**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)a
   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

1901 North 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).

1. Is your organization licensed by DSAMH to provide MH/SUD services in Delaware?

Yes

No

N/A (select if applying for Tier 3.A)

* 1. If yes, what programs are licensed? (Select all that apply)

Outpatient Treatment Services: Outpatient Services ASAM Level 1

Outpatient Treatment Services: Intensive Outpatient Treatment ASAM Level 2.1

Outpatient Treatment Services: Outpatient Services ASAM Level 1 and Intensive Outpatient Treatment ASAM Level 2.1

Opioid Treatment Services: Opioid Treatment Program (OTP) ASAM Level 1

OTP with mobile unit

OTP with medication unit

Co-Occurring Outpatient Services: Partial Hospitalization Program (PHP): Co-Occurring Treatment Services ASAM Level 2.5

Ambulatory Detoxification Services: WM Ambulatory Withdrawal Management with Extended On-site Monitoring ASAM Level 2

Ambulatory Detoxification Services: WM-23 Hour Ambulatory Withdrawal Management with Extended On-site Monitoring ASAM Level 2

Residential Detoxification Services: WM Clinically Managed Residential Withdrawal Management ASAM Level 3.2

Residential Detoxification Services: WM Medically Monitored Inpatient Withdrawal Management ASAM Level 3.7

Transitional Residential Treatment: Clinically Managed Low-Intensity Residential Treatment ASAM Level 3.1

Residential Treatment: Clinically Managed Population-Specific High Intensity Residential Treatment ASAM Level 3.3

Residential Treatment: Clinically Managed High Intensity Residential Treatment ASAM Level 3.5

Residential Treatment: Medically Monitored Intensive Inpatient Treatment ASAM Level 3.7

|  |
| --- |
| *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 9, 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 organization provides to participants. The service offering description should include the breadth and depth of service array provided.* |
| 1. **Population served** | *Describe your current clientele. Include demographic information such as age, gender, race/ethnicity, language(s), and available information related to social drivers of health such as justice involvement, socio-economic status, education level, etc.* |
| 1. **Size of the organization:**    1. **Count of FTE** | *Provide the actual or estimated number of FTE employed by your organization. This 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 organization during your most recent, complete, fiscal year. Each individual may only be counted once, regardless of the number of services received.* |

**SECTION III: TAP Program Proposal**

1. **Identify which Tier you are applying for (select one):**

***Please refer to the solicitation for a breakdown of each Tier in more detail, which can be found*** [***here***](https://atrc.dhss.delaware.gov/sor-grant#tier_award_program)***.***

**Tier 3.A (only for new partners):** Projects that implement opioid use disorder and/or stimulant use disorder (OUD/STUD) screening, brief intervention, and referral to treatment (SBIRT) and follow-up protocols.

**Tier 3.B:** Projects that implement OUD/STUD evidence-based practices.

**Tier 3.C:** Projects that implement specialized OUD/STUD programming for specific populations with unmet and/or elevated needs.

1. **Are you submitting an application for another Tier?**

Yes

No

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

Tier 3.A

Tier 3.B

Tier 3.C

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. **Target population description** | *Describe the specifications of the population that is intended to be served through this project. This includes any demographic or diagnostic criteria used.* |
| 1. **How was the target population identified?** | *Refer to the information source and/or experiences and rationale that support the need to provide these services to the intended population. Please note that information and data sources regarding special populations in Delaware with unmet and/or elevated needs are included in a separate tab of the pre-approved EBP reference list.* |
| 1. **Project Implementation Location(s)** | *Describe the physical location(s) where the project will be implemented.* |
| 1. **Tier 3.A *only:* What validated screening instrument and frequency of use are planned?** | *Identify the validated SUD (inclusive of OUD/STUD) screening instrument and provision of universal screening for client population at the appropriate frequency based on practice setting****.*** |
| 1. **Tier 3.B & 3.C *only*: What is the evidence-based practice (EBP) the project will use to guide the project?**   *\*Please refer to the solicitation for an approved list of EBPs.* | *Provide the name of the EBP/s here. These must be new or expanded EBP for your organization. Solicitation resources include a list of pre-approved EBPs.* |
| 1. **Tier 3.B & 3.C *only*: How will EBP fidelity be assured and monitored?** | *Specify your organization’s data collection/monitoring approaches to assess fidelity to the EBP standards and model.* |
| 1. **Tier 3.B & 3.C *only*: Will your project make any adaptations to EBP? If so, please describe the changes and your rationale.** | *Adaptations may be acceptable when they demonstrate a tailored or specialized approach for the project’s target population, especially those with unmet or elevated needs.* |
| 1. **How will the project address the needs of the target population?** | *Identify the connection between the proposed EBP and the needs of the target population.*  *Please note - any proposed EBP for Tier 3.C project proposals must show that the proposed EBP is appropriate and tailored to the specific population and needs identified.* |
| 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 your project identify individuals with OUD/STUD?** | *Describe how participants from the target population will be identified. Include a description of any new referral pathways and partners, new or existing data sets that are proposed to be used.* |
| 1. **How will your project engage hard-to-reach clients?** | *Describe the members of the target population that are considered “hard-to-reach”. Specify the proposed approach that addresses the identified barrier to engagement.* |
| 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 capacity or if individuals will be referred to other prescribers of Medications for Opioid Use Disorder.* |
| 1. **How will you ensure warm handoffs that extend beyond standard referral practices?** | *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.* |

**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. This number is also the target number for your organization’s GPRA served amount.* |
| **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 in three categories that measure “How Much” work is occurring, “How Well” it is being performed, and if anyone is “Better Off” as a result. The final determination of performance measures is subject to review and approval by DSAMH prior to commencement of any Agreement arising from this solicitation.

|  |  |  |
| --- | --- | --- |
| 1. **How Much?** Universal measures have been identified and are required for each tier award program. You have the option to propose additional measures of “how much”. | | |
| **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. |
| **Follow-up** | | Of those that were referred to treatment in the last month, the unduplicated count of those who received follow up to ensure a successful connection to treatment.   * Follow up 1st attempt success rate between 1- 14 days * Follow up 2nd attempt success rate between 15 - 30 days * Referral refused |
| **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. |
| **Tiers 3.B & 3.C Universal Measures** | | |
| **SDOH screen** | Number of unduplicated clients who were due for an SDOH screening in the last month who were screened. | |
| **SDOH positive** | Of those screened for SDOH in the last month, the unduplicated count of those who were positive. | |
| **SDOH referral** | Of those that screened positive for an SDOH in the last month, the unduplicated count of those who were referred to community partners. | |
| **MOUD** | Number of unduplicated clients who were prescribed or administered each of the following MOUD in the last month through this TAP-funded project.   * buprenorphine * oral naltrexone * long-acting, injectable naltrexone * methadone | |
| **Internal MOUD referral** | Number of unduplicated clients who were referred internally (within your agency) to MOUD treatment in the last month | |
| **External MOUD referral** | Number of unduplicated clients who were referred externally (outside your agency) to MOUD treatment in the last month | |
| **Medicaid Enrollment** | In the last month, what is the number of times that clients were linked to Medicaid enrollment services. | |
| **Intervention** | Number of unduplicated clients receiving intervention in the last month. | |
| **GPRA** | The Center for Substance Abuse Treatment (CSAT) Government Performance Results and Modernization Act (GPRA) Client-Level data collection at baseline, follow-up, and discharge is required for individuals receiving treatment AND/OR recovery support services | |
| **Optional - Identify additional project performance measures related to “how much”.**  If there are additional project performance measures needed to quantify the efforts/activities, that are not reflected in the required measures, please propose that measure(s) here. | | |

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| 1. **How Well?** Performance measures in this category support an evaluation of the quality of the program, or “how well” the project is performed. Required process measures are provided below. |

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| --- | --- |
| **Tier 3.B & 3.C Process Measures** | |
| **Time to Treatment Initiation** | Percentage of individuals who initiate SUD treatment within 14 days of an OUD diagnosis. |
| **Engagement in Treatment** | Rate of individuals who had two or more additional SUD services within 30 days of the initiation of a SUD treatment encounter. |
| ***Optional* - Identify additional project performance measures related to “how well”:** | |

|  |  |  |
| --- | --- | --- |
| 1. **Is anyone better off?** Performance measures in this category support an evaluation of the outcomes of the program by answering the question “Is anyone better off?”. Examples of outcome measure sources are provided below. Please propose at least one project performance measure. | | |
| **Tier 3.A, 3.B & 3.C** **Outcome Measures** | | |
| Potential Outcome Measure Data Sources   1. **Measure of improvement evaluated through GPRA section F**. “Mental and Physical Health Problems and Treatment/Recovery”. Calculated rate of improvement from intake to follow up and intake to discharge. GPRA should only be used by organizations providing treatment services under Tiers 3.B and 3.C. 2. **Patient functioning and/or quality of life instruments as collected through patient surveys or during provider encounters:** Reliable and valid patient-reported outcome instruments can be used to collect information on patient functioning and quality of life. The list below provides a sample of tools that can be used to capture functioning and quality of life for patients with SUD. The instruments can be administered to patients during a provider encounter or can be sent directly to patients via a survey.  * Brief Assessment of Recovery Capital (BARC-10) * Addiction Severity Index (ASI) * Brief Addiction Monitor (BAM) * RecoveryTrack * Functional Outcomes Survey 12-item Short Form (SF-12) * Functional Outcomes Survey 20-item Short Form (SF-20) * Functional Outcomes Survey 36 (SF-36) * WHOQOL * WHOQOL-BREF * Global Appraisal of Individual Need (GAIN-I) * Personal Wellbeing Index—Adult (PWI-A) * Behavior and Symptom Identification Scale-24 (BASIS-24) * Alcohol Quality of Life Scale (AQoLS)  1. **DSAMH Consumer Satisfaction Survey:** [MHSIP Adult Consumer Survey (Version 1.1) (delaware.gov)](https://dhss.delaware.gov/dhss/dsamh/files/cccs_survey_2010.pdf) | | |
| ***Required -* Propose project performance measures related to “is anyone better off”:**  **The proposed measure should assess project outcomes and should answer the question “is anyone better off” as a result of implementing the project.**  Suitable data sources for this measure are focused on impact and recovery (related to substance use and/or quality of life) and are frequently evaluated through a client experience survey mechanism. Potential outcome measure data sources are shared in the table above and include use of the GPRA.  Applicants must propose a measure for this category. The proposed measure must include a target or benchmark for expected outcomes.  Final measure specifications are subject to DSAMH approval. | | |
|  | Example: | Proposal: |
| **Applicant proposed performance measure:** | Percent of participants with improvement from initial assessment to 3-month assessment |  |
| **Target:** | >80% |  |
| **Tool:** | Brief Addiction Monitor (BAM) |  |
| **Measurement Interval:** | Three months between participants’ initial assessment and reassessment |  |

|  |  |
| --- | --- |
| 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:

* At least 2-3 hours of technical assistance during the project period
* 2 quarterly meetings, 1-hr each

I understand that at least one member from our implementation team must attend each technical assistance session 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. 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:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Tier Selection**  **(check one):** | **Tier 3.A:** Projects to implement OUD/STUD screening, brief intervention, referral to treatment (SBIRT), and follow-up | **Tier 3.B:** Projects to implement new evidence-based practices or bring programs into fidelity with EBPs for persons with OUD/STUD | **Tier 3.C:** Projects to implement specialized OUD/STUD programming or bring programs into fidelity for special populations with unmet and/or elevated needs |

**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: | |