*Please answer the following questions and submit completed application to* *DSAMH.ORT@delaware.gov*

|  |  |
| --- | --- |
| **Applicant Organization:** |  |

1. **Identify the key point of contact and other key personnel responsible for implementation of this project:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Title | Email | Phone Number |
| 1) |  |  |  |  |
| 2) |  |  |  |  |
| 3) |  |  |  |  |
| 4) |  |  |  |  |

1. **Please provide a brief overview of your organization or program, including types of services delivered, location(s), and the total number of patients served per year.**

|  |  |
| --- | --- |
| **Brief Organization/Project Overview** |  |
| **Types of Services Delivered** |  |
| **Location(s)** |  |
| **Total Number of Patients Served per Year** |  |

1. **Identify whether you are applying for:**
	1. [ ]  **Tier 2**
	2. [ ]  **Tier 3**
	3. [ ]  **Tier 2/3 Hybrid**
2. **Describe the project’s purpose and goals:**
3. **Provide the following information:**

|  |  |
| --- | --- |
| **Describe your population of focus and statement of need** |  |
| **What is the nature of problem** |  |
| **Identify unmet need(s) or emerging problem(s) to be addressed by the project** |  |
| **What are some characteristics of the population(s) of focus including cultural and racial/ethnic considerations and health disparities evident in the populations** |  |
| **What is the need for enhanced resources to address the identified need** |  |

1. **Please describe how your project will identify individuals with OUD/STUD.**
2. **Describe the mechanisms used by your project to extend beyond standard care to assertively engage hard-to-reach clients including “outside the four walls” approaches.**
3. **Identify the unduplicated number of individuals that will be served through the project.**
4. **Identify how your project will facilitate connection to – or direct provision of – Medications for Opioid Use Disorder and/or contingency management programming.**
5. **Describe the capability and experience of your project/organization to implement the project, your history in providing services to the population(s) of focus, and your experience with similar projects.**
6. **Provide an implementation work plan (implementation work plan template provided with this application package) for providing services under this project with key activities, timeframes, and persons responsible. The plan must cover start-up (to be completed no more than three months from award) through the full up to 15-month project. The timeline should identify the staff member who will take primary responsibility for implementing each activity undertaken as part of the project. If you are applying for a Tier 2/3 hybrid initiative, please identify when your project will move from Tier 2 to Tier 3 requirements (must be the first day of a quarter).**
7. **Identify the proposed data/metrics to be gathered over the up to 15 months of funding.**
8. **If you intend to use these funds in association with existing project in your organization, how will these funds complement but not supplant your existing funding? How will these new funds be used to cover expenses, activities, or functions that are not currently paid for with your current funding? What fiscal controls are in place to ensure that supplantation does not occur?**
9. **Provide your plan on how you will collect the required data for the project and how such data will be utilized to manage, monitor, and enhance the project. Provide a proposed budget with specific funding request to include costs such as staffing support, electronic health record adaptation, and other programmatic costs. Please use Excel budget template provided with this application package.**

**Further, please identify the name, title, and contact information for your organization/program’s designated data lead who will be responsible for submitting all data reports to DSAMH.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name |  | Title |  | Email |  | Phone Number |
| 1) |  |  |  |  |  |  |  |

Additional Information

[ ]  Select if all this information has already been submitted with the Tier 1 Application.

1. [ ]  Attach a copy of a W-9.
	1. All vendors must complete an on-line W-9: https://accounting.delaware.gov/suppliers/
2. [ ]  Attach a current State of Delaware Business License (from Division of Revenue) or IRS 501(c)3 exemption verification.
3. Provide a valid Data Universal Number System (DUNS) Number:
	1. Information on obtaining a DUNS number can be found at http://www.dnb.com
4. Provide a valid Delaware eSupplier Number:
	1. Information on supplier portal registry can be found at: esupplier.erp.delaware.gov
5. [ ] Attach a current Certificate of Liability Insurance Coverage.
	1. [ ]  Certificate Holder: **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, Springer Building, 1901 North Dupont Hwy, New Castle, DE 19720.
	2. 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 COI.
6. Provide a current Employer Identification Number (EIN):
7. [ ]  Attach a screenshot of an active listing on SAM.gov or evidence of application for SAM.gov listing.
	1. Example:

 

1. [ ] Additional insurance requirements contingent upon scope of work being performed.

Please submit completed application and supplemental materials to DSAMH.ORT@delaware.gov.