**DSAMH State Opioid Response 4.0 Grant**

**Tier Award Program**

**Health Equity Advancement Project (HEAP) Mini-Grants**

**Funding Application**

**SECTION I: Vendor Information**

Please fill in the boxes below with your organization and project team contact information.

1. **Applicant organization:**

|  |  |
| --- | --- |
| **Name of organization:** | [Company] |
| **Organization address:** |  |
| **Service area zip code(s):** |  |
| **Organization website (if applicable):** |  |
| **Organization email (if applicable; e.g.,** [**info@organizationname.com**](mailto:info@organizationname.com)**)** |  |

1. **Project lead:**

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

1. **Grant writer (if different from project lead):**

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

1. **Authorized official responsible for signing the contract:**

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

1. **Other key personnel responsible for implementation of this project:**

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

**SECTION II: Project Summary**

Please select the focus area(s) of your proposed project for the HEAP track that you are eligible for. Applicants may only apply for HEAP CBO **or** HEAP TX, but not both. Note that HEAP TX applicants must select either the introductory or innovation level. Refer to the solicitation for eligibility requirements and detailed descriptions of the focus areas:

☐ HEAP CBO 1: Internal capacity building to address OUD/STUD

☐ HEAP CBO 2: Enhanced OUD/STUD referral pathways

OR

☐ HEAP TX 1: Equity-focused data analytics: Introductory level

☐ HEAP TX 2: Equity-focused data analytics: Innovation level

1. Describe the overall purpose of your project.

*Provide a summary description of the project, including at least three goals, project activities to achieve those goals, desired outcomes, and why it is needed. Please demonstrate how your project relates to your selected focus area, as well as how your project relates to health equity and addresses the needs of your target population(s).*

1. Describe the target population(s) your project will reach and impact.

*List the specific target population(s) your project aims to reach. Describe your rationale for selecting this population(s) and their needs as it relates to OUD/STUD, including any data if available.*

1. Describe the external stakeholders you will engage in this project, including their names and their roles.

*List the external stakeholders and partners that you plan to engage with, including their role as it relates to this project.*

1. Describe how your project’s foundational work is likely to improve access and quality of care for racial/ethnic minorities with OUD/STUD.

*This response should specify how your project will address health equity and impact access to OUD/STUD care and outcomes for your selected target population(s).*

1. Identify how you will directly engage racial/ ethnic minorities in the design and implementation of your project. Describe any existing relationship(s) you may have with your target population(s).

*This response should specify how your selected target population(s) has been and/or will be engaged in project design and implementation, to ensure that your project appropriately addresses their needs. Be sure to describe any existing relationship(s) you have with them that you can leverage.*

1. Describe how success will be measured for your project. What outcome and impact measures will you assess?

*List at least three outcomes you will measure to track the success of your project. These may include changes in knowledge, behavior, or access to services. Please note that you will be asked to report on the metrics indicated here as part of midpoint and end-of-grant reporting.*

**SECTION III: Attestations**

Please review the following statements and check the boxes to acknowledge you have read and understood the requirements of the HEAP Mini-Grant.

☐ I understand that my organization must participate in **regular technical assistance calls** with BBS and Health Management Associates over the eight-month implementation period.

☐ I understand that SOR grant funds may be used to **supplement, but NOT supplant** existing funding for programs and services. Federal guidelines prohibit grant funds from being 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.

☐ I understand that my organization must participate in monthly monitoring meetings with BBS and my assigned DSAMH Program Integrity Specialist to provide updates on the status of key deliverables, accomplishments, barriers, and expenditures-to-date. My organization will also complete midpoint and final reports that describe key activities implemented, how grant funds were used to achieve project goals, and key data points demonstrating outcomes and impact.

☐ I understand that my organization is required to actively participate and present on project goals, implementation, and outcomes at the DSAMH Health Equity Summit in September 2025.

☐ I have completed the **budget template** and attached it to this 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.

**SECTION IV: Implementation Timeline**  
Please complete the following project implementation timeline to denote key anticipated activities, milestones, and deliverables, including at least eight activities (you may add additional rows as needed). Use check marks or colored cells to indicate the months in which each activity will take place. Excluding the initial disbursement, grant payments will be made contingent on successful implementation progress and proof of completion of deliverables as indicated below; refer to the solicitation for the disbursement structure.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Key Activities/Milestones/Deliverables** | **Feb** | **Mar** | **Apr** | **May** | **June** | **July** | **Aug** | **Sept** |
| (1) |  |  |  |  |  |  |  |  |
| (2) |  |  |  |  |  |  |  |  |
| (3) |  |  |  |  |  |  |  |  |
| (4) |  |  |  |  |  |  |  |  |
| (5) |  |  |  |  |  |  |  |  |
| (6) |  |  |  |  |  |  |  |  |
| (7) |  |  |  |  |  |  |  |  |
| (8) |  |  |  |  |  |  |  |  |

**Please submit your application to** [**DSAMH.ORT@delaware.gov**](mailto:DSAMH.ORT@delaware.gov) **by 5:00 p.m. on November 22, 2024.**