 listed attachment files, include that documentation in Other Attachment File 2.

Other Grants.gov Requirements

Applicants are limited to using the following characters in all attachment file names:

Valid file names may include only the following characters:

- A-Z
- a-z
- 0-9
- Underscore _
- Hyphen –

- Space
- Period .

If your application uses any other characters when naming your attachment files, your application will be rejected by Grants.gov.

Do not use special characters in file names, such as parenthesis ( ), #, ©, etc.

Scanned images must be scanned at 150-200 dpi/ppi resolution and saved as a jpeg or pdf file. Using a higher resolution setting or different file type could result in rejection of your application.

Waiver Request Process

Applicants may request a waiver of the requirement for electronic submission if they are unable to submit electronically through the Grants.gov portal because their physical location does not have adequate access to the Internet. Inadequate Internet access is defined as persistent and unavoidable access problems/issues that would make compliance with the electronic submission requirement a hardship. The process for applying for a waiver is described below. Questions on applying for a waiver may be directed to SAMHSA's Division of Grant Review, 240-276-1199.

All applicants must register in the System for Award Management (SAM) and Grants.gov, even those who intend to request a waiver. If you do not have an active SAM registration prior to submitting your paper application, it will be screened out and returned to you without review. Registration is necessary to ensure that information required for paper submission is available and that the applicant is ready to submit electronically if the waiver is denied. (See directions for registering in SAM and on Grants.gov above.)

A written waiver request must be received by SAMHSA at least 15 calendar days in advance of the application due date stated on the cover page of this RFA. The request must be either e-mailed to DGR.Waivers@samhsa.hhs.gov, or mailed to:

Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20857

Applicants are encouraged to request a waiver by e-mail, when possible. When requesting a waiver, the following information must be included:

- SAMHSA RFA title and announcement number

- Name, address, and telephone number of the applicant organization as they will appear in the application
- Applicant organization's DUNS number
- Authorized Organization Representative (AOR) for the named applicant
- Name, telephone number, and e-mail of the applicant organization's Contact Person for the waiver
- Details of why the organization is unable to submit electronically through the Grants.gov portal, explaining why their physical location does not have adequate access to the Internet.

The Office of Grant Review will either e-mail (if the waiver request was received by e-mail) or express mail/deliver (if the waiver request was received by mail) the waiver decision to the Contact Person no later than seven calendar days prior to the application due date. If the waiver is approved, a paper application must be submitted. (See instructions for submitting a paper application below.) SAMHSA will not accept any applications that are sent by e-mail or facsimile or hand carried. If the waiver is disapproved, the applicant organization must be prepared to submit through Grants.gov or forfeit the opportunity to apply. The written approval must be included as the cover page of the paper application and the application must be received by the due date.

A waiver approval is valid for the remainder of the fiscal year and may be used for other SAMHSA discretionary grant applications during that fiscal year. When submitting a subsequent paper application within the same fiscal year, this waiver approval must be included as the cover page of each paper application. The organization and DUNS number named in the waiver and any subsequent application must be identical.

A paper application will not be accepted without the waiver approval and will be returned to the applicant if it is not included. Paper applications received after the due date will not be accepted.

Instructions for Submitting a Paper Application with a Waiver

Paper submissions are due by **5:00 PM** on the application due date stated on the cover page of this RFA. **Applications may be shipped using only Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).** You will be notified by postal mail that your application has been received.

Note: If you use the USPS, you must use Express Mail.

SAMHSA will not accept or consider any applications that are sent by e-mail or facsimile or hand carried.

If you are submitting a paper application, you must submit an original application and 2 copies (including attachments). The original and copies must not be bound and nothing should be attached, stapled, folded, or pasted. Do not use staples, paper clips, or fasteners. You may use rubber bands.

Send applications to the address below:

For United States Postal Service:

Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**

Change the zip code to **20850** if you are using FedEx or UPS.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include "State/Tribal Youth Suicide Prevention Cooperative Agreements, RFA #SM-14-008**"** in item number 12 on the first page (SF-424) of your paper application. If you require a phone number for delivery, you may use (240) 276-1199.

Your application must be received by the application deadline or it will not be considered for review. Please remember that mail sent to federal facilities undergoes a security screening prior to delivery. You are responsible for ensuring that you submit your application so that it will arrive by the application due date and time.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application and, as a result, the designated office does not receive your application by the deadline, your application will be considered late and ineligible for review.

If you are submitting a paper application, the application components required for SAMHSA applications should be submitted in the following order:

- Application for Federal Assistance (SF-424)
- Abstract
- Table of Contents
- Budget Information Form (SF-424A)
- Project Narrative and Supporting Documentation

- Attachments
- Project/Performance Site Location(s) Form
- Disclosure of Lobbying Activities (Standard Form LLL, if applicable)
- Checklist – the Checklist should be the last page of your application.
- Documentation of nonprofit status as required in the Checklist

Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments, such as posters, will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Black print should be used throughout your application, including charts and graphs (no color). Pages should be typed single-spaced with one column per page. Pages should not have printing on both sides. Pages with printing on both sides run the risk of an incomplete application going to peer reviewers, since scanning and copying may not duplicate the second side. **Materials with printing on both sides will be excluded from the application and not sent to peer reviewers.**

With the exception of standard forms in the application package, all pages in your application should be numbered consecutively. **Documents containing scanned images must also contain page numbers to continue the sequence.** Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Appendix C – Using Evidence-Based Practices (EBPs)

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain interventions for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other interventions that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with an intervention that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population(s) of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. You may describe your experience either with the population(s) of focus or in managing similar programs. Information in support of your proposed practice needs to be sufficient to demonstrate the appropriateness of your practice to the individuals reviewing your application.

- Document the evidence that the practice(s) you have chosen is appropriate for the outcomes you want to achieve.

- Explain how the practice you have chosen meets SAMHSA's goals for this grant program.

- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population(s) of focus or your program, or to allow you to use resources more efficiently. You must describe any changes to the proposed service(s)/practice(s) that you believe are necessary for these purposes. You may describe your own experience either with the population(s) of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.

- Explain why you chose this evidence-based practice over other evidence-based practices.

- If applicable, justify the use of multiple evidence-based practices. Discuss how the use of multiple evidence-based practices will be integrated into the program, while maintaining an appropriate level of fidelity for each practice. Describe how

the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.

- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

Resources for Evidence-Based Practices:

You will find information on evidence-based practices in SAMHSA's *Guide to Evidence-Based Practices on the Web* at http://www.samhsa.gov/ebpwebguide. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Guide* provides a short description and a link to dozens of websites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

Please note that SAMHSA's *Guide to Evidence-Based Practices on the Web* also references another SAMHSA website, the National Registry of Evidence-Based Programs and Practices (NREPP). NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. NREPP is intended to serve as a decision support tool, not as an authoritative list of effective interventions. *Being included in NREPP, or in any other resource listed in the Guide, does not mean an intervention is "recommended" or that it has been demonstrated to achieve positive results in all circumstances.* You must document that the selected practice is appropriate for the specific population(s) of focus and purposes of your project.

In addition to the website noted above, you may provide information on research studies to show that the services/practices you plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, you may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

[Note: Please see Appendix F, Funding Restrictions, regarding allowable costs for EBPs.]

Appendix D – Statement of Assurance

As the authorized representative of [*insert name of applicant organization*] _____, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment from every mental health/substance abuse treatment service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;

- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and

- official documentation that all mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation, and certification; OR 2) official documentation from the appropriate agency of the applicable state, county, other governmental unit that licensing, accreditation, and certification requirements do not exist.[3] (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

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

[3] Tribes and tribal organizations are exempt from these requirements.

_____ _____

Signature of Authorized Representative Date

Appendix E – Intergovernmental Review (E.O. 12373) Requirements

States with SPOCs

This grant program is covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) 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. Certain jurisdictions have elected to participate in the EO process and have established State Single Points of Contact (SPOCs). A current listing of SPOCs is included in the application package and can be downloaded from the Office of Management and Budget (OMB) website at http://www.whitehouse.gov/omb/grants_spoc.

- Check the list to determine whether your state participates in this program. You do not need to do this if you are an American Indian/Alaska Native tribe or tribal organization.

- If your state participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the state's review process.

- For proposed projects serving more than one state, you are advised to contact the SPOC of each affiliated state.

- The SPOC should send any state review process recommendations to the following address within 60 days of the application deadline. For United States Postal Service: Diane Abbate, Director of Grant Review, Office of Financial Resources, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville, MD 20857. ATTN: SPOC – Funding Announcement No. SM-14-008. Change the zip code to 20850 if you are using another delivery service.

States without SPOCs

If your state does not have a SPOC and you are a community-based, non-governmental service provider, you must submit a Public Health System Impact Statement (PHSIS)[4]

[4] Approved by OMB under control no. 0920-0428; Public reporting burden for the Public Health System Reporting Requirement is estimated to average 10 minutes per response, including the time for copying the first page of SF-424 and the abstract and preparing the letter for mailing. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0920-0428. Send

to the head(s) of appropriate state and local health agencies in the area(s) to be affected no later than the application deadline. The PHSIS is intended to keep state and local health officials informed of proposed health services grant applications submitted by community-based, non-governmental organizations within their jurisdictions. If you are a state or local government or American Indian/Alaska Native tribe or tribal organization, you are not subject to these requirements.

The PHSIS consists of the following information:

- a copy of the first page of the application (SF-424); and
- a summary of the project, no longer than one page in length, that provides: 1) a description of the population to be served; 2) a summary of the services to be provided; and 3) a description of the coordination planned with appropriate state or local health agencies.

For SAMHSA grants, the appropriate state agencies are the Single State Agencies (SSAs) for substance abuse and mental health. A listing of the SSAs for substance abuse can be found on SAMHSA's website at http://beta.samhsa.gov. A listing of the SSAs for mental health can be found on SAMHSA's website at http://beta.samhsa.gov/sites/default/files/ssadirectory-mh.pdf. If the proposed project falls within the jurisdiction of more than one state, you should notify all representative SSAs.

---

comments regarding this burden to CDC Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428).

Appendix F – Funding Restrictions

SAMHSA grant funds must be used for purposes supported by the program and may not be used to:

- Pay for any lease beyond the project period.
- Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).
- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)
- Pay for housing other than residential mental health and/or substance abuse treatment.
- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.
- Only allowable costs associated with the use of federal funds are permitted to fund evidence-based practices (EBPs). Other sources of funds may be used for unallowable costs (e.g., meals, sporting events, entertainment). Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, or in-kind contributions.
- Make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA discretionary grant funds may be used for non-clinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.
- Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, SAMHSA discretionary grant funds may be used for non-cash incentives of up to $30 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual

participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to $30 cash or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow up. This amount may be paid for participation in each required interview.

- Meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the RFA. Grant funds may be used for light snacks, not to exceed $2.50 per person.

- Funds may not be used to distribute sterile needles or syringes for the hypodermic injection of any illegal drug.

- Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.

SAMHSA will not accept a “research” indirect cost rate. The grantee must use the “other sponsored program rate” or the lowest rate available.

Appendix G – Biographical Sketches and Job Descriptions

Biographical Sketch

Existing curricula vitae of project staff members may be used if they are updated and contain all items of information requested below. You may add any information items listed below to complete existing documents. For development of new curricula vitae include items below in the most suitable format:

1. Name of staff member
2. Educational background: school(s), location, dates attended, degrees earned (specify year), major field of study
3. Professional experience
4. Honors received and dates
5. Recent relevant publications
6. Other sources of support [Other support is defined as all funds or resources, whether federal, non-federal, or institutional, available to the Project Director/Program Director (and other key personnel named in the application) in direct support of their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes, and other means.]

Job Description

1. Title of position
2. Description of duties and responsibilities
3. Qualifications for position
4. Supervisory relationships
5. Skills and knowledge required
6. Personal qualities
7. Amount of travel and any other special conditions or requirements
8. Salary range
9. Hours per day or week

Appendix H – Sample Budget and Justification (no match required)

THIS IS AN ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION WITH GUIDANCE FOR COMPLETING SF-424A: SECTION B FOR THE BUDGET PERIOD

A. Personnel: Provide employee(s) (including names for each identified position) of the applicant/recipient organization, including in-kind costs for those positions whose work is tied to the grant project.

FEDERAL REQUEST

Position	**Name**	**Annual Salary/Rate**	**Level of Effort**	**Cost**
(1) Project Director	John Doe	$64,890	10%	$6,489
(2) Grant Coordinator	To be selected	$46,276	100%	$46,276
(3) Clinical Director	Jane Doe	In-kind cost	20%	0
			TOTAL	**$52,765**

JUSTIFICATION: Describe the role and responsibilities of each position.

(1) The Project Director will provide daily oversight of the grant and will be considered key staff.

(2) The Coordinator will coordinate project services and project activities, including training, communication and information dissemination.

(3) The Clinical Director will provide necessary medical direction and guidance to staff for 540 clients served under this project.

Key staff positions require prior approval by SAMHSA after review of credentials of resume and job description.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form S-424A) **$52,765**

B. Fringe Benefits: List all components that make up the fringe benefits rate

FEDERAL REQUEST

Component	Rate	Wage	Cost
FICA	7.65%	$52,765	$4,037
Workers Compensation	2.5%	$52,765	$1,319
Insurance	10.5%	$52,765	$5,540
		TOTAL	**$10,896**

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF-424A) $10,896

C. Travel: Explain need for all travel other than that required by this application. Local travel policies prevail.

FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
(1) Grantee Conference	Washington, DC	Airfare	$200/flight x 2 persons	$400
		Hotel	$180/night x 2 persons x 2 nights	$720
		Per Diem (meals and incidentals)	$46/day x 2 persons x 2 days	$184
(2) Local travel		Mileage	3,000 miles@.38/mile	$1,140
			TOTAL	**$2,444**

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

(1) Two staff (Project Director and Evaluator) to attend mandatory grantee meeting in Washington, DC.

(2) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on organization's policies/procedures for privately owned vehicle reimbursement rate. If policy does not have a rate use GSA.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF-424A) **$2,444**

D. Equipment: An article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit (federal definition).

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF-424A) **$ 0**

E. Supplies: **M**aterials costing less than $5,000 per unit and often having one-time use

FEDERAL REQUEST

Item(s)	**Rate**	**Cost**
General office supplies	$50/mo. x 12 mo.	$600
Postage	$37/mo. x 8 mo.	$296
Laptop Computer	$900	$900
Printer	$300	$300
Projector	$900	$900
Copies	8000 copies x .10/copy	$800
	TOTAL	**$3,796**

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

(1) Office supplies, copies and postage are needed for general operation of the project.

(2) The laptop computer and printer are needed for both project work and presentations for Project Director.

(3) The projector is needed for presentations and workshops. All costs were based on retail values at the time the application was written.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF-424A) **$ 3,796**

F. Contract: A contractual arrangement to carry out a portion of the programmatic effort or for the acquisition of routine goods or services under the grant. Such arrangements may be in the form of consortium agreements or contracts. A consultant is an individual retained to provide professional advice or services for a fee. The applicant/grantee must establish written procurement policies and procedures that are consistently applied. All procurement transactions shall be conducted in a manner to provide to the maximum extent practical, open and free competition.

COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.

FEDERAL REQUEST

Name	Service	Rate	Other	Cost
(1) State Department of Human Services	Training	$250/individual x 3 staff	5 days	$750
(2) Treatment Services	1040 Clients	$27/client per year		$28,080

Name	Service	Rate	Other	Cost
(3) John Smith (Case Manager)	Treatment Client Services	1FTE @ $27,000 + Fringe Benefits of $6,750 = $33,750	*****Travel at 3,124 @ .50 per mile = $1,562 *****Training course $175 *****Supplies @ $47.54 x 12 months or $570 *****Telephone @ $60 x 12 months = $720 *****Indirect costs = $9,390 (negotiated with contractor)	$46,167
(4) Jane Smith	Evaluator	$40 per hour x 225 hours	12 month period	$9,000
(5) To Be Announced	Marketing Coordinator	Annual salary of $30,000 x 10% level of effort		$3,000
			TOTAL	**$86,997**

JUSTIFICATION: Explain the need for each contractual agreement and how it relates to the overall project.

(1) Certified trainers are necessary to carry out the purpose of the statewide Consumer Network by providing recovery and wellness training, preparing consumer leaders statewide, and educating the public on mental health recovery.

(2) Treatment services for clients to be served based on organizational history of expenses.

(3) Case manager is vital to client services related to the program and outcomes.

(4) Evaluator is provided by an experienced individual (Ph.D. level) with expertise in substance abuse, research and evaluation, is knowledgeable about the population of focus, and will report GPRA data.

(5) Marketing Coordinator will develop a plan to include public education and outreach efforts to engage clients of the community about grantee activities, and provision of presentations at public meetings and community events to stakeholders, community civic organizations, churches, agencies, family groups and schools.

***Represents separate/distinct requested funds by cost category**

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF-424A) **$86,997**

G. Construction: **NOT ALLOWED** – Leave Section B columns 1& 2 line 6g on SF-424A blank.

H. Other: Expenses not covered in any of the previous budget categories

FEDERAL REQUEST

Item	**Rate**	**Cost**
(1) Rent*	$15/sq.ft x 700 sq. feet	$10,500
(2) Telephone	$100/mo. x 12 mo.	$1,200
(3) Client Incentives	$10/client follow up x 278 clients	$2,780
(4) Brochures	.89/brochure X 1500 brochures	$1,335
	TOTAL	**$15,815**

JUSTIFICATION: Break down costs into cost/unit (e.g. cost/square foot). Explain the use of each item requested.

(1) Office space is included in the indirect cost rate agreement; however, if other rental costs for service site(s) are necessary for the project, they may be requested as a direct

charge. The rent is calculated by square footage or FTE and reflects SAMHSA's fair share of the space.

***If rent is requested (direct or indirect), provide the name of the owner(s) of the space/facility. If anyone related to the project owns the building which is less than an arm's length arrangement, provide cost of ownership/use allowance calculations. Additionally, the lease and floor plan (including common areas) is required for all projects allocating rent costs.**

(2) The monthly telephone costs reflect the % of effort for the personnel listed in this application for the SAMHSA project only.

(3) The $10 incentive is provided to encourage attendance to meet program goals for 278 client follow-ups.

(4) Brochures will be used at various community functions (health fairs and exhibits).

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF-424A) **$15,815**

Indirect Cost Rate: Indirect costs can be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. For information on applying for the indirect rate go to: **http://rates.psc.gov/fms/dcs/map1.html**

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF-424A)

8% of personnel and fringe **(.08 x $63,661)** **$5,093**

==========

TOTAL DIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF-424A) $172,713

INDIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6j of form SF-424A) $5,093

TOTAL: (sum of 6i and 6j)

FEDERAL REQUEST – (enter in Section B column 1 line 6k of form SF-424A)
$177,806

==========

Provide the total proposed project period and federal funding as follows**:**

Proposed Project Period

a. Start Date: **09/30/2012** b. End Date: **09/29/2017**

BUDGET SUMMARY (should include future years and projected total)

Category	**Year 1**	**Year 2***	**Year 3***	**Year 4***	**Year 5***	**Total Project Costs**
Personnel	$52,765	$54,348	$55,978	$57,658	$59,387	$280,136
Fringe	$10,896	$11,223	$11,559	$11,906	$12,263	$57,847
Travel	$2,444	$2,444	$2,444	$2,444	$2,444	$12,220
Equipment	0	0	0	0	0	0
Supplies	$3,796	$3,796	$3,796	$3,796	$3,796	$18,980
Contractual	$86,997	$86,997	$86,997	$86,997	$86,997	$434,985
Other	$15,815	$13,752	$11,629	$9,440	$7,187	$57,823
Total Direct Charges	$172,713	$172,560	$172,403	$172,241	$172,074	$861,991
Indirect Charges	$5,093	$5,246	$5,403	$5,565	$5,732	$27,039
Total Project Costs	**$177,806**	**$177,806**	**$177,806**	**$177,806**	**$177,806**	**$889,030**

TOTAL PROJECT COSTS: **Sum of Total Direct Costs and Indirect Costs**

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF-424A) **$889,030**

***FOR REQUESTED FUTURE YEARS:**

1. Please justify and explain any changes to the budget that differs from the reflected amounts reported in the 01 Year Budget Summary.

2. If a cost of living adjustment (COLA) is included in future years, provide your organization's personnel policy and procedures that state all employees within the organization will receive a COLA.

IN THIS SECTION, REFLECT OTHER FEDERAL AND NON-FEDERAL SOURCES OF FUNDING BY DOLLAR AMOUNT AND NAME OF FUNDER e.g., Applicant, State, Local, Other, Program Income, etc.
Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions or non-federal means. [Note: Please see Appendix F, Funding Restrictions, regarding allowable costs.]

IN THIS SECTION, include a narrative and separate budget for each year of the grant that shows that no more than 15 percent of the total grant award will be used for either infrastructure development or for data collection, performance measurement, and performance assessment. Note that surveillance and training are considered direct prevention services.

Infrastructure Development	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Infra-structure Costs**
Personnel	$2,250	$2,250	$2,250	$2,250	$2,250	$11,250
Fringe	$558	$558	$558	$558	$558	$2,790
Travel	0	0	0	0	0	0
Equipment	$15,000	0	0	0	0	$15,000
Supplies	$1,575	$1,575	$1,575	$1,575	$1,575	$7,875
Contractual	$5,000	$5,000	$5,000	$5,000	$5,000	$25,000
Other	$1,617	$2,375	$2,375	$2,375	$2,375	$11,117
Total Direct Charges	$6,000	$11,758	$11,758	$11,758	$11,758	**$53,072**

Infrastructure Development	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Infra-structure Costs**
Indirect Charges	$750	$750	$750	$750	$750	**$3,750**
Total Infrastructure Costs	**$6750**	**$12,508**	**$12,508**	**$12,508**	**$12,508**	**$56,782**

Data Collection & Performance Measurement	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Data Collection & Performance Measurement Costs**
Personnel	$6,700	$6,700	$6,700	$6,700	$6,700	$33,500
Fringe	$2,400	$2,400	$2,400	$2,400	$2,400	$12,000
Travel	$100	$100	$100	$100	$100	$500
Equipment	0	0	0	0	0	0
Supplies	$750	$750	$750	$750	$750	$3,750
Contractual	$24,950	$24,950	$24,250	$24,950	$24,950	$124,750
Other	0	0	0	0	0	0
Total Direct Charges	$34,300	$34,300	$34,300	$34,300	$34,300	$171,500
Indirect Charges	$698	$698	$698	$698	$698	$3,490
Data Collection & Performance	**$34,900**	**$34,900**	**$34,900**	**$34,900**	**$34,900**	**$174,500**

Data Collection & Performance Measurement	Year 1	Year 2	Year 3	Year 4	Year 5	Total Data Collection & Performance Measurement Costs
Measurement						

Appendix I – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants (including those who plan to obtain IRB approval) must address the seven elements below. Be sure to discuss these elements as they pertain to on-line counseling (i.e., telehealth) if they are applicable to your program. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

- Describe the procedures you will follow to minimize or protect participants against potential risks, including risks to confidentiality.

- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

- Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $30.

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Attachment 2**, “Data Collection Instruments/Interview Protocols,” copies of all available data collection instruments and interview protocols that you plan to use.

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:

    - How you will use data collection instruments.

    - Where data will be stored.

    - Who will or will not have access to information.

    - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

- State:

    - Whether or not their participation is voluntary.

    - Their right to leave the project at any time without problems.

    - Possible risks from participation in the project.

    - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Attachment 3, "Sample Consent Forms"**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria for research involving human subjects. For assistance in determining if your proposed performance assessment meets the criteria in 45 CFR 46, Protection of Human Subjects Regulations, refer to the SAMHSA decision tree on the SAMHSA website, under "Applying for a New SAMHSA Grant," http://beta.samhsa.gov/grants/apply.aspx.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB

approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp, or ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

Appendix J – Addressing Behavioral Health Disparities

In April 2011, the Department of Health and Human Services (HHS) released its *Action Plan to Reduce Racial and Ethnic Health Disparities*. This plan outlines goals and actions HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to continuously assess the impact of their policies and programs on health disparities. The Action Plan is available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

The number one Secretarial priority in the Action Plan is to: "**Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities."** Grantees for this program will be required to submit a health disparities impact statement to identify subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to health disparities. This statement must outline the population/s of focus that will be involved in the project and the unduplicated number of individuals who are expected to receive services. It should be consistent with information in your application regarding access, service use and outcomes for the program. The disparities impact statement may be developed as a brief narrative or table (see "Sample Health Disparities Impact Statement" at the end of this appendix).

You also will be required to implement a data-driven quality improvement plan to decrease the differences in access, service use and outcomes among subpopulations that will be implemented throughout the project. This plan should include use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

Definition of Health Disparities:

Healthy People 2020 defines a health disparity as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Subpopulations

SAMHSA grant applicants are routinely asked to define the population they intend to serve given the focus of a particular grant program (e.g., adults with serious mental illness [SMI] at risk for chronic health conditions; young adults engaged in underage drinking; populations at risk for contracting HIV/AIDS, etc.). Within these populations of focus are *subpopulations* that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in language,

beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services; Native American youth may have an increased incidence of underage drinking due to coping patterns related to historical trauma within the Native American community; and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities. While these factors might not be pervasive among the general population served by a grantee, they may be predominant among subpopulations or groups vulnerable to disparities. It is imperative that grantees understand who is being served within their community in order to provide care that will yield positive outcomes, per the focus of that grant. In order for organizations to attend to the potentially disparate impact of their grant efforts, applicants are asked to address access, use and outcomes for subpopulations, which can be defined by the following factors:

- By race
- By ethnicity
- By gender (including transgender), as appropriate
- By sexual orientation (i.e., lesbian, gay, bisexual), as appropriate

HHS published final standards for data collection on race, ethnicity, sex, primary language and disability status, as required by Section 4302 of the Affordable Care Act in October 2011, http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208.

The ability to address the quality of care provided to subpopulations served within SAMHSA's grant programs is enhanced by programmatic alignment with the federal CLAS standards.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS standards were initially published in the Federal Register on December 22, 2000. Culturally and linguistically appropriate health care and services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, is increasingly seen as essential to reducing disparities and improving health care quality. The National CLAS Standards have served as catalyst and conduit for the evolution of the field of cultural and linguistic competency over the course of the last 12 years. In recognition of these changes in the field, the HHS Office of Minority Health undertook the National CLAS Standards Enhancement Initiative from 2010 to 2012.

The enhanced National CLAS Standards seek to set a new bar in improving the quality of health to our nation's ever diversifying communities. Enhancements to the National

CLAS Standards include the broadening of the definitions of health and culture, as well as an increased focus on institutional governance and leadership. The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care are comprised of 15 Standards that provide a blueprint for health and health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality, and help eliminate health care disparities.

You can learn more about the CLAS mandates, guidelines, and recommendations at: http://www.ThinkCulturalHealth.hhs.gov.

Sample Health Disparities Impact Statement:

1. Proposed number of individuals to be served by subpopulations in the geographic area

   Access: The numbers in the chart below reflect the proposed number of individuals to be served during the grant period and all identified subpopulations in the geographic area. The disparate populations are highlighted in the narrative below.

	FY 1	FY 2	FY 3	FY 4	Totals
Direct Services: Number to be served	200	175	100	125	600
By Race/Ethnicity					
African American	10	9	5	6	30
American Indian/Alaska Native	1	1	0	1	3
Asian	2	2	1	1	6
White (non-Hispanic)	103	91	52	65	311
Hispanic or Latino (not including Salvadoran)	32	28	16	20	96
Salvadoran	44	37	22	28	130
Native Hawaiian/Other Pacific Islander	4	3	2	2	11
Two or more Races	4	4	2	3	13
By Gender					
Female	110	96	55	69	330
Male	89	79	44	56	268
Transgender	1	0	1	0	2
By Sexual Orientation/Identity Status					
Lesbian	2	2	1	1	6
Gay	8	6	4	5	23
Bisexual	1	1	0	1	3

The population of Middle Lake, Massachusetts is predominantly represented by first- and second-generation Latino immigrants, mainly from El Salvador. There has been a recent increase of the immigrant population in the city with individuals primarily from Haiti and El Salvador. There is also a smaller Cambodian and African American population in the city. Nearly 40% of residents speak a language other than English in their homes, and a majority of those individuals are Spanish speakers. There is a high unemployment rate, low literacy rate and high level of poverty, in particular among the Salvadoran subpopulation, putting these individuals at greater risk for behavioral health issues when compared to national trends. However, our agency has served relatively low numbers of Salvadorans. Therefore, we have chosen to focus our efforts on the Salvadoran subpopulation.

2. A Quality Improvement Plan Using Our Data

   Use: Services and activities will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community. The project team will collaborate with the community enrichment program and the county health specialist consortium in planning the design and implementation of program activities to ensure the cultural and linguistic needs of grant participants are effectively addressed, particularly the disparate population.

   A continuous quality improvement approach will be used to analyze, assess and monitor key performance indicators as a mechanism to ensure high-quality and effective program operations. Program data will be used to monitor and manage program outcomes by race, ethnicity, and LGBT status within a quality improvement process. Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program domains.

   A primary objective of the data collection and reporting will be to monitor/measure project activities in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings will be integrated into program planning and management on an ongoing basis (a “self-correcting” model of evaluation). For example, referral to enrollment, treatment completion and discharge data will be reported to staff on an ongoing basis, including analyses and discussions of who may be more or less likely to enroll and complete the program (and possible interventions). The Evaluator will meet on a bi-weekly basis with staff, providing an opportunity for staff to identify successes and barriers encountered in the process of project implementation. These meetings will be a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success.

   Outcomes for all services and supports will be monitored across race and ethnicity to determine the grant’s impact on behavioral health disparities.

3. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

Diverse cultural health beliefs and practices

Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the Salvadoran subpopulation.

Preferred languages

Interpreters and translated materials will be used for non-English speaking clients as well as those who speak English, but prefer materials in their primary language. Key documents will be translated into Spanish.

Health literacy and other communication needs of all sub-populations identified in your proposal

All services programs will be tailored to include limited English proficient individuals. Staff will receive training to ensure capacity to provide services that are culturally and linguistically appropriate.

Appendix K – Electronic Health Record (EHR) Resources

The following is a list of websites for EHR information:

For additional information on EHR implementation please visit: http://www.healthit.gov/providers-professionals

For a comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC) please see: http://onc-chpl.force.com/ehrcert

For a listing of Regional Extension Centers (REC) for technical assistance, guidance, and information to support efforts to become a meaningful user of Electronic Health Records (EHRs), see: http://www.healthit.gov/providers-professionals/regional-extension-centers-recs#listing

Behavioral healthcare providers should also be aware of federal confidentiality regulations including HIPPA and 42CRF Part 2 (http://beta.samhsa.gov/HealthPrivacy/). EHR implementation plans should address compliance with these regulations.

For questions on EHRs and HIT, contact: SAMHSA.HIT@samhsa.hhs.gov.

Appendix L – Sample Logic Model

A logic model is a tool to show how your proposed project links the purpose, goals, objectives, and tasks stated with the activities and expected outcomes or “change” and can help to plan, implement, and assess your project. The model also links the purpose, goals, objectives, and activities back into planning and evaluation. A logic model is a *picture* of your project. It graphically shows the activities and progression of the project. It should also describe the relationships among the resources you put in (inputs), what you do (outputs), and what happens or results (outcomes). Your logic model should form a logical chain of “if-then” relationships that enables you to demonstrate how you will get to your desired outcomes with your available resources. Because your logic model requires you to be specific about your intended outputs and outcomes, it can be a valuable resource in assessing the performance of your project by providing you with specific outputs (objectives) and outcomes (goals) that can be measured.

The graphic on the following page provides an example of a logic model that links the inputs to program components, the program components to outputs, and the outputs to outcomes (goals).

Your logic model should be based on a review of your Statement of Need, in which you state the conditions that gave rise to the project with your target group. A properly targeted logic model will show a logical pathway from inputs to intended outcomes, in which the included outcomes address the needs identified in the Statement of Need.

Examples of **Inputs** (resources) depicted in the sample logic model include people (e.g., staff hours, volunteer hours), funds and other resources (e.g., facilities, equipment, community services).

Examples of **Program Components** (activities) depicted in the sample logic model include outreach; intake/assessment (e.g., client interview); treatment planning/treatment by type (e.g., methadone maintenance, weekly 12-step meetings, detoxification, counseling sessions, relapse prevention, crisis intervention); special training (e.g., vocational skills, social skills, nutrition, child care, literacy, tutoring, safer sex practices); other services (e.g., placement in employment, prenatal care, child care, aftercare); and program support (e.g., fundraising, long-range planning, administration, public relations).

Examples of **Outputs** (objectives) depicted in the logic model include waiting list length, waiting list change, client attendance, and client participation; number of clients, including those admitted, terminated, in program, graduated and placed; number of sessions per month and per client/month; funds raised; number of volunteer hours/month; and other resources required.

The **Inputs, Program Components** and **Outputs** all lead to the **Outcomes** (goals). Examples of Outputs depicted in the logic model include in-program (e.g., client satisfaction, client retention); and in or post-program (e.g., reduced drug use-self reports, urine, hair; employment/school progress; psychological status; vocational skills; safer sexual practices; nutritional practices; child care practices; and reduced delinquency/crime.

[**Note:** The logic model presented is not a required format and SAMHSA does not expect strict adherence to this format. It is presented only as a sample of how you can present a logic model in your application.]

Sample Logic Model

Resources (Inputs)	→	Program Components (Activities)	→	Outputs (Objectives)	→	Outcomes (Goals)
Examples		**Examples**		**Examples**		**Examples**
People Staff – hours Volunteer – hours Funds Other resources Facilities Equipment Community services		Outreach Intake/Assessment Client Interview Treatment Planning Treatment by type: Methadone maintenance Weekly 12-step meetings Detoxification Counseling sessions Relapse prevention Crisis intervention Special Training Vocational skills Social skills Nutrition Child care Literacy Tutoring Safer sex practices Other Services Placement in employment Prenatal care Child care Aftercare Program Support Fundraising Long-range planning Administration Public Relations		Waiting list length Waiting list change Client attendance Client participation Number of Clients: Admitted Terminated Inprogram Graduated Placed Number of Sessions: Per month Per client/month Funds raised Number of volunteer hours/month Other resources required		Inprogram: Client satisfaction Client retention In or postprogram: Reduced drug use – self reports, urine, hair Employment/school progress Psychological status Vocational skills Social skills Safer sexual practices Nutritional practices Child care practices Reduced delinquency/crime

Appendix M – Logic Model Resources

Chen, W.W., Cato, B.M., & Rainford, N. (1998-9). Using a logic model to plan and evaluate a community intervention program: A case study. International Quarterly of Community Health Education, 18(4), 449-458.

Edwards, E.D., Seaman, J.R., Drews, J., & Edwards, M.E. (1995). A community approach for Native American drug and alcohol prevention programs: A logic model framework. Alcoholism Treatment Quarterly, 13(2), 43-62.

Hernandez, M. & Hodges, S. (2003). Crafting Logic Models for Systems of Care: Ideas into Action. [Making children's mental health services successful series, volume 1]. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. http://cfs.fmhi.usf.edu or phone (813) 974-4651

Hernandez, M. & Hodges, S. (2001). Theory-based accountability. In M. Hernandez & S. Hodges (Eds.), Developing Outcome Strategies in Children's Mental Health, pp. 21-40. Baltimore: Brookes.

Julian, D.A. (l997). Utilization of the logic model as a system level planning and evaluation device. Evaluation and Planning, 20(3), 251-257.

Julian, D.A., Jones, A., & Deyo, D. (1995). Open systems evaluation and the logic model: Program planning and evaluation tools. Evaluation and Program Planning, 18(4), 333-341.

Patton, M.Q. (1997). Utilization-Focused Evaluation (3rd Ed.), pp. 19, 22, 241. Thousand Oaks, CA: Sage.

Wholey, J.S., Hatry, H.P., Newcome, K.E. (Eds.) (1994). Handbook of Practical Program Evaluation. San Francisco, CA: Jossey-Bass Inc.

W.K. Kellogg Foundation, (2004). Logic Model Development Guide. Battle Creek, MI. Available online at http://www.thepresidency.gov.za/learning/reference/logic_model.pdf.