Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

PPHF-2014-Access to Recovery (PPHF-2014)

(Short Title: ATR)

(Modified Announcement)

Request for Applications (RFA) No. TI-14-004

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

Key Dates:

Application Deadline	**Applications are due by March 31, 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.**

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2014 PPHF-2014-Access to Recovery (ATR) grants (PPHF-2014). The purpose of this program is to provide funding to Single-State Agencies (SSAs) for substance abuse services in the states, territories, tribes, and tribal organizations to carry-out voucher programs for substance abuse clinical treatment and recovery support services (including faith-based providers). Intended outcomes include increasing abstinence, improving client choice, expanding access to a comprehensive array of treatment and recovery support service options, strengthening an individual's capacity to build and sustain a life in recovery, and building sustainability. Monitoring outcomes, tracking costs, and preventing waste, fraud and abuse to ensure accountability and effectiveness in the use of federal funds are also important elements of the ATR program.

Funding Opportunity Title:	Access to Recovery (Short Title: ATR)
Funding Opportunity Number:	93.243
Due Date for Applications:	March 31, 2014
Anticipated Total Available Funding:	$45 million
Estimated Number of Awards:	Up to 5 awards
Estimated Award Amount:	Up to $3 million per year
Cost Sharing/Match Required	No
Length of Project Period:	Up to 3 years
Eligible Applicants:	States, territories, tribes, tribal organizations, and the District of Columbia [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 (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2014 PPHF-2014-Access to Recovery (ATR) grants (PPHF-2014). The purpose of this program is to provide funding to Single-State Agencies (SSAs) for substance abuse services in the states, territories, tribes, and tribal organizations to carry-out voucher programs for substance abuse clinical treatment and recovery support services (including faith-based providers). Intended outcomes include increasing abstinence, improving client choice, expanding access to a comprehensive array of treatment and recovery support service options, strengthening an individual's capacity to build and sustain a life in recovery, and building sustainability. Monitoring outcomes, tracking costs, and preventing waste, fraud and abuse to ensure accountability and effectiveness in the use of federal funds are also important elements of the ATR program.

A major goal of the ATR program is to ensure that clients have a genuine, free, and independent choice among a network of eligible providers. States, territories, tribes, and tribal organizations are encouraged to develop provider networks that offer an array of clinical treatment and recovery support services that can be expected to result in cost-effective, successful outcomes for the largest number of people. SAMHSA plans to fund a cross-section of previously funded ATR grantees and applicants that have never before received an ATR grant.

The population of focus includes individuals with substance use disorders, including: active military/national guard members, veterans (especially Operation Enduring Freedom and Operation Iraqi Freedom), individuals returning to the community from the criminal justice system, individuals involved with drug courts, clients leaving residential treatment, parenting, pregnant and postpartum women, individuals involved in the child welfare system, and individuals experiencing homelessness.

In accordance with SAMHSA's Strategic Initiative on Recovery Support, this program aims to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.

The ATR grant program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the racial and ethnic minority populations served. (See Appendix I: Addressing Behavioral Health Disparities).

ATR 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 fourth month of the project at the latest for new ATR grantees and by the third month for previously funded ATR grantees.

The ATR grants are authorized under Sections 501(d)(5) and 509 of the Public Health Service Act, as amended and are financed by 2014 Prevention and Public Health Funds (PPHF-2014). This announcement addresses Healthy People 2020, Substance Abuse Topic Area HP 2020-SA.

2. EXPECTATIONS

ATR grantees will be expected to use grant funds to facilitate individual choice and promote multiple pathways to recovery through the development and implementation of substance abuse treatment and recovery support service voucher systems. Multiple pathways to recovery may include, but are not limited to, the following: the use of anti-addiction medications, faith-based treatment and recovery support services, and peer-to-peer recovery support services.

States, territories, tribes, and tribal organizations should propose innovative strategies for their ATR projects to accomplish the following program objectives:

- Ensure genuine, free, and independent client choice for substance abuse clinical treatment and recovery support services appropriate to the level of care needed by the client. For the purposes of this grant program, choice is defined as a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection.

- Provide all substance abuse assessment, clinical treatment, and recovery support services funded through the ATR grant through vouchers given to a client by a state/territory/tribe/tribal organization. No funding may be given directly to a provider through a grant or contract to provide any services under this program, including assessments. By vouchering services, the ATR program employs an indirect funding mechanism[1].

[1] Indirect funding means that individual, private choice, rather than the Government, determines which substance abuse service provider eventually receives the funds. With indirect funding, the individual in need of the service is given a voucher, coupon, certificate, or other means of free agency, such that he or she has the power to select for himself or herself from among eligible substance abuse service providers, whereupon the voucher (or other method of payment) may be "redeemed" for the service rendered. Under "direct" funding, the Government or an intermediate organization with the same duties as a governmental entity purchases the needed services directly from the substance abuse service provider. Under this scenario, there are no intervening steps in which the client's choice comes into play. The government or intermediate organization selects the provider from which the client will receive services.

- Ensure each client receives an assessment for the appropriate level of services and is then provided a genuine, free, and independent choice among eligible providers, among them at least one provider to which the client has no religious objection.

- Allow eligible clients to use their vouchers to pay for assessment and other clinical treatment and recovery support services from a broad network of eligible providers. Eligible service providers for the voucher program may include the following: public and private, nonprofit, proprietary organizations, including faith-based and community-based organizations, as approved through established procedures by the states, territories, tribes, and tribal organizations.

- Ensure that faith-based organizations otherwise eligible to participate in this program are not discriminated against on the basis of their religious character or affiliation.

- Implement an incentive system for positive outcomes and taking active steps to prevent waste, fraud, and abuse.

- Expand clinical treatment and recovery support services by leveraging use of all federal funds, preventing cost shifting, and ensuring that these funds are used to supplement and not supplant current funding for substance abuse clinical treatment and recovery support services in the state. [Note: Applicants must include a statement of assurance stating that they will not use ATR funds to supplant current funding if they receive an award. See Appendix C, Statement of Assurance.]

In developing applications for the ATR program, applicants must establish a goal for the total number of clients to be served over the three years of the program ("three-years numbers-served goal") and identify key milestones over the three-year grant project that will result in achievement of the three-year numbers-served goal. Grantees are expected to meet the milestones identified in their applications and contributing to the overall target for the ATR program.

SAMHSA is especially interested in ensuring that the voucher systems supported through the ATR projects include the most cost-effective mix of clinical treatment and recovery support services necessary to achieve intended outcomes. Applicants must include both types of services in their proposed projects.

For many clients, it will be desirable to provide a full array of services with the emphasis changing as the client moves through the non-linear recovery process.

Applicants may wish to prioritize the proposed services/population of focus (e.g., services for methamphetamine-addicted clients, services for drug court clients, etc.) based on local needs.

SAMHSA is interested in supporting different organizational models to implement substance abuse voucher programs, including, but not limited to the following:

- Full implementation of the program through the state/territory/tribe/tribal organization.

- Implementation of the program through public/private partnerships (i.e., a contract between the state/territory/tribe/tribal organization and a lead private entity to implement all or part of the program).

States, territories, tribes, and tribal organizations may implement the program statewide, or may target geographic areas of greatest need, specific populations in need, or areas/populations with a high degree of readiness to implement a voucher program. States, territories, tribes, and tribal organizations may propose alternate models for consideration, as long as they conform to the expectations articulated above.

States, territories, tribes, and tribal organizations are encouraged to minimize the funds used to cover both the direct and indirect costs of administration of the program, to develop a system to manage the program on the basis of reasonable costs, to develop a system to provide incentives (up to $30) to eligible providers with superior outcomes, and to include a broad range of recovery support services. Appendix K of this announcement provides hypothetical examples of two projects that conform to these expectations. States, territories, tribes, and tribal organizations may wish to consult this appendix as a starting point for developing their ATR grant applications.

Newly funded grantees are expected to fully implement their voucher programs no later than 4 months after the award date. Previously funded grantees are expected to fully implement their voucher program no later than 3 months after the award date. See Appendix L for a listing of full implementation requirements for ATR-funded applicants. SAMHSA/CSAT will provide technical assistance to support grantees with meeting these implementation deadlines.

Grantees are expected to maintain two key staff on the grant project: Project Director and Fiscal Coordinator. Project Directors are required to commit a minimum of 75 percent level of effort to implementing the program and cannot be contractors.

The ATR program encourages innovation in the organization, delivery, and financing of clinical treatment and recovery support services. Therefore, you must propose to develop and implement a program that addresses each of the following components:

- Developing and maintaining an electronic voucher management system. Eligibility determinations for clinical treatment and recovery support service providers and for which service in the continuum of recovery will be included in the voucher reimbursement system.
- Eligibility determinations for clients, including management of a system for assessment and service determinations.
- Identifying and determining eligibility of new clinical treatment and recovery support service providers.
- Fiscal/cost accounting mechanisms that can track voucher implementation.
- Management of information systems to track performance and outcomes.
- Outreach to and partnership with grass-roots community- and faith-based organizations or other entities unknown to the SSA/tribe/tribal organization in order to ensure a broad array of choices for consumers.
- Infrastructure development and sustainability planning among enrolled community-based and faith-based organizations.
- Developing information technology capacity to upload performance data to SAMHSA. (Training and technical assistance will be offered on data collecting, tracking, and follow-up, as well as data entry).
- Development of a client follow-up system in order to locate and interview client's six-months post-intake.
- Activities to attract, develop, and sustain new clinical treatment and recovery support service providers.
- Oversight of standards and clear procedures to monitor, prevent and remediate fraud, waste and abuse.
- Establishment of referral pathways involving consumers in institutional systems such as the criminal justice system, State Departments of Corrections, probation, parole and jail authorities. This may include assistance with developing Memoranda of Understanding (MOUs) and other formal mechanisms to solidify client referrals.

Sustainability strategies to build capacity to continue these efforts after the grant ends must be addressed in Section C of the Project Narrative.

Applicants are expected to develop a structured action plan such as a S.M.A.R.T. (specific, measurable, attainable, relevant and time-bound) plan, Logic Model, or a Comprehensive Management Plan that outlines the goals, activities, measurable objectives, and milestones to be followed and modified as necessary.

Information about ATR is available at:

- Access to Recovery Implementation Toolkit, Volume 1, Phase 1 (http://store.samhsa.gov/shin/content/SMA10-ATRKIT/SMA10-ATRKIT-01.pdf)
- Access to Recovery Implementation Toolkit, Volume 2, Phase 2 (http://store.samhsa.gov/shin/content/SMA10-ATRKIT/SMA10-ATRKIT-02.pdf)

- Access to Recovery Implementation Toolkit, Volume 3, Phase 3 (http://store.samhsa.gov/shin/content/SMA10-ATRKIT/SMA10-ATRKIT-03.pdf)

Upon grant award, SAMHSA also will make available a broad range of technical assistance related to the above requirements.

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).

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 (co-pay or other cost sharing requirements are an acceptable use of SAMHSA grant funds). Grantees are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Grantees should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Administration or senior services) 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. SAMHSA acknowledges that members of federally recognized tribes, other AI/AN, or descendants who are eligible to receive services through the Indian Health Service have special protections and benefits under ACA.

Recovery from substance use disorders or substance use and mental disorders has been identified as a primary goal for this initiative. 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.

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 I: Addressing Behavioral Health Disparities.)

2.1 Data Collection and Performance Measurement

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

SAMHSA has established the performance targets for the ATR program. These targets will be reviewed, and may be revised, based on information provided in funded grantees' applications. Grantees will be expected to contribute to achievement of these targets.

To meet the GPRA requirements, SAMHSA must collect performance data from grantees. ATR grantees will be required to submit the performance data described below to SAMHSA. For the ATR program, SAMHSA will assess program performance through accountability measures as well as through client outcome measures. Grantees are required to submit to SAMHSA three types of data at varying points and frequencies: (1) GPRA data that collects information from clients at key points to measure changes in their outcomes, (2) voucher information which allows tracking of

vouchers issued, and (3) voucher transactions which allow tracking of vouchers redeemed.

GPRA client data must be collected in a face-to-face interview at baseline (i.e., the client's entry into the project), six months post-baseline, and at discharge (or exit from ATR services). Grantees are also expected to submit voucher information and voucher transaction data via the tools provided.

Grantees will be required to obtain an intake coverage rate (target number of clients expected to be served compared with actual number served) of 100 percent and a minimum 80 percent six-month follow-up rate. Note: The six-month follow-up rate is calculated by dividing the number of follow-ups completed within the specified window by the number of intakes for which six months has elapsed. GPRA data must be entered into CSAT's Services Accountability Improvement System (SAIS) (https://www.samhsa-gpra.samhsa.gov) within 7 business days of the interview forms (intake, six-month follow-up, and discharge) or voucher information and transaction forms being completed. Grantees are expected to take action necessary to ensure data are valid and reliable, and are submitted in a timely manner. Data reporting is required to commence upon admission of the first client.

Accountability Measures

SAMHSA will assess grantee performance using the following accountability measures:[2]

- Target number of clients to be served (grantees are expected to meet 100 percent of their client target);
- Number of vouchers issued and redeemed;
- Number of eligible clinical treatment providers – total number of providers, providers identified as faith-based and providers identified as secular;
- Number of eligible recovery support service providers – total number of providers, providers identified as faith-based and providers identified as secular;
- Clinical treatment services – total clients served, clients served by faith-based organizations and clients served by secular organizations;
- Recovery support services – total clients served, clients served by faith-based organizations and clients served by secular organizations;
- Combined services – total clients served, clients served by faith-based organizations and clients served by secular organizations;
- Grant draw down amounts;
- Administrative expenditures;

[2] Several performance measures will be reported for all providers, providers identified as faith-based and providers identified as secular. Grantees will receive training on how to provide this information using the provider identification number included in the Voucher Information Tool and Voucher Transaction Tool.

- Expenditures for clinical treatment services – total expenditures, expenditures for services provided by faith-based organizations, and expenditures for services provided by secular organizations;
- Expenditures for recovery support services – total expenditures, expenditures for services provided by faith-based organizations, and expenditures for services provided by secular organizations; and
- Combined expenditures for clinical treatment and recovery support services – total expenditures, expenditures for faith-based organizations, and expenditures for secular organizations.

Information should be provided on the type of service, date of service, and the days, partial days, or hour(s) of service provided. Each grantee should submit data on reimbursement rate per service (clinical treatment or recovery support service) per day, partial day, or hour(s) for the voucher program.

Outcome Measures

SAMHSA will assess outcomes for the ATR program through the National Outcome Measures (NOMs) for substance abuse treatment that SAMHSA has developed in partnership with the states. Grantees will be required to report performance in several areas relating to the client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice status. Grantees must collect and report data using the Discretionary Services Client Level GPRA tool which can be found at https://www.samhsa-gpra.samhsa.gov (click on 'Data Collection Tools/Instructions'), along with instructions for completing it. All sections of this tool must be completed for each client served. Data on clients who screen negative should not be submitted to CSAT and will not count toward meeting client targets. There are two other tools grantees are responsible for using to collect and report data to CSAT: the voucher information tool and a voucher transaction tool, which can be found at https://www.samhsa-gpra.samhsa.gov (click on 'Data Collection Tools/Instructions' and select ATR Tools), along with instructions for completing it.

Grantees use the voucher information tool to report the amount for which the voucher was issued, and the voucher transaction tool is used to report the amount for which a specific provider redeemed the voucher. These two tools are used primarily for tracking the status of each voucher that is issued to an ATR client. It is important to note that these two tools are not asked of the client. It is the responsibility of program staff to report this programmatic information. Grantees can retain responsibility for transmitting data submitted by providers to SAMHSA. However, grantees (states/territories/tribes/tribal organizations) can choose to allow providers to directly enter the required data.

Outcome data must be collected at the time of entry to and at exit from an episode of care and six months post entry. (For the purposes of the ATR program, an episode of care means the period of time from entry to exit from ATR-funded services, whether

they are clinical treatment services or recovery support services.) Please note that the substance use domain is framed in terms of rates of frequency of use; however, the primary outcome measure for this program is abstinence from substance use.

Outcome data will be collected by individual service providers or SSA/provider designees and given to the grantees (i.e., states/territories/tribes/tribal organizations). In a situation where a client is concurrently using multiple services, a single provider may be delegated the responsibility to collect data on client outcomes. Grantees (i.e., states/territories/tribes/tribal organizations) will be responsible for transmitting the outcome data and other performance data to SAMHSA. Data will be submitted on an ongoing basis. As stated previously, grantees (states/territories/tribes/tribal organizations) can retain responsibility for transmitting data submitted by providers to SAMHSA or they can choose to allow providers to submit the required data directly.

Applicants are strongly encouraged to review the required data collection forms at https://www.samhsa-gpra.samhsa.gov to determine what changes, if any, will be necessary to the data collection/management information systems within the state/territory/tribe/tribal organization, so that these changes can be factored into the proposed project. For example, it will be necessary for states/territories/tribes/tribal organizations to uniquely identify clients through the course of a clinical treatment/recovery support episode of care and provide basic demographic information. Client identifications (IDs) should be client specific and should also allow for clients to be tracked though multiple episodes of care.

The terms and conditions of the ATR grant award will include these data collection requirements. Grantees will be required to adhere to these terms and conditions.

Applicants should be aware that the SAIS reporting system will migrate to the Common Data Platform (CDP) during the life of the grant.

The collection of these data will enable CSAT to report on the NOMs, which have been defined by SAMHSA as key priority areas relating to substance use. 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.

2.2 Local Performance Assessment

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

determine whether the grantee is achieving the goals, objectives and outcomes intended to be achieved and whether adjustments need to be made to the project. Grantees will be required to report on their progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least quarterly.

At a minimum, the performance assessment should include the required performance measures identified above. Grantees may also consider outcome and process questions, such as the following:

Outcome Questions:

- What approaches and strategies resulted in accomplishing key outcome goals?
- What program/contextual factors were associated with positive outcomes?
- Which combination of services yielded the best client outcomes and which resulted in poor client outcomes? Why?
- Were certain approaches or service combinations more or less effective with diverse populations (e.g., women, adolescents, racial and ethnic groups, etc)?
- How durable were the effects of positive outcomes?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

Process Questions:

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What led to the changes in the original plan?
- What effect did the changes have on the planned project and performance assessment?
- 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)?

Performance assessments should be completed quarterly, and should be submitted not later than the end of the month following the end of the quarter.

In year 1 of the grant, no more than 20 percent of the grant award may be used for administrative costs (voucher management system, data collection, performance measurement, and performance assessment, including incentives for participating in the required data collection).

In year 2 and 3 of the grant, no more than 20 percent of the amount issued in vouchers may be used for administrative costs (not 20 percent of the total grant award).

2.3 Grantee Meetings

Grantees must plan to send a minimum of two people (including the Project Director) to at least one joint grantee meeting in each year of the grant (meetings will alternate between in person and virtual). You must include a detailed budget and narrative for this travel 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. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

II. AWARD INFORMATION

Proposed budgets cannot exceed $3 million 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 by 2014 Prevention and Public Health Funds (PPHF-2014).

Funding estimates for this announcement are based on potential funding from the Department of Health and Human Services' Prevention and Public Health Fund (PPHF). Applicants should be aware that the SAMHSA cannot guarantee that sufficient funds will be appropriated to fully fund this program.

These awards will be made as grants**.**

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are:

- State governments; applications must be submitted by SSA for Substance Abuse Services in the states, territories, or the District of Columbia.

- Federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations.

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval.

No more than one ATR application from any one state or territory or head of a tribe or tribal organization will be funded.

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-2 of this document; and

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

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/applying) 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/applying). These include:

- Access to Recovery Implementation Toolkit - http://store.samhsa.gov/product/Access-to-Recovery-Implementation-Toolkit/SMA10-ATRKIT;
- 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; and

- Charitable Choice Form SMA 170.

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 G of this document**.**

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be longer than 45 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 40, it is 41 pages long, not 40 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V – Application Review Information" of this document. Sustainability strategies must be addressed to build capacity to continue these efforts after the grant ends

  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 F through G. There are no page limits for these sections, except for Section F, 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 4** – 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, 3 and 4 combined. There are no page limitations for Attachment 2. 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**: Statement of assurance attesting that grant funds will not be used to supplant current funding. See Appendix C, Statement of Assurance.

  - **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**: Letter to the SSA (if applicable; see Appendix D - Intergovernmental Review (E.O. 12372) Requirements of this document).

- **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 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 March 31, 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 D 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), and
- Hospitals: 45 CFR Part 74, Appendix E.

In addition, SAMHSA's Access to Recovery grant recipients must comply with the following funding administrative cost restrictions:

- In year 1 of the grant, no more than 20 percent of the grant award may be used for administrative costs (voucher management system, data collection, and performance measurement and performance assessment, including incentives for participating in the required data collection).
- In year 2 and 3 of the grant, no more than 20 percent of the amount issued in vouchers may be used for administrative costs (not 20 percent of the total grant award).
- Post award technical assistance will be provided to assist grantees in adhering to the 20 percent limit.

Service Costs to be Included as Administrative Expenses

- Costs associated with eligibility determinations for clinical treatment and recovery services providers and for which services in the comprehensive array of clinical treatment and recovery support services will be included in the voucher reimbursement system.

- Costs associated with managing a system for client eligibility determination and assessment for appropriate level of care.

- Costs associated with identifying, screening, and determining eligibility for clinical treatment and recovery support services providers.

- Costs associated with fiscal/cost accounting mechanisms that can track voucher implementation.

- Costs associated with management of information systems for tracking outcomes and costs, including the costs of data collection and reporting.

- Costs associated with development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support providers.

- Costs associated with promoting of vouchers to client and provider organizations.

- Costs associated with oversight of standards and fraud and abuse issues.

- Costs related to key personnel including the ATR Project Director, Fiscal Coordinator, and other staff named in the grant as key personnel.

Be sure to identify these expenses in your proposed budget.

Please note that the types of cost associated with this grant that were not listed above can be found in Appendix N.

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

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-E below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-E.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program.

- The Project Narrative (Sections A-E) together may be no longer than 40 pages.

- You must use the five 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 F-G and Attachments 1-4 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)

- 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.

- 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 current system for providing substance abuse clinical treatment and, if available, recovery support services in the proposed target area (i.e., the state, territory or tribe, or subsection of the state, territory or tribe). Include the number of clinical treatment and recovery support service providers currently

funded by the state/territory/tribal organization, gaps in service delivery, and barriers to service access.

- Describe the nature and prevalence of substance abuse problems in the target area. Quantify the need for services, capacity of the service system to provide services, and the difference between the two. Discuss how the focus of the target area and/or service gaps will meet identified needs and/or contribute toward the reduction of health disparities.

- Explicitly state whether or not the state/territory/tribe/tribal organization already has a voucher system in place to pay for substance abuse treatment and recovery support services. If so, discuss any enhancements that would be required to implement the voucher program in proposed targeted areas. Explicitly state if no enhancements would be necessary.

Section B: Proposed Voucher Management System (25 points)

Applicants must address each item listed below in this section.

- State the unduplicated number of individuals you propose to serve by year for each of the three years of funding, 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 include the numbers to be served by race, ethnicity and gender.

- Describe the project plans to ensure that yearly client target numbers are met and program funds are used as planned in the program budget. Specifically describe how data, including federally mandated data, will be used to inform the management and quality improvement efforts of the program. Also, address management practices, partnerships with community stakeholders and providers, and the use of the electronic voucher management system, as well as any other plans to ensure achievement of targets and appropriate use of funds.

- Describe plans for ensuring that federally mandated data are collected at required intervals and uploaded to SAMHSA within the required timeframes. In the description, identify the entity(ies) that will be responsible for collecting data, especially the 6-month follow up data (e.g., providers, data collection team, contractors, etc.), and include a description of any incentives associated with 6-month follow-up data collection (either to clients [not to exceed $30] or to providers).

- Describe the approach that will be used to implement vouchers to pay for substance abuse treatment and recovery support services in the targeted implementation regions. In this section, include a clear description of each of the following:

- Organizational/management structure (e.g., state/territory/tribe/tribal organization will manage all components of the project implementation, state/territory/tribe/tribal organization will award a contract to assist with implementing key parts of the project [e.g., 6-month GPRA follow-up interviews]).

- Describe the entities, organizations, and institutions partnering in the program, including those that will refer clients into the ATR project for services (e.g., Drug Courts, Child Protective Services, Departments of Correction, community providers, etc.). Identify and describe their roles and responsibilities in implementing and ensuring the success of the voucher program and demonstrate their commitment to the project.

- Development and implementation of the electronic voucher management system or enhancements needed to implement the electronic voucher management system if the applicant already has a voucher system in place.

- Eligibility criteria for provider organizations, including: (1) standards for all eligible provider organizations and/or processes to ensure individuals receive appropriate services in safe settings from appropriate individuals, including plans to enforce those standards and processes; and (2) reporting requirements. Describe how eligibility criteria will be tailored to include grassroots, faith- and community-based organizations. Provide assurances that eligibility criteria will not result in discrimination or exclusion of grassroots, faith- and community-based organizations.

- Describe the process to enable clinical treatment and recovery support services providers, including those previously unable to compete successfully for federal funds, to participate in the voucher program (including faith-based and community-based providers). This process at a minimum should detail outreach efforts, enrollment efforts (including culturally and organizationally appropriate eligibility criteria), lines of communication (i.e., provider meetings, onsite visits, telephone, etc), and designation of liaisons between the state/territory/tribe/tribal organization and provider organizations to ensure ongoing collaboration. Clearly state how many of such clinical treatment and recovery support service providers are expected to be designated under this program. Affirm that faith-based organizations that otherwise satisfy program requirements will not be discriminated against on the basis of religious character or affiliation.

- Method/process for designating providers as eligible participants in the voucher program and for maintaining an up-to-date, client-friendly information

service to ensure client choice is always available and clients are aware of their choices (e.g., a website or 24-hour staffed help line).

- Eligibility criteria for clients to receive vouchers for clinical treatment and recovery support services.

- Policies and procedures for screening, assessment, level of care determinations, and the process for identifying available and appropriate clinical treatment and recovery support services options that will be offered to clients. The procedures should include a description of how client choice will be ensured. This section should also include a description of the process to ensure that clients receive a comprehensive assessment, using an instrument that assesses the need for clinical treatment and recovery support services **(See Appendix N for a discussion of clinical treatment and recovery support services, and Appendix O for information on screening, assessment, and level of care determination).**

- Process to ensure that clients receive vouchers for the most appropriate services and are transitioned between services based on established criteria **(See Appendices N and O for more information and resources about criteria)**. Include a description of care coordination or case management services to ensure that clients successfully enter clinical treatment and/or recovery support services following receipt of a voucher, regardless of where the client is seen for screening, assessment, and referral. Describe how these care coordination or case management services will contribute toward meeting identified needs and/or reducing health disparities.

- Provide evidence that voucher recipients will have a genuine, free, and independent choice among eligible clinical treatment and recovery support service options. Evidence is defined as having at least two providers available for each needed service, one of which should be a provider to which the client has no religious objection.

- Method/process for measuring client satisfaction in management of the voucher program.

- Submit a three-year plan for implementing the project. The plan must include specific milestones with target dates for their achievement and must identify the party(ies) responsible for achieving milestones. **(Appendix P of the RFA provides a model template for implementation planning.)**

- Describe how the state/territory/tribe/tribal organization will manage the program on the basis of reasonable costs. Include a justification if the applicant proposes to deviate from the cost ranges outlined in **Appendix R**.

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.

Section C: Proposed Implementation Approach (30 points)

- Describe your ability to fully implement the project within four months for new ATR grantees after the award date and within three months for previously funded ATR grantees. Implementation includes the following:

  - A fully functioning electronic voucher management system capable of issuing and tracking vouchers.
  - An enrolled and trained network of both clinical treatment and recovery support service providers, including faith-based organizations capable of serving ATR clients. (Based on previous ATR data, approximately 47 percent of all providers redeeming vouchers were recovery support service providers, and approximately 35 percent of all providers redeeming vouchers were faith-based organizations.)
  - Enrolling and serving clients.
  - Uploading federally mandated GPRA data at required intervals and within required timelines.
  - Submission to SAMHSA GPO signed Memoranda of Understanding (MOU) if state/territory/tribe/tribal organization is proposing to establish referrals from major institutional systems (Drug Courts, Department of Corrections, Child Protective Services, etc.) into ATR. One MOU should be established with each institutional system and should include specific details about referral pathways, how the two systems will partner, and potential number of referrals into ATR services. See **Appendix Q** for a sample MOU.

- Document which of the following capabilities the state/territory/tribe/tribal organization **currently possesses** to implement the voucher system:

  - Ability to make eligibility determinations for clients and providers.
  - Ability to manage and monitor a voucher program.
  - Ability to set reimbursement rates and monitor costs per person served.
  - Ability to collect and report data (either through an existing or planned system).
  - Ability to implement quality improvement activities including technical assistance and training.
  - Ability to establish and implement standards for clinical treatment and/or recovery support service providers.
  - Capability to conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.

- Capability to provide a list of eligible providers for anyone to whom a voucher is issued.

- Describe anticipated potential operational problems, if any, and propose feasible solutions to them, including seeking technical assistance from SAMHSA. Examples include:

  - Establishing referral pathways from major institutional systems into ATR services such as Drug Courts, Departments of Correction, or Child Protective Services Agencies.
  - Ensuring clients genuine, free, and independent choice of clinical treatment and/or recovery support providers in situations in which the range and number of providers are limited.
  - Handling significant numbers of clients eligible for vouchers who may exceed the state's ability to fund vouchers, and ensuring that resources are appropriately allocated during the course of the year.
  - Preventing potential conflict-of-interest among those conducting screening, assessment, level of care determination, and service provision.

- 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 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 people in recovery in assessing, planning, and implementing your project.

- Describe your plan to continue the project after the funding period ends. Also describe 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.

- 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 include the numbers to be served by race, ethnicity and gender.

- Provide a per-unit cost for this program. One approach might be to provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the grant and subtracting 20 percent for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served. Another approach might be to calculate a per-person or unit cost based upon your organization's history of providing a particular service(s). This might entail dividing the organization's annual expenditures on a particular service(s) by the total number of persons/families who received that service during the year. Another approach might be to deliver a cost per outcome achieved. Justify that this per-unit cost is providing high quality services that are cost effective. Describe your plan for maintaining and/or improving the provision of high quality services that are cost effective throughout the life of the grant.

Section D: Staff and Organizational Experience (15 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).

- Describe qualifications of the key staff, including the Project Director, Treatment and Recovery Support Services Coordinator, Information Technology Coordinator, and Fiscal Coordinator, to effectively implement and manage the proposed project.

Section E: Data Collection and Performance Measurement (20 points)

- Document your ability to collect and report on the required performance measures as specified in Section I-2.1 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-2.2 of this RFA and document your ability to conduct the assessment.

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 20 percent of the total grant award will be used for data collection, performance measurement and performance assessment. In year 1 of the grant, be sure to show that no more than 20 percent of the grant award may be used for administrative costs (voucher management system, data collection, and performance measurement and performance assessment, including incentives for participating in the required data collection). In year 2 and 3 of the grant, no more than 20 percent of the amount issued in vouchers may be used for administrative costs (not 20 percent of the total grant award). **Specifically identify the items associated with these costs in your budget**. An illustration of a budget and narrative justification is included in Appendix G, 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 F: 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.

- 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 F of this document.

Section G: 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 G of your application. See Appendix H 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 Substance Abuse Treatment's 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-2.1, 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 needed 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 Section 218 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:

Will Ferriss
Center for Substance Abuse Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 5-1101
Rockville, Maryland 20857
(240) 276-1658
will.ferriss@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Eileen Bermudez
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) 276-1412
eileen.bermudez@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-2 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 H of this announcement

    - Budgetary limitations as specified in Sections I, II, and IV-4 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-1.1 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 on the registration 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-E) 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 F-G) in this order and lettered consecutively.
- Other Attachment File 2: The second Other Attachment file will consist of the Attachments (Attachments 1-4) 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; and
- 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 "ATR and TI-14-004" 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 – Statement of Assurance

Statement of Assurance

As the authorized representative of *[insert name of organization]* _____, I assure SAMHSA that we will expand clinical treatment and recovery support services by leveraging use of all federal funds, preventing cost shifting, and ensuring that these funds are used to supplement and not supplant current funding for substance abuse clinical treatment and recovery support services in the state.

_____ _____

Signature of Authorized Representative Date

Appendix D – Intergovernmental Review (E.O. 12372) 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 TI-14-004. 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)[3]

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

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/sites/default/files/ssadirectory.pdf. 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.

If applicable, you must include a copy of a letter transmitting the PHSIS to the SSA in **Attachment 4, "Letter to the SSA.**" The letter must notify the state that, if it wishes to comment on the proposal, its comments should be sent no later than 60 days after the application deadline to the following address. **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: SSA – Funding Announcement No TI-14-004. Change the zip code to **20850** if you are using another delivery service.

In addition:

- Applicants may request that the SSA send them a copy of any state comments.
- The applicant must notify the SSA within 30 days of receipt of an award.

Appendix E – 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 F – 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 G – 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: Materials 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 arms 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 percent 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: https://rates.psc.gov/fms/dca/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**

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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 E, Funding Restrictions, regarding allowable costs.]

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	$24,950	$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 &	**$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
Performance Measurement						

Appendix H – 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/applying.

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 I – 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:

   a. 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.

   b. 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.

   c. 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 J – 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://www.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 K – Examples of How an SSA/Tribal Organization Could Implement a Voucher Program

Following are two examples of how an ATR grantee could use vouchers for assessment and level of care determination, as well as for substance use clinical treatment and/or recovery support services. Applicants should be innovative in their approaches.

Please note that technical assistance is available to all grantees to assist them in the development and implementation processes. We encourage all applicants to seek such assistance.

Example 1: State of West Riverton

Grant Award Date: August, 2014

Implementation Date: December, 2014

Client Target for Year 1: 1,406

Client Target for Year 2: 2,250

Client Target for Year 3: 2,969

Area of Focus: Middle and Southern Regions (25 counties)

Populations of Focus: The State of West Riverton Access to Recovery (ATR) initiative will focus on delivering services geared toward the following high-risk, underserved populations:

1. Substance abusing adolescents and young adults.
2. Low income individuals in crisis who are involved with child protective services, shelters and medical clinics as a result of drug dependence and abuse. Special emphasis and outreach is being placed on adult women.
3. Adults 18 and over who are involved with the criminal justice system/drug courts or those who are exiting the correctional system.

Outreach to Providers: West Riverton recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. All clinical treatment organizations must meet existing state licensing and certification standards for clinical treatment and assessment. For recovery support services not currently offered through West Riverton's State Department of Drug and Alcohol Substance Abuse Services (WRSDASAS), ATR recovery specialists refer clients to recovery support service providers who meet grantee-established eligibility standards. Therefore, in accordance with state administrative procedures, West Riverton published eligibility criteria and standards and created a list of eligible entities to provide

assessment and level of care determination, as well as clinical treatment and recovery support services. West Riverton makes diligent efforts to conduct outreach and marketing to providers previously unable to compete for federal funds, including faith-based and community organizations. West Riverton uses educational meetings to introduce the concept of ATR, provide enrollment information, and to give information about the recovery support services ATR vouchers will support. Enrollment meetings are utilized to enroll recovery support providers, to distribute the eligibility requirements for participation, and to offer help to providers for attaining the eligibility standards required for ATR participation. To aid with community outreach, the SSA designated a faith-based liaison to focus on outreach and engagement with the faith-based providers and other providers that may not have a history of working with the SSA. This liaison regularly meets with faith- and community-based providers, explains ATR processes, and identifies ways to strengthen the ATR collaboration with a special focus on sustainability. The SSA also requests technical assistance from SAMHSA to support outreach and enrollment of providers, with a focus on community- and faith-based organizations and customized outreach to recovery support services providers that offer peer-to-peer services.

Any provider interested in being part of the voucher program will be required to participate in a training program. Once a provider has completed the training, it will be enrolled officially in the ATR voucher program and the provider name and faith-based affiliation, if any, are added to the resource listing through the Helpline. The list of new providers is shared with county coordinators. At the outset of their voucher initiative, West Riverton developed an eligibility application process and incentives to improve outcomes. As part of the application process, providers agreed to receive 90% of the reimbursement rate for their services; 10% was withheld and set aside to be used to reimburse and encourage positive client outcomes.

Fifty (50) new clinical treatment providers met the licensing and certification criteria already established by the SSA. When West Riverton implemented the ATR program, 28 recovery support providers, including 13 faith-based organizations, had been identified, met the eligibility criteria, and agreed to the reimbursement rates established by West Riverton. The recovery support service providers agreed to the grantee established definitions of recovery support services and the reimbursement rates for these services (developed by the SSA). All of the aforementioned providers signed Memoranda of Understanding to provide ATR services should they be selected by a client. All received at least one GPRA training session. Outreach/recruitment activities and training are ongoing. Non-traditional providers unable to meet standards will receive technical assistance and training to help them meet the requirements. Faith-based programs that have the ability to provide clinical treatment services will receive assistance for achieving licensure. The West Riverton Faith-Based Association (FBA) will have responsibility for certifying unlicensed faith-based organizations that wish to provide recovery support services.

Outreach to Clients: West Riverton proposed to expand its current addiction programs by offering voucher driven alcohol and drug treatment/recovery support services in select regions. The scheduled implementation date was November 1, 2010.

West Riverton established a 24-hour, 7-day-a-week telephone line for their ATR project (800-FOR-HELP). This number made available a list of eligible assessment, treatment, and recovery support service providers (throughout the implementation region) for the voucher treatment system. West Riverton is committed to providing an administrative process which ensures individuals receive appropriate services in safe settings and services delivered by appropriate individuals. When the program opened it doors as scheduled, the 800 telephone number had been activated. This number, the West Riverton ATR website, and a major media kick-off blitz, gave the public direct and ready access to the multiple portals of entry for both potential clients and ongoing recruitment of potential caregivers. Potential clients are also able to do a brief screening and self assessment via the telephone or online. Initial appointments can be made by telephone or sent electronically. Referrals to the ATR are provided by partners at various sites, such as the public assistance/ child welfare offices, the juvenile and adult courts, the prison and jail sites and medical hospitals and clinics.

Additionally, all key staff were in place and all Helpline call center employees had attended thorough ATR customer service orientation and training on dealing with difficult/suicidal clients.

How vouchers are issued: A critical component of West Riverton's voucher program is its Electronic Information System (EIS). As clients submit a *request for services*, the enrolling provider enters the client into the electronic voucher system. A first task is to establish a client's identity and ascertain whether she or he had previously participated in the voucher program. If a client is new to the voucher system, they receive a *unique client number* and an initial client record is created. Initial contact information includes, at a minimum, name, social security number, birth date, and – where possible – substance use problem information. When the vouchers are issued (electronically) the client acknowledges by signature that he/she invoked their right to select from a list of providers appropriate to meet their assessed treatment/recovery support needs. The intake/assessment staff does a telephone follow up after 72 hours to ascertain whether or not the client kept the appointment. A bi-monthly call is made to the facility/organization to confirm the client is still in attendance. Any client who does not present for services is terminated from the ATR rolls after 60 days of non-activity. To re-enroll, a client must repeat the intake and assessment process. Separate vouchers are issued for each type of service. Vouchers have no cash value.

The SSA of West Riverton specifies that payments to providers be calculated on a service-by-service basis (unbundled), using a standardized rate schedule. The SSA specified that 90% of the rate be invoiced when services were delivered, and that the additional 10% be generated following outcomes reporting. In West Riverton, services allowable are determined by the particular type of voucher issued for the client and by

the services offered by the submitting provider. Individual services are restricted to clearly defined minimum and maximum time limits and established reimbursement rates. West Riverton provides a detailed account of the voucher and service types, rate schedule, incentive payment conditions, and restrictions in effect for their voucher program

Accountability: West Riverton is managing performance of ATR providers through outcomes monitoring, including tracking outcomes in SAMHSA's seven identified domains. The SSA monitors provider reporting of outcomes information on a monthly basis. At the end of the first 6 months of the first year, the SSA recognized six providers needed technical assistance to accurately report outcomes information. The SSA provided such technical assistance in a timely manner. At the end of the first year, however, four of the six providers were still unable to provide the outcomes information in each of the seven domains. As a result, West Riverton declared these four providers ineligible for the voucher program for the next year.

The SSA of West Riverton is utilizing a variety of administrative controls to safeguard potential fraud and abuse. An independent auditor will conduct a yearly audit pursuant to OMB Circular No. A-133. Unique client identification numbers will assure there is no duplication of services and payments. On-site audits will be done to assess the need for culturally competent services. Satisfaction surveys will be given to clients. All certified care providers will have to be recertified on a yearly basis. Program monitors will conduct random site visits twice a year to review client files and provider documentation. All client data will be tracked electronically.

Example 2: Eagle Band Tribal Organization

Grant Award Date: August, 2014

Implementation Date: December, 2014

Client Target for Year 1: 1,406

Client Target for Year 2: 2,250

Client Target for Year 3: 1,969

Area of Focus: The Eagle Band Tribal Organization is implementing its ATR project in five designated counties between Arizona and New Mexico.

Populations of Focus: The Eagle Band Tribal Organization is using Access to Recovery (ATR) to expand services to rural- and urban-dwelling American Indian/Alaska Natives (AI/AN) residing in Arizona and New Mexico.

Outreach to Providers: Prior to launching its voucher program, Eagle Band conducted outreach to a wide range of substance abuse service providers—both those involved in

clinical treatment and those involved in recovery support services. Outreach to enroll new clinical treatment and recovery support service providers included recruitment meetings, mass mailings, in-service trainings, public service announcements, and displays at conferences. Eagle Band recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. Eagle Band encouraged providers to become eligible organizations, explaining that the program would be most successful if clients have access to a variety of treatment and recovery service choices.

Prior to implementation, Eagle Band recruited 48 Tribal Councils and Indian Health provider organizations that provided resolutions demonstrating an interest in joining the ATR provider referral list. Clinical treatment providers must be licensed and/or certified. Recovery support service providers (such as healers or elders) must be in good standing with their respective tribal organization. Two major eligibility conditions were required of providers: 1) all providers must comply with Eagle Band established ATR eligibility standards; and 2) agreeing to provide the required outcomes (the SAMHSA required seven domains) and financial data. Nontraditional providers unable to meet eligibility standards receive technical assistance and training to help them meet the requirements. Faith-based and Native Healing programs that have the ability to provide clinical treatment services will receive assistance for achieving licensure. The Eagle Band Spiritual Healing Association (EBSHA) will have responsibility for certifying unlicensed faith-based organizations wishing to provide recovery support services. An Outreach Coordinator position has been created to conduct outreach and marketing to providers previously unable to compete for federal funds, including Healing and other faith-based and community organizations.

Eagle Band uses initial educational meetings to introduce the concept of ATR, provider enrollment information, and information about the recovery support services ATR vouchers will support. Enrollment meetings are utilized to enroll recovery support providers, to distribute the eligibility requirements for participation, and to offer help to providers for attaining eligibility standards required for ATR participation. Organizing these events has been an efficient way for Eagle Band to disseminate information and to answer questions and concerns posed by recovery support service providers.

Outreach to Clients:

With ATR, clients would receive vouchers to redeem at the providers of their choice. To recruit clients, Eagle Band is conducting significant outreach in a number of ways. Eagle Band is using a broad range of professional and community sources including self-referral, family, friends, self-help organizations, Tribal organizations, Tribal elders, Healers, faith-based organizations, human service organizations and professionals, health care professionals and centers, community-based organizations, employers, educational institutions, substance abuse treatment facilities, and recovery management services. The Eagle Band Coalition established an 800 information

number and a 24-hour access hotline through which certified addiction professionals conduct screenings, thereby facilitating access to clinical treatment and/or recovery support services.

How vouchers are issued:

Assessment voucher: The screening yields the assessment voucher. At the scheduled time, the client is assessed by qualified and trained staff. The assessment includes the Addiction Severity Index (ASI).

Clinical treatment voucher: Based on the results of the comprehensive assessment, a clinical treatment voucher is generated which includes level of care recommendations and all providers that offer the type and level of care indicated by the assessment. The automated voucher system enables the assessor to help the client compare various clinical treatment providers' services and capabilities so the client can make an informed choice. The clinical treatment voucher will contain the client's and assessor's signatures along with the client's choice of provider, clear instructions for the client's next steps – admission date, transportation arrangements (if needed), pre-treatment supports, recovery supports, etc.

Recovery support service voucher: An assessment provider offers multiple choices to the client in terms of recovery supports while awaiting clinical treatment, during clinical treatment, and during extended treatment along with clear instructions about next steps. The assessment produces a recovery supports voucher which includes services that might benefit the client based upon information gathered in the assessment. After the client chooses recovery supports, the client and assessor sign the voucher. The recovery supports voucher may be updated as the need for additional services arises during the course of the recovery process and in preparation for discharge.

Accountability:

Eagle Band put processes in place to prevent, detect, and investigate incidents of fraud and/or potential abuse. Since Eagle Band is using electronic tracking systems, ATR clients will be cross-referenced against other public data systems to identify the receipt of duplicative services and potential payments for the same service by more than one payer. Eagle Band plans to conduct random audits of provider billings and service data. Eagle Band will also be conducting on-site audits to assess the need for culturally competent services. Eagle Band required an initial review of provider service and billing practices before a provider was eligible to participate in ATR. In addition, Eagle Band will be utilizing client satisfaction surveys and medical chart and claims payment audits to reduce the likelihood of waste, fraud and abuse.

Eagle Band monitored provider reporting of outcomes information on a monthly basis. At the end of the first 6 months of the first year, Eagle Band recognized ten providers needed technical assistance to accurately report outcomes information. Eagle Band

provided such technical assistance in a timely manner. At the end of the first year, however, four of the ten providers were still unable to provide the outcomes information in each of the seven domains. As a result, Eagle Band declared these four providers ineligible for the ATR voucher program for the next year.

Appendix L – Implementation Components for ATR-Funded Applicants

If awarded an ATR IV grant, new applicants will be expected to fully implement the project within four months.

If awarded an ATR IV grant, previously funded ATR applicants will be expected to fully implement the project within three months.

Implementation for ATR projects involves having all of the following components in place and operational:

- Has developed and is operating a fully functioning electronic voucher management system capable of issuing and tracking vouchers.
- Has an enrolled and trained network of both clinical treatment and recovery support service providers, including faith-based organizations capable of serving ATR clients. (Based on ATR data, approximately 47% of all providers redeeming vouchers were recovery support service providers, and approximately 35% of all providers redeeming vouchers were faith-based organizations.)
- Has enrolled and is serving clients.
- Is uploading federally mandated GPRA data at required intervals and within required timelines.
- Has submitted to the SAMHSA Government Project Officer (GPO) signed Memoranda of Understanding (MOU) if SSA/Tribe/Tribal Organization is proposing to establish referrals from major institutional systems (Drug Courts, Department of Corrections, Child Protective Services, etc.) into ATR. One MOU should be established with each institutional system and should include specific details about referral pathways, how the two systems will partner, and potential number of referrals into ATR services. See **Appendix Q** for a sample MOU.

In addition, full implementation means that the grantee has the capability to:

- Make eligibility determinations for clients and providers.
- Manage and monitor a voucher program.
- Set reimbursement rates and monitor costs per person served.
- Collect and report data (either through an existing or planned system).
- Implement quality improvement activities including technical assistance and training.
- Establish and implement standards for clinical treatment and/or recovery support service providers.
- Conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.

- Provide a list of eligible providers for anyone to whom a voucher is issued.

Appendix M – Items Included as Administrative Expenses

- Development of the electronic voucher management system.
- Development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support providers.
- Management of a system for client eligibility determination and assessment for appropriate level of care.
- Identifying, screening and determining eligibility for clinical treatment and recovery support services.
- Eligibility determinations, outreach, recruitment, and enrollment of clinical treatment and recovery services providers in the ATR network including community and faith-based organizations.
- Fiscal/cost accounting mechanisms that can track voucher implementation.
- Management of information systems for tracking outcomes and costs, including the costs of data collection and reporting.
- Promoting of vouchers to client and provider organizations.
- Oversight of standards and fraud and abuse issues.

Please note that in years 2 and 3 only 20 percent of the amount redeemed in vouchers may be used as administrative expenses.

Appendix N – Comprehensive Array of Clinical Treatment and Recovery Support Services

Overview:

Research has established that there are many paths to recovery from alcohol and drug problems. Indeed, many resolve their alcohol and drug problems naturally, without any outside intervention. Others recover with the support of self-help groups such as Alcoholics Anonymous, peer-led recovery centers, and/or the faith community. Still others have found recovery through formal clinical treatment interventions. A variety of factors can influence which of these paths is taken successfully. For example, individuals with moderate problems and social support/stability are more apt to recover naturally or with minimal interventions. In contrast, people who seek treatment tend to have more serious problems.

To achieve the best outcomes at the lowest cost, SAMHSA encourages SSAs/Tribes/Tribal Organizations to provide access to a comprehensive array of clinical treatment and recovery support services as described below. Both components – clinical treatment services and recovery support services–are appropriate for many, if not all, individuals who meet the DSM-IV diagnostic criteria for substance dependence. However, not all services and/or interventions are needed by every individual in treatment for or in recovery from substance dependence. Those who meet the diagnostic criteria for substance abuse may require a less comprehensive range of services. In addition, the array of services described below need not be provided by a single entity but can be provided by a consortium of addiction treatment, health, and human service providers.

This array is not specific to any particular philosophy of clinical treatment and recovery, modality, or setting. It is a generic framework within which potential applicants can conceptualize service arrays, service capabilities, and appropriate managerial and administrative processes, including evaluation.

Methods of implementing the components of this array, the staff who deliver each service, the manner and setting in which different services are delivered, etc., should be based on individual assessment and level of care determination that considers 1) the needs of the individual; 2) the extent to which there are clinical treatment services, recovery support services, health, human services, housing, criminal justice supervision, and labor training alternatives in the jurisdiction of authority; and 3) the extent of available resources and agencies linked through coordinated case management.

In many cases, it will be desirable to provide various components of the array simultaneously, with the emphasis changing throughout the clinical treatment and recovery process. For example, in the earlier, acute phase of clinical treatment, heavier emphasis may be placed on clinical treatment services; the emphasis may switch toward recovery support as individuals move through rehabilitation and enter a maintenance phase of clinical treatment and recovery. In some cases, recovery support services alone will suffice.

Examples of Clinical Treatment and Recovery Support Services

Clinical treatment services are provided by individuals who are licensed, certified, or otherwise credentialed to provide clinical treatment services in the State, often in settings that address specific treatment needs. Examples of clinical treatment services include the following:

- Screening/assessment
- Brief intervention
- Treatment planning
- Detoxification
- Medical care
- Substance abuse education
- Individual counseling
- Group counseling
- Residential treatment
- Pharmacological interventions
- Co-occurring treatment services
- Family/marital counseling
- Case management
- Relapse prevention
- Continuing care (including face-to-face and telephone-based continuing care counseling)
- Alcohol/drug testing
- Family services, including family/marriage counseling and parenting and child development services
- Employment services and job training
- Outreach

Recovery support services are typically provided by paid staff or volunteers familiar with how their communities can support people seeking to live free of alcohol and drugs, and are often peers of those seeking recovery. Some of these services may require reimbursement while others may be available in the community free of charge. Examples of recovery support services include the following:

- Transportation to and from treatment, recovery support activities, employment, etc.
- Employment services and job training
- Case management/individual services coordination, providing linkages with other services (legal services, TANF, social services, food stamps, etc.)
- Outreach
- Relapse prevention
- Housing assistance and services
- Child care
- Family/marriage education
- Peer-to-peer services, mentoring, coaching
- Self-help and support groups, such as 12-step groups, SMART Recovery, Women for Sobriety, etc.
- Life skills
- Spiritual and faith-based support
- Education
- Parent education and child development
- Substance abuse education

Definitions for Recovery Support Services

Transportation

Commuting services are provided to clients who are engaged in treatment- and/or recovery support-related appointments and activities and who have no other means of obtaining transportation. Forms of transportation services may include public transportation or a licensed and insured driver who is affiliated with an eligible program provider.

Employment Services and Job Training

These activities are directed toward improving and maintaining employment. Services include skills assessment and development, job coaching, career exploration or placement, job shadowing or internships, résumé writing, interviewing skills, and tips for retaining a job. Other services include training in a specific skill or trade to assist individuals to prepare for, find, and obtain competitive employment such as skills training, technical skills, vocational assessment, and job referral.

Case Management

Comprehensive medical and social care coordination is provided to clients to identify their needs, plan services, link the services system with the client, monitor service delivery, and evaluate the effort.

Relapse Prevention

These services include identifying a client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

Housing Assistance and Services

These services include transitional housing, recovery living centers or homes, supported independent living, sober housing, short-term and emergency or temporary housing, and housing assistance or management. These services provide a safe, clean, and sober environment for adults with substance use disorders. Lengths of stay may vary depending on the form of housing. This assistance also includes helping families in locating and securing affordable and safe housing, as needed. Assistance may include accessing a housing referral service, relocation, tenant/landlord counseling, repair mediation, and other identified housing needs.

Child Care

These services include care and supervision provided to a client's child(ren), less than 14 years of age and for less than 24 hours per day, while the client is participating in treatment and/or recovery support activities. These services must be provided in a manner that complies with State law regarding child care facilities.

Family/Marriage Counseling and Education

Services provided to engage the whole family system to address interpersonal communication, codependency, conflict, marital issues and concerns, parenting issues, family reunification, and strategies to reduce or minimize the negative effects of substance abuse use on the relationship.

Peer-to-Peer Services, Mentoring, Coaching

Mutual assistance in promoting recovery may be offered by other persons who have experienced similar substance abuse challenges. These services focus more on wellness than illness. Mentoring and coaching may include assistance from a professional who provides the client counsel and/or spiritual support, friendship, reinforcement, and constructive example. Mentoring also includes peer mentoring which refers to services that support recovery and are designed and delivered by peers—people who have shared the experiences of addiction recovery. *Recovery support* is included here as an array of activities, resources, relationships, and services designed to assist an individual's integration into the community, participation in treatment, improved functioning or recovery.

Life Skills

Life skills services address activities of daily living, such as budgeting, time management, interpersonal relations, household management, anger management, and other issues.

Spiritual and Faith-based Support

These services assist an individual or group to develop spiritually. Activities might include, but are not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, and achieving serenity and peace of mind. Faith-based services include those provided to clients and using spiritual resources designed to help persons in recovery to integrate better their faith and recovery. Such services are usually provided in a religious or spiritual setting by spiritual leaders or other staff who are knowledgeable about the spiritual values of the community and are equipped to assist individuals in finding spirituality. Services include, but are not limited to, social support and community-engagement services, faith, or spirituality to assist clients with drawing on the resources of their faith tradition and community to support their recovery; mentoring and role modeling; and pastoral or spiritual counseling and guidance.

Education

Supported education services are defined as educational counseling and may include academic counseling, assistance with academic and financial applications, and aptitude and achievement testing to assist in planning services

and support. Vocational training and education also provide support for clients pursuing adult basic education, i.e., general education development (GED) and college education.

Parent Education and Child Development

An intervention or treatment provided in a psycho-educational group setting that involves clients and/or their families and facilitates the instruction of evidence-based parenting or child development knowledge skills. Parenting assistance is a service to assist with parenting skills; teach, monitor, and model appropriate discipline strategies and techniques; and provide information and advocacy on child development, age appropriate needs and expectations, parent groups, and other related issues.

Appendix O – Screening, Assessment, and Level of Care Determination

Screening

The purpose of screening is to quickly and cost-effectively rule out people without substance abuse problems and to identify the need for specialized substance abuse treatment.

The basic questions asked in the screening process are: 1) is a substance abuse problem present; and 2) does it require specialized care. Although we often think individuals seeking clinical treatment have been previously screened, some individuals seek specialized treatment directly.

If screening suggests an individual probably has a problem likely to require specialized treatment, the next step in the sequence may be thought of as the problem assessment.

Assessment

Assessment is the systematic process of interaction with an individual to observe, elicit, and subsequently assemble the relevant information required to manage his or her problems, both immediately and for the foreseeable future. An assessment gauges which of the available clinical treatment and recovery services options are likely to be most appropriate for the individual being assessed. Hence, assessment must occur prior to any referral of the individual to a particular kind of clinical treatment and/or recovery support service. When the same general approach is applied to all or most clients, assessment may have little impact.

Purpose of Assessment

- To characterize a problem –
  Substance abuse problems differ from person to person, often both in degree and in kind. What should emerge from an assessment is a detailed picture of the particular kind of substance abuse problem manifested by a particular individual at a particular point in time.

  In the absence of a clear, unambiguous picture at initial contact, appropriate decisions regarding care for the present and future may be difficult.

- To characterize an individual –

Substance abuse problems do not occur in a vacuum. Individuals who manifest them are at least as different from one another as they are from people without substance use disorders.

Some of these problems may be the result of abuse of drugs or alcohol; some may result in using drugs or alcohol; others may be independent problems. All are important in themselves, requiring assessment, (and often attention), in clinical treatment and/or recovery support programs. Individual characteristics may affect a person's acceptance (and, in consequence, the eventual outcome) of various forms of clinical treatment and/or recovery support services. Thus, detailed knowledge of individual characteristics can help provide the client with a list of appropriate clinical treatment and/or recovery support service options.

- To identify appropriate clinical treatment and/or recovery support service options–
  Assessment prior to clinical treatment and/or recovery support forms the basis on which individuals are provided a list of clinical treatment and/or recovery support options appropriate to their needs.

  Additional information on the individual will need to be gathered by program staff following the selection of a clinical treatment and/or recovery support program to plan the individual's ongoing course of care.

Level of Care Determination

Level of care determination is achieved through the client's selection of clinical treatment and recovery support alternatives that are both available and most likely to facilitate a positive outcome in a particular individual. Level of Care Determination:

- Focuses on matching clinical treatment and/or recovery support services to individual needs within the framework of client choice
- Defines expectations for each stage of care:
    - Acute intervention, including detoxification
    - Rehabilitation
    - Maintenance and relapse prevention

While choice among the various clinical treatment and/or recovery support services options resides with the individual, the assessor is responsible to ensure that the individual is fully conversant with all of the therapeutic alternatives available from eligible providers.

The Level of Care Determination Process

Level of Care determination is a complex matter, requiring consideration of individuals and their substance abuse problems, and knowledge of available

clinical treatment and recovery support services by both the assessor and the client.

The following general descriptors of clinical treatment and recovery support services represent the kinds of information most useful to help identify appropriate levels of care and clinical treatment and/or recovery support service options for individuals with substance abuse problems. When presented to clients in every-day language, the following information can assist clients in making an informed choice of the clinical treatment and/or recovery support service option(s) that may meet their needs:

- Philosophy and orientation of the program (e.g., medical model, social model, spiritual model, etc.);
- Stage of substance abuse problem or recovery at which the clinical treatment and/or recovery support service is directed (e.g., detoxification, rehabilitation, maintenance);
- Setting of the program (e.g., inpatient, outpatient, residential) and staffing; and
- Therapeutic approach/type of intervention

Additional Resources for Screening, Assessment, and Level of Care Determination

I. Resources to Implement Screening

In health care, screening is a process to identify people who have, or are at risk for, an illness or disorder. The purpose of screening is to target persons for clinical treatment and/or recovery support services, thus reducing the long-term morbidity and mortality related to the condition. In addition, by intervening early and raising the individual's level of concern about risk factors and substance-related problems, screening for drug and alcohol problems in community settings can reduce subsequent use.

Two types of screening procedures are typically used. The first includes self-report questionnaires and structured interviews; the second, clinical laboratory tests that can detect biochemical changes associated with excessive alcohol consumption or illicit drug use.

A variety of screening instruments are available. The majority of studies and implementation efforts have focused on screening for alcohol problems. The CAGE and AUDIT are the most commonly used screening tools. The DAST has also been used in conjunction with the AUDIT in several projects, where there has been an effort to implement this approach for persons with or at risk for a substance use disorder. Several new instruments have been developed, but not

yet rigorously tested, to assess harmful use of either alcohol or drugs (e.g., the CAGE-D, the ASSIST, the TCUDS, the GAIN-QS, the PDES).

Brown, RL and Rounds LA. 1995. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*, 94, 135-140.

Brown R, Leonard T, Saunders LA, et al. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, 151-160.

A bibliography with descriptions and evaluations of various interview, questionnaire, and laboratory test screening approaches is available from Project Cork.

Project Cork. 2002. *CORK Bibliography: Screening Tests.* 2001-2002, 58 Citations.
http://www.projectcork.org/bibliographies/data/Bibliography_Screening_Tests.html

Screening instruments have been developed or modified for use with different target populations, notably adolescents, offenders within the criminal justice system, welfare recipients, women, and the elderly. Several have been translated into other languages and have been evaluated for cultural sensitivity. Again, SAMHSA is not requiring a specific instrument or protocol, but choice of instruments or laboratory tests must be justified.

It is well recognized that screening instruments used with adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical settings. One example of a brief substance abuse screening instrument recently developed specifically for use with adolescents is the CRAFFT test.

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. 2002. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med*. 156(6): 607-14.

Additional screening tests and procedures targeted at adolescents, including the PDES and the GAIN-QS, are described in these publications:

Winters KC. 1992. Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addict Behav*. 17(5): 479-90.

Winters KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA) 99-3282.

Winters KC. 1999. *Treatment of Adolescents With Substance Use Disorders.*
Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99-3283.

Winters KC. 2001. Assessing adolescent substance use problems and other areas of functioning: State of the art. In: PM Monti, SM. Colby, and TA. O'Leary (eds). *Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions.* New York, Guilford Publications, Inc., pp. 80-108.

Dennis ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications. http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Martino S, Grilo CM, and Fehon DC 2000. Development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors* 25(1): 57-70.

Screening tests and procedures targeted at the elderly are described in these publications:

Blow, F.C. Consensus Panel Chair. 1998. *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.

Blow FC and Barry KL. 1999-2000. Advances in alcohol screening and brief intervention with older adults. *Advances in Medical Psychotherapy*. 10:107-124

Screening tests and procedures targeted at persons in the criminal justice system are described in these publications:

Inciardi JA Consensus Panel Chair 1994. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076

Peters, RH, Greenbaum, PE, Steinberg, ML, Carter, CR, Ortiz, MM, Fry, BC, Valle, SK. 2000. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal Substance Abuse Treatment*: 18(4): 349-58.

Simpson DD. 2001. Core set of TCU forms. Fort Worth: Texas Christian University, Institute of Behavioral Research. www.ibr.tcu.edu.

Efforts are ongoing to develop methods to better screen people with co-occurring substance use and mental disorders.

II. Assessment Instruments

Substance abuse assessment instruments are designed to determine the precise nature and severity of an individual's problems. Some instruments are also designed to help pinpoint specific diagnoses. While the results of assessment instruments do not necessarily specify the service needs of clients, the data collected from these instruments can help determine a client's level of care need and, thus, the options of eligible service providers.

- **Adult Assessment Instruments**

Addiction Severity Index (ASI)

ASI is a 30 to 40-minute, interviewer-administered instrument that assesses severity of alcohol and drug problems across several domains. The ASI has been tested extensively and used widely for initial client assessments and to measure client progress and outcomes. The ASI should be administered by trained clinicians.

McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E. An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *J Nerv Ment Dis* 168:26-33, 1980.

--and/or--

McLellan, A.T.; Kushner, H.; Metzger, D.; Peters F.; et al. The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat* 9:199-213, 1992.

Substance Use Disorders Diagnostic Schedule (SUDDS-IV)

"The SUDDS-IV is a comprehensive diagnostic assessment interview providing definitive documentation for substance-specific abuse or dependence diagnoses based on DSM-IV-TR criteria. It also screens for depression and anxiety disorders. In addition to diagnostic documentation, the SUDDS-IV provides valuable information for treatment planning and patient placement." (Source: www.evinceassessment.com)

Harrison, P. & Hoffman, N. (1987). Substance Use Disorders Diagnostic Schedule (SUDDS). St. Paul, MN: Norman G. Hoffman.

Minnesota Multiphasic Personality Inventory (MMPI)

"The Minnesota Multiphasic Personality Inventory (MMPI) is an objective verbal inventory designed as a personality test for the assessment of psychopathology consisting of 550 statements, 16 of which are repeated. The replicated statements were originally included to facilitate the first attempt at scanner scoring. Though they are no longer needed for this

purpose, they persist in the inventory." (Source: http://www.cps.nova.edu/~cpphelp/MMPI-2.html)
Hathaway, S. & McKinley, J. Manual for the Minnesota Multiphasic Personality Inventory. New York: Psychological Corporation; 1951, 1967, 1983.
--and/or--
Hathaway, S.; McKinley, J.; Butcher, J.; Dahlstrom, W.; Graham, J.; Tellegen, A.; et al. Minnesota Multiphasic Personality Inventory-2: manual for administration. Minneapolis: University of Minnesota Press; 1989.

The Recovery Attitude and Treatment Evaluator (RAATE)
"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)
Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

- **Adolescent Assessment Instruments**

Comprehensive Adolescent Severity Inventory (CASI)
CASI measures education, substance use, use of free time, leisure activities, peer relationships, family history and intrafamilial substance use, psychiatric status, and legal history. The CASI also incorporates results from urine drug screens and observations from the assessor. Psychometric studies on the CASI support the instrument's reliability and validity.
Meyers, Kathleen. *Comprehensive Adolescent Severity Inventory (CASI).* Philadelphia, PA: Penn/VA Center for Studies of Addiction, 1996. c. 176 p. [RJ 503.7 M4 1996]

Global Assessment of Individual Needs (GAIN)

Dennis, ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications.
http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Winters, KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.

III. Diagnostic Criteria

Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)

DSM-IV includes the most widely accepted criteria for diagnosing substance abuse and mental disorders. Based on data collected during an assessment, the DSM criteria for substance use disorders can be used to determine if someone has a "substance abuse" or "substance dependence" diagnosis. DSM-IV was first published in 1994 by the American Psychiatric Association, Washington D.C.

IV. Level of Care Determination, Continued Stay, and Discharge Criteria

Patient Placement Criteria for the Treatment of Substance-Related Disorders

The American Society of Addiction Medicine (ASAM) published the second edition of its *Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2) in 1996. ASAM's PPC-2R presents the criteria for determining which level of services best fits a client's needs. The PPC-2R now has both adult and adolescent criteria and the appropriate criteria should be used for each of these groups.

RAATE

"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)

Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

Appendix P – Model Template for Implementation Planning and Tracking

Task Name	Duration Total Number of Days	Start Date	Finish Date	Responsible Member of ATR Key Staff or Other Staff	Accomplished by Target Date? (Yes/No)	If No, list cause of delay and when task will be accomplished
Internal Administrative Actions	**Total Number of Days**					
Develop Project Implementation Plan						
Hire full-time permanent IT Coordinator						
Hire full-time permanent Fiscal Coordinator						
Develop MOU with Department of Correction						
Develop MOU with Child Protective Services						
Develop MOUs with community providers						
Set and finalize clinical treatment definitions and rates						
Set and finalize RSS definitions and rates						
Grants and Contracts Management						

Task Name	Duration Total Number of Days	Start Date	Finish Date	Responsible Member of ATR Key Staff or Other Staff	Accomplished by Target Date? (Yes/No)	If No, list cause of delay and when task will be accomplished
Finalize Contract I: Development and Hosting of Voucher Management System						
Develop information management service						
Train the trainers						
Finalize Contract II: TA to treatment and recovery support service providers and potential network members						
Develop strategies for determining provider TA needs						
Identify methods of TA (telephonic, web- based, in person, regional events)						

Task Name	Duration Total Number of Days	Start Date	Finish Date	Responsible Member of ATR Key Staff or Other Staff	Accomplished by Target Date? (Yes/No)	If No, list cause of delay and when task will be accomplished
Training for network clinical treatment and recovery support providers						
Develop training schedule						
Develop training curriculum						
Conduct trainings						
Outreach and Recruitment of Treatment and Recovery Support Service Providers						
Structure provider application process						
Finalize provider application template						
Develop provider manual						
Develop training						
Develop communications and marketing to providers Specify strategies_____						
Modify billing infrastructure						

Task Name	Duration Total Number of Days	Start Date	Finish Date	Responsible Member of ATR Key Staff or Other Staff	Accomplished by Target Date? (Yes/No)	If No, list cause of delay and when task will be accomplished
Conduct provider events						
Enroll providers						
GPRA-related Tasks						
Obtain GPRA Upload certification from SAMHSA						
Additional Tasks						

Appendix Q – Sample Memorandum of Understanding

Memorandum of Understanding

NO. B23-56-9-09-1234

This agreement is entered into by and between the San Bando Family and Services Administration, the Division of Mental Health and Addiction, (hereafter referred to as "DMHA") and the San Bando Department of Correction (hereafter referred to as "DOC"), and is executed pursuant to the terms and conditions set forth herein. In consideration of those mutual undertakings and covenants, the parties agree as follows:

I. PURPOSE

This Memorandum of Understanding ("MOU") is entered into by DMHA and the DOC in order that, under a grant from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT), the DMHA may provide increased chemical dependency recovery services to certain committed individuals who are being or who have been released from correctional facilities, are re-entering the community, and who are in need of the services provided by the San Bando Access to Recovery program (ATR). The parties agree to the division of responsibilities as outlined in Sections IV, V, VI, and VII.

II. AUTHORITY

The DMHA enters into this MOU pursuant to the authority found in NA 45-34-98(7). The San Bando DOC enters into this MOU pursuant to the authority found in NA -23-54-34(1).

III. TERM OF AGREEMENT

This MOU shall become effective July 1, 2014 and shall remain in effect through

September 30, 2017.

IV. RESPONSIBILITIES OF THE DMHA

The DMHA shall have the following responsibilities:

a) The DMHA shall provide chemical dependency recovery ("services") to the following three target populations:
   - Methamphetamine consuming individuals.
   - Women who are pregnant or who have dependent children.
   - Individuals re-entering the community from correctional facilities.

b) The service shall be paid for through ATR vouchers provided by the DMHA to services providers.
c) The services available through the ATR vouchers shall be the following:
    - Detoxification
    - Transportation
    - Relapse prevention
    - Addiction education
    - Housing assistance
    - Peer coaching services
    - Family and marital counseling
    - Employment services
    - Faith-based and/or community-based support
    - Parenting support services
    - Parenting education
    - Supportive education
    - AOD screening
    - Care coordination
    - Clinical assessment
    - Outpatient treatment
    - Independent treatment of co-occurring disorders

d) The DMHA shall ensure that all San Bando ATR program service providers provider culturally sensitive services to the greatest extent appropriate.

e) The DMHA shall be responsible for training all DOC staff in the policies and procedures of the San Bando ATR program with special emphasis on each of the following:
    - Client eligibility
    - Client choice
    - Referral procedure
    - Intake procedure
    - Outcome measures
    - Non-supplantation policy

f) The DMHA shall be responsible for providing any report or information required by SAMHSA/CSAT concerning the San Bando ATR program provided however that the San Bando DOC shall provide the DMHA with the reports and information required under the terms of this memorandum.

V. RESPONSIBILITIES OF THE SAN BANDO DOC

The DOC shall have the following referral policies:

a) Scope of work
   1. The DOC shall refer inmates to the ATR program as a part of their release procedure insofar as those re-entering the community are in need of the above services provided by the ATR program.
   2. ATR vouchers shall be provided for inmate who will reside in the following 3 counties upon their release from a State correctional facility: Vanley, Shorum, and West Fallsville counties.
   3. San Bando DOC shall identify at least 3,500 inmates being released from State correctional facilities who are in need of chemical dependency recovery services and refer those individuals to the San Bando ATR program.
   4. Referred inmates shall meet all of the following qualifications:
      1) The inmates shall reside following release in one of the three counties listed in the above section.

      2) The inmate shall have a history of substance abuse.

      3) The inmate shall have voluntarily expressed a willingness to participate in the San Bando ATR program.

      4) The inmate shall select a care coordination agency from among those available in the county in which the inmate resides or will reside following release.

   5. The San Bando DOC shall establish release protocols that provide the ATR care coordinators the ability to conduct the ATR intake interview prior to the inmate's release from a State correctional facility.
   6. During the period immediately preceding an inmate's release from a State correctional facility, the San Bando DOC shall refer to the ATR program inmates who meet the above requirements and who have participated in the following DOC programs:
      1) The Recovery from Addiction Program (RAP)

      2) The Sober and Purposeful Life Program (SPLP)

      3) Any other DOC chemical dependency programs or therapeutic communities.

In addition, the San Bando DOC may refer to the ATR program other inmates in the general population of a State correctional facility who are being released if the inmate otherwise meets the referral requirements contained in this MOU.

7. The San Bando DOC shall provide all referred inmates with a list of approved care coordinators for the ATR program in the county where the inmate will reside following release and shall allow the inmates to select a care coordinator from that list.
8. The San Bando DOC shall assure that no one influences the inmates' selections of a care coordinator from a care coordinator list.
9. The San Bando DOC agrees to provide the ATR care coordinator selected by an inmate with access to the inmate prior to the inmate's release from the State correctional facility.

b). Administrative and funding terms, requirements and limitations

1. The San Bando DOC acknowledges and agrees that no funds will be paid to the San Bando DOC for the purpose of performing the work related to the ATR program as outlined in the preceding scope of work.
2. Each quarter, the San Bando DOC shall provide the DMHA with projections of the individuals to be referred to the ATR program in each successive 6-month period, including the following:
    a. Name
    b. Facility at time of release
    c. County of release
    d. Date of release
    e. Sample matching data
    f. Re-entry coordinator and contact information
3. The San Bando DOC shall provide quarterly reports of the following to the DMHA:
    a. A comparison of (1) the recidivism rate of individuals referred to the ATR program with (2) the recidivism rate of a matched sample of individuals not referred to the program.
    b. The associated savings to the jurisdiction of San Bando.

VI. MUTUAL RESPONSIBILITIES

Each party shall cooperate with the other party and meet with the other party as necessary to further the objectives of this memorandum.

Each party agrees to meet regularly and to provide any information or documentation necessary to fulfill the responsibilities of the DMHA or San Bando DOC under this memorandum.

VII. SECURITY AND PRIVACY OF HEALTH INFORMATION

Through this MOU the parties wish to acknowledge their mutual obligations arising under laws and regulations of the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPPA), Privacy Regulations effective April 14, 2003, and Security Regulations effective on April 20, 2005; and (2) Confidentiality of Alcohol and Drug Abuse Patient Records (CADAPR). 45 CFR 164. 42 CFR 2.

The DMHA agrees to comply with all requirements of HIPPA and CADAPR in all activities related to the MOU, to maintain compliance throughout the life of the MOU, to operate any systems used to fulfill the requirements of this MOU in full compliance with HIPPA and CADAPR and to take no action which adversely affects San Bando's compliance with either federal statute.

To the extent required by the provisions of HIPPA and regulations promulgated there under, the DMHA assures that it will appropriately safeguard Protected Health Information (PHI), as defined by the regulations, which is made available to or obtained by the DMHA in the course of its work under the MOU. For the purposes of this MOU the term PHI shall include the protections under both 45 CFR 164 and 42 CFR 2. The DMHA agrees to comply with all applicable requirements of law relating to PHI with respect to any task or other activity it performs under this MOU, including the following:

- Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the DMHA receives, maintains, or transmits on behalf of the San Bando DOC;
- Not using or further disclosing PHI other than as permitted or required by this MOU or by applicable law;
- Using appropriate safeguards to prevent use or disclosure of PHI other than as provided by this MOU or by applicable law;
- Mitigating, to the extent practicable, any harmful effect that is known to the DMHA;
- Ensuring that any sub-contractors or agents to whom the DMHA provides PHI received from the San Bando DOC agree to the same restrictions, conditions, and obligations applicable to such party regarding PHI and agrees to implement reasonable and appropriate safeguards to protect it;
- Making available the information required to provide an accounting of disclosures pursuant to applicable law;
- At the termination of the MOU the protections in this agreement shall continue to be extended to any PHI maintained by the DMHA for as long as it is maintained.

The parties agree that all terms in this section of the MOU not otherwise defined shall be defined by reference to the same terms in the HIPPA in its implementing regulations.

VIII. MODIFICATION

This memorandum may be modified at any time by a written modification mutually agreed upon by both agencies.

IX. EFFECTIVE DATE

This memorandum of understanding is effective on the date that both signatories have executed this document.

The parties, having read and understood the terms of this memorandum do, by their respective signatures below, hereby agree to the terms and conditions thereof.

X. NON-COLLUSION AND ACCEPTANCE

The undersigned attests, subject to the penalties for perjury, that he/she is the agreeing party, or that he/she is the representative, agent, member or officer of the agreeing party, that he/she has not, nor has any other member, employee, representative, agent or officer of the division, firm, company, corporation or partnership representative by him/her, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid, any sum of money or other consideration for the execution of this agreement other than that which appears upon the face of the agreement.

XI. SIGNATURES

In Witness Whereof, DMHA and DOC have, through dually authorized representatives entered into this agreement. The parties having read and understand the foregoing terms of the Agreement do by their respective signatures dated below hereby agree to the terms thereof.

San Bando Department of Correction

_____

Commissioner

Date:_____

San Bando Division of Mental Health and Addiction

_____

Director

Date:_____

San Bando Budget Agency

_____

Director

Date:_____

Appendix R – Managing on the Basis of Reasonable Costs

SSAs/Tribes/Tribal Organizations are encouraged to manage the program on the basis of reasonable costs. Proposed per person costs for treatment and recovery support services to be provided under this initiative should be included in the application. In cases where it is not possible to include costs that are based on prior experience, the application should include an estimate of the cost of the service, as well as a plan and timeline for developing cost data based on experience.

The following are considered reasonable ranges by treatment or modality:

Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services - $200 to $1,200

Outpatient (Non-Methadone) - $1,000 to $5,000

Outpatient (Methadone) - $1,500 to $8,000

Intensive Outpatient- $1,000 to $7,500

Residential - $3,000 to $10,000

Peer Recovery Support Services- $1,000 to $2,500

If the SSA/Tribe/Tribal Organization deviates from these costs, it should provide a justification for doing so, in order for SAMHSA to determine reasonableness of costs. Reasonable cost is based on actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program (Center for Medicare and Medicaid Services, 2003). While cost ranges for recovery support services are not specified above, due to the great variations that exist, applicants are expected to provide costs for recovery support services that they intend to provide. Per person costs for each modality should be computed by dividing the number of persons served in each modality by the amount of the project budget used to fund that program component after subtracting out the costs of required data collection and submission.