**Application Form Contents:**

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**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.
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.
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

1. Has your organization successfully implemented a DSAMH-funded program under the following initiatives? (Select all that apply)

State Opioid Response (SOR) Tier Award Program (TAP)

Health Equity Advancement Project (HEAP)

None of the above

|  |
| --- |
| *Application Submission Instructions:*   * *Submit the completed application to* [*DSAMH.ORT@delaware.gov*](mailto:DSAMH.ORT@delaware.gov) *by* ***February 10, 2025****.* * *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 MYTP 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:**

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| --- | --- |
| **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 MYTP Proposal**

1. **Project Summary (maximum 500 words)**

In this section, provide a comprehensive summary of your proposed MYTP. Your description should clearly articulate:

* **What your project is**: Explain the core concept of your proposal and how it aligns with the goal of the MYTP funding opportunity.
* **Why it is needed**: Address the specific gaps or challenges in care for medically complex patients that your project aims to resolve.
* **Desired outcomes**: Highlight the improvements in care delivery and client outcomes you expect to achieve through your project.
* **Implementation needs and resources**: Provide a brief summary of the key resources and support you will request through this proposal to execute the project successfully.

As you prepare your summary, ensure that your project aligns with the MYTP objectives outlined below. Use these points as a guide to frame your proposal:

* **Incrementally Build Provider Capacity** 
  + Develop a phased plan to strengthen your organization’s ability to deliver medical services to current and prospective clients over the project’s duration.
  + Specify how your project will collaborate across the continuum of care to enhance the ability to receive and transfer medically complex patients across levels of care.
* **Initiate Delivery of Key Medical Services**
  + Identify and address the specific medical needs of your client population.
  + Demonstrate how you will hire and onboard essential staff (e.g., nurses for wound care).
* **Integrate Medical Care into SUD Care**
  + Outline how your project will deliver co-treatment models addressing key client needs such as wound care, long-acting injectables, infectious disease management, or physical health services.
  + Highlight innovative approaches, such as creating a modified ACT Team or hiring a consulting nurse practitioner, to address unmet low-to-mid-level medical needs and reduce treatment refusal rates.
* **Promote System Sustainability**
  + Emphasize your plan to innovate care models with the potential for long-term sustainability.
  + Discuss how your project will optimize Medicaid reimbursement, ensuring continuity and scalability of services beyond the grant period.

Your project description should seamlessly integrate the MYTP’s goals and objectives, demonstrating a clear vision for how your proposal will contribute to the development of sustainable, medically informed substance use care.

|  |
| --- |
| *Insert description here.* |

1. **Project Specifications:**

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| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **Target population description** | *Describe the diagnostic specifications of the medically complex population that is intended to be served through this project. If relevant, please include any demographic criteria used.* |
| 1. **How was the target population selected?** | *Refer to the information source and/or experiences and rationale that support the need to provide these services to the intended population.* |
| 1. **How will your project identify individuals with co-occurring OUD/STUD and physical health needs?** | *Describe how participants from the target population will be identified. Include a description of any new referral pathways and partners, screening or assessment processes, and new or existing data sets that are proposed to be used.* |
| 1. **Project Implementation Location(s)** | *Describe the physical location(s) and provide the address(es) where the project will be implemented.* |
| 1. **How will your organization increase its capacity to address co-occurring physical health and substance use conditions during this project period?** | *Describe the model of care and the specific services that will be provided. These must be new or expanded practices for your organization.* |
| 1. **How will the service(s) and/or role(s) be monitored to assure appropriate medical oversight and compliance?** | *Describe your organization’s experience with providing the service(s) and supervising the role(s) supported through this project. If your organization plans to partner with another organization, describe their experience. Specify your plans to ensure appropriate oversight and compliance.* |
| 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.* |
| 1. **How will the project address cultural and racial/ethnic considerations and health disparities within the target population?** | *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?** | *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. **How will you collaborate with step-down services to reduce the potential for treatment denial?** | *Identify which organizations you will collaborate with to support transitions to lower levels of care. Specify how your project will enhance these organizations’ ability to care for the presenting needs of clients discharging from your organization.* |

**SECTION IV: Data**

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| **Response Categories** | **Applicant Response**: Please enter your response following the guidance in each cell below. |
| 1. **What is the unduplicated number of new 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.

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| 1. **How Much?** Universal measures have been identified. You have the option to propose additional measures of “how much”. | |
| **Universal Measures - Required** | |
| **Naloxone** | Number of naloxone prescriptions written and provided to clients in the last month. |
| **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. |
| **Denials** | Number of clients who were referred to your organization in the last month and were denied treatment, by reason. |
| **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 - Required** | |
| **Integrated Care Plans** | Percentage of individuals with comprehensive care plans that include both medical and behavioral health components |
| **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”:** | |

|  |  |  |
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| 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 - Required** | | |
| **Hospital Admission Rates** | Rate of individuals who were admitted to any hospital for any reason.  ***Note****: This measure will be required following the launch of Delaware Treatment and Referral Network's DTRN360 behavioral health coordination platform.* | |
| **Emergency Department Utilization** | Rate of individuals who were treated at the Emergency Department for any reason.  ***Note****: This measure will be required following the launch of Delaware Treatment and Referral Network's DTRN360 behavioral health coordination platform.* | |
| Potential Outcome Measure Data Sources for Selection (See below)   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. Note that providers selecting this measure need to collect and analyze the measure; DSAMH is not able to calculate this measure on subrecipients’ behalf. 2. **Patient functioning and/or quality of life instruments as collected through patient surveys or during provider encounters:** Reliable and valid patient-reported outcome instruments can be used to collect information on patient functioning and quality of life. The list below provides a sample of tools that can be used to capture functioning and quality of life for patients with SUD. The instruments can be administered to patients during a provider encounter or can be sent directly to patients via a survey.  * 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 one additional project performance measure 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 |  |

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| 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:

* Project-Based Learning Series sessions, bi-weekly over the first six months and monthly for the remainder of the funding 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. **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 services they’ve selected to implement will be embedded into their organization to 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**

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* $150,000 for the first year and 300,000 in years two and three, with a total funding cap of $750,000 for the full term (May 1, 2025, to September 29, 2027). DSAMH reserves the right to award lower amounts based on a project’s proposed scope and impact.

**Implementation Plan: Delaware SOR 4.0 Tier Award Program: MYTP**

**Purpose:** Providers applying for the SOR 4.0 MYTP funding opportunity 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 the award.

**Instructions:** Complete the implementation plan based on your proposed project using the tables below. Start by listing the 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. Consider the four key phases of your project: (1) planning and design, (2) implementation, (3) monitoring, and (4) programmatic/financial sustainability. Ensure the requested award amount aligns with your budget submission.

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| **Applicant Organization:** |  | **Project Director:** |  |
| **Anticipated Project Start Date:**  *Note: Delays in the review process may impact the start date.* | 5/1/25 | **Data Lead:** |  |
| **Anticipated Project End Date:** | 9/29/27 | **Requested Award Amount:**  *Reminder: cannot exceed $300,000 annually with a total funding cap of $750,000 for the full term.* |  |

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| **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. |
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**Phase 1: Planning & Design**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE FOR PHASE 1… | | | | | | | | | | | | |
| **Objective** | | **Key Activities to Accomplish Objective** | **Potential Technical Assistance/ Resource Needs** | **Timeline** | | | | | | | | | |
| **May**  **2025** | **June**  **2025** | **July**  **2025** | **August2025** | **September**  **2025** | **FY26**  **Q1** | **FY26**  **Q2** | **FY26**  **Q3** | **FY26**  **Q4** | **FY27**  **Q1-Q4** |
| **Objective 1:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
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**Phase 2: Implementation**

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| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE FOR PHASE 2… | | | | | | | | | | | | |
| **Objective** | | **Key Activities to Accomplish Objective** | **Potential Technical Assistance/ Resource Needs** | **Timeline** | | | | | | | | | |
| **May**  **2025** | **June**  **2025** | **July**  **2025** | **August2025** | **September**  **2025** | **FY26**  **Q1** | **FY26**  **Q2** | **FY26**  **Q3** | **FY26**  **Q4** | **FY27**  **Q1-Q4** |
| **Objective 1:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
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**Phase 3: Monitoring**

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| Goal: | INSERT OVERARCHING GOAL DESCRIPTION HERE FOR PHASE 3… | | | | | | | | | | | | |
| **Objective** | | **Key Activities to Accomplish Objective** | **Potential Technical Assistance/ Resource Needs** | **Timeline** | | | | | | | | | |
| **May**  **2025** | **June**  **2025** | **July**  **2025** | **August2025** | **September**  **2025** | **FY26**  **Q1** | **FY26**  **Q2** | **FY26**  **Q3** | **FY26**  **Q4** | **FY27**  **Q1-Q4** |
| **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 FOR PHASE 4… | | | | | | | | | | | | |
| **Objective** | | **Key Activities to Accomplish Objective** | **Potential Technical Assistance/ Resource Needs** | **Timeline** | | | | | | | | | |
| **May**  **2025** | **June**  **2025** | **July**  **2025** | **August2025** | **September**  **2025** | **FY26**  **Q1** | **FY26**  **Q2** | **FY26**  **Q3** | **FY26**  **Q4** | **FY27**  **Q1-Q4** |
| **Objective 1:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 2:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
| **Objective 3:** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Point Person**: | |
| **Potential Partners/Stakeholders**: | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |