SECTION I: Standard Eligibility Requirements

Required Application Attachments

*Please submit current copies of all supplemental application materials listed below at the time of application. Incomplete applications may not be reviewed.*

1. Budget Template (See section VII, question 2)
   1. The budget template is provided in a required Excel format and is posted along with the application, solicitation, and related forms. The budget template must be filled out and submitted with the application. A recorded budget tutorial providing an overview of how to use the template is available online [here](https://atrc.dhss.delaware.gov/wp-content/uploads/2023/06/Budget-Tutorial_Final.mp4).
2. Current State of Delaware Business License (from Division of Revenue) **or** IRS 501(c)3 exemption verification
3. Your business license is obtained from the Delaware Division of Revenue and is generally issued for 1 year. Licenses usually expire on 12/31 and must be renewed to maintain TAP award eligibility. Website: [Delaware One Stop: Register](https://onestop.delaware.gov/Operate_Register) and license your business to operate in Delaware.
4. If applicable, IRS 501(c)3 exemption status can be obtained by searching for your organization on the IRS website: [Search for Tax Exempt Organizations | Internal Revenue Service (irs.gov)](https://www.irs.gov/charities-non-profits/search-for-tax-exempt-organizations#letter). A screen print must be provided.
5. Unique Entity Identifier (UEI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. The Unique Entity ID is a 12-character alphanumeric ID assigned to an entity by SAM.gov. Instructions on how to find your UEI are [here](https://www.fsd.gov/gsafsd_sp?id=kb_article_view&sysparm_article=KB0041254&sys_kb_id=a05adbae1b59f8982fe5ed7ae54bcbba&spa=1).
   2. A screenshot of full entity status from SAM.gov must be provided with your application submission.
6. Delaware eSupplier Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. The eSupplier Number is created by registering at the supplier portal registry website: [esupplier.erp.delaware.gov](http://esupplier.erp.delaware.gov/). This number does not require renewal; however, vendors should verify and ensure information is fully up to date on the supplier portal registry.
7. Current Certificate of Liability Insurance Coverage.
   1. **DHSS must be listed as the Certificate Holder**:

The Department of Health and Social Services (DHSS)

Division of Substance Abuse and Mental Health (DSAMH)

Contracts Unit

Administration Building

1. N. Dupont Hwy

New Castle, DE 19720

* 1. Additional Insured: **Do not** list “Department of Health & Social Services (DHSS) and the Division of Substance Abuse & Mental Health (DSAMH)” as the additional insured on the Certificate of Insurance (COI).

|  |
| --- |
| *Application Submission Instructions:*   * *Answer all questions for your chosen Tier.* * *Submit the completed application to* [*DSAMH.ORT@delaware.gov*](mailto:DSAMH.ORT@delaware.gov) *by February 15, 2024.* * *Submit the application in Word and Excel.* * *Do NOT print/scan to PDF. This will delay your application review.* * *NO handwritten applications will be accepted.* |

**SECTION II: Vendor Information**

1. **Applicant organization:**

|  |  |
| --- | --- |
| **Name of organization\*:** |  |
| \**The name of the organization is used for legal purposes and must be the same as the name that is shown on the Certificate of Insurance and Business License.* | |

1. **Application contacts responsible for responding to application questions:**

*Identify the primary contact and backup contact who will be available and able to answer timely questions regarding responses submitted in the application. Notification of changes to the primary contact must be sent to the* [*DSAMH.ORT@delaware.gov*](mailto:DSAMH.ORT@delaware.gov) *mailbox when they occur.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
| Primary: |  |  |  |
| Backup: |  |  |  |

1. **Authorized official who will be responsible for signing the Letter of Agreement:**

*The authorized official must have the authority necessary to execute the Agreement on behalf of the organization.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
|  |  |  |  |

1. **Designated data lead responsible for all data reports to DSAMH:**

*The data lead must be familiar with the organization’s data collection methods and sources and be able report data submission as required to support the Agreement.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
|  |  |  |  |

1. **Other key personnel responsible to be included on TAP communications for implementation of this project:**

*Examples of key personnel include programmatic or clinical leads, quality program officers, administrative and/or executive staff.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name** | **Title** | **Email** | **Phone Number** |
| 1) |  |  |  |  |
| 2) |  |  |  |  |
| 3) |  |  |  |  |

1. **Applicant overview:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **Types of services offered** | *Describe the services that your Emergency Department (ED) currently provides to SUD/OUD and/or suspected overdose patients. The service offering description should include the breadth and depth of service array provided.* |
| 1. **Populations served** | *Provide a broad overview of your current ED patient population. Include demographic information such as age, gender, race/ethnicity, language(s), and available information related to social drivers of health.* |
| 1. **Size of the organization:**    1. **Count of FTE** | *Provide the actual or estimated number of FTE employed in the ED. The answer to this question provides an orientation to the scale of the organization in relation to the scale of the project as proposed in the next section.* |
| * 1. **Count of unique individuals served in the most recent fiscal year** | *Please calculate the number of individuals served by your ED during your most recent, complete, fiscal year.* |

**SECTION III: TAP 3.A-H Program Proposal**

1. **Are you currently receiving funding from TAP?**

Yes

No

* 1. **If yes, select the other Tier(s) you are awarded:**

Tier 3.A

Tier 3.B

Tier 3.C

Tier 3.D

1. **Describe the project’s overview (maximum 250 words):**

*This section should provide a summary description of the project: what it is, why it is needed, desired outcomes and brief summary of implementation needs and resources requested in this proposal. If multiple applications are being submitted, this description should include a brief reference to how it is linked to other Tier Award Program project proposals while clearly distinguishing scope for the project proposed in this application.*

1. **Project specifications:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **Who is your target population?** | *Describe the specifications of the population that is intended to be screened through this project. This includes any demographic or diagnostic criteria used.* |
| 1. **How was the target population identified?** | *Please identify whether you are using a universal or selective screening approach and provide a rationale. Refer to the information source and/or experiences that support the need to provide screening to the intended population.* |
| 1. **At which location(s) will the project be implemented?** | *Describe the physical location(s) where the project will be implemented.* |
| 1. **What validated SUD screening instrument is planned?** | *Identify the validated SUD (inclusive of OUD/STUD) screening instrument and provision of screening for client population.* |
| 1. **Please describe your planned OUD/STUD screening and brief intervention protocol.** | *Describe and provide a rationale for the screening process you plan to implement, including target populations, frequency, staff/technology involved, an intervention approach responsive to screening scores.* |
| 1. **How will the project address cultural and racial/ethnic considerations and health disparities within the target population?** | *The response to this question must specify how your organization’s project implementation will ensure that the target population’s culture, race, ethnicity and known health disparities are explicitly addressed.* |
| 1. **What resources and programs does your organization currently utilize to support the population?** *This project proposal may not duplicate existing resources and programs.* | *Identify resources and programs that currently exist prior to the implementation of this proposed project. This project proposal may not duplicate existing resources and programs.* |
| 1. **What is the need for enhanced resources to address the identified need?** | *Specify why there is a need for the enhanced resources requested through this project. Be clear about how the enhanced resource is linked to the needs of the target population and proposed approach.* |
| 1. **How will you make these services accessible and available to all members of the target population? What additional measures will you implement?** | *Specify implementation strategies that will ensure services are accessible. Strategies should take into account social drivers of health that are commonly experienced as barriers to access including examples such as transportation, employment, housing and childcare. Additional measures should consider hours of operations, alternatives to on-site service delivery and access accommodations for pregnant and parenting people.* |

1. **Client engagement:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **How will you make referrals? How will you ensure warm handoffs that extend beyond standard referral practices?** | *Describe your referral process (including whether you will use the Delaware Treatment and Referral Network or another process/platform, and why). Also, describe additional steps your organization will take to ensure that any referral to additional services is successful. Specify how this approach goes beyond standard referral practices.* |
| 1. **How will your project “close the loop” on referrals?** | *Describe your project’s approach to ensuring that clients have engaged with the internal or external programs to which they were referred.* |
| 1. **How will your project connect clients to medications for opioid use disorder?** | *Identify your referral pathways and partnerships. Specify if you have in-house prescription and administration protocols or if individuals will be referred to other prescribers of Medications for Opioid Use Disorder.* |

**SECTION IV: Data**

|  |  |
| --- | --- |
| **SOR 3.0 Outcomes:** Delawareans have positive treatment outcomes and long-term recovery from opioid and stimulant use disorders. | |
| 1. **Population Indicators** (select all that apply to the proposed initiative) | Delawareans have rapid access to low-barrier medications for OUD.  Delawareans have access to services that address stimulant use.  Special health needs populations: racial & ethnic minorities, LGBTQ+, older adults, pregnant and parenting people, individuals in high-need zip codes, and justice involved have access to evidence-based services.  Social determinants of health are addressed concurrently to treatment.  Delawareans have support navigating care transitions and do not fall through the cracks.  Delawareans are reached that would not otherwise access supports through assertive outreach and engagement.  Partnerships and new care pathways are created with entities that have high touch engagement with people who have OUD/STUD.  Delawareans receive recovery support services that facilitate pathways to long-term recovery, promote quality of life, and support community integration. |

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response**: Please enter your response following the guidance in each cell below. |
| 1. **What is the unduplicated number of individuals expected to be served through the project?** | *Estimate the number of unique individuals that will be reached through implementation of this project.* |
| **i. Data source & rationale for estimate:** | *Describe the basis for your estimate. What existing data sources and experience were taken into account for this calculation?* |

**Performance Measures**

Performance measures are required of TAP awardees. Final determination of performance measures is subject to review and approval by DSAMH prior to commencement of any Agreement arising from this solicitation.

|  |  |
| --- | --- |
| 1. Universal measures are required for this program. You have the option to propose additional measures. See page 3 of the solicitation document for more details on measures. | |
| **Tier 3.A Universal Measures** | |
| **Due** | Number of unduplicated clients who were due for a screening in the last month. |
| **Screened** | Number of unduplicated clients who were due for a screening in the last month who were screened. |
| **Positive** | Of those screened in the last month, the unduplicated count of those who were positive. |
| **Referred** | Of those that screened positive in the last month, the unduplicated count of those who were referred to treatment. |
| **Engaged** | Of those that screened positive in the month before last, the unduplicated count of those who were connected/engaged in treatment in the last month. |
| **Optional: Identify additional project performance measures.**  If there are additional project performance measures that are not reflected in the required measures, please propose those measure(s) here. Emergency Departments are encouraged to identify metrics to highlight receptivity of the project by the target patient population (follow-up rates, attempts needed per patient, etc). | |

|  |  |
| --- | --- |
| 1. **What is your plan on how you will collect the required data for the project and use it for management, monitoring, and enhancement?** | *Describe steps your organization will take to ensure that required data are collected. Specify how data measurement is incorporated into management and monitoring workflows.* |

**SECTION V: Technical Assistance**

1. **Participation:**

I understand that TAP requires participation in technical assistance. My organization will attend two quarterly meetings, 1-hr each.

I understand that at least one member from our implementation team must attend each quarterly meeting and will be responsible to transfer information back to the other members of our team.

1. **TA Priorities:**

Technical assistance will be provided virtually in a discussion group format with organizations implementing projects in the same tier. Are you also interested in 1:1 coaching in addition to the discussion format?

Yes

No

**SECTION VI: Implementation Plan**

1. **Implementation Work Plan:** The DSAMH required implementation work plan template must be completed (see below). Please note, creation of an implementation work plan includes identification of your implementation work team members.

|  |  |
| --- | --- |
| 1. Describe your organizational capacity and capability to implement this project. This may include prior experience, expertise with the population, clinical champions, or other relevant organization capability. | *Responses should consider the scope of the project in relation to the current capability and historical capacity of your organization.* |

1. **Sustainability:** Sustainability refers to the ability of the organization to maintain new positions and programming past the duration of the award. This requires strategies to identify long-term funding options and to build programmatic sustainability through clinical resources and operational changes necessary to fully integrate the project into the organization.

The DSAMH-required implementation plan template addressing sustainability must be completed (see Implementation Plan, Phase 4).

**SECTION VII: Budget & Sustainability**

Federal guidelines require funds available through this opportunity be used to “Supplement Not Supplant”. This means that grant funds may be used to supplement existing activities. Grant funds may not be used to supplant current funding of existing activities. “Supplant” is defined as replacing funding of a recipient’s existing program with funds from a federal grant.

1. **Attestation:**

I understand that SOR grant funds may be used to supplement, but not supplant existing funding for programs and services. [Enter name of organization] will have the following fiscal controls in place to ensure that supplantation does not occur (please check all that apply):

*Policies and procedures that require multiple layers of approval based on the dollar amounts being processed.*

*Accounting system funding reports that provide details of receipt and disbursement.*

*Separate appropriations managed for each account.*

*Separate account codes on the Chart of Accounts to track the SOR 3.0 TAP share and non-SOR 3.0 TAP share for all transactions.*

*Third party audit (if applicable per § 200.501 Audit requirements)*

*Internal audit*

*Other, please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Budget Request:** The DSAMH required budget template must be completed and submitted along with the application.

*Please note, a summary of limitations on the use of funds available through this opportunity are included in a separate worksheet of the budget template. Failure to review and follow these requirements may result in negative audit findings, recoupment, or other compliance actions.*

**Implementation Plan: Delaware SOR 3.0 Tier Award Program**

**Purpose:** Providers applying for the SOR 3 Tier Award Program (TAP) should use this implementation plan to: (a) articulate their program goals and objectives; (b) outline anticipated work, including activities and responsible staff persons; and (c) provide the anticipated timeline for executing their implementation plan. Missing or incomplete applications may be denied or returned for revisions, which may impact selection for award.

**Instructions:** Complete the implementation plan based on your Tier selection. Start by listing goal(s) identified in your project application, and insert additional rows as needed. For each objective, mark the timeline column(s) with an “x” for when key activities will be implemented. Be sure to consider the four key phases of your project: (1) planning and design, (2) implementation, (3) monitoring, and (4) programmatic/financial sustainability, as you complete the implementation plan. Please ensure the requested award amount aligns with your budget submission.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant Organization:** |  | **Project Director:** |  |
| **Anticipated Project Start Date:** | 4/1/24 | **Data Lead:** |  |
| **Anticipated Project End Date:** | 9/29/24 | **Requested Award Amount:** |  |

**Phase 1: Planning & Design**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE… | | | | | | | | |
| OBJECTIVE | | **KEY ACTIVITIES TO ACCOMPLISH OBJECTIVE** | **POTENTIAL TECHNICAL ASSISTANCE/ RESOURCE NEEDS** | **TIMELINE (IN MONTHS)** | | | | | |
| **1 - Apr** | **2 - May** | **3 - June** | **4 - July** | **5 - Aug** | **6 - Sept** |
| 1: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 2: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 3: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |

**Phase 2: Implementation**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE… | | | | | | | | |
| OBJECTIVE | | **KEY ACTIVITIES TO ACCOMPLISH OBJECTIVE** | **POTENTIAL TECHNICAL ASSISTANCE/ RESOURCE NEEDS** | **TIMELINE (IN MONTHS)** | | | | | |
| **1 - Apr** | **2 - May** | **3 - June** | **4 - July** | **5 - Aug** | **6 - Sept** |
| 1: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 2: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 3: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |

**Phase 3: Monitoring**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE… | | | | | | | | |
| OBJECTIVE | | **KEY ACTIVITIES TO ACCOMPLISH OBJECTIVE** | **POTENTIAL TECHNICAL ASSISTANCE/ RESOURCE NEEDS** | **TIMELINE (IN MONTHS)** | | | | | |
| **1 - Apr** | **2 - May** | **3 - June** | **4 - July** | **5 - Aug** | **6 - Sept** |
| 1: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 2: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 3: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |

**Phase 4: Programmatic and Financial Sustainability**

1. **Is your organization enrolled in Medicaid, Medicare, Commercial/Private or Tricare insurance programs?**

Yes

No

*If not, please enroll:* [*delawarePRET@gainwelltechnologies.com*](mailto:delawarePRET@gainwelltechnologies.com) *800-999-3371, option 0, then option 4*

1. **Are the services proposed to be provided to the target population potentially able to be reimbursed under Medicaid, Medicare, Commercial/Private or Tricare insurance programs?**

Yes

No

1. **What is the organization’s plan for financial *and* programmatic support of project activities after the award period? *(Use the template below to articulate your organization’s sustainability plan. Please be sure to include information about how you will engage leadership and staff to sustain this project. In addition, be sure to include your plan to incorporate the selected evidence-based practice(s) into standard care after the project ends.)***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE… | | | | | | | | |
| OBJECTIVE | | **KEY ACTIVITIES TO ACCOMPLISH OBJECTIVE** | **POTENTIAL TECHNICAL ASSISTANCE/ RESOURCE NEEDS** | **TIMELINE (IN MONTHS)** | | | | | |
| **1 - Apr** | **2 - May** | **3 - June** | **4 - July** | **5 - Aug** | **6 - Sept** |
| 1: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 2: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |
| 3: ENTER OBJECTIVE HERE… | |  |  |  |  |  |  |  |  |
| Point Person: | |
| Potential Partners/Stakeholders: | |