

**Department of Health and Human Services
Substance Abuse and Mental Health Services
Administration**

**Cooperative Agreement to Benefit Homeless
Individuals for States**

(Short Title: CABHI-States)

(Initial Announcement)

Request for Applications (RFA) No. TI-15-003

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

PART 1: Programmatic Guidance

[Note to Applicants: This document must be used in conjunction with SAMHSA's "Request for Applications (RFA): PART II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each RFA. PART II includes requirements that are common to all SAMHSA RFAs. You must use both documents in preparing your application.]

Key Dates:

Application Deadline	Applications are due by April 9, 2015.
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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) are accepting applications for fiscal year (FY) 2015 Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States) grants. The purpose of this jointly funded program is to enhance or develop the infrastructure of states and their treatment service systems to increase capacity and provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services, permanent supportive housing, peer supports, and other recovery support services to:

- Individuals who experience chronic homelessness and have substance use disorders, serious mental illnesses (SMI), or co-occurring mental and substance use disorders; and/or
- Veterans who experience homelessness/chronic homelessness and have substance use disorders, SMI, or co-occurring mental and substance use disorders.

As a result of this program, SAMHSA seeks to: 1) improve statewide strategies to address planning and coordination of behavioral health and primary care services, and permanent housing to reduce homelessness; 2) increase the number of individuals, residing in permanent housing, who receive behavioral health treatment and recovery support services; and 3) increase the number of individuals placed in permanent housing and enrolled in Medicaid and other mainstream benefits (e.g., SSI/SSDI, Temporary Assistance for Needy Families [TANF], Supplemental Nutrition Assistance Program [SNAP]).

Funding Opportunity Title:	Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States)
Funding Opportunity Number:	TI-15-003
Due Date for Applications:	April 9, 2015
Anticipated Total Available Funding:	\$15.181 million (Up to \$7.438 million or 49 percent from CSAT’s Treatment Systems for Homeless and up to \$7.742 million or 51 percent from CMHS’ Homeless Prevention Program)

Estimated Number of Awards:	6 to 8 awards
Estimated Award Amount:	Up to \$3 million per year for Tier 1 states and up to \$1.8 million per year for Tier 2 states. Each grant award will consist of 49 percent CSAT funds and 51 percent CMHS funds, even if an applicant requests less than the maximum award amount.
Cost Sharing/Match Required	No
Length of Project Period:	Up to 3 years
Eligible Applicants:	Eligible applicants are State Mental Health Authorities (SMHAs) or Single State Agencies (SSAs) for Substance Abuse in partnership. [See <u>Section III-1</u> of this RFA for complete eligibility information.]

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

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) are accepting applications for fiscal year (FY) 2015 Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States) grants. The purpose of this jointly funded program is to enhance or develop the infrastructure of states and their treatment service systems to increase capacity and provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services; permanent supportive housing; peer supports; and other recovery support services to:

- Individuals who experience chronic homelessness and have substance use disorders, serious mental illnesses (SMI), or co-occurring mental and substance use disorders; and/or
- Veterans who experience homelessness/chronic homelessness and have substance use disorders, SMI, or co-occurring mental and substance use disorders.

As a result of this program, SAMHSA seeks to: 1) improve statewide strategies to address planning, coordination, and integration of behavioral health and primary care services, and permanent housing to reduce homelessness; 2) increase the number of individuals, residing in permanent housing, who receive behavioral health treatment and recovery support services; and 3) increase the number of individuals placed in permanent housing and enrolled in Medicaid and other mainstream benefits (e.g., Supplemental Security Income/Social Security Disability Insurance [SSI/SSDI], Temporary Assistance for Needy Families [TANF], Supplemental Nutrition Assistance Program [SNAP]).

The goal of the CABHI-States program is to ensure, through state and local planning and service delivery, that individuals who experience chronic homelessness and have substance use disorders, SMI, or co-occurring mental and substance use disorders, and/or veterans who experience homelessness/chronic homelessness and have substance use disorders, SMI, or co-occurring mental and substance use disorders, (hereinafter referred to as "population[s] of focus") receive sustainable permanent supportive housing, treatment, recovery supports, and Medicaid and other mainstream benefits. To achieve this goal, SAMHSA will support three primary types of activities:

1. Development of a new statewide plan or enhancement of an existing statewide plan to ensure sustained partnerships across public health and housing systems that will result in short- and long-term strategies to support efforts to reduce homelessness.
2. Delivery of behavioral health, housing support, peer, and other recovery-oriented services.
3. Assistance to the state Medicaid eligibility agency in developing a streamlined application process for the population(s) of focus and assistance to providers (e.g., alcohol and drug treatment facilities, homeless service providers) seeking to become qualified Medicaid providers; to engage and enroll eligible persons constituting the population(s) of focus in Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP).

The CABHI-States grant program closely aligns with SAMHSA's Strategic Initiative on Recovery Support. For more information on SAMHSA's six strategic initiatives you can visit <http://www.samhsa.gov/about-us/strategic-initiatives>. The program also 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 PART II: Appendix G – Addressing Behavioral Health Disparities).

CABHI-States is one of SAMHSA's services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the 4th month of the project at the latest.

CABHI-States grants are authorized under Section 509 and 520A of the Public Health Service Act, as amended. The combination of these authorities permits SAMHSA to announce and administer this jointly funded grant program as it is described in this document. This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD and Substance Abuse Topic Area HP 2020-SA.

Definitions

For the purposes of this RFA, states, territories, and the District of Columbia will collectively be referred to as "states".

For the purposes of this RFA, the term "behavioral health" refers to a state of mental/emotional health and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicidal ideation, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders

and related problems, treatments and services for mental and substance use disorders, and recovery support.

“Mental and substance use disorders” are referred to throughout this document. This phrase is meant to be inclusive of mental disorders, SMIs, substance use disorders, and co-occurring substance use and mental disorders.

“Permanent Housing” means community-based housing without a designated length of stay (e.g., no limit on the length of stay). Housing is decent, affordable, and integrated in the community. It may include an apartment or single room occupancy in a building (congregate housing), rent-subsidized apartments, or houses in the open housing market (scattered housing), as well as designated units within privately owned buildings.

“Permanent Supportive Housing” refers to housing that is considered permanent (rather than temporary or short-term) and offers tenants a range of supportive services aimed at promoting recovery from mental and/or substance use disorders. There should not be any arbitrary limits for the length of stay for the tenant as long as the tenant complies with the lease requirements (consistent with local landlord-tenant law).

“Homeless” as characterized under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, and defined by the December 5, 2011, Final Rule Defining Homeless (76 FR 75994), establishes four categories of homelessness. These categories are: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution; (2) Individuals and families who will imminently lose their primary nighttime residence; (3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or (4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

“Chronic homelessness” as characterized under the McKinney-Vento Homeless Assistance Act, as amended by S. 896 of the “Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 means, with respect to an individual or family, that the individual or family—(i) is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter; (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least 4 separate occasions in the last 3 years; and (iii) has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, SMI, developmental disability, posttraumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability,

including the co-occurrence of 2 or more of those conditions. In addition, a person who currently lives or resides in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, and has resided there for fewer than 90 days shall be considered chronically homeless if such person met all of the requirements described above prior to entering that facility.

In addition, for the purposes of this RFA, the terms “homeless” and “chronically homeless” also may include individuals who are “doubled-up”—a residential status that places individuals at imminent risk for becoming homeless—defined as sharing another person’s dwelling on a temporary basis where continued tenancy is contingent upon the hospitality of the primary leaseholder or owner and can be rescinded at any time without notice.

2. EXPECTATIONS

SAMHSA expects grantees to develop and implement enhancements to state infrastructure and an array of integrated services and supports designed to reduce homelessness and chronic homelessness among the population(s) of focus.

These cooperative agreements are designed to bring together stakeholders across the homeless service system to develop and/or enhance a State Interagency Council on Homelessness. This is a coordinated network that may develop policies, expand workforce capacity, disseminate best practices, and implement mechanisms and other reforms to improve the integration and efficiency of recovery support systems for the population(s) of focus. Concurrently, community-based services will be provided either by the grantee and/or via sub-award to domestic public and private nonprofit entities (e.g., local governments or community- and faith-based organizations) that are responsible for administering behavioral health services directly or through contractual agreements.

For FY 2015, funding is available in two tiers based on reported numbers of chronically homeless populations according to the HUD 2014 Point-in-Time count estimates. Tier 1 states are eligible for up to \$3 million per year. Tier 2 states are eligible for up to \$1.8 million per year. (See [Section III-1](#): Eligible Applicants).

Although CSAT and CMHS funds are jointly funding a spectrum of infrastructure, behavioral health treatment, and recovery support services, **applicants must track and report the use of funds separately**. Regardless of the total amount of grant funding requested by the applicant, the total project costs in the proposed budget must reflect a split of 49 percent CSAT funds and 51 percent CMHS funds. Applicants must submit one budget that includes a column for CMHS requested funds and a column for CSAT requested funds. (See Part II: Appendix F – Sample Budget and Justification).

CSAT and CMHS funds may be used for infrastructure development, evaluation, screening and assessment, and behavioral health treatment and recovery support of individuals diagnosed with **co-occurring mental and substance use disorders**.

Only CMHS funds may be used to pay for treatment and recovery support services for individuals who only have a mental disorder. CMHS funds **may not** be used to pay for treatment and recovery support services for individuals with **only** a substance use disorder.

Only CSAT funds may be used to pay for treatment and recovery support services for individuals who only have a substance use disorder. CSAT funds **may not** be used to pay for treatment and recovery support services for individuals with **only** mental disorders.

Tier 1 grantees may receive up to \$1.47 million (49 percent) per year from CSAT and up to \$1.53 million (51 percent)] per year from CMHS for a total of \$3 million per year. Tier 2 grantees may receive up to \$882,000 (49 percent) per year from CSAT and up to \$918,000 (51 percent) per year from CMHS for a total of \$1.8 million per year.

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after your award. In this statement you must propose: (1) the number of individuals to be served during the grant period and identify subpopulations (i.e., racial, ethnic, sexual and gender minority groups) vulnerable to behavioral health disparities; (2) a quality improvement plan for the use of program data on access, use, and outcomes to support efforts to decrease the differences in access to, use, and outcomes of service activities; and (3) methods for the development of policies and procedures to ensure adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

State Infrastructure Development

Grantees may use **up to 25 percent of the total grant award** for infrastructure development/improvements at the state level to increase/improve statewide capacity to provide effective, accessible treatment and recovery support services, and to create a more integrated and collaborative system of care for individuals and families experiencing homelessness. Grantees may use **up to 20 percent of this amount** for data collection, performance measurement, and performance assessment.

The proposed project is **required** to include the following state infrastructure activities:

- Establishing a State Interagency Council on Homelessness, co-led by the grantee and partnering behavioral health authority (State Mental Health Authorities (SMHAs) or the Single State Agencies (SSAs) for Substance Abuse), to meet the goals outlined in this RFA. If a State Interagency Council on

Homelessness exists, the grantee may use the existing Council if the membership requirements are met and if the Council agrees to focus a portion of activities on state infrastructure development or improvements. In addition to the co-leads, members must be comprised of, at a minimum, representatives from the state Medicaid Agency; health department; veterans affairs; public housing authorities; service providers; state SSI/SSDI Outreach, Access, and Recovery (SOAR); individuals (non-veterans) and veterans) who are homeless or have experienced homelessness and are recovering from substance use disorders, SMIs, or co-occurring mental and substance use disorders; and the SAMHSA government project officer. Additional membership based on the goals, objectives, or specific population(s) of focus is encouraged (e.g., criminal justice, State Health Information Technology [HIT] Coordinator). Membership requires standardized signed contracts or signed Memorandum of Understanding (MOUs).

- The State Interagency Council on Homelessness should meet at least quarterly per year to: achieve the goals and objectives of the grant project's statewide plan; increase coordination with other entities engaged in planning the jurisdiction's response to homelessness (e.g., Continuums of Care [CoC], Emergency Solutions Grant recipients, those involved in implementing local 10-year plans to end homelessness); and to ensure the provision of direct treatment and recovery support services to the population(s) of focus.
- Development of a new statewide plan or enhancement of an existing statewide plan to ensure sustained partnerships across public health and housing systems that will result in short- and long-term strategies to support those experiencing homelessness who have behavioral health issues. These responsibilities include but are not limited to: identifying service gaps, participating in infrastructure reform, policy development, involving individuals who experience homelessness at the policy and practice level. **Note: The draft statewide plan is due by the 2nd month of the grant project.** Examples of activities that may be included in the plan are:
 - Develop and/or improve policies to create seamless coordination and delivery of services across multiple systems (e.g., mainstream benefits, behavioral health, primary care, housing). For example, collaborate with CoCs to enhance coordinated assessment systems to meet the needs of the population(s) of focus, in order to improve access to housing and mainstream services to ensure the type and level of assistance provided to individuals and families is tailored to meet their specific needs.
 - Identify and develop, through partnership with the state Medicaid eligibility/determination office, a process that accelerates and streamlines Medicaid enrollment for eligible individuals who experience homelessness.

- Develop Medicaid provisions (e.g., Medicaid billable services) that are used to cover the various services needed for eligible individuals who experience homelessness.
- Assist substance abuse treatment, mental health service, and homeless providers in becoming Medicaid providers and developing Medicaid reimbursement mechanisms.
- Identify, develop, and train staff on SOAR and create partnerships with the SSA offices to address seamless processing for SSI/SSDI applications.
- Train case managers and other staff on medical documentation needs of individuals seeking mainstream benefits.

In addition to required activities, other **allowable** infrastructure activities include the following types of activities:

- Adopt and/or enhance computer systems, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care process, integration with related support services, and outcomes.
- Assist providers in implementing HIT solutions to support effective coordination of care for the population(s) of focus. Activities could include supporting adoption and/or enhancement of management information system (MIS), certified electronic health records (EHRs), telehealth systems, mobile apps, tablet-based delivery of assessments, care coordination dashboards, etc., to document and manage delivery of services, to enable integration and coordination with related support services, etc. (see Appendix IV – Electronic Health Record [EHR] Resources).
- Training/workforce development to help staff or other providers in the community identify mental health or substance abuse issues or provide effective services consistent with the purpose of the grant program.

Community-Based Services

Grantees must use **not less than 75 percent of the total grant award** for the provision of treatment and recovery support services for the population(s) of focus. Applicants must identify the organizations (i.e., domestic public and private nonprofit entities, including local governments or community- and faith-based organizations) that will provide treatment and recovery support services to the population(s) of focus either directly or through sub-awards. Each sub-awardee (e.g., domestic public or private nonprofit entity) may use **up to 10 percent of their funds** for data collection and performance measurement, and performance assessment (see Sections I-[2.2](#) and [2.3](#)).

These community-based organizations may be, but are not limited to the following: substance use or mental health treatment provider agencies, peer providers, health centers, housing entities, primary care, or other agencies that serve the population(s) of focus that can meet the requirements specified in this RFA.

Applicants must ensure that sites will have the capacity to permanently house and serve the population(s) of focus. The applicant is responsible for ensuring that Government Performance and Results Modernization Act of 2010 (GPRA) data are collected and entered within the prescribed time periods.

The applicant will determine the evidence-based screening, assessment, and treatment intervention(s) to be used. [Note: The grantee is responsible for overseeing all aspects of the EBP implementation including but not limited to: training, certification, monitoring, use of assessment tools, etc.]

Grantees must ensure that coordinated and integrated services provided to enrolled clients include the following **required** activities:

- Outreach and other engagement strategies to enroll clients (including screening and assessment, for the presence of substance use disorders, SMI, or co-occurring mental and substance use disorders). Information obtained from the screening and assessment should be used to develop appropriate treatment approaches. Grantees will be required to report aggregate diagnostic data utilizing (DSM-5) information for all enrolled clients.
- Direct treatment for the population(s) of focus. Treatment must be provided in outpatient, day treatment or intensive outpatient, or short-term residential programs. Short-term residential programs must be 90 days or less in duration and at a cost not to exceed 6.5 percent of the total sub-award annually for all recipients. Case management or other strategies to link with and retain clients in housing and other necessary services, including but not limited to primary care services, and to coordinate these services with other services provided to the client.
- Engage and enroll the population(s) of focus into Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP, etc.).
- Trauma-informed services to include an emphasis on implementation of trauma-informed approaches in programs, services, and systems, including trauma-specific interventions that are designed to address the consequences of trauma in the individual and to facilitate healing. This may include assessment and interventions for emotional, sexual, and physical abuse.
- Hire a supported employment specialist to enhance state and community capacity to provide and expand evidence-based supported employment

programs for the population(s) of focus. Hire a full-time SOAR Specialist to increase access to the disability income benefit programs for the population(s) of focus.

- Hire peer recovery support specialist(s) to deliver peer recovery support services designed and delivered by people with lived experience in recovery from mental illness and/or substance use disorders.
- Access to recovery support services designed to improve access to and retention in services and to continue treatment gains, which may include some or all of the following as appropriate for each client:
 - Vocational, child care, educational and transportation services
 - Independent living skills (e.g., budgeting and financial education)
 - Employment readiness, training, and placement
 - Crisis care
 - Medications management
 - Self-help programs
 - Discharge planning
 - Psychosocial rehabilitation
- Placement in permanent housing for enrolled individuals.

SAMHSA grant funds may not be used to fund housing. The applicant must sign the Statement of Assurance (See [Appendix II, Statement of Assurance](#), in this document) documenting the availability of permanent housing units that match the number of clients targeted to be enrolled in the grant project for each year of the grant. The Statement of Assurance must be included in Attachment 1 of the application.

Following application review, if your application's score is within the funding range, the government project officer (GPO) will contact you to submit the following documentation within a specified time frame:

1. For a U.S. Department of Housing and Urban Development (HUD) funded applicant or provider, a copy of the current executed grant agreement from HUD that includes permanent housing for the population(s) of focus (e.g., for Continuum of Care [CoC], Emergency Solutions Grant [ESG], Housing Opportunities for Persons with AIDS [HOPWA], HOME, or Community Development Block Grants [CDBG]); or

From a non-HUD funded applicant, a letter from a comparable housing program funding source verifying a current, executed grant or contract agreement. The letter must include the following information:

- a. Brief summary describing the funding source, including any funding requirements and/or restrictions, and
 - b. Amount of funding provided per year for the applicant's permanent housing program.
2. Type of permanent housing and number of housing units already secured (annually, must be equivalent to the number of individuals to be enrolled in grant project).
 3. Amount program participants pay toward housing.
 4. Information about clients':
 - a. choice in housing;
 - b. option in level and type of services received;
 - c. tenancy rights (e.g., privacy in unit, leasing); and
 - d. eligibility to be considered for permanent housing despite substantially greater vulnerability (i.e., multiple severe physical and behavioral health disabilities, history of criminal justice involvement, SMI, severe substance use disorder, and co-occurring mental and substance use disorders).

If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.

In addition to **required** activities, other **allowable** direct services include the following types of activities:

- Limited outreach and screening to identify incarcerated individuals who may experience chronic homelessness upon release from a jail or detention facility; and provision to those identified with a post-release housing and behavioral health services plan.
- Education, screening, and counseling for hepatitis and other sexually transmitted diseases.
- Active steps to reduce HIV/AIDS risk behaviors by their clients. Active steps include client screening and assessment, and either direct provision of

appropriate services or referral to and close coordination with other providers of appropriate services.

Grantees must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are ineligible for public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Grantees are also expected to facilitate the health insurance application and enrollment process for eligible uninsured 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 funds may not be used to pay for primary care, emergency medical services for physical conditions, or prescription drugs. Medical care and prescriptions for participants must be provided through other funding sources and/or by other providers (e.g., community health centers, Health Care for the Homeless programs, or other medical providers). SAMHSA grantees may not require that program participants engage in services as a condition of housing tenancy. Tenants, however, may be given a choice to live in sober housing as long as the grantee can provide an alternative living unit should the tenant relapse. Grantees are expected to work actively with program participants to engage them in appropriate behavioral health and recovery services.

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).

According to the National Survey on Drug Use and Health, individuals who experience mental illness or who use illegal drugs have higher rates of tobacco use than the total population. Data from the National Health Interview Survey, the National Death Index, and other sources indicate earlier mortality among individuals who have mental and substance use disorders than among other individuals. Due to the high prevalence rates of tobacco use and the early mortality of the population(s) of focus for this grant program, grantees are encouraged to promote abstinence from tobacco products (except with regard to accepted tribal traditional practices) and to integrate tobacco cessation strategies and services in the grant program. Applicants are encouraged to set annual targets for the reduction of past 30-day tobacco use among individuals receiving direct client services under the grant.

Recovery from mental disorders and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and

want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF> for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

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

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

2.1 Using Evidence-Based Practices

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

- Identify the evidence-based practice(s) you propose to implement for the specific population(s) of focus.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective for the specific population(s) of focus.

- If you are proposing to use more than one evidence-based practice, provide a justification for doing so and clearly identify which service modality and population(s) of focus each practice will support.
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus.

[Note: See PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

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

2.2 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. In addition to demographic data (gender, age, race, and ethnicity) on all clients served, grantees will be required to report performance on the following GPRA performance measures: abstinence from use, housing status, employment status, criminal justice system involvement, access to services, retention in services, and social connectedness. This information will be gathered using a uniform data collection tool provided by SAMHSA. The current tool is being updated and will be provided upon award. An example of the type of data collection tool required can be found at <http://www.samhsa-gpra.samhsa.gov>.

Data will be collected via a face-to-face interview using this tool at three data collection points: intake to services, six months post intake, and at discharge. Grantees will be expected to do a GPRA interview on all clients in their specified unduplicated target number and are also expected to achieve a six-month follow-up rate of 80 percent. Once data are collected, grantees are required to utilize the Common Data Platform (CDP), SAMHSA's web-based data collection and reporting tool. All data must be submitted through the CDP within seven days of data collection.

Grantees and sub-awardees will be provided extensive training on the system and its requirements post award.

The collection of these data will enable CSAT and CMHS to report on key outcome measures relating to substance use and mental health. In addition to these outcomes, data collected by grantees will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use and outcomes nationwide. Grantees are

encouraged to explore using HIT to improve data collection, including integrating EHR systems with Homeless Management Information Systems and/or GPRA reporting systems to minimize provider re-entry of data.

In addition to these measures, grantees will be expected to report biannually on their progress and performance on achieving the goals and objectives of the grant project resulting from the three primary grant activities (see Section I.1-Purpose).

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

2.3 Local Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above) to assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. Performance assessments also should be used to determine whether your project is having/will have the intended impact on behavioral health disparities. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

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

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
- What program/contextual/cultural/linguistic factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/sexual identity (sexual orientation/gender identity)?
- How durable were the effects?
- How many individuals were reached through the program and how many were enrolled in Medicaid and other mainstream programs as a result of participation in the program?
- What program and contextual factors were associated with increased access to and enrollment in Medicaid and mainstream programs?

- What was the effect of the permanent housing, recovery support, or treatment on key outcome goals?
- What program and contextual factors were associated with positive clinical and housing outcomes?
- Was the intervention effective in maintaining the project outcomes at 6-month follow-up?

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 grant project implementation match the grant proposal?
 - What types of changes were made to the originally proposed project?
 - What led to the changes in the original plan?
 - What effect did the changes have on the planned intervention and performance assessment?
- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National CLAS Standards?
- 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)?
- What activities and actions taken by the State Interagency Council on Homelessness helped improve the clinical and housing outcomes of sub-awardees?
- Are the targets and indicators linked and used to inform quality improvement activities for the state?
- What efforts have been taken to overcome administrative and clinical barriers in enrolling individuals in Medicaid and mainstream programs? How are these efforts informing the implementation and/or enhancement of the long-term sustainability of integrated community systems that provide permanent housing and supportive services throughout the state?

The performance assessment should be completed annually and submitted to SAMHSA as a supplement to the continuation application.

No more than 20 percent of the up to 25 percent expended for state infrastructure may be used by the grantee for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-[2.2](#) and [2.3](#) above. Each sub-awardee may use up to 10 percent of its funds for data collection and performance measurement, and performance assessment (see Sections I-[2.2](#) and [2.3](#)).

2.4 Grantee Meetings

Grantees must plan to send a minimum of two people (including the Project Director and evaluator) to at least one joint grantee meeting in Year 2 of the grant project. 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

Funding Mechanism: Cooperative Agreement

Anticipated Total Available Funding: \$15.181 million (49 percent from CSAT's Treatment Systems for Homeless and 51 percent from CMHS' Homeless Prevention Program)

Estimated Number of Awards: 6 to 8 awards

Estimated Award Amount: Up to \$3 million per year for Tier 1 states and up to \$1.8 million per year for Tier 2 states (49 percent from CSAT's Treatment Systems for Homeless and 51 percent from CMHS' Homeless Prevention Program).

Length of Project Period: Up to 3 years

Proposed budgets cannot exceed \$3 million for Tier 1 states and \$1.8 million for Tier 2 states 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 goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Each grant award will consist of 49 percent CSAT funds and 51 percent CMHS funds, even if an applicant requests less than the maximum award amount. 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.

Cooperative Agreement

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

Role of Grantee:

- Comply with the requirements in this RFA and the terms and conditions set forth in the Notice of Award (NoA).
- Monitor and ensure that sub-awardees collect and report GPRA data, and agree to provide SAMHSA with the data required for GPRA.
- Implement and assess the program in full cooperation with SAMHSA staff members.
- Ensure that individuals served by the grant project are those who experience chronic homelessness and have substance use disorders, SMI, or co-occurring mental and substance use disorders, or are veterans who experience homelessness/chronic homelessness, and have substance use disorders, SMI, or co-occurring mental and substance use disorders.
- Establish or use an existing State Interagency Council on Homelessness to meet at least quarterly per year, co-led by the Grantee and partnering behavioral health authority (SMHA or SSA), to meet the goals outlined in this RFA.
- Develop a strategy for supporting provider sites in the adoption of HIT (if applicable).
- Prior to awarding sub-awards, the grantee must submit, for each proposed sub-award, required documentation indicated in this RFA (e.g., availability of housing units, evidence of credentials) and receive approval of sub-award(s).
- Submit the draft statewide plan by the 2nd month of the grant project for review and approval.
- Collect, evaluate, and report grantee infrastructure, process, and outcome data.

- Respond to requests for program-related data.
- Prepare SAMHSA required reports.

Role of SAMHSA Staff:

- Review and approve the draft statewide plan and work collaboratively with the grantee to implement and adapt the statewide plan based on information gathered through the project.
- Participate on the State Interagency Council on Homelessness (for the purposes of this grant) and in the selection of members that will further enhance and develop the infrastructure, build capacity, and guide grant project implementation.
- Review and approve planned state infrastructure activities and provide related technical assistance (if applicable).
- Assist the grantee to meet quality improvement goals in an efficient manner.
- Provide advice and assistance in developing the performance assessment.
- Foster learning, collaboration and coordination with other federally-funded activities. Examples include facilitating communication and connection with SAMHSA regional offices, HUD Continuums of Care, HUD field offices, SAMHSA Addiction Technology Transfer Centers (ATTCs); and HRSA resources.
- Provide training, observation of practice, consultative services, peer monitoring, and other services envisioned under this program in collaboration with SAMHSA technical assistance resources.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are either the State Mental Health Authority (SMHA) or the Single State Agency (SSA) in the states listed below. However, SAMHSA’s expectation is that both the SSA and the SMHA will work in partnership to fulfill the requirements of the grant. To demonstrate this collaboration, applicants must provide a letter of commitment from the partnering entity in **Attachment 4** of the application. If the SMHA and the SSA are one entity, applicants must include a statement to that effect in **Attachment 4**.

FY 2015 CABHI-States RFA Tiers

Award Tier	Maximum Annual Award Amount	Eligible Applicants	
Tier 1	\$3,000,000	California District of Columbia Florida Maryland Minnesota Missouri New Jersey	New York North Carolina Oregon Puerto Rico Texas Virginia
Tier 2	\$1,800,000	Alabama Alaska American Samoa Arkansas Delaware Guam Idaho Indiana Iowa Kansas Kentucky Maine Marshall Islands Micronesia	Montana Nebraska New Hampshire New Mexico North Dakota Northern Mariana Islands Palau Rhode Island South Carolina South Dakota Vermont Virgin Islands West Virginia Wyoming

SAMHSA believes that limiting eligibility to states is the most efficient and effective way to facilitate a systems approach (i.e., strengthen or develop infrastructure). In addition,

states are in a unique position to efficiently and effectively impact the goals of the U.S. Interagency Council on Homelessness (USICH) Strategic Plan.

States that received an FY 2013 or FY 2014 CABHI-States grant are not eligible to apply because they are currently receiving funding for this program. In addition, eligibility is being restricted because SAMHSA seeks to further expand the impact of the CABHI-States program across the nation.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

3. EVIDENCE OF EXPERIENCE AND CREDENTIALS

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. Direct service providers at the state level and sub-awardees of grant funds must meet four additional requirements related to the provision of services.

The four requirements are:

- A provider organization for direct client services (e.g., substance abuse treatment, mental health treatment) appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;
- Each mental health/substance abuse treatment provider organization must have at least 2 years experience (as of the due date of the application) providing relevant services in the geographic area(s) in which services are to be provided (official documents must establish that the organization has provided relevant services for the last 2 years);
- Each mental health/substance abuse treatment provider organization must comply with all applicable local (city, county) and state licensing, accreditation and certification requirements, as of the due date of the application; and
- Each entity must either:
 - be qualified to receive third party reimbursements and have an existing reimbursement system in place; OR
 - have established links to other behavioral health or primary care organizations with existing third party reimbursement systems.

[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license. See Appendix II, Statement of Assurance, in this document.]

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

- a letter of commitment from every mental health/substance abuse treatment provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which the services are to be provided;
- official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist;
- official documentation that mental health/substance abuse treatment provider organizations are qualified to receive third-party reimbursements and have an existing reimbursement system in; **OR** official documentation that mental health/substance abuse treatment provider organizations have established links to other behavioral health or primary care organizations with existing third party reimbursement systems for services.

If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.

IV. APPLICATION AND SUBMISSION INFORMATION

In addition to the application and submission language discussed in PART II: Section I, you must include the following in your application:

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

- **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 30 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in [Section V](#) – Application Review Information of this document.

The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in Sections F and 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 PART II-V: Supporting Documentation. Supporting documentation should be submitted in black and white (no color).

- Applicants for this program are required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form is posted on SAMHSA's website at <http://www.samhsa.gov/grants/applying/forms-resources>.
- **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 is no page limitation 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:** (1) Identification of at least one experienced, licensed mental health/substance abuse treatment provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) letters of commitment from these direct service provider organizations; **(Do not include any letters of support – it will jeopardize the review of your application if you do.)** (4) the Statement of Assurance (provided in [Appendix II](#) of this announcement) signed by the authorized representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that: a) all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time; b) the availability of permanent housing units match the number of clients targeted to be enrolled in the grant project for each year of the grant; and c) provider treatment organizations are qualified to receive

third party reimbursements or have established links to other organizations with existing third party reimbursement systems.

- **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 from the partnering SMHA or SSA or a letter confirming the SSA and SMHA are one entity (see [Section III-1](#) of this document)

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **April 9, 2015**.

3. FUNDING LIMITATIONS/RESTRICTIONS

- No more than 25 percent of the total grant award may be used for infrastructure development/improvements at the state level. No more than 20 percent of this amount may be used for data collection, performance measurement and performance assessment, including incentives for participating in the required data collection follow-up.
- Grantees must devote **not less than 75 percent of the total grant award** to expand and enhance treatment and recovery services for the population(s) of focus through sub-awards to domestic public or private nonprofit entities that are responsible for administering behavioral health services either directly or through contractual agreements. Each domestic public or private nonprofit entity may use **up to 10 percent of its funds** for data collection and performance measurement, and performance assessment (see Sections I-[2.2](#) and [2.3](#)).
- Grantees must submit a budget that reflects a split of 49 percent CSAT funds and 51 percent CMHS funds. (See PART II: Appendix F – Sample Budget and Justification.)
- No more than 6.5 percent of the total grant award may be used for short-term residential treatment (90 days or less).

Be sure to identify these expenses in your proposed budget.

SAMHSA grantees also must comply with SAMHSA’s standard funding restrictions, which are included in PART II: Appendix D – Funding Restrictions.

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 30 pages.
- You must use the five sections/headings listed below in developing your Project Narrative. **You must indicate the Section letter and number in your response or it will not be considered, i.e., type “A-1”, “A-2”, etc., before your response to each question.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.
- Although the budget and supporting documentation for the proposed project are not scored review criteria, the Review Group will consider their appropriateness after the merits of the application have been considered. (See PART II: Sections IV and V and Appendix F).
- 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(s) of focus and Statement of Need (10 points)

1. Identify the proposed catchment area and the proposed population(s) of focus to be served by the grant project. Provide a comprehensive demographic profile of your population(s) of focus in terms of race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic characteristics, and sexual identity (sexual orientation, gender identity).
2. Discuss the relationship of your population(s) of focus to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your proposed services, citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of the proposed project and intent of the RFA.

3. Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective services for the population(s) of focus in the proposed catchment area that is consistent with the purpose of the program and intent of the RFA. Describe the nature of the problem, including infrastructure and service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus based on data. Identify the source of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., from state needs assessments, SAMHSA's National Survey on Drug Use and Health), and/or national data (e.g., from SAMHSA's National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control and Prevention [CDC] reports, and Census data). This list is not exhaustive; applicants may submit other valid data, as appropriate for your program.

Section B: Proposed Evidence-Based Service/Practice (25 points)

1. Describe the purpose of the proposed project, including its goals and objectives. These must relate to the intent of the RFA and performance measures you identify in Section E: Data Collection and Performance Measurement.
2. Describe the evidence-based and trauma-informed practices and services proposed for outreach, screening and assessment, behavioral health treatment (specify types), and recovery support services that meet the required activities specified in the RFA and are appropriate for the population(s) of focus. If you are proposing activities in addition to those required, please specify and discuss.
3. Describe how the proposed practices and services will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability. [See Appendix I: Using Evidence-Based Practices (EBPs).]
4. Identify ways in which you will work with sub-awardees and state planning partners in implementing the practices and services, including training, certification, and monitoring.
 - Clearly describe how the provision of the evidence-based intervention by the sub-awardees will be monitored by the grantee.
 - Describe how you will identify and justify any modifications or adaptations you may need to make to practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes.

5. If an EBP does not exist/apply for your population(s) of focus, fully describe the practice(s) you plan to implement, explain why it is appropriate for the population(s) of focus, and justify its use compared to an existing EBP. Describe how the proposed practice(s) will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability.
6. Explain how your choice of EBP(s) and practice(s) will help you address disparities in service access, use and outcomes for subpopulations.

Section C: Proposed Implementation Approach (30 points)

1. Describe how the proposed project aligns with SAMHSA's Strategic Initiatives, specifically Recovery Support.
2. Identify any organization(s) that will participate in the proposed project and the geographic areas/jurisdictions in which they will provide behavioral health services. Describe the need in these areas, as well as the experience and ability of these entities to deliver evidence-based practice(s). Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of commitment from these organizations in **Attachment 1** of your application.
3. Provide a chart or graph depicting a realistic time line for the entire project period showing key activities, milestones, and responsible staff. These key activities should include the requirements outlined in [Section I-2: Expectations](#). Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than 4 months after grant award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]
4. Describe plans to establish or use an existing State Interagency Council on homelessness consistent with the requirements outlined in [Section I-2: Expectations \(State Infrastructure Development\)](#).
5. Describe the types of activities you propose to include in a new statewide plan or enhance an existing statewide plan to ensure sustained partnerships across public health and housing systems that will result in short- and long-term strategies to support the population(s) of focus and meet the required activities in this RFA. Discuss ways in which you will work with sub-awardees and other providers to implement and monitor the activities in the statewide plan.
6. Describe the steps you will take to assist the state Medicaid eligibility agency in developing a streamlined application process for the population(s) of focus (if applicable).

7. Describe how you will provide technical assistance to service providers on the Medicaid streamlined application process (if applicable).
8. Describe how you will assist providers (e.g., substance use treatment providers, mental health providers, homeless services providers) seeking to become qualified Medicaid providers (if applicable).
9. Describe how you will ensure that sub-awardees engage and enroll eligible persons in Medicaid and other mainstream benefit programs.
10. Describe how you will monitor sub-awardee(s) in the areas of outreach, screening and assessment, client enrollment, behavioral health treatment, and recovery support services of the proposed project that meet the required activities specified in the RFA.
11. Describe how you will ensure that providers will screen, assess for, and document the presence of substance use disorders, SMI, and co-occurring mental and substance use disorders, and use the information to develop appropriate treatment approaches for the population(s) of focus.
12. State the unduplicated number of individuals you propose to serve annually, 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. Explain how you arrived at this number. You are required to include the numbers to be served by race, ethnicity, gender, and sexual orientation. Include:
 - Grant project enrollment by sub-awardee;
 - Individuals assisted with enrollment for third party networks and mainstream benefits; and
 - Provider organizations assisted with enrollment in third party networks.
13. Describe how you will ensure that service providers will identify, recruit and retain the population(s) of focus. Discuss how the proposed approach to identify, recruit and retain the population(s) of focus considers the language, beliefs, norms, values and socioeconomic factors of this/these population(s).
14. Describe how the required SOAR Specialist(s), Supported Employment Specialist(s), and if applicable, the Peer Recovery Support Specialist(s) will engage with enrolled clients, including the proposed services they will deliver.

15. Describe how the proposed activities will be implemented and how they will adhere to the National Standards for CLAS in Health and Health Care. For additional information go to <http://ThinkCulturalHealth.hhs.gov>.
16. Provide a per-unit cost for this program. 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.

[NOTE: 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.]

Section D: Staff and Organizational Experience (15 points)

1. Discuss the capability and experience of the applicant organization and sub-awardee(s) 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.
2. Provide a complete list of staff positions for the project, including the Project Director, Evaluator, Peer Recovery Support Specialist(s), Supported Employment Specialist(s), SOAR Specialist(s), and other key personnel, showing the role of each and their level of effort and qualifications.
3. 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).
4. Describe how your staff will ensure the input of consumers representing the population(s) of focus in assessing, planning, and implementing your project.

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

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

2. Describe the data-driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed and reduced.
3. Describe your plan for conducting the local performance assessment as specified in Section I-2.3 of this RFA and document your ability to conduct the assessment.

SUPPORTING DOCUMENTATION

Section F: Biographical Sketches and Job Descriptions

See PART II: Appendix E – Biographical Sketches and Job Descriptions, for instructions on completing this section.

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 III](#) of this document for guidelines on these requirements

VI. ADMINISTRATION INFORMATION

1. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.2, grantees must comply with the reporting requirements listed on the SAMHSA website at <http://www.samhsa.gov/grants/grants-management/reporting-requirements>. Further, CSAT and CMHS funds must be separately tracked in a formal accounting system and grantees must be able to differentiate the CSAT funds used exclusively for treatment and recovery support services for individuals who have a substance use disorder, CMHS funds used exclusively for treatment and recovery support services for individuals who have a SMI, and CSAT and CMHS funds used for overlapping purposes (e.g., infrastructure development, evaluation, screening and assessment, treatment and recovery supports for individuals diagnosed with co-occurring mental and substance use disorders). Based on this information, grantees must report in annual and final Federal Financial Reports (SF 425) their total grant expenditures, CSAT expenditures, CMHS expenditures, CSAT expenditures for overlapping purposes and CMHS expenditures for overlapping purposes.

VII. AGENCY CONTACTS

For questions about program issues contact:

Bradford Milton
Center for Substance Abuse Treatment

Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 5-1058
Rockville, Maryland 20857
(240) 276-1745
bradford.milton@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 I – Using Evidence-Based Practices (EBPs)

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

- Document the evidence that the practice(s) you have chosen is appropriate for the outcomes you want to achieve.
- Explain how the practice you have chosen meets SAMHSA’s goals for this grant program.
- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population(s) of focus or your program, or to allow you to use resources more efficiently. You must describe any changes to the proposed service(s)/practice(s) that you believe are necessary for these purposes. You may describe your own experience either with the population(s) of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.
- Explain why you chose this evidence-based practice over other evidence-based practices.
- If applicable, justify the use of multiple evidence-based practices. Discuss how the use of multiple evidence-based practices will be integrated into the program.

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

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

Resources for Evidence-Based Practices:

You will find information on evidence-based practices at <http://store.samhsa.gov/resources/term/Evidence-Based-Practice-Resource-Library>. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Resource Library* provides a short description and a link to dozens of websites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

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

[Note: Please see PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

Appendix II – Statement of Assurance

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

- a letter of commitment from every mental health/substance abuse treatment service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and
- official documentation that all mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)
- official documentation indicating that the availability of permanent housing units matches the number of clients targeted to be enrolled in the grant project for each year of the grant and that the housing units qualify as permanent housing, as outlined in the RFA.
- official documentation that mental health/substance abuse treatment provider organizations are qualified to receive third party reimbursements and have an existing reimbursement system in place; **OR** official documentation that mental

health/substance abuse treatment provider organizations have established links to other behavioral health or primary care organizations with existing third party reimbursement systems for services.

Signature of Authorized Representative

Date

Appendix III – 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 (unless you are providing the web link to the instrument(s)/protocol(s)).

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.

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 (240) 453-6900. SAMHSA-specific questions should be directed to the program contact listed in Section VII of this announcement.

Appendix IV – 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), please 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.