Application Readiness Checklist

*Complete this checklist before submitting your application.*

*Reminder: Incomplete applications may not be reviewed.*

|  |  |
| --- | --- |
| **✔** | **Application Requirements** |
|  | Budget is complete, follows the instructions in the "Guide" tab of the Excel template, includes clear justifications for all proposed costs, and only includes allowable expenses. |
|  | All required sections of the application form are fully completed, including narratives, checkboxes, and contact information. |
|  | Implementation Plan is complete, aligns with the proposed project activities and sustainability goals, and follows the format provided in the required template. |
|  | All four required attachments are included and current (not expired):  Budget Template (Excel format)  Certificate of Liability Insurance (must be valid and not expired)  Business License or 501(c)3 verification (must be current)  SAM.gov UEI screenshot (must show active status and expiration date) |
|  | Application is submitted in Microsoft Word format, and budget in Excel format (not PDF). |
|  | All checkboxes in the application form are marked with a ✔ (highlighting will not be accepted). |
|  | My organization meets the eligibility requirements and has been in operation for at least two years. |
|  | I have read and understand all instructions in the solicitation and application materials. |

|  |
| --- |
| **Application Submission Instructions**:   * Submit the completed application and all FOUR supplemental documents to [DSAMH.ORT@delaware.gov](mailto:DSAMH.ORT@delaware.gov) by **June 2, 2025**. * Submit the application in Microsoft Word and budget in Excel format. **Applications and budgets submitted as PDFs may not be reviewed**. * No handwritten applications will be accepted. * All checkboxes must be filled out with a check mark. Highlighting will not be accepted*.* * Incomplete applications may not be reviewed.   **Note**: Grant writing-related resources are available on DSAMH’s ATRC Website, which can be accessed [here](https://atrc.dhss.delaware.gov/resource-library) in the Resource Library. Be sure to insert “Grant Writing” in the Keyword Search, which will populate links to 10 modules (PPTs and associating recordings/videos) and a Grant Writing Workbook designed to guide you through each step of developing a proposal. |

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**Submission & Revision Dates**

|  |  |
| --- | --- |
| **Application Submission Date** | Click or tap here to enter text. |
| **Last Revision Date (if applicable)** | Click or tap here to enter text. |

## SECTION I: Required Attachments & Eligibility Confirmation

Required Application Materials & Attachments

In addition to this application form, applicants must also attach the following **FOUR required documents** to their email submission. Incomplete applications may not be reviewed.

**Note:** The organization’s name must match across all documents.

1. Budget Template (See section VI, 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/funding-opportunity/tier-4-a).
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. Visit the OneStop website for more information: <https://onestop.delaware.gov/Operate_Register>
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 screenshot **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. Add number on the line above. No screenshot is required.
   2. 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. As a part of the LOA requirements, TAP subrecipients must obtain at their own cost and expense and keep in force and effect during the term of the LOA, including all extensions, the minimum coverage limits specified below with a carrier satisfactory to the State. All Subrecipients must carry the following coverage depending on the type of service or product being delivered:
      * Worker’s Compensation and Employer’s Liability Insurance in accordance with applicable law.
      * Commercial General Liability - $1,000,000 per occurrence/$3,000,000 per aggregate.
      * [21 Del. C. § 2118](https://delcode.delaware.gov/title21/c021/sc01/index.html); and Comprehensive coverage for all leased vehicles, which shall cover the replacement cost of the vehicle in the event of collision, damage, or other loss.
      * Automotive Liability Insurance covering all automotive units used in the work (including all units leased from and/or provided by the State to Subrecipient pursuant to this Agreement as well as all units used by Subrecipient, regardless of the identity of the registered owner, used by Subrecipient for completing the Work required by this Agreement to include but not limited to transporting Delaware clients or staff), providing coverage on a primary non-contributory basis with limits of not less than:
        + $1,000,000 combined single limit each accident, for bodily injury;
        + $250,000 for property damage to others;
        + $25,000 per person per accident Uninsured/Underinsured Motorists coverage;
        + $25,000 per person, $300,000 per accident Personal Injury Protection (PIP) benefits as provided for in [21 Del. C. § 2118](https://delcode.delaware.gov/title21/c021/sc01/index.html); and
        + Comprehensive coverage for all leased vehicles, which shall cover the replacement cost of the vehicle in the event of collision, damage, or other loss.
   2. The Subrecipient must carry at least one of the following depending on the scope of work being performed:
      * Medical/Professional Liability - $1,000,000 per occurrence/$3,000,000 per aggregate
      * Miscellaneous Errors and Omissions - $1,000,000 per occurrence/$3,000,000 per aggregate
      * Product Liability - $1,000,000 per occurrence/$3,000,000 aggregate
   3. **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. Tier 4.A of the Tier Award Program is targeted to non-behavioral health/SUD treatment providers. Practices providing SUD treatment are **NOT** eligible. Does your practice provide SUD treatment and/or recovery?

Yes

No

1. Has your agency/organization been in business for at least two years?

Yes

No

## SECTION II: Vendor Information

1. **Applicant organization:**

|  |  |
| --- | --- |
| **Name of organization\*:** | Click or tap here to enter text. |
| \**The name of the organization is used for legal purposes and must be the same as the name shown on the Certificate of Insurance and Business License or proof of 501(c)3 status.* | |

1. **Applicant administrative location:**

|  |  |
| --- | --- |
| **Address\*:** | Click or tap here to enter text. |
| \**This address will be used for legal purposes and must be the same as the address shown on the Certificate of Insurance and Business License or proof of 501(c)3 status.* | |

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

*Identify the grant writer, project lead (if different from grant writer), and backup contact who will be available and able to answer timely questions regarding responses submitted in the application. Notification of changes to the project lead must be sent to* [*DSAMH.ORT@delaware.gov*](mailto:DSAMH.ORT@delaware.gov)*.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
| **Project Lead**: Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Grant Writer**: Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Backup Contact**: Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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. Signatures will be facilitated electronically, through DocuSign.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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 to report data submission as required to support the Agreement.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

1. **Executive-level (C-suite) contact:**

*The executive-level contact must have approved this application submission and agrees to be available to support the team if/as needed, in addition to making themselves available to DSAMH leadership during the project period if/as needed.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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* ***currently*** *provides to participants. The service offering description should include the breadth and depth of service array provided. (Maximum 250 words).*  Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |
| 1. **Size of the organization:**    1. **Count of FTE** | *Provide the actual or estimated number of FTE* ***currently*** *employed by your organization. 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.*  Click or tap here to enter text. |
| * 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.*  Click or tap here to enter text. |

1. Does your organization have a website?

No

Yes, our website can be accessed at this link: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **DocuWare Group Email Address** (payment notifications): Click or tap here to enter text.

*Please provide an organization-level email address (e.g., admin@organization.org) that multiple staff members can access. This email will be used to receive automated notifications related to payment transactions. It should not be a personal email address.*

1. Is your organization currently receiving any additional grant funding from the State of Delaware or the Federal Government for opioid use disorder services? Or do you have a contract with the State of Delaware that is funded by a grant?

​​No

​​Yes, we are receiving the following funding:

Prescription Opioid Settlement Distribution Commission

State Funds

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SECTION III: TAP Program Proposal

|  |
| --- |
| 1. **Describe the project’s overview (maximum 250 words):**   *This section should provide a summary description of your proposed project aligned with the goals of this solicitation. Describe your project: what it is, why it is needed, desired outcomes, and a brief summary of implementation needs and resources requested in this proposal. Please be sure to include how this funding will enable sustainable SBIRT implementation following the conclusion of this grant funded project period.* |
| Click or tap here to enter text. |

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.*  Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |
| 1. **Project implementation location(s)** | *Describe the physical location(s) and* ***provide the address(es)*** *where the project will be implemented.*  Click or tap here to enter text. |
| 1. **Which validated screening instrument will you use? At what frequency?** | *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.**Refer to the TAP 4.A SBIRT Guidance included in the solicitation package for examples and guidance on screening tools.*  Click or tap here to enter text. |
| 1. **Who are your planned referral partners?** | *Please list out the SUD/BH treatment organizations that you plan to refer clients to, as part of your SBIRT implementation.*  Click or tap here to enter text. |
| 1. **How will the project address the needs of the target population?** | *Identify the connection between the proposed* *screening tool and the needs of the target population.*  Click or tap here to enter text. |
| 1. **What resources and programs do your organization currently utilize to support the population?** | *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.*  Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |
| 1. **How will you make these services accessible and available to all members of the target population? What additional measures will you implement?** | *Specify the implementation strategies that will ensure services are accessible. Strategies should take into account social drivers of health that are commonly experienced, such as barriers to access including transportation, employment, housing, and childcare. Additional measures should consider hours of operations, alternatives to on-site service delivery, and accommodations for pregnant and parenting people.*  Click or tap here to enter text. |

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, and new or existing data sets that are proposed to be used.*  Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |

## SECTION IV: Data

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response**: Please enter your response following the guidance in each cell below. |
| * + - 1. **Anticipated Project Reach**   **a. 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.*  Click or tap here to enter text. |
| **b. Data source & rationale for estimate:** | *Describe the basis for your estimate. What existing data sources and experience were taken into account for this calculation?*  Click or tap here to enter text. |

**Performance Measures**

TAP subrecipients must report performance in three categories:

* “How Much” work is occurring,
* “How Well” it is being performed, and
* if anyone is “Better Off” as a result.

All subrecipients will be expected to report on the standard universal measures (“How Much”) and process measures (“How Well”) listed below. You may propose additional measures in these areas, but this is optional. Applicants **must** propose their own “Better Off” (outcome) measures. 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.” | |
| **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. |
| ***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.*  Click or tap here to enter text. | |

|  |  |
| --- | --- |
| * + - 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. | |
| **Process Measures** | |
| **Follow-up** | Of those that were referred to treatment in the last month, the unduplicated number 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 number of those who were connected/engaged in treatment in the last month. |
| ***Optional* - Identify additional project performance measures related to “how well”:**  Click or tap here to enter text. | |

|  |  |  |
| --- | --- | --- |
| * + - 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. | | |
| **Outcome Measures** | | |
| *Using a validated, evidence-based screening tool allows providers to not only identify risk related to substance use but to establish an objective baseline for future comparison. Because these tools are scientifically validated, they provide reliable data that can demonstrate meaningful changes over time.*  **FOR MEDICAL/CLINICAL PROVIDERS:**  Medical/clinical providers should follow the steps below to screen, intervene, and rescreen patients to assess changes in substance use risk over time:   * **Initial Screening:** Administer a validated substance use screening tool to obtain a numeric score or risk level (e.g., none, mild, moderate, or severe). This establishes a baseline level of risk. * **Brief Intervention and Referral:** Provide a brief intervention to motivate reduced substance use. If the patient is willing, refer them to a substance use treatment program or a community-based resource (e.g., a 12-Step program). * **Follow-Up Screening:** Re-administer the same screening tool after an appropriate interval based on the original risk level:   + None to Mild Risk: Rescreen annually   + Moderate Risk: Rescreen every 1 to 3 months   + Severe Risk: Rescreen within 1 month * **Interpret Results**: Compare the rescreening results to the baseline:   + Improved score (e.g., moderate to mild): Reduced risk—intervention may be working.   + No change: Risk remains the same—may need a different or intensified approach.   + Worsened score: Increased risk – care plan should be adjusted accordingly.   **FOR COMMUNITY-BASED ORGANIZATIONS (CBOs):**  CBOs play a critical role in care coordination and referral support. The following steps help demonstrate client outcomes:   * **Initial Screening:** Administer a validated screening tool to assess current substance use risk (e.g., mild, moderate, or severe). * **Brief Intervention and Referral:** Offer a brief intervention and, if the individual is receptive, provide a referral to appropriate substance use treatment or a community-based support resource. * **Track Referral Outcomes (Closed-Loop Referrals):** Monitor whether the individual successfully engaged with the referred service. This includes:   + Verifying attendance or participation (closed-loop confirmation)   + Continuing outreach and support for those who do not engage, including motivational interventions and harm reduction services | | |
| ***REQUIRED –* Identify at least one measure and propose at least one target related to “is anyone better off”:**  **Medical/Clinical Providers will measure reduction in substance use risk score**   * **Measure:** % of patients whose risk level (based on AUDIT, DAST, or ASSIST) decreased at follow-up screening   **CBOs will measure closed-loop referrals completed**   * **Measure:** % of referrals to behavioral health or SUD services that result in at least one completed appointment (i.e., the referral loop is closed).   Applicants must propose a measure for this category. Approved providers are responsible for collecting and reporting data using the selected performance measurement tool. Final measure specifications are subject to DSAMH approval. | | |
|  | **Example:** | **Proposal(s):** |
| **Applicant proposed performance measure:** | % of patients whose DAST score decreased at follow-up screening | Click or tap here to enter text. |
| **Target:** | >80% | Click or tap here to enter text. |
| **Tool:** | Drug Abuse Screening Test (DAST-10) | Click or tap here to enter text. |
| **Measurement Interval:** | At baseline, and monthly after participants’ initial assessment | Click or tap here to enter text. |

|  |  |
| --- | --- |
| * + - 1. **What is your plan for 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.*  Click or tap here to enter text. |

## SECTION V: Technical Assistance

**Participation:**

I understand that TAP requires participation in technical assistance (TA). My organization will attend:

* At least 5 hours of technical assistance during the project period
* Quarterly meetings, 1 hour each
* Additional TA as required by DSAMH for performance or compliance support

I understand that at least one individual connected to the project must attend each mandatory learning session and will be responsible for transferring information back to the other members of our team.

## SECTION VI: Budget

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**.** Our organization will have the following fiscal controls in place to ensure that supplanting 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 4.0 TAP share and non-SOR 4.0 TAP share for all transactions.*

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

*Internal audit.*

*Other, please specify:* Click or tap here to enter text.

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

* A highlight of limitations on the use of funds available through this opportunity are included in the Guide tab of the budget template. **Failure to review and follow these requirements may result in negative audit findings, recoupment, or other compliance actions.**
* Budget requests can be made up to $75,000. DSAMH reserves the right to award lower amounts based on a project’s proposed scope and impact.

## SECTION VII: Implementation & Sustainability Plan

1. **Implementation Plan:** The DSAMH required implementation plan template must be completed (see below). Please note, creation of an implementation plan includes identification of your project team members.
2. **Project Team Collaboration:** If your Grant Writer and Project Lead are *not* the same person, have you discussed the project proposal as a team?

Yes

No

N/A: grant writer and project lead are the same.

1. **DTRN Registration:** Are you registered with Delaware’s Treatment and Referral Network (DTRN), the statewide, comprehensive electronic referral network for behavioral health and substance use disorder treatment? DTRN is a free, state-run, network that aids in referring clients to treatment.

Yes

No

If NO, you must add registration as an activity to be completed within the first 30 days of your implementation plan.

1. **Fidelity Monitoring Attestations:**

I understand that as part of the Tier 4.A initiative, my organization will be required to monitor the degree to which SBIRT is being delivered with fidelity to the evidence-based SBIRT model, using the SBIRT Proficiency Checklist provided by DSAMH.

My organization commits to participating in up to four fidelity monitoring assessments. These will be conducted in person (at least one in the first quarter of the funding period and another in the final quarter). As part of this, my organization will designate a staff member who regularly performs SBIRT to participate in the assessment.

My organization will use findings from the fidelity monitoring assessments to develop a targeted improvement plan.

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. Applicants are required to describe how the SBIRT process will be embedded into their organization to ensure sustainability beyond the grant period. *Note: The required implementation plan template addressing sustainability must be completed (see Implementation Plan, Phase 4).*

**Implementation Plan: Delaware SOR 4.0 Year 2 Tier Award Program: Tier 4.A**

**Purpose:** Providers applying for the SOR 4 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 using the tables below. Be sure to consider the four key phases of your project: (1) planning and design, (2) implementation, (3) monitoring, and (4) programmatic/financial sustainability. Please ensure the requested award amount aligns with your budget submission.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicant Organization:** | Click or tap here to enter text. | **Project Director:** | Click or tap here to enter text. | |
| **Anticipated Project Start Date:** | 10/1/25 | **Data Lead:** | Click or tap here to enter text. | |
| **Project End Date:** | 9/29/26 | **Requested Award Amount:**  *(Reminder: cannot exceed $75,000, must match total budget amount)* | Click or tap here to enter text. | |
| **Organizational Capacity:** *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.* | | | |
| Click or tap here to enter text. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Phase 1. Planning & Design** | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., April -August 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| **Potential TA Needs for Phase 1:** | | | | |
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| **Phase 2. Implementation** | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., April -August 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
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| **Potential TA Needs for Phase 2:** | | | | |
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| **Phase 3. Monitoring** | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., April -August 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
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| **Potential TA Needs for Phase 3:** | | | | |
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| **Phase 4. Sustainability** | | | | |
| 1. **Is your organization enrolled in and currently billing to Medicaid, Medicare, Commercial/Private or Tricare insurance programs?**   ​​​ Yes, enrolled but not yet billing  Yes, enrolled & billing  ​​​ No  *If no, 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. Preference will be given to projects that prioritize sustainability planning up-front (e.g., build EBP, promising practice, or innovation into their long-term operational design rather than using funds for temporary staff augmentation).* | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., April -August 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
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| **Potential TA Needs for Phase 4:** | | | | |
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