Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Minority Aids Initiative

Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS

(Short Title: TCE-HIV: High Risk Populations)

(Initial Announcement)

Funding Opportunity Announcement (FOA) No. TI-17-011

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 "Funding Opportunity Announcement (FOA) PART II: Administrative and Application Submission Requirements for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each FOA. PART II includes requirements that are common to all SAMHSA FOAs. You MUST use both documents in preparing your application.

Key Dates:

Application Deadline	**Applications are due by May 3, 2017.**
Intergovernmental Review (E.O. 12372)	**Applicants must comply with E.O. 12372 if their state(s) participate(s). Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after 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 the application deadline. Comments from the Single State Agency are due no later than 60 days after the 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) 2017 Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (Short Title: TCE-HIV: High Risk Populations) cooperative agreements. The purpose of this program is to increase engagement in care for racial and ethnic minority individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for HIV or HIV positive that receive HIV services/treatment. The program also aims to contribute to the nation's achievement of the 90-90-90 goals regarding HIV status and treatment.

Funding Opportunity Title:	Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (Short Title: High Risk Populations)
Funding Opportunity Number:	TI-17-011
Due Date for Applications:	May 3, 2017
Anticipated Total Available Funding:	$28,594,750
Estimated Number of Awards:	Up to 57
Estimated Award Amount:	Up to $500,000 per year
Cost Sharing/Match Required	No
Length of Project Period:	Up to five years

Eligible Applicants:	Eligibility is restricted to local-level public and private nonprofit entities that provide substance use and co-occurring services, and have established linkages to primary HIV services including: • Local governments, • Federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations, • Urban Indian organizations, • Public or private universities and colleges, and • Community- and faith-based organizations. States and grantees that received awards under TI-15-006 and Ti-16-011 are not eligible to apply. See Section III-1 of this FOA for complete eligibility information.

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

IMPORTANT: SAMHSA is transitioning to the National Institutes of Health (NIH)'s electronic Research Administration (eRA) grants system. Due to this transition, SAMHSA has made changes to the application registration, submission, and formatting requirements for all Funding Opportunity Announcements (FOAs). All applicants must register with NIH's **eRA Commons** in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

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) 2017 Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (Short Title: TCE-HIV: High Risk Populations) cooperative agreements. The purpose of this program is to increase engagement in care for racial and ethnic minority individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for HIV or HIV positive that receive HIV services/treatment. The program also aims to contribute to the nation's achievement of the 90-90-90 goals regarding HIV status and treatment.

This program will focus on high risk populations including racial/ethnic minority populations, such as black young men who have sex with men (YMSM) (ages 18-29), and other high-risk populations such as Latino YMSM and men who have sex with men (MSM) (ages 30 years and older), and gay, bisexual, and transgender individuals who have a SUD or COD who are HIV positive or at risk for HIV/AIDS. This cooperative agreement will support the following activities: linkage to care for racial and ethnic minority individuals with SUD and/or COD treatment needs who are HIV positive or at high risk for HIV, including SUD and/or COD treatment and recovery support services; HIV/AIDS testing and case management services, including linkage and provision of HIV care and treatment; Hepatitis testing, vaccination, and referral/linkage for treatment and case management; housing support services; outreach; and enhancement and expansion of infrastructure and capacity to retain clients in SUD/COD and HIV/AIDS care.

The expected outcomes for the program include increasing the number of individuals with SUD/COD who are HIV positive that are on antiretroviral therapy (ART) and linked to HIV care, reducing the impact of behavioral health problems, reducing HIV risk and incidence, reducing trauma related conditions, and increasing access to and retention in treatment for individuals with co-existing behavioral health, HIV, and hepatitis conditions. This program will ensure that individuals who have been diagnosed with a SUD and/or COD and who are HIV positive or most at risk for HIV/AIDS have access to and receive appropriate behavioral health services. Cooperative agreement funds must be used to serve people diagnosed with a SUD as their primary condition.

The program supports the goals of the 2020 National HIV/AIDS Strategy (NHAS) that focuses on reducing new HIV infections, improving health outcomes, and reducing HIV-related disparities with an emphasis on groups with a greater burden of HIV including young black gay and bisexual men, transgender women, persons who are homeless or unstably housed, and those who live in the southern United States. This program also supports the national and global effort to address HIV through the 90-90-90 goals, with specific focus on the second 90, increasing the number of people who are HIV positive who received HIV-related health care. This grant program is part of the Congressional Minority AIDS Initiative, which was developed to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and to reduce HIV-related health disparities. This program will also align with goals of the National Viral Hepatitis Action Plan which identifies people who inject drugs (PWID) as a priority population.

The National Institute on Drug Abuse (NIDA) Research Report indicates that the interactions of drug abuse and HIV/AIDS extend far beyond injection drug use. The report has three key findings: 1) drug abuse impairs judgment and good decision making, leaving people prone to engage in HIV risk behaviors, including risky sexual behavior and non-adherence to HIV treatment; 2) drug abuse adversely affects health and may exacerbate disease progression; and 3) because of these linkages, drug abuse treatment *is* HIV prevention (View the Report at https://www.drugabuse.gov/sites/default/files/rrhiv.pdf).

According to National Survey on Drug Use and Health (NSDUH) data collected between 2009 and 2013[1], about one in seven individuals with HIV/AIDS had used an illicit drug intravenously in their lifetime (13.52 percent), slightly more than two thirds had used an illicit drug but not intravenously (67.45 percent), and 19.02 percent had never used an illicit drug. Nearly one quarter of persons with HIV/AIDS was in need of treatment for alcohol use or illicit drug use in the past year (22.96 percent).

[1] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2013: Special unpublished tabulation.

This program also aligns with the goals of the National Viral Hepatitis Action Plan which addresses the need to reduce new viral hepatitis infections, reduce deaths and improve the health of people living with viral hepatitis, and reduce hepatitis-related disparities. The Action Plan identifies PWID as a priority population for prevention and treatment services.

HIV-infected persons, MSM, and PWID are disproportionately affected by viral hepatitis and related adverse health conditions. Grantees will be required to integrate their efforts to reduce the rate of HIV with activities to prevent new viral hepatitis infections, identify hepatitis infected persons via testing, and improve referrals and linkages to care and treatment. Grantees must make every attempt to identify persons infected with viral hepatitis early in the course of their disease. All clients who are considered to be at risk for viral hepatitis (B and C), as specified by United States Preventive Services Task Force (USPSTF) recommendations for hepatitis B[2] and hepatitis C[3,4] screening, must be tested for viral hepatitis (B and C). All clients testing positive for viral hepatitis (B or C) must be referred for treatment.

Applicants are encouraged to use a trauma informed approach following SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach* (http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884).

The TCE-HIV: High Risk Populations 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 PART II: Appendix E – Addressing Behavioral Health Disparities.)

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[2] *Final Recommendation Statement: Hepatitis B Virus Infection: Screening, 2014a*. U.S. Preventive Services Task Force. October 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-virus-infection-screening-2014

[3] *Final Recommendation Statement: Hepatitis C: Screening*. U.S. Preventive Services Task Force. December 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening

[4] *Final Recommendation Statement: Hepatitis B in Pregnant Women: Screening*. U.S. Preventive Services Task Force. October 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-in-pregnant-women-screening

The TCE-HIV: High Risk Populations program supports the SAMHSA Healthcare and Health Systems Integration Strategic Initiative. For more information on SAMHSA's six strategic initiatives visit http://www.samhsa.gov/about-us/strategic-initiatives.

This program is one of SAMHSA's services programs. SAMHSA intends that its services cooperative agreements result in the delivery of services as soon as possible after the award. Service delivery should begin by the fourth month of the project at the latest.

TCE-HIV: High Risk Populations Cooperative Agreements are authorized under Section 509 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2020, Substance Abuse Topic Area HP 2020-SA.

2. EXPECTATIONS

SAMHSA expects grantees to engage the population of focus and link them to appropriate community-based behavioral health services/systems including primary HIV care and ART, primary health care, housing, and other recovery support services. Bi-directional collaboration with other federal agencies, such as Ryan White [Health Resources and Services Administration (HRSA)] and the Housing Opportunities for Persons with AIDS (HOPWA) [Housing and Urban Development (HUD)] are strongly encouraged to ensure client services.

For the purpose of this FOA, linkage to care is defined as attendance at a routine HIV medical care visit within three months of HIV diagnosis. Retention is defined as having at least one HIV medical care visit in each six-month period of a 24-month measurement period, with a minimum of 60 days between the first medical visit in the prior six-month period and the last medical visit in the subsequent six-month period.[5]

For the purposes of this FOA, appropriate behavioral health services include engagement services (e.g., outreach, assessment, service planning); outpatient treatment services; intensive outpatient treatment services; substance use or mental disorders residential treatment services; medication-assisted treatment (MAT); community support services such as case management (e.g., assessment, planning, linking, monitoring, and advocacy), and recovery support services http://www.samhsa.gov/recovery.

Applicants must provide services to racial/ethnic minority individuals living with or at risk for HIV/AIDS. Applicants are encouraged to prioritize racial/ethnic minority YMSM (ages 18-29), MSM (ages 30 and older), and gay, bisexual, and transgender individuals as a population of focus.

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[5] http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf

According to recent Centers for Disease Control and Prevention (CDC) data[6], young African American MSM are significantly affected and now account for more new HIV infections in the United States (10,100 in 2014) than any other subgroup by race/ethnicity, age, and sex. Applicants are not required to focus solely on YMSM. However, applicants who propose to provide services to YMSM are asked to describe their experience and effectiveness in serving this population within the last two years.

SAMHSA integrates its activities with those of the NHAS and 90-90-90 indicators through targeted goals such as: 100 percent of individuals will be screened for SUD and HIV; 100 percent of those screened positive for HIV will receive a warm handoff to the service home for HIV treatment; 90 percent of those screened are engaged in care; and 90 percent of those engaged in care achieve reduced substance use and HIV viral suppression. The cooperative agreement will also support the goal of linking 90 percent of those who are HIV positive with housing services. To further align with the 90-90-90 NHAS indicators, clients who screen negative for HIV or hepatitis will be engaged in SUD treatment and linked to HIV and hepatitis risk-reduction education. Measurements of activities conducted through this cooperative agreement will also need to be linked to the HHS Core HIV Indicators, as appropriate. [7]

The key staff for this program will be the Project Director (person responsible for overseeing, monitoring, and managing the grant) with at least a 20 percent level of effort, the Program Coordinator (person responsible for day to day operations of the grant) with a 100 percent level of effort, and the Program Evaluator (person responsible for evaluating the processes and outcomes of the grant) with at least a 20 percent level of effort.

Required Activities:

You must use cooperative agreement funds primarily to support allowable direct services to serve people diagnosed with a SUD as their primary condition. This includes the following activities:

SUD/Co-Occurring Disorders (COD) Treatment Services:

- Applicants must propose to **expand** and/or **enhance** (SUD/COD) treatment and recovery support services. Applicants must demonstrate that service providers have the necessary cultural, gender, and sexual orientation competencies to serve the proposed population(s) by providing clear examples of previous work with the population(s) of focus.

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[6] CDC Fact Sheet – HIV Among Gay and Bi-Sexual Men (September 2014): https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf
[7] http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf

- **Service Expansion:** Applicants may propose to **increase access and availability of services to a larger number of clients as a result of the award.** For example, if a treatment organization currently serves 50 persons per year and has a waiting list of 50 persons (but no funding to serve these persons), the applicant may propose to expand service capacity to be able to admit some or all of those persons on the waiting list. Applicants must state clearly the number of additional clients to be served during each year of the proposed cooperative agreement.

- **Service Enhancement:** Applicants may propose to improve **the quality and/or intensity of services,** for instance, by adding evidence-based practices (EBP) or approaches to treatment, or adding a new service to address emerging trends or unmet needs. For example, a treatment project may propose to add intensive gender-specific programming to the current treatment protocol for a population of women and their children being served by the program. **Applicants proposing to enhance services must indicate the number of clients who will receive the new enhancement services.**

- Applicants must also screen and assess clients for the presence of CODs and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having CODs. [For more information on the process of selecting screening instruments to identify co-occurring mental and substance use disorders, go to www.samhsa.gov/co-occurring/.]

- Applicants must also develop linkages/partnerships, as evidenced by memoranda of agreements (MOAs) or contracts with community-based organizations with experience in providing other services not provided by the grantee necessary for optimizing health outcomes for clients. Applicants must specify the roles of collaborating organizations in responding to the targeted need. MOAs and contracts must specify the terms and conditions of the services to be provided, including the level and intensity of these services. A list of participating and coordinating organizations and the services they will provide must be included in **Attachment 1**, along with corresponding MOA(s).

HIV Testing and Case Management Services:

- All clients and their drug-using and/or sexual partners must be offered HIV rapid preliminary antibody testing at enrollment, including rapid fourth-generation HIV diagnostic testing. Quality assurance measures must be developed and implemented to appropriately conduct HIV testing.

- Clients who test positive for HIV must be provided or linked to confirmatory testing, with follow-up by the grantee on the client's HIV status, as appropriate (clinician, case manager, etc.).

- All grantees must provide on-site HIV testing in accordance with state and local requirements, including linking clients who request to be tested offsite to facilities that are certified by the local health department. The cost of HIV test kits, test controls, other supplies (e.g., gloves, biohazardous waste containers, etc.), staff time, and training must be incorporated into the grant application budget.

- Applicants must develop a plan for case management of all clients who have a preliminary positive HIV and confirmatory HIV test result as described in Section B of the Project Narrative. The process of case management includes comprehensive assessment of the client's needs and development of an individualized service plan. Applicants must provide a plan for providing referrals and linkages to follow-up care and treatment for all individuals who have a positive HIV and confirmatory HIV test result. It is expected that persons diagnosed with HIV will be linked to HIV medical care within hours or days of being diagnosed. All persons with a preliminary or confirmed HIV diagnosis should be successfully linked to care within 30 days.

- Grantees must develop MOAs with primary HIV treatment and care providers, including Ryan White providers, to strengthen integration of care through case management and include these MOAs in **Attachment 1** of the application.

- Applicants must provide a plan for provision of services to identify stable housing for program participants.

Grantees will be required to report the number of HIV test kits and counseling sessions purchased with SAMHSA grant funds; data on rapid HIV and confirmatory test results; risk behaviors; and other data that may be required by SAMHSA. When necessary, grantees will be expected to work with providers with whom they have linkages/partnerships or to whom they make referrals in order to gather this data.

Viral Hepatitis Testing and Referral:

- All clients who are considered to be at risk for viral hepatitis (B and C), as specified by the USPSTF recommendations for hepatitis B[8] and hepatitis C[9,10]

[8] *Final Recommendation Statement: Hepatitis B Virus Infection: Screening, 2014a*. U.S. Preventive Services Task Force. October 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-virus-infection-screening-2014

screening, must be tested in accordance with state and local requirements, either onsite or through referral. Grantees may use **up to five percent** of annual award funds for the following hepatitis testing and services (based on risk and USPSTF guidelines):

- Viral hepatitis B and C (antibody and confirmatory) testing;
- Viral hepatitis A and B vaccination;
- Purchase of test kits and other required supplies (e.g., gloves, biohazardous waste containers, etc.); and
- Training for staff related to viral hepatitis (B and C) testing.

- Applicants must provide a plan for providing referrals and linkages to follow-up care and treatment for all individuals infected with viral hepatitis (B or C) in Section B of the Project Narrative. MOAs demonstrating that you have partnerships and linkages with appropriate treatment providers must be included in **Attachment 1** of your application.

Grantees must report all positive viral hepatitis test results to the local and state health department, as appropriate.

Grantees will be required to report to SAMHSA on the number of viral hepatitis test kits purchased with SAMHSA grant funds, the number of positive tests, and data on referrals and linkages to follow-up care. When necessary, grantees will be expected to work with providers with whom they have linkages/partnerships or to whom they make referrals in order to gather this data.

Allowable Activities:

Other allowable activities include but are not limited to the following:

- MAT is an evidence-based SUD treatment therapy. SAMHSA supports the right of individuals with an opioid or alcohol use disorder to be given access to MAT as

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[9] *Final Recommendation Statement: Hepatitis C: Screening*. U.S. Preventive Services Task Force. December 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening

[10] *Final Recommendation Statement: Hepatitis B in Pregnant Women: Screening*. U.S. Preventive Services Task Force. October 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-in-pregnant-women-screening

appropriate under the care of a physician. Recognizing that MAT may be an important part of a comprehensive SUD treatment plan, SAMHSA grantees may use **up to five percent** of the annual cooperate agreement award to pay for FDA-approved medications for the treatment of SUDs (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium) as part of a comprehensive treatment plan when the client has no other source of funds to do so.

- If a client presents with an opioid use disorder (OUD), the grantee may offer appropriate MAT services or refer appropriately. If a client is on or has been prescribed a medication for the treatment of an OUD when they enter the program, they must be allowed to continue that treatment.

- Applicants must affirm in the Statement of Assurance in Appendix B, that the TCE-HIV project for which funds are sought will not deny appropriate and eligible clients access to the program because of their use of FDA-approved medications for the treatment of SUDs (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium). Specifically, methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's OUD must be permitted. Similarly, medications available by prescription must be permitted under the following conditions:

  - the client is receiving those medications as part of treatment for a diagnosed SUD.

  - a licensed clinician, acting within their scope of practice, has examined the client and determined that the medication is an appropriate treatment for their SUD.

  - the medication was appropriately authorized through prescription by a licensed prescriber.

  In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. This Assurance must be included in **Attachment 1** of the application.

- Training/workforce development to help your staff or other collaborating providers identify mental or substance use disorder issues or provide effective services consistent with the purpose of this grant program.

The Health Information Technology for Economic and Clinical Health Act place strong emphasis on the widespread adoption and implementation of electronic health record (EHR) technology. Accordingly, all SAMHSA grantees that provide clinical services to individuals are encouraged to demonstrate ongoing use of a certified EHR system in each year of their SAMHSA grant. A certified EHR is an electronic health record system that has been tested and certified by an approved Office of National Coordinator for Health Information Technology's certifying body.

Other Expectations:

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. (See PART II: Appendix E, Addressing Behavioral Health Disparities.)

Although people with behavioral health conditions represent about 25 percent of the U.S. adult population, these individuals account for nearly 40 percent[11] of all cigarettes smoked and can experience serious health consequences[12]. A growing body of research shows that quitting smoking can improve mental health and addiction recovery outcomes. Research shows that many smokers with behavioral health conditions want to quit, can quit, and benefit from proven smoking cessation treatments. SAMHSA strongly encourages all grantees to adopt a tobacco-free facility/grounds policy 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 not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that

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[11] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (March 20, 2013). *The NSDUH Report: Adults with Mental Illness or Substance Use Disorder Account for 40 Percent of All Cigarettes Smoked.* Rockville, MD. http://media.samhsa.gov/data/spotlight/spot104-cigarettes-mental-illness-substance-use-disorder.pdf

[12] U.S. Department of Health and Human Services. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

are not sufficiently covered by an individual's health insurance plan. Grantees should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health 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 utilized first when available for that individual.

Recovery from mental 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 of recovery 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.

SAMHSA encourages all grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services, where appropriate. SAMHSA will encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support.

2.1 Using Evidence-Based Practices

SAMHSA's services cooperative agreements are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An EBP refers to approaches to prevention or treatment that are validated by some form of documented research evidence. However, SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See

Appendix A of this document for additional information about using EBPs. In Section C of your project narrative, you will need to:

- Identify the EBP(s) you propose to implement for the specific population(s) of focus. If an EBP does not exist/apply for your program/population(s) of focus, describe the service/practice you plan to implement as an appropriate alternative.

- If you are proposing to use more than one EBP, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.

- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus. Indicate whether/how the practice(s) will be adapted for a specific population. SAMHSA encourages you to consult with an expert or the program developer to complete any modifications to the chosen EBP. This is especially important when adapting EBPs for specific underserved populations for whom there are fewer EBPs.

In selecting an EBP, be mindful of how your choice of an EBP or practice may impact disparities in service access, use, and outcomes for your population(s) of focus. While this is important in providing services to all populations, it is especially critical for those working with underserved and minority populations.

[Note: See PART II: Appendix C - Standard Funding Restrictions, regarding allowable costs for 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. Grantees will be required to report performance on the following 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. Grantees will be required to submit data via SAMHSA's Performance Accountability and Reporting System (SPARS); access will be provided upon award. An example of the type of data collection tool required can be found at http://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.

Data will be collected via a face-to-face interview using this tool at three data collection points: at intake to services, at 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. All data must be submitted through the specified online data submission tool within seven days of data collection or as specified after award. **Grantees and sub-awardees will be provided extensive training on the system and its requirements post award.**

The collection of these data will enable SAMHSA to report on key outcome measures relating to the grant program. 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.

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 (see Section I-2 Expectations).

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

Grantees also will be required to report on HIV and hepatitis using the new Rapid HIV and Hepatitis Testing (RHHT) form. The website that houses the RHHT form is: https://rhht.samhsa.gov/.

2.3 Local Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above), assess their progress, and use this information to improve management of their funded 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. Annual performance assessment reports should be submitted as a separate document as this information is not included as part of the regular progress reports (i.e., the biannual reports) required for this program. 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 orientation/gender identity?

- How durable were the effects?

- Was the intervention effective in maintaining the project outcomes at six-month follow-up?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to ensure 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 types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS)?

- What led to the changes in the original plan?

- What effect did the changes have on the planned intervention 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)?

- What strategies were used to maintain fidelity to the EBP or intervention across providers over time?

- How many individuals were reached through the program?

No more than 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.2 and 2.3 above.

2.4 Infrastructure Development (maximum 15 percent of total grant award)

Although services cooperative agreement funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use **no more than 15 percent** of

the total services award for the following types of infrastructure development, if necessary to support the direct service expansion of the funded project, and describe your use of the funds for these activities in Section B of the Project Narrative.

Following are examples of infrastructure activities:

- Developing partnerships with other service providers for service delivery.
- Adopting and/or enhancing your computer system, management information system, EHRs, etc., to document and manage client needs, care process, integration with related support services, and outcomes.
- Training/workforce development to help your staff or other providers in the community identify mental or substance use disorder issues or provide effective services consistent with the purpose of the funded program.
- Policy development to support needed service system improvements (e.g., rate-setting activities, establishment of standards of care, adherence to the National CLAS Standards in Health and Health Care, development/revision of credentialing, licensure, or accreditation requirements)[13].

2.5 Grantee Meetings

Grantees must plan to send a minimum of two people (including the Project Director) to at least one joint grantee meeting in every other year of the grant. For this grant cohort, grantee meetings will likely be held in years two and four of the grant. 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 three days. These meetings are usually held in the Washington, D.C. area and attendance is mandatory.

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[13] For purposes of this FOA, "policy" refers to programs and guidelines adopted and implemented by institutions, organizations, and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders ("legislation and other orders") proposed or pending before the Congress or any state government, state legislature, or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

II. AWARD INFORMATION

Funding Mechanism: Cooperative Agreement

Anticipated Total Available Funding: $28,594,750

Estimated Number of Awards: Up to 57

Estimated Award Amount: Up to $500,000 per year

Length of Project Period: Up to five years

Proposed budgets cannot exceed $500,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Funding estimates for this announcement are based on an annualized Continuing Resolution and do not reflect the final FY 2017 appropriation. Applicants should be aware that funding amounts are subject to the availability of funds.

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 terms of the cooperative agreement, including implementation activities described in the approved grant proposal and fulfillment of requirements described in Section I of the FOA.
- Monitor and ensure that sub-recipients collect and report GPRA data.
- Collect, evaluate, and report to SAMHSA all required performance data.
- Respond to requests for program-related data.
- Collaborate with SAMHSA/CSAT staff and SAMHSA contractors in all aspects of the cooperative agreement.
- Submit all required forms, data, and reports in a timely fashion.
- Participate in grantee meetings.
- Participate in cross-site evaluation, if applicable.
- Collaborate with the technical assistance providers (programmatic and evaluation) and other federally-funded resources.

- Document intended and actual changes resulting from the project's activities.

Role of SAMHSA Staff:

- Assume overall responsibility for monitoring the conduct and progress of the grant program.
- Participate, as needed on policy, steering, and other task forces for the grant program.
- Facilitate linkages to other SAMHSA/federal government resources and help grantees access appropriate technical assistance.
- Monitor the development and collection of process and outcome measures and ensure compliance with GPRA data requirements.
- Participate in partnerships and collaborative activities with other federal HIV projects, such as Ryan White/HRSA, HOPWA/HUD, and CDC.
- Approve key staff responsible for the management, leadership, oversight, and evaluation of the cooperative agreement.
- Review and approve cooperative agreement reports including evaluation reports; conduct site visits; and make recommendations to SAMHSA regarding the continuation of the project.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligibility is restricted to local-level public and private nonprofit entities that provide substance use and co-occurring services, and have established linkages to primary HIV services including:

- Local governments,
- Federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations,
- Urban Indian organizations (UIOs),
- Public or private universities and colleges, and
- Community- and faith-based organizations.

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of AI/ANs 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 AIs/ANs in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its

approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

UIO (as identified by the Office of Indian Health Service Urban Indian Health Programs through active Title V grants/contracts) means a non-profit corporate body situated in an urban center governed by an urban Indian-controlled board of directors, and providing for the maximum participation of all interested individuals and groups, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a). UIOs are not tribes or tribal governments and do not have the same consultation rights or trust relationship with the federal government.

Applicants must demonstrate partnership with primary HIV treatment and care providers. Applicants must document this partnership, which can be demonstrated by letters of commitment and MOAs from partnering organizations in **Attachment 1** of the application.

Given the focus on local service provision, SAMHSA is limiting these awards to direct treatment service providers and local governments. Therefore, states are not eligible to apply. Also, in an effort to impact the second prong of the 90-90-90 goal by allowing for expansion to a number of new organizations and additional communities receiving TCE-HIV grant awards, grantees that received an award under the following FOAs are not eligible to apply: TI-15-006 Targeted Capacity Expansion: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS and TI-16-011 Targeted Capacity Expansion HIV: Substance Use Disorder Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS.

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. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client (e.g., SUD treatment) services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;

- Each mental health/substance use disorder treatment provider organization must have at least two years' experience (as of the due date of the application) providing relevant services (official documents must establish that the organization has provided relevant services for the last two years); and

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

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

Following application review, if your application's score is within the fundable range, the government project officer (GPO) may contact you to request that additional documentation be sent by email, or to verify that the documentation you submitted is complete.

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

IV. APPLICATION AND SUBMISSION INFORMATION

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

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

- **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 D of this document. **It is highly recommended that you use the sample budget format in Appendix D. This will expedite review of your application.**

- **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 section provides additional information necessary for the review of your application. This supporting documentation must be attached to your application using the Other Attachments Form from the Grants.gov application package. Additional instructions for completing these sections and page limitations for Biographical Sketches/Position Descriptions are included in PART II: Section II-3.1, Required Application Components, and Appendix D, Biographical Sketches and Position Descriptions. Supporting documentation should be submitted in black and white (no color).

- **Budget Justification and Narrative** – The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)

- 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 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. Use the Other Attachments Form from Grants.gov to upload the attachments.

    - **Attachment 1:** (1) Identification of at least one experienced, licensed mental health/substance use disorder 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 and the services they will provide; (3) letters of commitment and corresponding MOA(s) from these direct service provider organizations including primary HIV treatment and care providers **(Do not include any letters of support. Reviewers will not consider them if you do.)**; (4) the Statement of Assurance (provided in Appendix B of this announcement) signed by the authorized representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that all listed providers meet the two-year experience requirement, are appropriately licensed, accredited and certified, and that if the application is within the

funding range for an award, the applicant will send the GPO the required documentation within the specified time.

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

- **Attachment 3:** Sample Consent Forms.

- **Attachment 4:** Copy of letter to the SSA transmitting the Public Health System Impact Statement (PHSIS) [if applicable; see PART II: Appendix B, Intergovernmental Review (E.O. 12372) Requirements].

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **May 3, 2017**.

IMPORTANT: Due to SAMHSA's transition to NIH's eRA grants system, SAMHSA has made changes to the application registration, submission, and formatting requirements.

Please be sure to read PART II of this FOA very carefully to understand the requirements for SAMHSA's new grant system. Applicants will need to register with NIH's eRA Commons in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

3. FUNDING LIMITATIONS/RESTRICTIONS

- No more than 15 percent of the total grant award may be used for developing the infrastructure necessary for expansion of services.

- No more than 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, including incentives for participating in the required data collection follow-up.

- Up to five percent of the total grant award may be used to pay for FDA-approved medications for the treatment of SUDs (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium, etc.) as part of a comprehensive treatment plan when the client has no other source of funds to do so.

- Up to five percent of grant funds may be used for the following hepatitis testing and services (based on risk and the USPSTF guidelines): viral hepatitis B and C (antibody and confirmatory) testing; viral hepatitis A and B vaccination; purchase of test kits and other required supplies (e.g., gloves, biohazardous waste containers, etc.); and training for staff related to viral hepatitis (B and C) testing.

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 C, Standard Funding Restrictions.

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

All SAMHSA grant programs are covered under Executive Order (E.O.) 12372, as implemented through HHS regulation at 45 CFR Part 100. Under this Order, states may design their own processes for reviewing and commenting on proposed federal assistance under covered programs. See PART II: Appendix B for additional information on these requirements as well as requirements for the Public Health System Impact Statement.

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, i.e., type "A-1", "A-2", etc., before your response to each question.** You may not combine two or more questions or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.7. **Only information included in the appropriate numbered question will be considered by reviewers.** Your application will be scored according to how well you address the requirements for each section of 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 (15 points)

1. Identify your population(s) of focus. Provide a comprehensive demographic profile of this population in your local area in terms of race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status.

2. Discuss the differences in access, service use, and outcomes for your population of focus in comparison with the general population in the local service area, citing relevant data. Describe how the proposed project will improve these disparities in access, service use, and outcomes.

3. Describe the nature of the problem, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus identified in your response to question A.1. To the extent available, use local data to describe need and service gaps, supplemented with state and/or national data. Identify the source of the data.

4. Describe your experience and effectiveness in serving YMSM within the last two years, if applicable.

Section B: Proposed Implementation Approach (30 points)

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

2. Provide a chart or graph depicting a realistic time line for the entire five years of the project period showing dates, key activities, and responsible staff. These key

activities should include the requirements outlined in Section I-2: Expectations. [NOTE: Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than four months after grant award. The time line should be part of the Project Narrative. It should not be placed in an attachment.]

3. Describe how the key activities in your timeline will be implemented.

4. Describe how the proposed activities will adhere to the National CLAS Standards (go to http://ThinkCulturalHealth.hhs.gov). Select one element from each of the CLAS Standards: 1) Governance, Leadership, and Workforce; 2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability, and specifically describe how these activities will address each element you selected.

5. Describe how you will screen and assess clients for the presence of CODs and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such CODs.

6. Describe how you will identify, recruit, and retain the population(s) of focus, and how this approach will take into consideration the language, beliefs, norms, values, and socioeconomic factors of this/these population(s).

7. Identify whether you are planning to expand and/or enhance SUD/COD treatment services as outlined in Section I-2: Expectations. Provide the number of additional clients to be served by the service expansion or enhancement.

8. Describe your plans and processes for supporting the following required activities as outlined in Section I-2: Expectations:

    a. Providing onsite HIV rapid preliminary antibody testing to all clients at enrollment, as well as the referral process to appropriate confirmatory testing for those clients who test positive.

    b. Providing case management services to all clients who have a preliminary positive HIV and confirmatory HIV test result. The process of case management includes comprehensive assessment of the client's needs and development of individualized substance use disorder treatment and HIV service plans. All persons with a preliminary or confirmed HIV diagnosis should be successfully linked to care within 30 days.

    c. Providing onsite, viral hepatitis (B and C) testing or referrals for testing for all clients who are considered to be at risk and in accordance with state and local requirements and CDC recommendations.

d. Providing referrals to treatment for all clients testing positive for viral hepatitis (B or C).

e. Providing linkage to services to identify stable housing for clients in need of housing.

9. Identify any other organization(s) that will partner in the proposed project. Describe their specific roles and responsibilities. Demonstrate their commitment to the project by including Letters of Commitment and corresponding MOA(s) from each partner in **Attachment 1** of your application.

10. State the unduplicated number of individuals you propose to serve (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 and that it is reasonable given your budget request. You are required to include the numbers to be served by race, ethnicity, gender (including transgender populations), and sexual orientation.

11. If you plan to use grant funds for infrastructure development, describe the infrastructure changes you plan to implement and how they will enhance/improve access, service use, and outcomes for the population of focus. If you do not plan to use grant funds for infrastructure development, indicate so in your response.

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

1. Describe the EBP(s) that will be used. Document how each EBP chosen is appropriate for the outcomes you want to achieve. Justify the use of each EBP for your population of focus. Explain how the chosen EBP(s) meet SAMHSA's goals for this program. If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP.

2. Explain how your choice of an EBP or practice will help you address disparities in service access, use, and outcomes for your population(s) of focus.

3. Describe any modifications that will be made to the EBP or practice and the reasons the modifications are necessary. If you are not proposing any modifications, indicate so in your response.

4. Explain how you will monitor the delivery of the EBPs to ensure that they are implemented according to the EBP guidelines.

Section D: Staff and Organizational Experience (10 points)

1. Discuss the capability and experience of the applicant organization with similar projects and populations. Demonstrate that the applicant organization has 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. Discuss the capability and experience of other partnering organizations with similar projects and populations. Demonstrate that other partnering 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.

3. Provide a complete list of staff positions for the project, including the Project Director, Program Coordinator, Program Evaluator, and other key personnel, showing the role of each and their level of effort and qualifications. Demonstrate successful project implementation for the level of effort budgeted for the Project Director and key staff.

4. Discuss how key staff members have demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s). If key staff members are to be hired, discuss the credentials and experience the new staff must possess to work effectively with the population of focus.

5. Describe how your staff will ensure the input of clients, families, and people in recovery 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 FOA.

2. Describe your specific plan for:
   - data collection,
   - management,
   - analysis, and
   - reporting.

   The data collection plan must specify the staff person(s) responsible for tracking the measureable objectives that are identified in your response to question B1.

3. Describe your plan for conducting the local performance assessment as specified in Section I-2.3 of this FOA and document your ability to conduct the assessment.

4. Describe the quality improvement process that will be used to track whether your performance measures and objectives are being met, and how these data will inform the ongoing implementation of the project.

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.

An illustration of a budget and narrative justification is included in Appendix D - Sample Budget and Justification, of this document. **It is highly recommended that you use the Sample Budget format in Appendix D. This will expedite review of your application.**

Be sure your proposed budget reflects the funding limitations/restrictions specified in Section IV-3. **Specifically identify the items associated with these costs in your budget.**

The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)

REQUIRED SUPPORTING DOCUMENTATION

Section F: Biographical Sketches and Position Descriptions.

See PART II: Appendix D, 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 C of this document 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 CSAT National Advisory Council.
- availability of funds;
- equitable distribution of awards in terms of geography (including urban, rural, and remote settings) and balance among populations of focus and program size; and
- In accordance with 45 CFR 75.212, SAMHSA reserves the right not to make an award to an entity if that entity does not meet the minimum qualification standards as described in section 75.205(a)(2). If SAMHSA chooses not to award a fundable application, SAMHSA must report that determination to the designated integrity and performance system accessible through the System for Award Management (SAM) [currently the Federal Awardee Performance and Integrity Information System (FAPIIS)].

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. Grantees will be asked to submit reports biannually.

VII. AGENCY CONTACTS

For questions about program issues contact:

Andrea M. Harris, MS, LCADC, CPP
Center for Substance Abuse Treatment, Division of Services Improvement
Substance Abuse and Mental Health Services Administration
(240) 276-2441
Andrea.harris@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
(240) 276-1412
FOACSAT@samhsa.hhs.gov

Appendix A – 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 EBP(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 for 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 EBP over other EBPs.

- If applicable, justify the use of multiple EBPs. Discuss how the use of multiple EBPs will be integrated into the program. Describe how the effectiveness of each EBP will be quantified in the performance assessment of the project.

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

Resources for Evidence-Based Practices (EBPs):

You will find information on EBPs 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 EBPs 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 C – Standard Funding Restrictions, regarding allowable costs for EBPs.]

Appendix B – 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.

- official documentation that all mental health/substance use disorder treatment provider organizations participating in the project have been providing relevant services for a minimum of two 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 two years; and

- official documentation that all mental health/substance use disorder 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.[14] (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, and certification requirements exist does not constitute adequate documentation.)

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

- TCE-HIV project for which funds are sought will not deny appropriate and eligible clients access to the program because of their use of FDA-approved medications

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

for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium). Specifically, methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder must be permitted.

_____ _____

Signature of Authorized Representative Date

Appendix C – 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 individuals who misuse substances, 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 of 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 misuse 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 obtain 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 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 D – 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. Applicants must use their own documented travel policies. If an organization does not have documented travel policies, the federal GSA rates must be used.

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). Organizations should follow their documented capitalization policy thresholds.

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 (federal definition) 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 misuse, 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) are 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. **Effective with 45 CFR 75.414(f), any non-federal entity that has never received a negotiated indirect cost rate, except for those non-federal entities described in Appendix VII part 75 (D)(1)(b), may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. If an organization has a federally approved rate of 10%, the approved rate would prevail.**

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**

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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: 09/30/2017 b. End Date: 09/29/2022

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 PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs.]

IN THIS SECTION, include a narrative and separate budget for each year of the grant that shows the percent of the total grant award that will be used for infrastructure development; data collection, performance measurement, and performance assessment; to pay for FDA-approved medications for the treatment of SUDs; and hepatitis testing and services. **Be sure the budget reflects the funding restrictions in Section IV-3.**

Infrastructure Development	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Infra-structure Costs**
Personnel	$2,250	$2,250	$2,250	$2,250	$2,250	$11,250
Fringe	$558	$558	$558	$558	$558	$2,790
Travel	0	0	0	0	0	0
Equipment	0	0	0	0	0	0
Supplies	$1,575	$1,575	$1,575	$1,575	$1,575	$7,875
Contractual	$5,000	$5,000	$5,000	$5,000	$5,000	$25,000
Other	$1,617	$2,375	$2,375	$2,375	$2,375	$11,117
Total Direct Charges	$11,000	$11,758	$11,758	$11,758	$11,758	$58,032
Indirect Charges	$750	$750	$750	$750	$750	$3,750
Total Infrastructure Costs	**$11,750**	**$12,508**	**$12,508**	**$12,508**	**$12,508**	**$61,782**

Data Collection & Performance Measurement	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Data Collection & Performance Measurement Costs**
Personnel	$6,700	$6,700	$6,700	$6,700	$6,700	$33,500
Fringe	$2,400	$2,400	$2,400	$2,400	$2,400	$12,000
Travel	$100	$100	$100	$100	$100	$500
Equipment	0	0	0	0	0	0
Supplies	$750	$750	$750	$750	$750	$3,750
Contractual	$24,950	$24,950	$24,950	$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
Total Data Collection & Performance Measurement Costs	**$34,998**	**$34,998**	**$34,998**	**$34,998**	**$34,998**	**$174,990**

FDA Approved Medications for SUD Treatment	Year 1	Year 2	Year 3	Year 4	Year 5	Total FDA Approved Medications for SUD Treatment Costs
Personnel	$2,250	$2,250	$2,250	$2,250	$2,250	$11,250
Fringe	$558	$558	$558	$558	$558	$2,790
Travel	0	0	0	0	0	0
Equipment	0	0	0	0	0	0
Supplies	$1,575	$1,575	$1,575	$1,575	$1,575	$7,875
Contractual	$5,000	$5,000	$5,000	$5,000	$5,000	$25,000
Other	$1,617	$2,375	$2,375	$2,375	$2,375	$11,117
Total Direct Charges	$11,000	$11,758	$11,758	$11,758	$11,758	**$58,032**
Indirect Charges	$750	$750	$750	$750	$750	**$3,750**
Total FDA Approved Medications for SUD Treatment Costs	**$11,750**	**$12,508**	**$12,508**	**$12,508**	**$12,508**	**$61,782**

Hepatitis Testing and Services	Year 1	Year 2	Year 3	Year 4	Year 5	Total Hepatitis Testing and Services Costs
Personnel	$2,250	$2,250	$2,250	$2,250	$2,250	$11,250
Fringe	$558	$558	$558	$558	$558	$2,790
Travel	0	0	0	0	0	0
Equipment	0	0	0	0	0	0
Supplies	$1,575	$1,575	$1,575	$1,575	$1,575	$7,875
Contractual	$5,000	$5,000	$5,000	$5,000	$5,000	$25,000
Other	$1,617	$2,375	$2,375	$2,375	$2,375	$11,117
Total Direct Charges	$11,000	$11,758	$11,758	$11,758	$11,758	**$58,032**
Indirect Charges	$750	$750	$750	$750	$750	**$3,750**
Total Hepatitis Testing and Services Costs	**$11,750**	**$12,508**	**$12,508**	**$12,508**	**$12,508**	**$61,782**