**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 on DSAMH’s Addiction Treatment Resource Center (ATRC) website, within the Tier 4.B and 4.C Grant Details pages, here: <https://atrc.dhss.delaware.gov/funding-opportunities#tap>.
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 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. 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.
   2. A screenshot of your eSupplier number from the [esupplier.erp.delaware.gov/](http://esupplier.erp.delaware.gov/) website **must** be provided with your application submission.
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. Has your agency/organization been in business for at least two years?

Yes

No

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

Yes

No

* 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:*   * *Submit the completed application to* [*DSAMH.ORT@delaware.gov*](mailto:DSAMH.ORT@delaware.gov) *by* ***October 24, 2024****.* * *Submit the application in Word and budget in Excel.* * *Do NOT print/scan to PDF. This will delay your application review.* * *No handwritten applications will be accepted.* * *All checkboxes must be filled out with a check mark. Highlighting will not be accepted.*   *Note: Grant writing-related resources are available on DSAMH’s ATRC Website, which can be accessed* [*here*](https://atrc.dhss.delaware.gov/resource-library) *via 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.* |

**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 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) *when they occur.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Email** | **Phone Number** |
| Project Lead: |  |  |  |
| Grant Writer: |  |  |  |
| Backup Contact: |  |  |  |

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** |
|  |  |  |  |

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** |
|  |  |  |  |

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** |
|  |  |  |  |
|  |  |  |  |
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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** |
|  |  |  |  |

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.* |

1. Is your organization currently receiving any additional grant funding from the State of Delaware or the Federal Government? 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 4.B:** Projects that implement new evidence-based practices, promising practices, and/or innovations for individuals at risk for, or with, opioid use disorder (OUD) and/or stimulant use disorder (STUD). If you select Tier 4.B, please specify whether you are applying as a treatment provider or a CBO:

4.B Treatment Provider Track

4.B CBO Track

**Tier 4.C:** Projects to implement tailored OUD/STUD programming to improve outcomes for a sub-population of individuals with OUD/STUD. If you select Tier 4.C, please specify whether you are applying as a treatment provider or a CBO:

4.C Treatment Provider Track

4.C CBO Track

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

Yes

No

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

Tier 4.B

Tier 4.C

Note that you must submit a separate application for the other Tier.

* 1. The number of awards and funding available are limited. If applying for more than one Tier, **indicate which application is your priority if you can only be selected for one award.**

Tier 4.B

Tier 4.C

1. **Are you currently receiving funding from DSAMH through the TAP initiative or the Health Equity Advancement Project (HEAP)?**

Yes

No

* 1. **If yes, select the other projects you are awarded:**

TAP Tier 3.A

TAP Tier 3.B

TAP Tier 3.C

HEAP Mini-Grant

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 a brief summary of implementation needs and resources requested in this proposal. NOTE: All applicants must review and heed the project design guidance posted alongside this solicitation package on DSAMH’s ATRC Website:*

* *Project Design Guidance for the CBO Track:* [*https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-CBO-Track\_\_FINAL.pdf*](https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-CBO-Track__FINAL.pdf)
* *Project Design Guidance for the Treatment Provider Track:* [*https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-Treatment-Provider-Track\_\_FINAL.pdf*](https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-Treatment-Provider-Track__FINAL.pdf)

*Insert description here.*

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.* |
| 1. **Project Implementation Location(s)** | *Describe the physical location(s) and provide the address(es) where the project will be implemented.* |
| 1. **What is the *new* evidence-based practice (EBP), promising practice *or* innovation your organization will implement during this project period?**   *Reminder: All applicants must review and heed the project design guidance posted alongside this solicitation package on DSAMH’s ATRC Website (for* [*CBOs*](https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-CBO-Track__FINAL.pdf) *and for* [*treatment providers*](https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-Treatment-Provider-Track__FINAL.pdf)*).* | *Provide the name of the EBP, promising practice, or innovation here. These must be new or expanded practices/innovations for your organization. Solicitation guidance document resources include a list of sample project concepts for treatment providers and CBOs, for your reference. Be sure to note whether your organization is proposing an EBP, promising practice, or innovation that is NOT listed in the guidance documents.* |
| 1. **How will EBP/promising practice fidelity be assured and monitored?** | *Specify your organization’s approaches and capacity to assess, monitor, and assure fidelity to the practice standards/model you plan to implement.* |
| 1. **How will the project address the needs of the target population?** | *Identify the connection between the proposed project and the needs of the target population.*  *Please note: Tier 4.C project proposals must show that the proposed EBP, promising practice, or innovation is appropriate and tailored to the specific sub-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 do 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 consider 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 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, and 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**

|  |  |
| --- | --- |
| **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 considered 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”. | |
| **Universal Measures** | |
| **SDOH Referral** | Of those that screened positive for an SDOH in the last month, the unduplicated number 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 |
| **MOUD Referral** | Number of unduplicated clients who were referred internally (within your agency) and externally (outside your agency) to MOUD treatment in the last month. |
| **Medicaid Enrollment** | In the last month, 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. | |

|  |  |
| --- | --- |
| 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** | |
| **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. | | |
| **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 4.B and 4.C. 2. **Measure of improvement evaluated through client surveys**, like the [Multidimensional Inventory of Recovery Capital](https://socialwork.buffalo.edu/resources/multidimensional-inventory-recovery-capital.html) (MIRC) or [Brief Assessment of Recovery Capital](https://www.recoveryanswers.org/assets/barc10.pdf) (BARC-10). 3. **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.  * 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) * Perceived Stress Scale (PSS-10)  1. **DSAMH Consumer Satisfaction Survey:** <https://atrc.dhss.delaware.gov/resource/dsamh-consumer-satisfaction-survey> | | |
| ***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. 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: |
| **Applicant proposed performance measure:** | Percent of participants who report reduced substance use |  |
| **Target:** | >80% |  |
| **Tool:** | Brief Addiction Monitor (BAM) |  |
| **Measurement Interval:** | At baseline, and every 3 months after participants’ initial assessment |  |

|  |  |
| --- | --- |
| 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.* |

**SECTION V: Technical Assistance**

1. **Participation:**

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

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

I understand that at least one member from our implementation team must attend each technical assistance session and will be responsible for transferring 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.
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 (a statewide, comprehensive referral network for behavioral health and substance use disorder 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.B or 4.C initiative, my organization will be required to monitor the degree to which the project is being delivered with fidelity to the model chosen.

My organization commits to participating in up to two fidelity monitoring assessments. These will be conducted in person (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 implements the project’s practice/model 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 in their application how the EBP, promising practice, or innovation they’ve selected to implement will be embedded into their organization ensure sustainability of the program beyond the grant period, thereby maintaining continuous support for individuals at risk.

*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. **INSERT ORGANIZATION NAME** 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 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:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.
* Budget requests can be made up to $300,000. DSAMH reserves the right to award lower amounts based on a project’s proposed scope and impact. Please reference the TAP project design guidance (for [CBOs](https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-CBO-Track__FINAL.pdf) and for [treatment providers](https://atrc.dhss.delaware.gov/wp-content/uploads/2024/02/Project-Design-Guidance-for-the-Treatment-Provider-Track__FINAL.pdf)) posted alongside this solicitation package on DSAMH’s ATRC Website.

**Implementation Plan: Delaware SOR 4.0 Tier Award Program: Tiers 4.B/4.C**

**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 based on your Tier selection using the tables below. 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:**  *Note: Delays in the review process may impact the start date.* | 1/23/25 | **Data Lead:** |  |
| **Anticipated Project End Date:** | 9/29/25 | **Requested Award Amount:**  **(Reminder: cannot exceed $300,000)** |  |

|  |  |  |
| --- | --- | --- |
| **Tier Selection**  **(check one):** | **Tier 4.B:** Projects that implement new promising practices, evidence-based practices, and/or innovations for individuals at risk for, or with, opioid use disorder (OUD) and stimulant use disorder (STUD). | **Tier 4.C:** Projects to implement tailored OUD/STUD programming for to improve outcomes for a sub-population of individuals with OUD/STUD. |

|  |
| --- |
| **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. |
|  |

**Phase 1: Planning & Design**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE… | | | | | | | | | | | |
| **Objective** | | **Key Activities to Accomplish Objective** | **Potential Technical Assistance/ Resource Needs** | **Timeline** | | | | | | | | |
| **Month 1** | **Month 2** | **Month 3** | **Month 4** | **Month 5** | **Month 6** | **Month 7** | **Month 8** | **Month 9** |
| **Objective 1:** | |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |  |  |  |
| **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** | | | | | | | | |
| **Month 1** | **Month 2** | **Month 3** | **Month 4** | **Month 5** | **Month 6** | **Month 7** | **Month 8** | **Month 9** |
| **Objective 1:** | |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |  |  |  |
| **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** | | | | | | | | |
| **Month 1** | **Month 2** | **Month 3** | **Month 4** | **Month 5** | **Month 6** | **Month 7** | **Month 8** | **Month 9** |
| **Objective 1:** | |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |  |  |  |
| **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. 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).*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Goal**: | INSERT OVERARCHING GOAL DESCRIPTION HERE… | | | | | | | | |
| **Objectives** | | **Key Activities to Accomplish Objective** | **Potential Technical Assistance/ Resource Needs** | **Timeline** *(insert months or quarters in boxes below)* | | | | | |
|  |  |  |  |  |  |
| **Objective 1:** | |  |  |  |  |  |  |  |  |
| **Point Person:** | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |