Application Readiness Checklist

*Complete this checklist before submitting your application.*

*Reminder: Incomplete applications may not be reviewed.*

|  |  |
| --- | --- |
| **✔** | **Application Requirements** |
|  | Budget is complete, follows the instructions in the "Guide" tab of the Excel template, includes clear justifications for all proposed costs, and only includes allowable expenses. |
|  | All required sections of the application form are fully completed, including narratives, checkboxes, and contact information. |
|  | Implementation Plan is complete, aligns with the proposed project activities and sustainability goals, and follows the format provided in the required template. |
|  | All required attachments are included and current (not expired):  Budget Template (Excel format)  Certificate of Liability Insurance (must be valid and not expired)  Business License or 501(c)3 verification (must be current)  SAM.gov UEI screenshot (must show active status and expiration date)  Letter of support from partner organization, if applicable. (Refer to Section III questions 4-5 for details) |
|  | Application is submitted in Microsoft Word format, and budget in Excel format (not PDF). |
|  | All checkboxes in the application form are marked with a ✔ (highlighting will not be accepted). |
|  | My organization meets the eligibility requirements and has been in operation for at least two years. |
|  | I have read and understand all instructions in the solicitation and application materials. |

**Application Submission Instructions:**

* Submit the completed application and all required supplemental documents to [DSAMH.ORT@delaware.gov](mailto:DSAMH.ORT@delaware.gov) by **June 10, 2025.**
* Submit the application in Microsoft Word and budget in Excel format. **Applications and budgets submitted as PDFs may not be reviewed**.
* No handwritten applications will be accepted.
* All checkboxes must be filled out with a check mark. Highlighting will not be accepted*.*
* Incomplete applications may not be reviewed.

**Note**: Grant writing-related resources are available on DSAMH’s ATRC Website, which can be accessed [here](https://atrc.dhss.delaware.gov/resource-library) 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.

**Contents**

[SECTION I: Required Attachments & Eligibility Confirmation 3](#_Toc197954505)

[SECTION II: Vendor Information 5](#_Toc197954506)

[SECTION III: TAP Program Proposal 8](#_Toc197954507)

[SECTION IV: Data 14](#_Toc197954508)

[SECTION V: Technical Assistance 17](#_Toc197954509)

[SECTION VI: Budget 17](#_Toc197954510)

[SECTION VII: Implementation & Sustainability Plan 18](#_Toc197954511)

**Submission & Revision Dates**

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

### SECTION I: Required Attachments & Eligibility Confirmation

Required Application Attachments

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

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

1. ​​​Budget Template (See section VI, question 2)
   1. The budget template is provided in a required Excel format and is posted along with the application, solicitation, and related forms. The budget template must be filled out and submitted with the application. A recorded budget tutorial providing an overview of how to use the template is available [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. Visit the OneStop website for more information: <https://onestop.delaware.gov/Operate_Register>
4. If applicable, IRS 501(c)3 exemption status can be obtained by searching for your organization on the IRS website: [Search for Tax Exempt Organizations | Internal Revenue Service (irs.gov)](https://www.irs.gov/charities-non-profits/search-for-tax-exempt-organizations#letter). A screenshot **must** be provided.

1. ​​​Unique Entity Identifier (UEI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 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).
3. A screenshot of full entity status from SAM.gov **must** be provided with your application submission.

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

### SECTION II: Vendor Information

1. **Applicant organization:**

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

1. **Applicant administrative location:**

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

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

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

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

1. **Authorized official who will be responsible for signing the Letter of Agreement:**

*The authorized official must have the authority necessary to execute the Agreement on behalf of the organization. Signatures will be facilitated electronically, through DocuSign.*

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

1. **Designated data lead responsible for all data reports to DSAMH:**

*The data lead must be familiar with the organization’s data collection methods and sources and be able to report data submission as required to support the Agreement.*

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

1. **Other key personnel responsible to be included on TAP communications for implementation of this project:**

*Examples of key personnel include programmatic or clinical leads, quality program officers, administrative and/or executive staff.*

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

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

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

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

1. **Applicant Overview:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **Types of services offered** | *Describe the services that your organization* ***currently*** *provides to participants. The service offering description should include the breadth and depth of service array provided*.  *(Maximum 250 words)*   Click or tap here to enter text. |
| 1. **Population served** | *Describe your* ***current*** *clientele. Include demographic information such as age, gender, race/ethnicity, language(s), and available information related to social drivers of health such as justice involvement, socio-economic status, education level, etc.*    Click or tap here to enter text. |
| 1. **Size of the organization:** 2. **Count of FTE** | *Provide the actual or estimated number of FTE* ***currently*** *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.*    Click or tap here to enter text. |
| 1. **Count of unique individuals served in the most recent fiscal year** | *Please calculate the number of individuals served by your organization during your most recent, complete, fiscal year. Each individual may only be counted once, regardless of the number of services received.*  Click or tap here to enter text. |

1. **Does your organization have a website?**

No

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

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

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

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

​​No

​​Yes, we are receiving the following funding:

Prescription Opioid Settlement Distribution Commission

State Funds

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

### SECTION III: TAP Program Proposal

1. **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 EBPs or promising practices for the general treatment population.

**Tier 4.C:** Projects that implement tailored EBPs or promising practices to improve outcomes for a specific high-risk or underserved sub-population.

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, Grassroots Messaging and Awareness Campaign (GMAC), or the Health Equity Advancement Project (HEAP)?**

Yes

​ No

* 1. **If yes, which program?**

Tier 4.A

Tier 4.B

​ Tier 4.C

HEAP Mini-Grant

GMAC

1. **Which SOR goal does your project most closely align with?**Funded projects must align with **one of two** primary TAP goals: **(Select one)**

Increase engagement in treatment

Improve care transitions\*

1. **Choose a project design category:**Each goal has specific project design options. **Based on the goal selected above, choose one project description within that category.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Goal** | **Project Category** | **Project Description** (Select One) | **Possible EBPs** |
| **Increase Engagement in Treatment** | Implement an EBP/ Evidence-Informed Practice to increase engagement in treatment | **Tier B** – Implement as designed.  **Tier C** – Tailored for a special population. | * Motivational Interviewing * Twelve-Step Facilitation Therapy * Harm Reduction Approaches |
| Provide case management to individuals with medical, behavioral, and social care needs. | **Tier B** – Implement case management for use across populations.  **Tier C** – Tailor the case management program to better meet the needs of a special population. | * **Intensive Case Management (ICM)** * Strengths based case management |
| **Improve Care Transitions\*** | Implement an evidence-based or evidence-informed model to improve care transitions from levels of care across two or more treatment provider organizations. | **Tier B** – Implement as designed.  **Tier C** – Tailored for a special population. | * **Transitional Care Model (TCM)** * Brokerage Model * Clinical Case Management * Intensive case Management * **Comprehensive Care Coordination** * Peer Recovery Support Services |

*\* CBOs may partner with other providers or other organizations providing healthcare to implement the transition model. Partner(s) must provide a letter of support to the applicant and the partner organization may not apply for funding for the same project design category.*

1. **Describe the project’s overview (maximum 250 words):**

*This section should provide a summary description of the project, expanding on the project description selected in the question above. Please describe what the project is, why it is needed, desired outcomes, and a brief summary of implementation needs and resources requested in this proposal.*

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

1. **Project Specifications:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **Target population description** | *Describe the specifications of the population that is intended to be served through this project. This includes any demographic or diagnostic criteria used.*  Click or tap here to enter text. |
| 1. **How was the target population identified?** | *Refer to the information source and/or experiences and rationale that support the need to provide these services to the intended population.*  Click or tap here to enter text. |
| 1. **Project Implementation Location(s)** | *Describe the physical location(s) and* ***provide the address(es****) where the project will be implemented.*  Click or tap here to enter text. |
| 1. **What is the *new* evidence-based practice (EBP), promising practice *or* innovation your organization will implement during this project period?** | *Provide the name of the EBP, promising practice, or innovation here. These must be new or expanded practices/innovations for your organization.*     Click or tap here to enter text. |
| 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.*  Click or tap here to enter text. |
| 1. **How will the project address the needs of the target population?** | *Identify the connection between the proposed 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.*     Click or tap here to enter text. |
| 1. **What resources and programs do your organization currently utilize to support the population?** | *Identify resources and programs that currently exist prior to the implementation of this proposed project. This project proposal may not duplicate existing resources and programs.*     Click or tap here to enter text. |
| 1. **What is the need for enhanced resources to address the identified need?** | *Specify why there is a need for the enhanced resources requested through this project. Be clear about how the enhanced resource is linked to the needs of the target population and proposed approach.*   Click or tap here to enter text. |
| 1. **How will you make these services accessible and available to all members of the target population? What additional measures will you implement?** | *Specify 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.*     Click or tap here to enter text. |

1. **Client Engagement:**

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response:** Please enter your response following the guidance in each cell below. |
| 1. **How will your project identify individuals with OUD/STUD?** | *Describe how participants from the target population will be identified. Include a description of any new referral pathways and partners, and new or existing data sets that are proposed to be used.*   Click or tap here to enter text. |
| 1. **How will your project engage hard-to-reach clients?** | *Describe the members of the target population that are considered “hard-to-reach”. Specify the proposed approach that addresses the identified barrier to engagement.*   Click or tap here to enter text. |
| 1. **How will your project connect clients to medications for opioid use disorder?** | *Identify your referral pathways and partnerships. Specify if you have in-house prescription and administration capacity or if individuals will be referred to other prescribers of Medications for Opioid Use Disorder.*   Click or tap here to enter text. |
| 1. **How will you ensure warm handoffs that extend beyond standard referral practices?** | *Describe additional steps your organization will take to ensure that any referral to additional services is successful. Specify how this approach goes beyond standard referral practices.*   Click or tap here to enter text. |

### SECTION IV: Data

|  |  |
| --- | --- |
| **Response Categories** | **Applicant Response**: Please enter your response following the guidance in each cell below. |
| * + - 1. **Anticipated Project Reach**   **a. What is the unduplicated number of individuals expected to be served through the project?** | *Estimate the number of unique individuals that will be reached through implementation of this project.*   Click or tap here to enter text. |
| **b. Data source & rationale for estimate:** | *Describe the basis for your estimate. What existing data sources and experience were considered for this calculation?*     Click or tap here to enter text. |

**Performance Measures**

TAP subrecipients must report performance in three categories:

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

All subrecipients will be expected to report on the standard universal measures (“How Much”) and process measures (“How Well”) listed below. You may propose additional measures in these areas, but this is optional. Applicants must propose their own “Better Off” (outcome) measures. The final determination of performance measures is subject to review and approval by DSAMH prior to commencement of any Agreement arising from this solicitation.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **How Much?** Universal measures have been identified and are required for each tier award program. You have the option to propose additional measures of “how much”. | | | | | |
| **Universal Measures** | | | | | |
| **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 * 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**  *(If Applicable)* | 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.*  *Click or tap here to enter text.* | | | | | |
|  | | | | | |
| 1. **How Well?** Performance measures in this category support an evaluation of the quality of the program, or “how well” the project is performed. Required process measures are provided below. | | | | | |
| **Process Measures** | | | | | |
| **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”:**     Click or tap here to enter text. | | | | | |
|  | | | | | |
| 1. **Is anyone better off?** Performance measures in this category support an evaluation of the outcomes of the program by answering the question “Is anyone better off?”. Examples of outcome measure sources are provided below. Please propose at least one project performance measure. | | | | |
| **Outcome Measures** | | | | |
| Potential Outcome Measure Data Sources:   1. [**Brief Assessment of Recovery Capital (BARC-10)**](#BARC10)**:** Assesses recovery capital (personal, social, and community resources) to support recovery. Aids in treatment planning and progress monitoring. 2. **Functional Outcomes Survey 12-item Short Form (**[**SF-12**](#SF12)**):** Assesses physical and mental health (summary scores: PCS and MCS). Used to track changes during SUD treatment. 3. **Functional Outcomes Survey 36 (**[**SF-36**](#SF36)**):** Comprehensive measure of 8 health domains. Used to assess functioning and wellbeing over time. 4. **World Health Organization (WHO) Quality of Life Assessment** [**WHOQOL**](#WHOQOL) **&** [**WHOQOL-BREF**](#WHOQOLBREF)**:** Measures physical, mental, social, and environmental QOL. WHOQOL-BREF is a 26-item short version. 5. **Personal Wellbeing Index (**[**PWI-A**](#PWIA)**):** Measures subjective wellbeing across life domains. Useful for non-clinical progress tracking.   **Perceived Stress Scale (**[**PSS-10**](#PSS10)**):** Assesses perceived stress over past month. Used for relapse risk management and planning. | | | | |
| ***Required -* Propose at least one 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.  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(s):** |
| **Applicant proposed performance measure:** | | | Percent of participants who report improved mental health and/or overall functioning | Click or tap here to enter text. |
| **Target:** | | | >70% | Click or tap here to enter text. |
| **Tool:** | | | SF-12 Health Survey | Click or tap here to enter text. |
| **Measurement Interval:** | | | At baseline, and every 6 months thereafter | Click or tap here to enter text. |

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

### 

### SECTION V: Technical Assistance

**Participation:**

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

* At least 5 hours of technical assistance during the project period
* Quarterly meetings, 1-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.

### SECTION VI: Budget

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

1. **Attestation:**

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

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

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

​ *Separate appropriations managed for each account.*

​​ *Separate account codes on the Chart of Accounts to track the SOR 4.0 TAP share and non-SOR 4.0 TAP share for all transactions.*

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

*Internal audit.*

​ *Other, please specify:* ​\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_​

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

* A highlight of limitations on the use of funds available through this opportunity are included in the Guide tab of the budget template. **Failure to review and follow these requirements may result in negative audit findings, recoupment or other compliance actions.**
* Budget requests can be made up to $200,000. DSAMH reserves the right to award lower amounts based on a project’s proposed scope and impact.

### SECTION VII: Implementation & Sustainability Plan

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

1. **Project Team Collaboration:** If your Grant Writer and Project Lead are *not* the same person, have you discussed the project proposal as a team?

​​Yes

​​No

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

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

​​Yes

​​No

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

1. **Fidelity Monitoring Attestations:**

​​I understand that as part of the Tier 4.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.

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 demonstrate in their implementation plan how the EBP or promising practice 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.

**Implementation Plan: Delaware SOR 4.0 Year 2 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 selected 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. Be sure to consider the four key phases of your project: (1) planning and design, (2) implementation, (3) monitoring, and (4) programmatic/financial sustainability. Please ensure the requested award amount aligns with your budget submission.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant Organization:** | Click or tap here to enter text. | **Project Director:** | Click or tap here to enter text. |
| **Anticipated Project Start Date:** | October 2025 | **Data Lead:** | Click or tap here to enter text. |
| **Anticipated Project End Date:** | *9/29/2026* | **Requested Award Amount:**  *(Reminder: cannot exceed $200,000, must match total budget amount)* | Click or tap here to enter text. |
| **Organizational Capacity:** Describe your organizational capacity and capability to implement this project. This may include prior experience, expertise with the population, clinical champions or other relevant organization capability. Responses should consider the scope of the project in relation to the current capability and historical capacity of your organization. | | | |
| Click or tap here to enter text. | | | |

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| **Phase 1. Planning & Design** | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., October – December 2025)* | **Person Responsible** | **Potential Partners/**  **Stakeholders** |
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| **Potential TA Needs for Phase 1:** | | | | |
| Click or tap here to enter text. | | | | |
| **Phase 2. Implementation** | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., October 2025 – September 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
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| **Potential TA Needs for Phase 2:** | | | | |
| Click or tap here to enter text. | | | | |
| **Phase 3. Monitoring** | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., Ongoing, November 2025 – September 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
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| **Potential TA Needs for Phase 3:** | | | | |
| Click or tap here to enter text. | | | | |
| **Phase 4. Sustainability** | | | | |
| 1. **Is your organization enrolled and currently billing to Medicaid, Medicare, Commercial/Private or Tricare insurance programs?**   ​​​ Yes, enrolled but not yet billing  Yes, enrolled & billing  ​​​ No  *If no, please enroll:* [*delawarePRET@gainwelltechnologies.com*](mailto:delawarePRET@gainwelltechnologies.com) *800-999-3371, option 0, then option 4* | | | | |
| 1. **Are the services proposed to be provided to the target population potentially able to be reimbursed under Medicaid, Medicare, Commercial/Private or Tricare insurance programs?**   Yes  ​​​No | | | | |
| 1. **What is the organization’s plan for financial *and* programmatic support of project activities after the award period?**   *Use the template below to articulate your organization’s sustainability plan. Please be sure to include information about how you will engage leadership and staff to sustain this project. Preference will be given to projects that prioritize sustainability planning up-front (e.g., build EBP, promising practice, or innovation into their long-term operational design rather than using funds for temporary staff augmentation).* | | | | |
| **Objectives** | **Key Activities** | **Timeline**  *(e.g., January -September 2026)* | **Person Responsible** | **Potential Partners/ Stakeholders** |
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| **Potential TA Needs for Phase 4:** | | | | |
| Click or tap here to enter text. | | | | |