Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

FY 2024

Minority AIDS Initiative: Substance Use Disorder (SUD) Prevention and Treatment Pilot Program

(Short Title: MAI PT Pilot)

(Initial Announcement)

Notice of Funding Opportunity (NOFO) No. TI-24-005

Assistance Listing Number: 93.243

Key Information:

Application Deadline	**Applications are due by July 12, 2024.**
FY 2024 NOFO Application Guide	Throughout the NOFO there will be references to the FY 2024 NOFO Application Guide (Application Guide). The Application Guide provides detailed instructions on preparing and submitting your application. Please review each section of the Application Guide for important information on the grant application process, including the registration requirements, required attachments, and budget.
Intergovernmental Review (E.O. 12372)	Applicants must comply with E.O. 12372 if their state(s) participate(s). Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after the application deadline. See *Section I of the Application Guide.*
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	Applicants must send the PHSIS to appropriate state and local health agencies by the administrative deadline. Comments from the Single State Agency are due no later than 60 days after the application deadline.

Electronic Grant Application Submission Requirements	**You must complete three (3) registration processes**: 1. System for Award Management (SAM); 2. Grants.gov; and 3. eRA Commons. See ***Section A of the Application Guide*** (Application and Submission Requirements) to begin this process.

Table of Contents

EXECUTIVE SUMMARY 5

I. PROGRAM DESCRIPTION 7

1. PURPOSE 7
2. KEY PERSONNEL 8
3. REQUIRED ACTIVITIES 9
4. ALLOWABLE ACTIVITIES 15
5. USING EVIDENCE-BASED PRACTICES, ADAPTED, AND COMMUNITY-DEFINED EVIDENCE PRACTICES 18
6. DATA COLLECTION/PERFORMANCE MEASUREMENT AND PROJECT PERFORMANCE ASSESSMENT 19
7. OTHER EXPECTATIONS 20
8. RECIPIENT MEETINGS 24

II. FEDERAL AWARD INFORMATION 24

1. GENERAL INFORMATION 24
2. COOPERATIVE AGREEMENT REQUIREMENTS 25

III. ELIGIBILITY INFORMATION 26

1. ELIGIBLE APPLICANTS 26
2. COST SHARING AND MATCHING REQUIREMENTS 26
3. OTHER REQUIREMENTS 27

IV. APPLICATION AND SUBMISSION INFORMATION 28

1. ADDRESS TO REQUEST APPLICATION PACKAGE 28
2. CONTENT AND FORM OF APPLICATION SUBMISSION 28
3. UNIQUE ENTITY IDENTIFIER AND SYSTEM FOR AWARD MANAGEMENT 33
4. APPLICATION SUBMISSION REQUIREMENTS 33
5. FUNDING LIMITATIONS/RESTRICTIONS 34
6. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS 35
7. OTHER SUBMISSION REQUIREMENTS 35

V. APPLICATION REVIEW INFORMATION 35

1. EVALUATION CRITERIA 35

2. BUDGET JUSTIFICATION, EXISTING RESOURCES, OTHER SUPPORT. 38
3. REVIEW AND SELECTION PROCESS 39

VI. FEDERAL AWARD ADMINISTRATION INFORMATION 40
1. FEDERAL AWARD NOTICES 40
2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS 40
3. REPORTING REQUIREMENTS 40

VII. AGENCY CONTACTS 41

Appendix A – Ending the HIV Epidemic in the U.S. Priority Jurisdictions 42

Appendix B – Contingency Management 43

EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP), are accepting applications for the fiscal year (FY) 2024 Minority AIDS Initiative: Substance Use Disorders (SUD) Prevention and Treatment Pilot Program (Short Title: MAI PT Pilot). The purpose of this program is to provide substance use prevention, substance use disorder (SUD) treatment, HIV, and viral hepatitis prevention and treatment services for racial and ethnic individuals vulnerable to a SUD and/or mental health condition, HIV, viral hepatitis, and other infectious disease (e.g., sexually transmitted infections, or STIs). Recipients will be expected to take a syndemic approach to SUD, HIV, and viral hepatitis by providing SUD prevention and treatment to racial and ethnic individuals at risk for or living with HIV. With this program, SAMHSA aims to pilot this approach, which combines comprehensive prevention and treatment services, while increasing engagement in care for people at increased risk for SUD, HIV, viral hepatitis, and other infectious diseases.

Funding Opportunity Title:	Minority AIDS Initiative: Substance Use Disorders (SUD) Prevention and Treatment Pilot Program (Short Title: MAI PT Pilot)
Funding Opportunity Number:	TI-24-005
Due Date for Applications:	July 12, 2024
Estimated Total Available Funding:	$5,700,000
Estimated Number of Awards:	Up to 8 (At least 1 award will be made to American Indian/Alaska Native (AI/AN) tribes, or tribal organizations pending sufficient application volume.)
Estimated Award Amount:	Up to $700,000 per year
Cost Sharing/Match Required:	No
Anticipated Project Start Date:	September 30, 2024
Anticipated Award Date:	No later than September 29, 2024
Length of Project Period:	Up to 5 years

Eligible Applicants:	Eligible applicants are States and Territories, including the District of Columbia, political subdivisions of States, Indian tribes, or tribal organizations (as such terms are defined in section 5304 of title 25), health facilities, or programs operated by or in accordance with a contract or award with the Indian Health Service, or other public or private non-profit entities, including faith-based organizations. [See Section III-1 for complete eligibility information.]
Authorizing Statute:	Sections 509 and 516 of the Public Health Service Act, as amended.

I. PROGRAM DESCRIPTION

1. PURPOSE

The purpose of this program is to provide substance use prevention, substance use disorder (SUD) treatment, HIV, and viral hepatitis prevention and treatment services for racial and ethnic medically underserved individuals vulnerable to a SUD and/or mental health condition, HIV, viral hepatitis, and other infectious disease (e.g., STIs). The populations of focus for this program are individuals who are particularly vulnerable to or living with HIV/AIDS, including an emphasis on gay, bisexual, and other men who have sex with men, men who have sex with men and women (MSMW), Black, Latino, and American Indian/Alaska Native (AI/AN) men who have sex with men (MSM), Asian and Pacific Islander, Black women, transgender men and women, youth aged 13–24 years, and People who Inject Drugs (PWID).

According to the Centers for Disease Control and Prevention (CDC), the spread of HIV in the United States is mainly through anal or vaginal sex or by sharing drug-use equipment. However, although these risk factors are the same for everyone, due to a range of social, economic, and demographic factors, such as stigma, discrimination, income, education, and geographic region, some racial and ethnic groups are more affected than others when compared to their percentage of the United States population. In 2021, the CDC reported that although Black/African Americans represented 13 percent of the US population, they accounted for 42 percent (15,305) of the 36,801 new HIV diagnoses; Latino/Hispanic people represent 18.7 percent of the US population[1] but accounted for 29 percent (10,494) of HIV diagnoses in the US and dependent areas.[2] Between 2017 and 2021, AI/AN, Native Hawaiian and other Pacific Islander populations were the only demographic groups identified by the CDC with an increase in HIV diagnoses in the United States.[3]

Viral hepatitis also impacts some racial and ethnic groups disproportionally. Non-Hispanic blacks were almost twice as likely to die from hepatitis C as compared to the white population and while having comparable case rates for hepatitis B in 2020, non-Hispanic blacks were 2.5 times more likely to die from hepatitis B than non-Hispanic whites (Office of Minority Health, 2022).[4] Additionally, the percentage of people aged 12 or older with past year substance use disorder (SUD) differed by race and ethnicity with

---

[1] 2020 Census Illuminates Racial and Ethnic Composition of the Country

[2] HIV Diagnoses

[3] HIV in the United States by Race/Ethnicity: HIV Diagnoses

[4] Office of Minority Health. (2022). Hepatitis and African Americans. U.S. Department of Health & Human Services. https://minorityhealth.hhs.gov/hepatitis-and-african-americans

the highest rates among American Indian/Alaska Native populations (24.0 percent), followed by Black, non-Hispanic populations (18.4 percent) (SAMHSA, 2023).[5]

SAMHSA's MAI PT Pilot is informed by the key strategies and priority jurisdictions outlined in the Ending the HIV Epidemic in the U.S. (EHE) initiative, the Viral Hepatitis National Strategic Plan and the STI National Strategic Plan. The program also supports the National HIV/AIDS Strategy (NHAS) and the 2023-2026 SAMHSA Strategic Plan. Recipients will be expected to take a syndemic approach to SUD, HIV, and viral hepatitis by providing SUD prevention and treatment to racial and ethnic individuals at risk for or living with HIV. Services provided should be consistent with SAMHSA and HHS policy, including, as appropriate, the policies in Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders.

SAMHSA encourages grant recipients to address the diverse behavioral health needs of underserved communities as defined by Executive Order 13985. Recipients must also serve all individuals equitably and administer their programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age, religion, and sex (including gender identity, sexual orientation, and pregnancy). Recipients must also agree to comply with federal conscience laws, where applicable.

Priority (10 additional points) will be given to applicants implementing services in the Ending the HIV Epidemic in the U.S. (EHE) priority jurisdictions[6] (see Appendix A).

The Minority AIDS Initiative: SUD Prevention and Treatment Pilot Program is authorized by under Sections 509 and 516 of the Public Health Service Act, as amended.

2. KEY PERSONNEL

Key personnel are staff members who must be part of the project, whether or not they receive a salary from the project. Key personnel must make a major contribution to the project. Key personnel and staff selected for the project should reflect the diversity in the geographic catchment area.

Key personnel for this program are the Project Director, the Program Coordinator, the Lead Prevention Navigator, and the Program Evaluator.

- **Project Director:** responsible for oversight of the entire project, including overseeing, monitoring, and managing the award. At least a 20 percent level of effort is required (may be included in the Prevention or Treatment budget).

---

[5] Substance Abuse and Mental Health Services Administration. (2023). Strategic Plan: Fiscal Year 2023-2026. Publication No. PEP23-06-00-002. National Mental Health and Substance Use Policy Laboratory. https://www.samhsa.gov/sites/default/files/samhsa-strategic-plan.pdf

[6] EHE Priority Jurisdictions

- **Program Coordinator:** responsible for overseeing the day-to-day management and operations of the award, including supervising staff; 100 percent level of effort is required.
- **Prevention Navigator:** responsible for conducting outreach and prevention navigation services in the community, including community-based screening and testing and implementing environmental strategies; 100 percent level of effort is required**.**
- **Program Evaluator:** responsible for evaluating the processes and outcomes of the award; and working with the SAMHSA cross-site evaluation team on additional data collection efforts as needed. At least a 20 percent level of effort is required.

Recipients are encouraged to consider filling the Project Director, Program Coordinator, Prevention Navigator, and other staff positions with individuals with lived and living experience, or in recovery with SUD, co-occurring SUDs and mental health conditions; experienced with HIV risk reduction behavior change;[7] or living with HIV. This experience, along with relevant content expertise, is acceptable in lieu of education, as appropriate.

If you receive an award, you will be notified if the individual(s) designated for these positions have been approved. If you need to replace Key Personnel during the project period, SAMHSA will review the credentials and job description before approving the replacement.

3. REQUIRED ACTIVITIES

You must provide a description in B.2. of the Project Narrative of how you plan to implement all the required activities listed below.

You are expected to begin the delivery of services no later than by the fifth month of the award. You are expected to serve the unduplicated number of individuals proposed in the Project Narrative (B.1).

Recipients are required to carry out each of these activities.

Community-based organizations must be involved as either the primary recipient, sub-recipient, or partner organization to support the implementation of the overall project. **Applicants that do not involve a community-based organization either as the primary recipient, sub-recipient, or partner organization will be screened out and not considered for review.** See Attachment 1 for additional guidance.

Organizational Readiness Assessment for Prevention Navigator Services:

[7] For example, use of syringe service programs, experience taking PrEP or PEP, etc.

- **Within the first four months, conduct and submit the results of an organizational readiness assessment (ORA)** within the catchment area to identify existing community substance use, HIV, viral hepatitis, and STI prevention and treatment assets, strengths, opportunities, and gaps relevant to the program's goals. The ORA will encompass the identification of available internal and external resources to address gaps and opportunities. The ORA will identify environmental prevention strategies aimed at changing or influencing community conditions, standards, institutions, structure, systems, and policies at the individual and community levels. ORA results will support the implementation of prevention strategies, culturally responsive programming, and capacity development. This assessment is in alignment with SAMHSA's Strategic Prevention Framework.

NOTE: The ORA must be approved by the Government Project Officer (GPO). Detailed guidance and an ORA template will be provided upon award.

Substance Use Prevention and Treatment:

- Conduct outreach and engagement strategies to increase participation in, and access to, substance use prevention and treatment education services in vulnerable communities that are reflective of their diverse background and language, as appropriate.
- Conduct screening and assessment of substance use disorders (SUD) and co-occurring mental and substance use disorders (COD) and link individuals to appropriate services.
- Develop and implement a low barrier approach that offers SUD prevention and treatment services, including Food and Drug Administration (FDA)-approved medications to treat SUDs, inclusive of opioid use disorder (OUD) and alcohol use disorder (AUD). It is allowable to provide services in-house or by referral and linkage to other SUD treatment providers at the request of the participant, if deemed medically necessary or due to capacity issues.
- Provide trauma-informed, non-judgmental, culturally responsive and informed, evidence-based SUD/COD prevention, treatment and recovery support services to individuals with or vulnerable to HIV, including outpatient services, intensive outpatient services, and the use FDA-approved medications for the treatment of SUDs and/or COD. Recovery support services should be in alignment with those allowable expenditures through the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) and the Community Mental Health Services Block Grant (MHBG).
- Provide mental health promotion and psychosocial support.

Infectious disease testing, prevention, education, and treatment, including HIV, viral hepatitis, and STIs:

- Screen individuals and their partners on-site for HIV, viral hepatitis, and STIs using culturally and linguistically appropriate methods.

- If HIV treatment, viral hepatitis B and C treatment, and Pre-Exposure Prophylaxis (PrEP) services are not offered by the recipient organization in-house, develop Memoranda of Agreement (MOAs) with the following referral partners, as appropriate. (Note: If a MOA cannot be completed by the application deadline, a Letter of Commitment (LOC) will be sufficient for the purposes of this application.) The MOA or LOC **must** be submitted with your application in **Attachment 1**. See **Attachment 1** for instructions on completing this requirement. **Failure to submit this required documentation with your application will result in your application being screened out and not considered for award.** Note: Though offering Post-Exposure Prophylaxis (PEP) either in-house or by referral is required, PEP documentation is not required with your application; instead, it must be submitted within four months of the award and prior to implementation of grant activities.
    - Primary HIV treatment and care providers, including Ryan White providers, to strengthen integration of care through case management.
    - Treatment providers for referrals and linkages to follow-up care and treatment for individuals with viral hepatitis (B and C).
    - Care providers for referrals and linkages to PrEP.
    - Care providers for referrals and linkage to PEP.
- Implement infectious disease quality assurance guidelines using established methods.[8]
- Provide HIV testing, prevention education, and referral and linkage to treatment, including:
    - Screen and assess individuals with or vulnerable to HIV, for the presence of CODs[9] and use the information obtained from the screening and assessment to develop culturally and linguistically appropriate treatment approaches for these individuals.
    - Offer on-site rapid HIV testing to all participants, as well as their partners as appropriate. On-site rapid HIV testing must follow CDC guidance and individual state requirements and may include HIV self-test kits. Note that on-site rapid HIV testing **cannot** be offered by referral to other organizations.
    - For people who receive an on-site rapid positive HIV test result, provide case management, confirmatory testing on-site (preferred) or by referral, and if confirmed, provide referral and linkage to HIV treatment as

[8] CDC HIV, Viral Hepatitis, STD, and TB Quality Measures

[9] SAMHSA Co-Occurring Disorders and Other Health Conditions

necessary. HIV treatment should begin preferably within hours but not longer than 30 calendar days after diagnosis.

  - For people with a prior HIV diagnosis, ensure they are already linked to HIV treatment. If they are not in HIV treatment, provide referral and linkage to HIV treatment, preferably within hours but not longer than 30 calendar days.

  - For people who test HIV negative but are at increased likelihood of acquiring HIV, provide in-house case management, HIV prevention education, including, but not limited to, information about harm reduction, PrEP, PEP, and HIV prevention behavior-change methodologies (e.g., use of condoms, syringe services programs (SSPs) as appropriate).

  - Provide in-house case management and, if necessary, referral and linkage to PrEP for individuals who are at increased likelihood of acquiring HIV, preferably within hours but not longer than 30 calendar days.

  - Provide in-house case management and, if necessary, referral and linkage to PEP services for individuals in emergency situations following a possible HIV exposure. PEP must be started within 72 hours of exposure.

- Viral Hepatitis Prevention, Vaccination, and Referral and Linkage to Treatment
  - Test all participants with increased likelihood of acquiring viral hepatitis (B and C) either on-site or through referral and linkage in accordance with state and local requirements. Hepatitis A testing may also be performed if an outbreak is currently taking place in the recipient's geographic area. People who are vulnerable to hepatitis C virus (HCV) include persons who have more than one sex partner, use needles, syringes, or other drug injection equipment, or exchange sex for drugs or money.

  - Provide hepatitis A and B vaccination to participants as necessary.

  - For people who test positive for hepatitis B and/or hepatitis C, provide case management and referral and linkage to treatment. Case management includes comprehensive assessment of the client's needs and development of an individualized service plan, including infectious disease prevention and/or treatment services, as well as helping clients with funding for treatment, including HCV treatment, as necessary. **Note:** SAMHSA funds cannot be used to pay for treatment for hepatitis B or C.

- Sexually Transmitted Infections (gonorrhea, chlamydia, and syphilis and other STIs)[10]

[10] See also SAMHSA's Dear Colleague Letter regarding the use of grant funds to address STIs, including syphilis.

- Screen and test individuals and their partners on-site for STIs.[11]
- For people who test positive for STIs, provide referral and linkages to treatment services as needed.[12]

NOTE: In **Attachment 1**, you **must** provide documentation indicating the following service(s) will be offered in-house or by referral: (a) HIV treatment and care; (b) referrals and linkages to follow-up care and treatment for individuals with viral hepatitis (B or C); and (c) referrals and linkages for PrEP.

1) In-House Implementation: If the organization will offer HIV treatment services, viral hepatitis services (B or C), and/or PrEP in-house, provide the following information: Describe your plan to implement the above treatment service(s) in-house with resources from your organization and/or any other funding source already in place. The funding source **must** be provided for each service you plan to offer in-house. Note that SAMHSA funds cannot be used to cover the costs of HIV treatment, viral hepatitis treatment, primary care services, PrEP, or PEP.

2) Service(s) Provided by Referral: If the applicant organization will offer HIV treatment services, viral hepatitis services (B or C), and/or PrEP by referral to partner organizations, provide the following information: Identify the partner organization that will provide the service(s) and include the MOA with that organization which formalizes this partnership. If a MOA cannot be completed by the application deadline, a Letter of Commitment (LOC) will be sufficient for the purposes of this application. If a LOC is submitted and funding is received, a MOA for all required providers must be finalized and in place prior to the start of project activities. **MOAs or LOCs are required for each referral partner providing any or all of the required services described directly above under the heading 'Service(s) Provided by Referral' or the grant application will be screened out and not considered for review.**

Case Management/Peer Support Services

- Provide case management, referral, and linkage to services as necessary based on the participant's individual needs. Case management includes:
  - Comprehensive assessment of the participant's needs and development of an individualized service plan including, but not limited to, engaging in infectious disease prevention and/or treatment services;
  - Helping participants access funding for treatment, including HCV treatment, as necessary;

---

[11] STI National Strategic Plan 2021-2025

[12] CDC: Sexually Transmitted Infections Treatment Guidelines, 2021

    - Healthcare system navigation;
    - Psychoeducation;
    - Supportive counseling; and
    - Linkage to psychosocial supportive services to address social determinants of health.
- Provide Peer Support Services to include utilizing peer mentors, recovery coaches, or recovery support specialists who may have lived experience with any of the following:
    - Individuals that are living with HIV/AIDS and taking antiretroviral therapy.
    - Individuals that are HIV-negative but have lived experience with HIV prevention methodologies such as taking or have taken PrEP or other HIV prevention behavior change methodologies.
    - Individuals with lived experience of hepatitis B and C treatment and hepatitis C recovery.
    - Individuals with lived experience with and are in active recovery for SUD, mental health conditions, or COD.
- Provide navigation services to link individuals to care for mental health conditions, substance use, HIV, and viral hepatitis, where indicated. Navigation services should include housing support services with referral and linkage as appropriate. Navigation should also include follow-up to ensure individuals are engaged and retained in treatment.

Harm Reduction Services

- Provide evidence-based harm reduction education, supplies and services[13] in-house, either singularly or in collaboration with community-based harm reduction programs and/or SSPs. Harm reduction services funded under this award must adhere to federal, state, and local laws, regulations, and other requirements related to such programs or services.
- Distribute naloxone and other opioid overdose reversal medications, drug checking equipment (e.g., fentanyl and xylazine test strips), and provide overdose prevention education to the populations of focus regarding the use of substances including, but not limited to, fentanyl, other synthetic opioids, and other emerging drug trends such as xylazine.

[13] SAMHSA Harm Reduction

- Provide equipment and supplies to enhance harm reduction efforts as appropriate and allowable per federal, state, and local laws.[14] Federal funds cannot be used to purchase drug paraphernalia.

Training and Workforce Development/Sustainability

- Training for staff to provide culturally and linguistically appropriate services for substance use treatment, prevention, mental health, HIV prevention, SUDs, CODs, and harm reduction strategies.
- Training on the proper storage, distribution, and use of medication and testing supplies used by the project, including HIV and viral hepatitis tests, vaccinations, and naloxone and other opioid overdose reversal medications. Training for opioid overdose reversal medications must also be offered to anyone who receives these medications as a component of this award.
- Training in evidence-based practices (EBPs) for service providers, such as medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD), motivational interviewing, intensive case management (ICM), community reinforcement approach (CRA), or peer supports.
- Train Prevention Navigators to provide all testing services including screening individuals vulnerable to substance use and infectious disease using an approved SAMHSA screening tool, as well as HIV, viral hepatitis, and STI testing methodologies and viral hepatitis (A and B) vaccination.
- Develop and implement strategies to provide, increase, or enhance access to services for people of all underserved groups in the community in accordance with Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) Standards.

4. ALLOWABLE ACTIVITIES

Recipients should select allowable activities that will support the implementation of a comprehensive HIV and SUD prevention and treatment program. Allowable activities are not required. Applicants may propose to use funds for the following activities after ensuring they can carry out all of the required activities:

- Develop and implement tobacco cessation programs, activities, and/or strategies.
- Implement a communication campaign focused on reducing stigma related to harm reduction.
- Implement efforts that may improve diversity, equity, inclusion, and accessibility to individuals vulnerable to a SUD and/or mental health condition, HIV, viral hepatitis, and other infectious disease.

---

[14] See list of allowable harm reduction services and supplies on SAMHSA's harm reduction website.

- Use data to understand who is served and disproportionately served (for example, overserved or underserved) to guide and improve program implementation.
- Develop and implement outreach and referral pathways that engage all demographic groups representative of the identified community.
- Develop and implement evidence-based contingency management (CM) programs to treat stimulant use disorder and concurrent substance misuse, and to improve retention in care. **Clients may not receive contingencies totaling more than $75 per budget period.** If you plan to implement CM programs, you must certify that you will comply with all applicable conditions and training requirements, as well as provide a plan, within 90 days of grant award, to ensure: primary grant recipient staff and if applicable sub-awardee(s) receive appropriate education on CM prior to implementation; describe the role of individuals in delivery and monitoring of CM services; the incentivized behaviors, and the approach to verification; the type of CM services to be offered; the process for monitoring fidelity to evidence-based practices; and oversight of primary grant recipient staff and if applicable sub-awardee(s) CM implementation and operation, as outlined in Appendix B of this NOFO. The Statement of Certification must be provided in **Attachment 11** of your application.
- Provide recovery housing for eligible individuals to include those actively engaged in MOUD and MAUD treatment and other psychosocial services. Recovery housing is one component of the SUD treatment and recovery continuum of care. Recipients must describe the mechanism in their jurisdiction that assures the recovery housing program is guided by any regulation, credentialing, or certification requirements, and demonstrate how the recovery housing program abides by these requirements set forth by the state or local government. If no mechanism exists, recipient must demonstrate how recovery housing programs adhere to federal standards (SAMHSA's Best Practices for Recovery Housing).
- Provide SUD prevention, treatment, and recovery as well as COD services for long-term survivors and people aging with HIV.
- Provide participants with educational information on how and where to obtain HIV self-test kits, especially when telemedicine services are offered.
- Provide behavioral health CLAS standards training to service providers, including translation of materials, as needed, for other languages of the population of focus.
- Provide both supportive counseling and motivational interviewing internally and in making referrals, and linkages to necessary external services and resources.
- Provide supportive services that address behavioral health disparities, social determinants of health, and adverse childhood experiences to prevent the onset of mental health conditions and SUDs and reduce risk for HIV/viral hepatitis and STIs.

- Provide early supportive services addressing the social/emotional needs of high-risk youth to increase resiliency and coping skills that can reduce the risk for substance use, mental health challenges, and suicide.
- Provide Mpox activities conducted in conjunction with SAMHSA supported work as allowable in SAMHSA's Mpox Dear Colleagues letter[15]. Such activities include, but are not limited to, navigating people served by award funds to testing, treatment, and prevention resources identified through collaboration with local health departments and mental health support of individuals with Mpox served by this award or referral and linkage to these services.
- Screen for symptomatic tuberculosis and test participants for latent or active tuberculosis and provide treatment either on-site or by referral and linkage as appropriate.
- Address the intersection between oral and behavioral health by providing dental kits to promote oral health for individuals experiencing unsheltered homelessness (i.e., dental kits are limited to items such as toothpaste, toothbrush, dental floss, non-alcohol containing mouthwash).
- Distribute safer sex kits, including condoms.
- Use of telehealth and/or telemedicine services to deliver SUD, HIV, viral hepatitis, and STI prevention education and treatment services.
- Provide public education on "Good Samaritan" laws related to harm reduction in the recipient State.
- Dispensing medications other than those purchased by the award as prescribed by a licensed medical prescriber is allowable.
- Provide warm hand-off referrals to appropriate employment and transportation services to ensure comprehensive support for program participants.

Capacity Building Optional Allowable Activity

Capacity-building involves strengthening the ability of an organization to meet identified goals so that it can sustain or improve the delivery of services. Capacity-building activities may include, but are not limited to, training, education, and technical assistance; expansion of partnerships; and the development of program materials. SAMHSA recognizes that you may need to implement capacity-building activities to provide or expand prevention strategies and/or direct services or improve their effectiveness. In B.2 of the Project Narrative, applicants must describe the use of funds for capacity building, such as:

[15] https://www.samhsa.gov/sites/default/files/colleague-letter-monkeypox.pdf

- Developing partnerships with other providers for service delivery and with stakeholders, including prevention-focused organizations, serving the population of focus, including underserved and diverse populations.
- Policy development to support needed service system improvements (e.g., rate-setting activities, establishment of standards of care, development or revision of credentialing, licensure, or accreditation requirements)[16]

5. USING EVIDENCE-BASED PRACTICES, ADAPTED, AND COMMUNITY-DEFINED EVIDENCE PRACTICES

You should use SAMHSA's funds to provide services or practices that have a proven evidence base and are appropriate for the population(s) of focus. Evidence-based practices are interventions that promote individual-level or population-level outcomes. They are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the people receiving the services. See SAMHSA's Evidence-Based Practices Resource Center and the National Network to Eliminate Disparities in Behavioral Health to identify evidence-informed and culturally appropriate mental illness and substance use prevention, treatment, and recovery practices that can be used in your project.

An ***evidence-based practice*** (EBP) is a practice that has been documented with research data to show its effectiveness. A ***culturally adapted practice*** refers to the systematic modification of an EBP that considers language, culture, and context in a way that is compatible with the clients' cultural patterns, meaning, and values. ***Community-defined evidence practices*** (CDEPs) are practices that communities have shown to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community.

Both researchers and practitioners recognize that EBPs, culturally adapted practices, and CDEPs are essential to improving the effectiveness of treatment and prevention services. While SAMHSA realizes that EBPs have not been developed for all populations and/or service settings, application reviewers will closely examine proposed interventions for evidence base and appropriateness for the population of focus. If an EBP(s) exists for the population(s) of focus and types of problems or disorders being addressed, it is expected you will use that/those EBP(s). If one does not exist but there

[16] For purposes of this NOFO efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders ("legislation and other orders") proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, and recipients may not use federal funds for such activities. This restriction extends to both grassroots lobbying efforts and direct lobbying. However, for state, local, and other governmental recipients, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

are culturally adapted practices, CDEPs, and/or culturally promising practices that are appropriate, you may implement these interventions.

In Section C of your Project Narrative, identify the practice(s) from the above categories that are appropriate or can be adapted to meet the needs of your specific population(s) of focus. You must discuss the population(s) for which the practice(s) has (have) been shown to be effective and document that it is (they are) appropriate for your population(s) of focus. You must also address how these interventions will improve outcomes and how you will monitor and ensure fidelity to the practice. For information about monitoring fidelity, see the Fidelity Monitoring Checklist. In situations where an EBP is appropriate but requires additional culturally informed practices, discuss this in C.1.

6. DATA COLLECTION/PERFORMANCE MEASUREMENT AND PROJECT PERFORMANCE ASSESSMENT

Data Collection/Performance Measurement

You must collect and report data for SAMHSA to meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your plan for data collection and reporting in Section E of the Project Narrative.

Recipients are required to report the following performance measures:

- Number of individuals *served* through grant funded activities by demographic group.[17]
- Number of individuals *reached* through population-based prevention efforts by demographic group.[18]
- Number of individuals provided substance misuse prevention education services.
- Number of individuals provided HIV risk factor and risk reduction education services.
- Number of individuals assessed for SUDs and/or CODs.
- Number of individuals tested for HIV, viral hepatitis, and/or STI.
- Number of individuals who test positive for HIV, viral hepatitis and/or STI.

[17] Number of individuals reached refers to grant-funded population-based prevention strategies aimed at impacting an entire population. Because there is no direct interaction with populations affected by the prevention strategies implemented, counts of people reached are typically estimates obtained from sources such as the US Census (population of targeted community) or media outlets (estimated readership or audience size).

[18] Number of individuals reached refers to grant-funded population-based prevention strategies aimed at impacting an entire population. Because there is no direct interaction with populations affected by the prevention strategies implemented, counts of people reached are typically estimates obtained from sources such as the US Census (population of targeted community) or media outlets (estimated readership or audience size).

- Number of individuals linked to services.

This information will be gathered using a uniform data collection tool provided by SAMHSA. Recipients are required to submit data in SAMHSA's Performance Accountability and Reporting System (SPARS); access will be provided upon award. Additional information about SPARS can be found at https://spars.samhsa.gov/.

Data are to be submitted quarterly in SPARS within 30 days of the end of each reporting period. Training and technical assistance on SPARS data collection and reporting will be provided after award.

The data you collect allows SAMHSA to report on key outcome measures. Performance measures are also used to show how programs reduce disparities in behavioral health access, increase client retention, expand service use, and improve outcomes. Performance data will be reported to the public as part of SAMHSA's Congressional Budget Justification.

Recipients and sub-recipients are required to participate in a SAMHSA-funded cross-site evaluation to build the evidence base of the program. Recipients are not responsible for conducting the evaluation. However, they must participate fully in the evaluation-related activities. Additional details will be provided upon award.

Project Performance Assessment

Recipients must periodically review their performance data to assess their progress and use this information to improve the management of the project. The project performance assessment allows recipients to determine whether their goals, objectives, and outcomes are being achieved and if changes need to be made to the project. This information is included in your Programmatic Progress Report (See Section VI.3 for a description of reporting requirements.)

In addition, one key part of the performance assessment is determining if your project has or will have the intended impact on behavioral health disparities. You will be expected to collect data to evaluate whether the disparities you identified in your Disparity Impact Statement (DIS) are being effectively addressed.

For more information, see the *Application Guide, Section D - Developing Goals and Measurable Objectives and Section E - Developing the Plan for Data Collection and Performance Measurement.*

7. OTHER EXPECTATIONS

SAMHSA Values That Promote Positive Behavioral Health

SAMHSA expects recipients to use funds to implement high-quality programs, practices, and policies that are recovery-oriented, trauma-informed, and equity-based to improve

behavioral health.[19] These are part of SAMHSA's core principles, as documented in our strategic plan.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recipients promote partnerships with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster:

- *Health*—managing one's illnesses or symptoms and making informed, healthy choices that support physical and emotional well-being;
- *Home*—having a stable and safe place to live;
- *Purpose*—conducting meaningful daily activities, such as a job or school; and
- *Community*—having supportive relationships with families, friends, and peers.

Recovery-oriented systems of care embrace recovery as:

- emerging from hope;
- person-driven, occurring via many pathways;
- holistic, supported by peers and allies;
- culturally-based and informed;
- supported through relationship and social networks;
- involving individual, family, and community strengths and responsibility;
- supported by addressing trauma; and based on respect.

Trauma-informed approaches recognize and intentionally respond to the lasting adverse effects of experiencing traumatic events. SAMHSA defines a trauma-informed approach through six key principles:

1. *Safety*: participants and staff feel physically and psychologically safe;
2. *Peer Support:* peer support and mutual self-help are vehicles for establishing safety and hope, building trust, enhancing collaboration, and using lived experience to promote recovery and healing;
3. *Trustworthiness and Transparency*: organizational decisions are conducted to build and maintain trust with participants and staff;
4. C*ollaboration and Mutuality:* importance is placed on partnering and leveling power differences between staff and service participants;
5. *Cultural, Historical, and Gender Issues*: culture- and gender-responsive services are offered while moving beyond stereotypes/biases; and

[19] "Behavioral health" means the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

6. *Empowerment, Voice, and Choice*: organizations foster a belief in the primacy of the people who are served to heal and promote recovery from trauma.

It is critical for recipients to promote the linkage to recovery and resilience for individuals and families affected by trauma.

Behavioral health equity is the right to access high-quality and affordable health care services and supports for all populations, regardless of the individual's race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. By improving access to behavioral health care, promoting quality behavioral health programs and practices, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further reduced by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity.

Behavioral Health Disparities

If your application is funded, you must submit a Behavioral Health Disparity Impact Statement (DIS) no later than 60 days after award. *See Section G of the Application Guide*. Progress and evaluation of DIS activities must be reported in annual progress reports (see Section VI.3 Reporting Requirements).

The DIS is a data-driven, quality improvement approach to advance equity for all. It is used to identify underserved and historically under-resourced populations at the highest risk for experiencing behavioral health disparities. The purpose of the DIS is to create greater inclusion of underserved populations in SAMHSA's grants.

The DIS aligns with the expectations related to Executive Order 13985.

Language Access Provision

Per Title VI of the Civil Rights Act of 1964, recipients of federal financial assistance must take reasonable steps to make their programs, services, and activities accessible to eligible persons with limited English proficiency. Recipients must administer their programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). (See the Application Guide *Section J - Administrative and National Policy Requirements.*)

Tribal Behavioral Health Agenda

SAMHSA, working with tribes, the Indian Health Service, and National Indian Health Board, developed the National Tribal Behavioral Health Agenda (TBHA). Tribal

applicants are encouraged to briefly cite the applicable TBHA foundational element(s), priority(ies), and strategies their application addresses. Tribal applicants are also encouraged to refer to The Indigenous HIV/AIDS Syndemic Strategy, Weaving Together the National HIV, STI, and Viral Hepatitis Plans, which was released in November 2022 and can be found here. Applicants may also refer to the Tribal Opioid Response Strategic Agenda: Healing Our Nations Together, developed by NIHB and Northwest Portland Area Indian Health Board (NPAIHB), alongside tribal policymakers, national experts, service providers, and community members, which can be found here.

Tobacco and Nicotine-free Policy

You are encouraged to adopt a tobacco/nicotine inhalation (vaping) product-free facility/grounds policy and to promote abstinence from all tobacco products (except accepted tribal traditions and practices).

Reimbursements for the Provision of Services

Recipients must first use revenue from third-party payments (such as Medicare or Medicaid) from providing services to pay for uninsured or underinsured individuals. Recipients must implement policies and procedures that ensure other sources of funding (such as Medicare, Medicaid, private insurance, etc.) are used first when available for that individual. Grant award funds for payment of services may be used for individuals who are not covered by public or other health insurance programs. Each recipient must have policies and procedures in place to determine affordability and insurance coverage for individuals seeking services. Program income revenue generated from providing services must first be used to pay for programmatic expenses related to the proposed grant activities.

Recipients must also assist eligible uninsured clients with applying for health insurance. If appropriate, consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health Administration or senior services).

Inclusion of People with Lived Experience Policy

SAMHSA recognizes that people with lived experience are fundamental to improving mental health and substance use services and should be meaningfully involved in the planning, delivery, administration, evaluation, and policy development of services and supports to improve processes and outcomes.

Behavioral Health for Military Service Members and Veterans

Recipients are encouraged to address the behavioral health needs of active-duty military service members, national guard and reserve service members, veterans, and military families in designing and implementing their programs. Where appropriate, consider prioritizing this population for services.

Behavioral Health for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex (LGBTQI+) Individuals

In line with the Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals and the behavioral health disparities that the LGBTQI+ population faces, all recipients are encouraged to address the behavioral health needs of this population in designing and implementing their programs.

Behavioral Health Crisis and Suicide Prevention

Recipients are encouraged to develop policies and procedures that identify individuals at risk of suicide/crisis; and utilize or promote SAMHSA national resources, such as the 988 Suicide & Crisis Lifeline, the SAMHSA Helpline/Treatment Locator, and FindSupport.gov.

8. RECIPIENT MEETINGS

SAMHSA will hold virtual recipient meetings and expects you to fully participate in these meetings.

II. FEDERAL AWARD INFORMATION

1. GENERAL INFORMATION

Funding Mechanism:	Cooperative Agreement
Estimated Total Available Funding:	$5,700,000
Estimated Number of Awards:	Up to 8 (At least 1 award will be made to American Indian/Alaska Native (AI/AN) tribes or tribal organizations pending sufficient application volume.)
Estimated Award Amount:	$700,000 per year, inclusive of indirect costs
Length of Project Period:	Up to 5 years
Anticipated Start Date	September 30, 2024

Your annual budget cannot be more than $700,000 in total costs (direct and indirect) in any year of the project. Annual continuation awards will depend on the availability of funds, progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

2. COOPERATIVE AGREEMENT REQUIREMENTS

These awards are being made as cooperative agreements because they require substantial post-award federal programmatic participation in the oversight of the project. Under this cooperative agreement, the roles and responsibilities of recipients and SAMHSA staff are:

Role of Recipient:

The Recipient must:
1) Comply with terms and conditions of the cooperative agreement award, and
2) Collaborate with SAMHSA staff in project implementation and monitoring.

In addition, the recipient must:
1) Comply with the terms of the MAI: SUD Prevention and Treatment Pilot Program, including implementation of all required activities.
2) Provide SAMHSA with all required performance data.
3) Submit all required forms, data, and reports on a quarterly basis.
4) Participate in monthly/bi-monthly/quarterly conference calls with the GPO.
5) Review progress toward meeting goals and objectives of the program. If program shows persistent and substandard performance, the Project Director will work with the GPO to develop a Collaborative Action Plan (CAP). By developing a CAP, the recipient communicates to the GPO an awareness of substandard performance, an intent to improve, and a process for improving.

Role of SAMHSA Staff:

The GPO handles programmatic monitoring, including as-needed check-ins with the Grants Management Specialist (GMS), and site visits. The GPO will work with you on implementing program and evaluation activities and will make recommendations about program continuance. Your GPO will also oversee the publication of any project results and packaging and dissemination of products and materials to make the findings available to the field. SAMHSA staff will**:**

1) Conduct monthly/bi-monthly/quarterly conference calls with recipient to provide guidance and make recommendations for technical assistance.
2) Maintain regular communication with recipients throughout program implementation during routine conference calls.
3) Review and approve all key personnel.
4) Review and approve performance data and progress reports.
5) Ongoing review of recipient progress toward meeting goals and objectives of the program, as well as other performance indicators. If recipient shows persistent and substandard performance, work with Project Director to develop a Collaborative Action Plan (CAP), which is a requirement for the recipient to develop and implement a plan to improve performance. If performance does not improve, the GPO may take further action.

6) If indicated, provide technical assistance with selection of evidence-based/culturally responsive and/or evidence-informed substance use and HIV interventions.
7) Direct the recipients to the Prevention Technology Transfer Center (PTTC) and Addiction Technology Transfer Center (ATTC) offices for technical assistance.
8) If indicated, oversee the development and implementation of a multi-site evaluation in partnership with evaluation contractors and recipients.

The GMS is responsible for all business management aspects of negotiation, award, and financial and administrative aspects of the cooperative agreement. The GMS uses information from site visits, reviews of expenditure and audit reports, and other appropriate means to ensure the project operates in compliance with all applicable federal laws, regulations, guidelines, and the terms and conditions of award.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are states and territories (Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), including the District of Columbia, political subdivisions of states, Indian tribes, or tribal organizations (as such terms are defined in section 5304 of title 25), health facilities, or programs operated by or in accordance with a contract or award with the Indian Health Service, or other public or private non-profit entities, including faith-based organizations.

All non-profit entities must provide documentation of their non-profit status in **Attachment 8** of your application.

A tribal organization is the recognized body of any AI/AN tribe; any legally established organization of AI/ANs controlled, sanctioned, or chartered by such governing body, or is democratically elected by the adult members of the Indian community to be served by such organization and includes the maximum participation of AI/ANs in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the award requirements.

An organization may submit more than one application; however, each application must focus on a different population of focus and/or a different geographic/catchment area(s).

For general information on eligibility for federal awards, see https://www.grants.gov/learn-grants/grant-eligibility.

2. COST SHARING AND MATCHING REQUIREMENTS

Cost sharing/match is not required in this program.

3. OTHER REQUIREMENTS

Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with an established record of service delivery and expertise will be able to provide the required services quickly and effectively. Applicants are encouraged to include appropriately credentialed organizations that provide services to underserved, diverse populations. All required activities must be provided by applicants directly, by subrecipients, or through referrals and linkages to partner agencies. In **Attachment 1**, applicants must submit evidence that three additional requirements related to the provision of services have been met.

The three requirements are:

1. A provider organization for direct client substance use prevention and substance use disorder treatment services appropriate to the award must be involved in the project. The provider must be the applicant organization. More than one provider organization may be involved, but this requirement must be met by the applicant organization.

2. Each substance use prevention and treatment provider organization (which must include the applicant, as well as any partners) must have a minimum of 2 consecutive years of experience immediately prior to the submission of their application providing relevant services to communities disproportionately affected by HIV/AIDS and HIV-related health disparities. Official documents must establish that the organization has provided relevant services for the last two years immediately prior to the submission of their application. This requirement must be met by the applicant organization.

3. Each mental health/substance use disorder prevention, treatment, or recovery support provider organization must be in compliance with all applicable local (city, county) and state licensing, accreditation, and certification requirements, as of the due date of the application.

The above requirements apply to all service provider organizations. If the state licensure requirements are not met by the organization, an individual's license cannot be used instead of the state requirement. Eligible tribes and tribal organization mental health/substance use disorder prevention, treatment, recovery support providers must be in compliance with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application. In Attachment 1, you must include a statement certifying that the service provider organizations meet these requirements.

Following the review of your application, if the score is in the fundable range, the GPO may request that you submit additional documentation or verify that the documentation

submitted is complete. **If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.**

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

The application forms package can be found at Grants.gov Workspace or eRA ASSIST. Due to potential difficulties with internet access, SAMHSA understands that applicants may need to request paper copies of materials, including forms and required documents. See *Section A of the Application Guide* for more information on obtaining an application package.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

REQUIRED APPLICATION COMPONENTS:

You must submit the standard and supporting documents outlined below and in *Section A of the Application Guide (Required Application Components).* All files uploaded must be in Adobe PDF file format. See *Section B of the Application Guide* for formatting and validation requirements.

SAMHSA will not accept paper applications except under special circumstances. If you need special consideration, the waiver of this requirement must be approved in advance. See *Section A - 3.2 of the Application Guide (Waiver of Electronic Submission)*.

- **SF-424** – Fill out all Sections of the SF-424.
  - In **Line 4** (Applicant Identifier), enter the eRA Commons Username of the PD/PI.
  - In **Line 8f**, enter the name and contact information of the Project Director identified in the budget and in Line 4 (eRA Commons Username).
  - In **Line 17** (Proposed Project Date), enter: a. Start Date: 9/30/2024; b. End Date: 9/29/2029.
  - **In Line 18** (Estimated Funding), enter the amount requested or to be contributed for the first budget/funding period only by each contributor.
  - **Line 21** is the authorized official and should not be the same individual as the Project Director in Line 8f.

    It is recommended new applicants review the sample of a completed SF-424.

- **SF-424A BUDGET INFORMATION FORM –** Fill out all Sections of the SF-424A using the instructions below. **The totals in Sections A, B, and D must match.**

  - **Section A –** Budget Summary: If cost sharing/match is **not required,** use the first row only (Line 1) to report the total federal funds (e) and non-federal

funds (f) requested for the **first year** of your project only. If cost sharing/match **is required,** use the **second row** (Line 2) to report the total non-federal funds (f) for the **first year** of your project only.

- **Section B –** Budget Categories: If cost sharing/match is **not required**, use the first column only (Column 1) to report the budget category breakouts (Lines 6a through 6h) and indirect charges (Line 6j) for the total funding requested for the **first year** of your project only. If cost sharing/match is required, use the second column (Column 2) to report the budget category breakouts for the **first year** of your project only.

- **Section C –** If cost sharing/match is **not required** leave this section blank. If cost sharing/match **is required** use the second row (line 9) to report non-federal match for the **first year** only.

- **Section D –** Forecasted Cash Needs: Enter the total funds requested, broken down by quarter, only for **Year 1** of the project period. Use the first row for federal funds and the second row (Line 14) for **non-federal** funds.

- **Section E –** Budget Estimates of Federal Funds Needed for the Balance of the Project: Enter the total funds requested for the out years (e.g., Year 2, Year 3, Year 4, and Year 5). For example, if funds are being requested for five years total, enter the requested budget amount for each budget period in columns b, c, d, and e (i.e., four out years). — (b) First column is the budget for the second budget period; (c) Second column is the budget for the third budget period; (d) Third column is the budget for the fourth budget period; (e) Fourth column is the budget for the fifth budget period. Use Line 16 for federal funds and Line 17 for non-federal funds.

See *Section B of the Application Guide* to review common errors in completing the SF-424 and the SF-424A. These errors will prevent your application from being successfully submitted.

See instructions on completing the SF-424A form at Sample SF-424A (No Match Required).

It is highly recommended you use the Budget Template on the SAMHSA website.

- **PROJECT NARRATIVE – (Maximum 10 pages total)**
  The Project Narrative describes your project. It consists of Sections A through E. (Remember that if your Project Narrative starts on page 5 and ends on page 15, it is 11 pages long, not 10 pages.) Instructions for completing each section of the Project Narrative are provided in Section V.1 – Application Review Information.

- **BUDGET JUSTIFICATION AND NARRATIVE**
  You must submit the budget justification and narrative as a file entitled "BNF" (Budget Narrative Form). (*See Section A – 2.2 of the Application Guide - Required Application Components*.)

- **ATTACHMENTS 1 THROUGH 11**

  Except for Attachment 4 (Project Timeline), do not include any attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider these attachments.

  To upload the attachments, use the:
    - Other Attachment Form if applying with Grants.gov Workspace.
    - Other Narrative Attachments if applying with eRA ASSIST.

  - ***Attachment 1: Letters of Commitment/Service Providers/Evidence of Experience and Credentials***
    1. Identification of at least one experienced, credentialed substance use prevention and treatment provider organization.
    2. A list of all direct service provider organizations that will partner in the project, including the applicant agency, and the direct services each organization will provide.
    3. Letters of Commitment from these direct service provider organizations; **(Do not include any letters of support. Reviewers will not consider them.** A letter of support describes general support of the project, while a Letter of Commitment outlines the specific contributions an organization will make in the project.)
    4. Statement of Certification — You must provide a written statement certifying that all partnering service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements.
    5. Documentation of community-based organization involvement as either:
       - Primary applicant: A statement of certification that the primary applicant is a community-based organization; or
       - Sub-recipient or partner organization: A Memorandum of Understanding (MOU) from a community-based organization that will either be a sub-recipient or partner to the primary applicant. If an MOU cannot be completed by the application deadline, a Letter of Commitment (LOC) will be sufficient for the purposes of this application. If a LOC is submitted and funding is received, an MOU with the community-based organization must be finalized prior to the start of project activities.

       Failure to provide a statement of certification that the primary applicant is a community-based organization or an MOU/LOC from a community-based organization as a subrecipient or partner will

result in the application being screened out and not considered for review.

6. Documentation indicating the following service(s) will be offered in-house or by referral and linkage: (a) HIV treatment and care; (b) referrals and linkages to follow-up care and treatment for individuals with viral hepatitis (B and C); and (c) referrals and linkages for PrEP.
    a. In-House Implementation: If the organization will offer HIV treatment services, viral hepatitis care and treatment services (B and C), and/or PrEP in-house, provide the following information: Describe your plan to implement the above treatment service(s) in-house with resources from your organization and/or any other funding source already in place. The funding source **must** be provided for each service you plan to offer in-house. Note: SAMHSA funds cannot be used to cover the costs of HIV treatment, viral hepatitis treatment, primary care services, and/or PrEP.
    b. Service(s) Provided by Referral and Linkage: If the organization will offer HIV treatment services, viral hepatitis care and treatment services (B and C), and/or PrEP by referral and linkage to partner organizations, provide the following information: Identify the partner organization that will provide the service(s) and include the MOA with that organization which formalizes this partnership. If a MOA cannot be completed by the application deadline, a Letter of Commitment (LOC) will be sufficient for the purposes of this application. If a LOC is submitted and funding is received, a MOA for all required providers must be finalized prior to the start of project activities. MOAs must include a data sharing agreement to allow for reporting individual-level data to meet the reporting requirements of this cooperative agreement in compliance with Health Insurance Portability and Accountability Act (HIPAA). **MOAs or LOCs are required for each referral partner providing one of the above required services.** Generic MOAs or LOCs will not be sufficient to fulfil this requirement; **MOAs or LOCs must explicitly detail the required service being provided and include details about the data-sharing agreement.**

       Note: Offering the required services using a combination of in-house and referral partnerships is acceptable as long as you provide the above required information in **Attachment 1**. **Failure to provide your in-house implementation documentation or LOCs/MOAs with HIV treatment, viral hepatitis B and C treatment and PrEP providers will result in your application being screened out and not considered for review.**

- ***Attachment 2: Data Collection Instruments/Interview Protocols***
  You do not need to include standardized data collection instruments/interview protocols in your application. If the data collection instrument(s) or interview

protocol(s) is/are not standardized, submit a copy. Provide a publicly available web link to the appropriate instrument/protocol.

- ***Attachment 3: Sample Consent Forms***
  Include, as appropriate, informed consent forms for:
  - service intervention;
  - exchange of information, such as for releasing or requesting confidential information.

- ***Attachment 4: Project Timeline***
  Reviewers will assess this attachment when scoring Section B of your Project Narrative. The timeline cannot be more than two pages. See instructions in Section V, B.3.

- ***Attachment 5: Biographical Sketches and Position Descriptions***
  See *Section F of the Application Guide - Position Descriptions* for information on completing position descriptions. Position descriptions should be no longer than one page each.

- ***Attachment 6: Letter to the State Point of Contact***
  Review information in Section IV.6 and see *Section I of the Application Guide (Intergovernmental Review)* for detailed information on E.O. 12372 requirements to determine if this applies.

- ***Attachment 7: Confidentiality and SAMHSA Participant Protection/ Human Subjects Guidelines***
  This **required** attachment is in response to *Section C of the Application Guide* and reviewers will assess the response.

- ***Attachment 8: Documentation of Non-profit Status***
  Proof of non-profit status must be submitted by private non-profit organizations. Any of the following is acceptable evidence of non-profit status:
  - A reference to the applicant organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations as described in section 501(c)(3) of the IRS Code.
  - A copy of a current and valid Internal Revenue Service tax exemption certificate.
  - A statement from a State taxing body, State Attorney General, or other appropriate state official certifying the applicant organization has non-profit status.
  - A certified copy of the applicant organization's certificate of incorporation or similar document that establishes non-profit status.
  - Any of the above proof for a state or national parent organization and a statement signed by the parent organization that the applicant organization is a local non-profit affiliate.

Note: The applicant organization must have received non-profit status by the time the application is submitted.

- ***Attachment 9: Documentation of Catchment Area***
All applicants **must** submit a list of counties in which your project will be implemented. If your project will be implemented in or include as a catchment area one or more of the 57 Ending the HIV Epidemic in the U.S. priority jurisdictions (see Appendix A), you must provide a written statement documenting that this is the case and list the EHE priority jurisdiction(s) in which your program will be implemented. **Applicants that submit information documenting that their project will be implemented in one of the EHE priority jurisdictions will receive 10 additional points in Section A of the Project Narrative. Applicants that do not submit this documentation will NOT receive the 10 additional points**, even if elsewhere in your application you include EHE jurisdictions**.**

- ***Attachment 10: Form SMA 170 – Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations.*** You must complete Form SMA 170 if your project is providing substance use prevention or treatment services.

- **Attachment 11: Contingency Management Statement of Certification**
If you plan to implement contingency management with MAI funds, you must provide a written statement certifying that you will comply with the conditions and training requirements for contingency management as outlined in **Appendix B** of this NOFO.

3. UNIQUE ENTITY IDENTIFIER AND SYSTEM FOR AWARD MANAGEMENT

Section A of the Application Guide has information about the three registration processes you must complete including obtaining a Unique Entity Identifier and registering with the System for Award Management (SAM). You must maintain an active SAM registration throughout the time your organization has an active federal award or an application under consideration by an agency. This does not apply if you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110.

4. APPLICATION SUBMISSION REQUIREMENTS

Submit your application no later than 11:59 PM (Eastern Time) on **July 12, 2024**.

If you have been granted permission to submit a paper copy, the application must be received by the above date and time. Refer to *Section A of the Application Guide* for information on how to apply.

All applicants MUST be registered with NIH's eRA Commons, Grants.gov, and the System for Award Management (**SAM.gov**) **in order to submit this application.**

The process could take up to six weeks**.** (See *[Section A](#)* *of the Application Guide* for all registration requirements).

If an applicant is not currently registered with the eRA Commons, Grants.gov, and/or SAM.gov, the registration process MUST be started immediately. If an applicant is already registered in these systems, confirm the SAM registration is still active and the Grants.gov and eRA Commons accounts can be accessed.

WARNING: BY THE DEADLINE FOR THIS NOFO THE FOLLOWING TASKS MUST BE COMPLETED TO SUBMIT AN APPLICATION:

- **The applicant organization MUST be registered in NIH's eRA Commons;**

  AND

- **The Project Director MUST have an active eRA Commons account (with the PI role) affiliated with the organization in eRA Commons.**

No exceptions will be made.

DO NOT WAIT UNTIL THE LAST MINUTE TO SUBMIT THE APPLICATION. Waiting until the last minute, may result in the application not being received without errors by the deadline.

5. FUNDING LIMITATIONS/RESTRICTIONS

The funding restrictions for this project must be identified in your budget for the following:

- Food can be included as a necessary expense[20] for individuals receiving SAMHSA funded mental and/or substance use disorder treatment services not to exceed $10.00 per person per day.
- Recovery housing is an allowable cost. Funds may not be used to pay for non-recovery housing, housing application fees, or housing security deposits.
- Grant funds **may not** be used to purchase medications for the treatment of HIV; viral hepatitis treatment; Mpox testing, vaccination, or treatment; STI treatment; PrEP or PEP.
- Grant funds **may not** be used for the purchase of pipes/pipettes or syringes or needles for the prevention and control of infectious diseases or other drug

[20] Appropriated funds can be used for an expenditure that bears a logical relationship to the specific program, makes a direct contribution, and be reasonably necessary to accomplish specific program outcomes established in the grant award or cooperative agreement. The expenditure cannot be justified merely because of some social purpose and must be more than merely desirable or even important. The expenditure must neither be prohibited by law nor provided for through other appropriated funding.

paraphernalia. However, certain other supplies related to harm reduction are allowable expenses, including:

- Medication lock boxes;
- Sharps disposal and medication disposal kits;
- Substance test kits, including test strips for xylazine, fentanyl and other synthetic drugs; and
- Wound care management supplies.

- Funds **may not** be used to make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services (See 42 U.S.C. § 1320a-7b).

  Note: A recipient or treatment or prevention provider may provide up to $30 noncash incentive to individuals to participate in required data collection follow-up. This amount may be paid for participation in each required follow-up interview. For programs including contingency management as a component of the treatment program, clients may not receive contingencies totaling more than $75, per budget period. The incentive amount may be subject to change.

Recipients must also comply with SAMHSA's Standards for Financial Management and Standard Funding Restrictions in *Section H of the Application Guide.*

6. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

All SAMHSA programs are covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (HHS) regulation at 45 CFR Part 100. Under this Order, states may design their own processes for reviewing and commenting on proposed federal assistance under covered programs. See the Application Guide, *Section I - Intergovernmental Review* for additional information on these requirements as well as requirements for the Public Health System Impact Statement (PHSIS).

7. OTHER SUBMISSION REQUIREMENTS

See *Section A of the Application Guide* for specific information about submitting the application.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes your plan for implementing the project. It includes the Evaluation Criteria in Sections A-E below. The application will be reviewed and scored according to your response to the evaluation criteria.

In developing the Project Narrative, use these instructions:

- The Project Narrative (Sections A - E) may be no longer than **10 pages**.
- You must use the five sections/headings listed below in developing your Project Narrative.
- **Before the response to each criterion, you must indicate the section letter and number (i.e., "A.1," "A.2," etc.).** You do not need to type the full criterion in each section.
- Do not combine two or more criteria or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.1. **Reviewers will only consider information included in the appropriate numbered criterion.**
- Your application will be scored based on how well you address the criteria in each section.
- The number of points after each heading is the maximum number of points a review committee may assign to that section. Although scoring weights are not assigned to individual criterion, each criterion is assessed in determining the overall section score.
- Any cost-sharing in your application will not be a factor in the evaluation of your response to the Evaluation Criteria.

SECTION A: Population of Focus and Statement of Need (up to 20 points – approximately 1 page)
NOTE: Ten (10) additional points will be given in this section for those organizations serving clients in the EHE Priority Jurisdiction (See Appendix A) provided that documentation has been submitted in Attachment 9. Therefore, applicants serving clients in the EHE priority jurisdictions can receive a maximum of 20 points. All other applicants can only obtain a maximum of 10 points for this section.

1. Identify and describe your population(s) of focus and the geographic catchment area where you will deliver services that align with the intended population of focus. Provide a demographic profile of the population of focus to include the following: race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status.
2. Describe the extent of the problem in the catchment area, including service gaps and disparities experienced by underserved and historically under-resourced populations. Document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus identified in A.1. Identify the source

of the data (for example, the National Survey on Drug Use and Health (NSDUH), County Health Rankings, Social Vulnerability Index, etc.).

SECTION B: Proposed Implementation Approach (30 points – approximately 5 pages, not including Attachment 4 – Project Timeline)

1. Describe the goals and measurable objectives of your project and align them with the Statement of Need described in A.2. (See the Application Guide, *Section D - Developing Goals and Measurable Objectives*) for information of how to write SMART objectives – Specific, Measurable, Achievable, Relevant, and Time-bound). Provide the following table:

Number of Unduplicated Individuals to be Served with Award Funds					
Year 1	Year 2	Year 3	Year 4	Year 5	Total

2. Describe how you will implement all Required Activities in Section I. If funds will be used for capacity-building, describe how those funds will be used.

3. In **Attachment 4**, provide no more than a two-page chart or graph depicting a realistic timeline for the entire five years of the project period showing dates, key activities, and responsible staff. The key activities must include the required activities outlined in Section I [**NOTE**: Be sure to show that the project can be implemented, and service delivery can begin as soon as possible and no later than four months after the award. **The timeline does not count towards the page limit for the Program Narrative.]**

SECTION C: Proposed Evidence-based, Adapted, or Community defined Evidence Service/Practices (25 points — approximately 2 pages)

1. Identify the EBPs, culturally adapted practices, or CDEPs that you will use. Discuss how each intervention chosen is appropriate for your population(s) of focus and the intended outcomes you will achieve. Describe any modifications (e.g., cultural) you will make to the EBP(s)/CDEP(s) and the reasons the modifications are necessary. If you are not proposing to make any modifications, indicate so in your response.

2. Describe the monitoring process you will use to ensure the fidelity of the EBPs/CDEP(s), evidence-informed and/or promising practices that will be implemented. (See information on fidelity monitoring in Section I.5.)

SECTION D: Staff and Organizational Experience (15 points – approximately 1 page)

1. Demonstrate the experience of your organization with similar projects and/or providing services to the population(s) of focus, including underserved and historically under-resourced populations.

2. Identify other organization(s) that you will partner with in the project. Describe their experience providing services to the population(s) of focus and their specific roles and responsibilities for this project. Describe the diversity of partnerships. If applicable, include Letters of Commitment from each partner in **Attachment 1.** If you are not partnering with any other organization(s), indicate so in your response.

3. Provide a complete list of staff positions for the project, including the Key Personnel (Project Director, Program Coordinator, Lead Prevention Navigator, and Program Evaluator) and other significant personnel. For each staff member describe their:
   - Role;
   - Level of Effort (stated as a percentage of full-time employment, such as 1.0 (full-time) or 0.5 (half-time) and not number of hours); and
   - Qualifications, including their experience providing services to the population of focus, familiarity with the culture(s) and language(s) of this population, and working with underserved and historically under-resourced populations.

SECTION E: Data Collection and Performance Measurement (10 points – approximately 1 page)

1. Describe how you will collect the required data for this program and how such data will be used to manage, monitor, and enhance the program (see the *Application Guide, Section E – Developing the Plan for Data Collection and Performance Measurement*).

2. BUDGET JUSTIFICATION, EXISTING RESOURCES, OTHER SUPPORT (Other federal and non-federal sources)

You must provide a narrative justification of the items included in your budget. In addition, if applicable, you must provide a description of existing resources and other support you expect to receive for the project as a result of cost matching. Other support is defined as funds or resources, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions, or non-federal means. (This should correspond to Item #18 on your SF-424, Estimated Funding.) Other sources of funds may be used for unallowable costs (e.g., sporting events, entertainment).

See the *Application Guide, Section K – Budget and Justification* for information on the SAMHSA Budget Template. **It is highly recommended that you use the template.** Your budget must reflect the funding limitations/restrictions noted in Section IV-5. **Identify the items associated with these costs in your budget.**

3. REVIEW AND SELECTION PROCESS

Applications are peer-reviewed according to the evaluation criteria listed above.

Award decisions are based on the strengths and weaknesses of your application as identified by peer reviewers. Note the peer review results are advisory and there are other factors SAMHSA might consider when making awards.

The program office and approving official make the final decision for funding based on the following:

- Approval by the Center for Substance Abuse Treatment National Advisory Council (NAC), when the individual award is over $250,000.

- Availability of funds.

- At least 1 award will be made to American Indian/Alaska Native (AI/AN) tribes or tribal organizations pending sufficient application volume.

    - American Indian and Alaska Native tribes or tribal organizations should self-identify in their SF-424 (#9) to be considered for this set-aside. American Indian and Alaska Native tribes or tribal organizations that do not self-identify in the SF-424 will NOT be considered for this set-aside even if your organization would otherwise be eligible.

- An organization may submit more than one application; however, each application must focus on a different population of focus and/or a different geographic/catchment area(s).

- Ten (10) points will be given to applicants implementing services in the Ending the HIV Epidemic in the U.S. (EHE) priority jurisdictions.

- Submission of any required documentation that must be received prior to making an award.

- SAMHSA is required to review and consider any Responsibility/Qualification (R/Q) information about your organization in SAM.gov. In accordance with 45 CFR 75.212, SAMHSA reserves the right not to make an award to an entity if that entity does not meet the minimum qualification standards as described in section 75.205(a)(2). You may include in your proposal any comments on any information entered into the R/Q section in SAM.gov about your organization that a federal awarding agency previously entered. SAMHSA will consider your comments, in addition to other information in R/Q, in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

VI. FEDERAL AWARD ADMINISTRATION INFORMATION

1. FEDERAL AWARD NOTICES

You will receive an email from eRA Commons that will describe how you can access the results of the review of your application, including the score that your application received.

If your application is approved for funding, a Notice of Award (NoA) will be emailed to the following: 1) the Signing Official identified on page 3 of the SF-424 (Authorized Representative section); and 2) the Project Director identified on page 1 of the SF-424 (8f). The NoA is the sole obligating document that allows recipients to receive federal funding for the project.

If your application is not funded, an email will be sent from eRA Commons.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

If your application is funded, you must comply with all terms and conditions of the NoA. See information on standard terms and conditions. See the Application Guide, *Section J - Administrative and National Policy Requirements* for specific information about these requirements. You must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS 690). To learn more, see the HHS Office for Civil Rights website.

In addition, if you receive an award, HHS may terminate it if any of the conditions in CFR § 200.340 (a)(1)-(4) are met. No other termination conditions apply.

3. REPORTING REQUIREMENTS

Recipients are required to submit annual Programmatic Progress Reports within 30 days of the end of the reporting period.

The report must discuss:
(Prevention and Treatment programming activities must be addressed separately)

- Updates on key personnel, budget, or project changes (as applicable)
- Progress achieving goals and objectives and implementing evaluation activities
- Progress implementing required activities, including accomplishments, challenges and barriers, and adjustments made to address these challenges
- Problems encountered serving the populations of focus and efforts to overcome them
- Progress and efforts made to achieve the goal(s) of the DIS, including qualitative and quantitative data and any updates, changes, or adjustments as part of a quality improvement plan.

You must submit a final performance report within 120 days after the end of the project period. This report must be cumulative and include all activities during the entire project period.

Management of Award:

Recipients must also comply with standard award management reporting requirements, unless otherwise noted in the NOFO or NoA.

Funds from each SAMHSA Center must be tracked separately in the recipient account system identifying funds used for different purposes under the specific funding streams. Applicants must include the amount expended for each funding stream in block 12 of the Federal Financial Report (FFR).

VII. AGENCY CONTACTS

For program and eligibility questions, contact:

MAI Programmatic Team
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
MAI-Braided@samhsa.hhs.gov

For fiscal/budget questions, contact:

Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
(240) 276-1940
FOACSAT@samhsa.hhs.gov

For review process and application status questions, contact:

Tiffany Gray
Office of Financial Resources, Division of Grant Review
Substance Abuse and Mental Health Services Administration
(240) 276-0541
Tiffany.Gray@samhsa.hhs.gov

Appendix A – Ending the HIV Epidemic in the U.S. Priority Jurisdictions[21]

(48 Counties; San Juan, Puerto Rico; Washington, D.C.; Seven States)

Counties: **Arizona** Maricopa County **California** Alameda County Los Angeles County Orange County Riverside County Sacramento County San Bernardino County San Diego County San Francisco County **Florida** Broward County Duval County Hillsborough County Miami-Dade County Orange County Palm Beach County Pinellas County **Georgia** Cobb County DeKalb County Fulton County Gwinnett County **Illinois** Cook County **Indiana** Marion County	**Louisiana** East Baton Rouge Parish Orleans Parish **Maryland** Baltimore City Montgomery County Prince George's County **Massachusetts** Suffolk County **Michigan** Wayne County **Nevada** Clark County **New Jersey** Essex County Hudson County **New York** Bronx County Kings County New York County Queens County **North Carolina** Mecklenburg County **Ohio** Cuyahoga County Franklin County Hamilton County	**Pennsylvania** Philadelphia County **Tennessee** Shelby County **Texas** Bexar County Dallas County Harris County Tarrant County Travis County **Washington** King County **Washington, D.C.** **Territories:** Puerto Rico San Juan Municipio **States** Alabama Arkansas Kentucky Mississippi Missouri Oklahoma South Carolina

[21] EHE Priority Jurisdictions | HIV.gov

Appendix B – Contingency Management

To mitigate the risk of fraud and abuse, while also promoting evidence-based practice, recipients who plan to implement contingency management (CM) interventions as part of their SAMHSA grant award will be required to comply with the following conditions:

1. The type of CM model chosen will be consistent with the needs of the population of focus.

2. To ensure fidelity to evidence-based practice, staff who will implement, administer, and supervise CM interventions are required to undergo CM-specific training prior to implementing CM. Training should be delivered by an advanced degree holder who is experienced in the implementation of evidence-based contingency management activities. Training should be easily accessible, and it can be delivered live or through pre-recorded training sessions. When participants receive training through pre-recorded sessions, they should have an opportunity to pose questions and to receive responses in a timely manner.

   Education must include the following elements:

   - The core principals of contingency management;
   - Target behavior;
   - The population of focus;
   - Type of reinforcer (incentive);
     Magnitude (or amount) of reinforcer;
   - Frequency of reinforcement distribution;
   - Timing of reinforcement distribution;
   - Duration reinforcement(s) used;
   - How to describe contingency management to eligible and ineligible patients;
   - Evidence-based models of contingency management and protocols to ensure continued adherence to evidence-based principles;
   - The importance of evidence-based practice on patient outcomes;
   - Testing methods and protocols for target substance use disorders and/or behaviors;
   - Allowable incentives, appropriate selection of incentives, storage of incentives, the distribution of incentives, and immediacy of awards;
   - Integration of contingency management into comprehensive clinical activities and program design (contingency management should be integrated into services, counseling and treatment activities that provide ongoing support to the clients);
   - Documentation standards;
   - Roles and responsibilities, including the role of the supervisor, decision maker, and direct care staff; and
   - Techniques for supervisors to provide on-going oversight and coaching.

Within **90 days of grant award**, you must submit your plan to ensure: (1) primary grant recipient staff and sub-awardee(s), if applicable, receive appropriate education on contingency management prior to implementation; and (2) oversight of contingency management implementation and operation for primary grant recipient staff and sub-awardee(s), if applicable.

The CM Incentive is offered or furnished pursuant to an evidence-based CM intervention.

3. The recipient's organization must maintain written documentation in the patient's medical record that includes:

I. The type of CM model and incentives offered that are recommended by the client's licensed health care professional;

II. A description of the CM Incentive furnished;

III. An explanation of the health outcome or target behavior achieved; and

IV. A tally of incentive values received by the patient to confirm that per incentive and total incentive caps are observed.

4. Receipt of the CM Incentive is contingent upon achievement of a specified target behavior, consistent with the beneficiary's treatment plan that has been verified with objective evidence.

5. The CM Incentive is recommended by the client's treating clinician, who is licensed under applicable state law.

6. The CM Incentive is not cash, but may be tangible items, vouchers, or payment of bills that are of equivalent value to the individual's total or accrued incentive earnings. Incentives must be consistent with recovery and should not allow purchase of weapons, intoxicants, tobacco, or pornography. Furthermore, incentives should not allow purchase of lottery tickets or promote gambling.

7. No person markets the availability of a CM Incentive to induce a patient to receive federally reimbursable items or services or to receive such items and services from a particular provider or supplier.