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.A-H 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).
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.

1. ☐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.

1. ☐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

|  |
| --- |
| *Application Submission Instructions:* 1. *Submit the completed application to* *DSAMH.ORT@delaware.gov* *by* ***February 24, 2025****.*
2. *Submit the application in Word and budget in Excel.*
3. *Do NOT print/scan to PDF. This will delay your application review.*
4. *No handwritten applications will be accepted.*
5. *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 associati 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.* |

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* *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** |
| 1) |  |  |  |  |
| 2) |  |  |  |  |
| 3) |  |  |  |  |

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 current behavioral health screening/referral services that your organization provides to participants.*  |
| 1. **Populations served**
 | *Provide a broad overview of your current ED patient population. Include demographic information such as age, gender, race/ethnicity, language(s), and available information related to social drivers of health. (Aggregate percentage split of the last full year’s available data is sufficient.) Please include approximate annual patient volume per site (if more than one).* |

**SECTION III: TAP 4.A-H Program Proposal**
[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. **Describe the project’s overview (maximum 300 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. Please be sure to include how this funding will enable sustainable implementation, following the conclusion of this grant funded project period.*

|  |
| --- |
| *[Type your response here]* |

1. **Project specifications:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **At which location(s) will the project be implemented?**
 |  |
| 1. **What validated SUD screening instrument is planned?**
 |  |
| 1. **Please describe your planned OUD/STUD screening and brief intervention protocol.**
 |  |
| 1. **How will the project address cultural and racial/ethnic considerations and health disparities within the target population?**
 |  |
| 1. **What resources and programs does your organization currently utilize to support the population?** *This project proposal may not duplicate existing resources and programs.*
 |  |
| 1. **What is the need for enhanced resources to address the identified need?**
 |  |
| 1. **How will you make these services accessible and available to all members of the target population? What additional measures will you implement?**
 |  |

1. **Client engagement:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **How will you make referrals? How will you ensure warm handoffs that extend beyond standard referral practices?**
 |  |
| 1. **How will your project “close the loop” on referrals?**
 |  |
| 1. **How will your project connect clients to and/or initiate MOUD as part of their treatment plan?**
 |  |

**SECTION IV: Data**

* + - 1. **Clients Served:**

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

**Performance Measures**

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

|  |
| --- |
| 1. Universal measures are required for this program. You have the option to propose additional measures. See page 3 of the solicitation document for more details on measures.
 |
| **Tier 4.A-H Universal Measures** |
| **Screened** | Number of unduplicated clients who were due for a screening in the last month who were screened. |
| **Positive** | Of those screened in the last month, the unduplicated count of those who were positive. |
| **Referred** | Of those that screened positive in the last month, the unduplicated count of those who were referred to treatment. |
| **Engaged** | Of those that screened positive in the month before last, the unduplicated count of those who were connected/engaged in treatment in the last month. |
| **Optional: Identify additional project performance measures.** If there are additional project performance measures that are not reflected in the required measures, please propose those measure(s) here. Emergency departments are encouraged to identify metrics to highlight receptivity of the project by the target patient population (follow-up rates, attempts needed per patient, etc.). |

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

**SECTION V: Technical Assistance**

1. **Participation:**

☐ I understand that TAP requires participation in technical assistance. My organization will attend TAP quarterly meetings.

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

1. **TA Priorities:**

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

☐ Yes

☐ No

**SECTION VI: Implementation Plan**

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

If NO, please ensure that the team understands the goals and activities of the project proposal prior to the required Provider Presentation Meeting, as both roles will be asked to participate in the application review process.

1. **Fidelity Monitoring Attestations:**

☐ I understand that as part of the Tier 4.A-H 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 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 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.

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

**SECTION VII: Budget & Sustainability**

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

1. **Attestation:**

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

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

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

☐ *Separate appropriations managed for each account.*

☐ *Separate account codes on the Chart of Accounts to track the SOR 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.*

**Implementation Plan: Delaware SOR 4.0 Tier Award Program: Tier 4.A-H**

**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. 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.

Please note the different timeline markers for each phase. Phase 1 should list Preparation phase objectives/activities (late May/early June through September 2025), marked by months. Phases 2 and 3 should list Implementation phase objectives/activities (October 2025 through September 2027), marked by quarters. Phase 4 should list objectives/activities to support sustainability; as each organization’s sustainability plan will be unique, the timeline markers have been left blank for you to fill in as appropriate for your plan.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant Organization:**  |  | **Project Director:**  |  |
| **Anticipated Project Start Date:** | May 30, 2025 | **Data Lead:**  |  |
| **Anticipated Project End Date:** | September 29, 2027 | **Requested Award Amount:*****(Reminder: cannot exceed $250,000)*** |  |

|  |
| --- |
| **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… |
| **Objectives** | **Key Activities to** **Accomplish Objective** | **Potential Technical Assistance/Resource Needs** | **2025 Timeline (in months)** |
| **1 - May** | **2 - June** | **3 - July** | **4 - Aug** | **5 - Sept** |
| **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… |
| **Objectives** | **Key Activities to** **Accomplish Objective** | **Potential Technical Assistance/Resource Needs** | **2025-2027 Timeline (in quarters)** |
| **Q4 2025** | **Q1 2026** | **Q2 2026** | **Q3 2026** | **Q4 2026** | **Q1 2027** | **Q2 2027** | **Q3 2027** |
| **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… |
| **Objectives** | **Key Activities to** **Accomplish Objective** | **Potential Technical Assistance/Resource Needs** | **2025-2027 Timeline (in quarters)** |
| **Q4 2025** | **Q1 2026** | **Q2 2026** | **Q3 2026** | **Q4 2026** | **Q1 2027** | **Q2 2027** | **Q3 2027** |
| **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. **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.)*

|  |  |
| --- | --- |
| 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**: |