# Appendix A: Cover Page

**University of Nevada, Reno Center for the Application of Substance Abuse Technologies**

*In response to:*

**NOFO**

**SOR Funding**

**Deadline for Submission and Time: May 15, 2023**

*Our application is respectfully submitted as follows:*

|  |  |
| --- | --- |
| **Company Name:** |  |
| **Site Address where services will be administered:** |  |
| **Mailing Address: (If different)** |  |
| **Phone:** |  |
| **Executive Director/CEO:** |  |
| **Primary Contact for Proposal:** |  |
| **Primary Contact Email Address:** |  |

*As a duly authorized representative, I hereby certify that I have read, understand, and agree to all terms and conditions contained within this request for applications and that information included in our organization’s application hereby submitted is accurate and complete.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Signed:** |  | | **Date:** | |  |
| **Print Name:** | |  | **Title:** |  | |

# Appendix B: Application Form

This form is required to be completed in its entirety. **All fields are mandatory**. If not appropriate or applicable, place N/A. Any failure to respond to any question, may result in disqualification. Do not add or delete from this Application Form. **Font type is to be Arial 11 pt.** Word limitations are considered maximum word counts and Applicants may choose to write fewer words.

**Organization Type.** Define the primary applicant’s organization type as registered with the State of Nevada Secretary of State Office. *Note: Different funding sources have limits on type of organizations that may receive funding.* If unsure, refer to your business license. **You must check one.**

☐ Public Agency ☐ 501(c)(3) Nonprofit ☐ Private **☐** Higher Education **☐** Tribal

**☐** Other Click or tap here to enter text.

**Geographic Area of Service**

| ***PROVIDE PRIMARY LOCATION WHERE SERVICES WILL BE PROVIDED. FOR EXAMPLE, WASHOE COUNTY, STATEWIDE OR BY ZIP CODE. SELECT ONLY ONE AND DESCRIBE IN BOX ADJACENT.*** | |
| --- | --- |
| **☐ CITY, OR ZIP CODE** | Click or tap here to enter text. |
| **☐ COUNTY** | Click or tap here to enter text. |
| **☐ REGION** | Click or tap here to enter text. |
| **☐ STATEWIDE** | Click or tap here to enter text. |

**C. Applicant Organization**

| **ALL SECTIONS OF THE APPLICANT ORGANIZATION ARE MANDATORY AND N/A IS NOT ACCEPTABLE. APPLICANTS THAT DO NOT PROVIDE A FEDERAL TAX IDENTIFICATION NUMBER AND A UNIQUE ENTITY IDENTIFIER (UEI) NUMBER WILL BE DISQUALIFIED.** | | |
| --- | --- | --- |
| **ORGANIZATION NAME** | Click or tap here to enter text. | |
| **MAILING ADDRESS** | Click or tap here to enter text. | |
| **PHYSICAL ADDRESS** | Click or tap here to enter text. | |
| **CITY** | Click or tap here to enter text. | **NV** |
| **ZIP (9-DIGIT ZIP REQUIRED)** | Click or tap here to enter text. | |
| **FEDERAL TAX ID #** | Click or tap here to enter text. | |
| **UNIQUE ENTITY IDENTIFIER (UEI) NUMBER** | Click or tap here to enter text. | |

**D. Program Manager, Point of Contact**

|  |  |  |
| --- | --- | --- |
| **PROGRAM CONTACT IS THE INDIVIDUAL WHO WILL BE RESPONSIBLE FOR THE ACTIVITIES OF THE GRANT (I.E. MEETING SCOPE OF WORK DELIVERABLES).** | | |
| **NAME** | Click or tap here to enter text. | |
| **TITLE** | Click or tap here to enter text. | |
| **PHONE** | Click or tap here to enter text. | |
| **E-MAIL** | Click or tap here to enter text. | |
| **SAME MAILING ADDRESS AS SECTION C? ☐ YES ☐ NO, USE BELOW ADDRESS INFORMATION** | | |
| **ADDRESS** | Click or tap here to enter text. | |
| **CITY** | Click or tap here to enter text. | **NV** |
| **ZIP (9-DIGIT ZIP REQUIRED)** | Click or tap here to enter text. | |

**E. FISCAL OFFICER**

| **FISCAL CONTACT IS INDIVIDUAL RESPONSIBLE FOR THE BUDGET AND SUBMISSION OF REIMBURSEMENT REQUESTS.** | | |
| --- | --- | --- |
| **NAME** | Click or tap here to enter text. | |
| **TITLE** | Click or tap here to enter text. | |
| **PHONE** | Click or tap here to enter text. | |
| **EMAIL** | Click or tap here to enter text. | |
| **SAME MAILING ADDRESS AS SECTION C? ☐YES ☐ NO, USE BELOW ADDRESS INFORMATION** | | |
| **ADDRESS** | Click or tap here to enter text. | |
| **CITY** | Click or tap here to enter text. | **NV** |
| **ZIP (9-DIGIT ZIP REQUIRED)** | Click or tap here to enter text. | |

1. **KEY PERSONNEL (ADD ROWS IF REQUIRED)**

| **KEY PERSONNEL ARE DIRECTLY RESPONSIBLE FOR PROJECT DELIVERABLES.** Key personnel are employees, consultants, subcontractors, or volunteers who have the required qualifications and professional licenses to provide the proposed services. The GPRA Coordinator is required. | | |
| --- | --- | --- |
| **NAME** | **TITLE** | **LICENSED?** |
| Click or tap here to enter text. | Program Manager (Mandatory Field)  If licensed, License Type:  License Number: | ☐Yes ☐ No |
| Click or tap here to enter text. | Individual responsible for Progress Report | ☐Yes ☐ No |
| Click or tap here to enter text. | Individual responsible for Requests for Reimbursement | ☐Yes ☐ No |
| Click or tap here to enter text. | Individual collecting/submitting GPRA data | ☐Yes ☐ No |

1. **THIRD PARTY (E.G. MEDICAID) PAYER IDENTIFICATION**

|  |  |
| --- | --- |
| **A RESPONSE OF YES MEANS YOU ARE CURRENTLY ENROLLED AS A PROVIDER AND NOT THAT YOU ARE IN THE PROCESS.** | |
| Are you currently a registered provider with the Division of Health Care Finance and Policy (DHCFP) – Nevada Medicaid? | ☐Yes ☐ No |
| Are you currently registered as a provider with the Health Plan of Nevada? | ☐Yes ☐ No |
| Are you currently registered as a provider with United Health Care? | ☐Yes ☐ No |
| Are you currently registered as a provider with Blue Cross/Blue Shield Anthem? | ☐Yes ☐ No |
| Are you currently registered as a provider with Silver Summit? | ☐Yes ☐ No |
| Please identify any other third-party payors billed (e.g., insurance companies) your organization is registered with as a provider type for billing purposes.  Click or tap here to enter text. | |

|  |  |
| --- | --- |
| **Current provider types (PT) for third-party payors:**  PT 11 Hospital, Inpatient  PT 12 Hospital, Outpatient  PT 13 Psychiatric Hospital  PT 14 Behavioral Health Outpatient  PT 17 Specialty Clinic (e.g. CCBHC, FQHC)  PT 20 Physician  PT 26 Psychologist  PT 32 Community Paramedicine  PT 47 Indian Health Programs and Tribal Clinics  PT 54 Targeted Case Management  PT 60 School Based  PT 63 Residential Treatment Center (RTC)  PT 82 Behavioral Health Rehabilitative Treatment | ☐Yes ☐ No ☐Yes ☐ No  ☐Yes ☐ No  ☐Yes ☐ No ☐Yes ☐ No  ☐Yes ☐ No  ☐Yes ☐ No ☐Yes ☐ No  ☐Yes ☐ No  ☐Yes ☐ No  ☐Yes ☐ No  ☐Yes ☐ No |
| **Other, Please Define:** Click or tap here to enter text. | |

1. **CERTIFICATION OF PROVIDER**

| **ANSWERS ARE SPECIFIC TO THE ORGANIZATION CERTIFICATION AT THE TIME OF THE SUBMITTAL AND NOT ANY TEAM MEMBER CERTIFICATIONS.** | |
| --- | --- |
| Are you JCAHO (Joint Commission) Certified? | ☐Yes ☐ No |
| Are you SAPTA Certified under Nevada Revised Statute (NRS) 458, and Nevada Administrative Code (NAC) 458 *and* do you have a minimum of two (2) years providing substance use disorder treatment? | ☐Yes ☐ No |
| OR, are you able to provide memorandums of understanding (MOU)s with community partners who will provide treatment and are able to provide proof of SAPTA certification in good standing? | ☐Yes ☐ No |
| Please identify any additional certifications your organization (not individuals) holds: Click or tap here to enter text. | |

**I. CURRENT FUNDING (FEDERAL, STATE, AND PRIVATE FUNDING).**

|  |  |  |  |
| --- | --- | --- | --- |
| **FEDERAL, STATE AND PRIVATE FUNDING. PRIVATE FUNDING MAY BE IDENTIFIED AS TOTAL. ANY FEDERAL OR STATE FUNDS MUST BE DETAILED OUT. ADD ROWS AS REQUIRED. THIS INCLUDES ALL FEDERAL OR STATE GRANTS. STATE GRANTS ARE NOT PRIVATE FUNDING.** | | | |
| **Funding** | **Type** | **Project Period End Date** | **Current or Previous Amount Awarded ($)** |
| *Example: State Opioid Response Grant* | *Grant* | *September 2023* | *$100,000* |
| 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. **CAPACITY AND SUSTAINABILITY**

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| --- |
| **Define what you have done to increase sustainability efforts within the last three years (i.e. Medicaid billable, increased other forms of funding) to reduce your reliance on federal or state grant funding. Do not exceed 200 words.** |
| Click or tap here to enter text. |

**TARGET POPULATION (SELECT ONLY ONE).**

**☐** (A) Adults

**☐** (Y) Youth/Adolescents

**☐** (B)Both, must demonstrate capacity and capability in application

1. **PRIORITY AREA (Note – Applicants may not check more than one priority area). Applicants may submit more than one application. Checking more than one priority area may result in disqualification. The priority service areas must match your population of focus in K.**

**☐** TARGET 1: MEDICATION FOR OPIOID USE DISORDERS AND/OR BEHAVIORAL HEALTH TREATMENT SERVICE EXPANSION

**☐** TARGET 2: TRIBAL TREATMENT AND RECOVERY SERVICES

**☐** TARGET 3: RECOVERY SUPPORT SERVICES

**☐** TARGET 4: ENHANCED SUPPORTS FOR CHILDREN AND/OR FAMILIES

**☐** TARGET 5: HOSPITAL BASED MOUD INDUCTION

**☐** TARGET 6: RECOVERY HOUSING

**☐** TARGET 7: RURAL AND FRONTIER MOBILE RECOVERY UNITS

1. **PROJECT ABSTRACT**

|  |  |
| --- | --- |
| **The project abstract serves as a succinct description of the proposed project and a description of how the funds will be used. The abstract should be clear, accurate, concise, and without reference to other parts of the application. The abstract should be single spaced. Do not exceed 250 words. (Name, Priority Area, and Estimated Budget do not count towards the 250 words.)** | |
|  | |
| **NAME OF PROJECT:** Click or tap here to enter text. | |
| Click or tap here to enter text. | |
| **Priority Area** | Click or tap here to enter text. |
| **Estimated Budget (Pull from Budget)** | Click or tap here to enter text. |

1. **ORGANIZATIONAL CAPACITY DESCRIPTION**

|  |
| --- |
| **The Organization Description must include an overview of your organization demonstrating not less than two (2) years of operation, its structure, and relevant experience. Describe organization’s qualifications and experiences to implement the proposed project and previous experience related in scope and complexity to the Proposed Project. (Single Spaced, with a maximum of 500 words.)** |
|  |
| Click or tap here to enter text. |

1. **PROJECT DESIGN AND IMPLEMENTATION**

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| --- |
|  |
| **The Project Design and Implementation should provide a detailed description of the program and service array that is proposed to be funded. The following questions should be answered concisely and completely. Maximum of 1,500 words (single spaced).** |
| **1. Describe how the project will address the *Target Population.***  Click or tap here to enter text.  **2. Describe the program activities and how they relate to the overall goals of the project: SOW objectives and how the objectives will be achieved.**  Click or tap here to enter text.  **3. Describe how many individuals in each ASAM appropriate level of care you are expecting to seek reimbursement for will be served monthly and annually. *This will translate into the number of GPRAs that will need to be collected.***  Click or tap here to enter text.  **4. Define the evidence-based practice(s) or promising practice(s) being utilized.**  Click or tap here to enter text.  **5. Describe how proposed services meet the requirements of being culturally inclusive and what activities will be done to reach underserved priority populations.**  Click or tap here to enter text. |

1. **CAPABILITIES AND COMPETENCIES**

|  |
| --- |
| **Describe the capabilities of the applicant, the subrecipients, and/or contractors to successfully implement the project. This section should also state the competencies of the staff assigned to the project. Describe the roles, experiences, and tenure of key employees who will be running the day-to-day operations of the project. Maximum of 500 words, single spaced.** |
|  |
| Click or tap here to enter text.  . |

1. **DATA COLLECTION**

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| --- |
| **Describe the data and systems that your organization currently utilizes to collect unduplicated client level data, number of services provided, who collects the data, who is responsible for performance measurement and how the data it used to guide and evaluate current program activities. Identify if the organization has an electronic health record system, and what that system is. *(Selected organizations will be required to collect and submit data specific to: Client Level Data System (CLDS), GPRA, TEDS, or other data collection/systems based on the funding sources.) Maximum of 500 words, single spaced.*** |
|  |
| Click or tap here to enter text. |

1. **SCOPE OF WORK**

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| --- |
| **Complete the form below, provide a description of the services proposed that includes objectives, strategies and how data will be collected to ensure the activity is performed. CASAT will work with selected providers to detail out the performance measures associated with the scope of work. Do not exceed three pages. Applicant chooses how many goals to complete. Add more lines as needed. (Please note: Certain areas will have specific standards and goals which will be added prior to start of award).** |
|  |
| Describe the primary goal the program wishes to accomplish with this subaward.  **Goal 1: Collect and submit GPRA data for individuals served under SOR funded activities, with a minimum compliance of 80%.**   | **Objective** | **Activities | Strategies** | **How Data will be Collected/ Documentation** | | --- | --- | --- | | 1. Data collection and reporting will be provided, as required by the project. | 1. Participate in GPRA monthly meetings  2. A minimum of 80% of appropriate individuals will complete the GPRA within 1 week of intake  3. A minimum of 80% of individuals will complete the 6 month follow up GPRA  4. A minimum of 80% of individuals will complete the discharge GPRA | 1. Meeting notes from monthly GPRA calls  2. Weekly submission of GPRA reporting sheet to CASAT  3. Weekly upload of completed GPRAs to batch uploading system |   Describe the most important secondary goal the program plans to accomplish with this subaward.  **Goal 2:** Click or tap here to enter text.   | **Objective** | **Activities | Strategies** | **How Data will be Collected | Documentation** | | --- | --- | --- | | 1.  2. | 1.  2. | 1.  2. |   **Goal 3:** Click or tap here to enter text.   | **Objective** | **Activities | Strategies** | **How Data Collected | Documentation** | | --- | --- | --- | | 1.  2. | 1.  2. | 1.  2. |   **Goal 4:** Click or tap here to enter text.   | **Objective** | **Activities | Strategies** | **How Data Collected | Documentation** | | --- | --- | --- | | 1.  2. | 1.  2. | 1.  2. |   **Add additional Goals as required.** |

1. **Project Manager CV/Resume (One-Page)**

|  |
| --- |
| **Insert a brief resume/biography with highlights of the Program Manager (from Section F), who is responsible for the program deliverables to include education, licensure, and applicable experience for the proposed scope of work. The state reserves the right to request additional resumes or CVs based on program activities. Do not exceed 400 words.** |
| Click or tap here to enter text. |

## Budget Narrative Double Click on the table to open