Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Access to Recovery (Short Title: ATR)

(Initial Announcement)

Request for Applications (RFA) No. TI-07-005

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.275

Key Dates:

Application Deadline	**Applications are due by June 7, 2007.**

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I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of fiscal year (FY) 2007 funds for Access to Recovery (ATR) grants. The ATR grants provide funding to States, Tribes, and Tribal organizations to carry-out voucher programs for substance abuse clinical treatment and recovery support services pursuant to sections 501(d)(5) and 509 of the Public Health Service Act (42 U.S.C. sections 290aa(d)(5) and 290bb-2). This program addresses Healthy People 2010 focus area 26 (Substance Abuse).

The Access to Recovery (ATR) Program is part of a Presidential initiative to provide client choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. Monitoring outcomes, tracking costs, and preventing waste, fraud and abuse to ensure accountability and effectiveness in the use of Federal funds are also important elements of the ATR program. Through the ATR grants, States, Territories, the District of Columbia, Tribes, and Tribal Organizations (hereinafter collectively referred to as "States") will have flexibility in designing and implementing voucher programs, consistent with proven models, to meet the needs of clients in the State. The key to successful implementation of the voucher programs supported by the ATR grants will be the relationship between the States and clients receiving services, to ensure that clients have a genuine, free, and independent choice among eligible providers. States are encouraged to support a mixture of clinical treatment and recovery support services that can be expected to achieve the program's goal of achieving cost-effective, successful outcomes for the largest number of people. Current ATR grantees as well as entities meeting the eligibility criteria that have not received an ATR grant may apply. See Section III-Eligibility Information for additional information about eligibility for the ATR program.

There is a growing awareness of the devastating impact of methamphetamine use on communities. Methamphetamine is a highly addictive stimulant that can have serious effects on a user's physical, mental, and social well-being. SAMHSA/CSAT is committed to reducing methamphetamine use and is working toward a target of $25 million per year within the ATR program to address this problem. Accordingly, States are encouraged to include vouchers for methamphetamine-related treatment and recovery support services within their proposed ATR projects.

2. EXPECTATIONS

ATR grantees will be expected to use their ATR grant funds to facilitate individual choice and promote multiple pathways to recovery through the development and implementation of substance abuse treatment and recovery support service voucher systems.

States should propose innovative strategies for their ATR projects to accomplish the following:

- Ensure genuine, free, and independent client choice for substance abuse clinical treatment and recovery support services appropriate to the level of care needed by the client. For the purposes of this grant program, choice is defined as a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection.

- Provide all substance abuse assessment, clinical treatment, and recovery support services funded through the ATR grant through vouchers given to a client by a State/Territory/Tribe or its designee. No funding shall be given directly to a provider through a grant or contract to provide any services under this program, including assessment.[1]

- Ensure each client receives an assessment for the appropriate level of services and is then provided a genuine, free, and independent choice among eligible providers, among them at least one provider to which the client has no religious objection.

- Allow eligible clients to pay for assessment and other clinical treatment and recovery support services from a broad network of eligible providers, including organizations that have not previously received public funding. Eligible service providers for the voucher program may include the following: public and private, nonprofit, proprietary, as well as faith-based and community organizations, as approved through established procedures by the State/Territory/Tribe.

- Ensure that faith-based organizations otherwise eligible to participate in this program are not discriminated against on the basis of their religious character or affiliation.

- Maintain accountability by creating an incentive system for positive outcomes and taking active steps to prevent waste, fraud and abuse.

- Expand clinical treatment and recovery support services by leveraging use of all Federal funds, preventing cost shifting, and ensuring that these funds are used to supplement and not supplant current funding for substance abuse clinical treatment and recovery support services in the State. [Note: States must include a letter in Appendix 4 of the application certifying that they will not use ATR funds to supplant current funding if they receive an award.]

In developing applications for the ATR program, applicants must establish a three year numbers served goal for the program and identify key milestones over the three year grant project that will result in achievement of the three year goal. Applicants should be aware that SAMHSA is seeking

[1] Indirect funding means that individual, private choice, rather than the Government, determines which substance abuse service provider eventually receives the funds. With indirect funding, the individual in need of the service is given a voucher, coupon, certificate, or other means of free agency, such that he or she has the power to select for himself or herself from among eligible substance abuse service providers, whereupon the voucher (or other method of payment) may be "redeemed" for the service rendered. Under "direct" funding, the Government or an intermediate organization with the same duties as a governmental entity purchases the needed services directly from the substance abuse service provider. Under this scenario, there are no intervening steps in which the client's choice comes into play. The government or intermediate organization selects the provider from which the client will receive services.

to serve 135,000 people over the three years of the ATR program (25,000 in year 1; 55,000 in year 2; and 55,000 in year 3). Grantees will be held accountable for meeting the milestones they have identified in their applications and contributing to the overall target for the ATR program. If a grantee fails to meet a milestone, future funding may be delayed until the grantee provides evidence that the milestone has been met.

SAMHSA is especially interested in ensuring that the voucher systems supported through the ATR projects include the most cost effective mix of clinical treatment and recovery support services necessary to achieve intended outcomes. Applicants must include both types of services in their proposed projects and are encouraged to devote substantial funds to recovery support services. Within the 2004 cohort of ATR grantees, 49% of funds spent on vouchers were allocated to recovery support services. SAMHSA encourages ATR grantees to continue strong support for recovery support services. In many cases, it will be desirable to provide various components of the service continuum simultaneously, with the emphasis changing throughout the clinical treatment and recovery process. For example, in the earlier, acute phase of clinical treatment, heavier emphasis may be placed on clinical treatment services; the emphasis may switch toward recovery support as individuals move through rehabilitation and enter a maintenance phase of clinical treatment and recovery. In some cases, depending on the results of the initial assessment, recovery support services alone will suffice.

SAMHSA is also interested in the use of voucher systems to support methamphetamine-related treatment and recovery support services and is working toward a target of $25 million per year within the ATR program for this purpose. Accordingly, States are encouraged to include vouchers for methamphetamine-related treatment and recovery support services within their proposed ATR projects. All applicants will be required to discuss the need for methamphetamine-related treatment and recovery support services in the target population/community and to indicate whether and how their proposed projects address the need for these services. Funded grantees will be required to report performance, progress and financial information for their projects as a whole as well as for their methamphetamine-related activities.

SAMHSA is interested in supporting a range of models to implement substance abuse voucher programs, including:

- Full implementation of the program through a designated lead State or sub-State agency.

- Implementation of the program through public/private partnerships (i.e., a contract between the State and a lead private entity to implement all or part of the program).

States may implement the program Statewide or may target geographic areas of greatest need, specific populations in need, or areas/populations with a high degree of readiness to implement a voucher program. States may propose alternate models for consideration, as long as they conform to the expectations articulated above.

States are encouraged to minimize the funds used to cover both the direct and indirect costs of administration of the program, to develop a system to manage the program on the basis of reasonable

costs, to develop a system to provide incentives to eligible providers with superior outcomes, and to include a broad range of stakeholders in planning and designing their proposal.

Appendix E of this announcement provides hypothetical examples of a program that conforms to these expectations. States may wish to consult this appendix as a starting point for developing their ATR Grant applications.

Due to the unique nature of this grant program, SAMHSA recognizes that applicants may wish to entertain an array of program and administrative options. To respond, SAMHSA will make available both pre-application and post-award technical assistance to applicants and current and future providers of substance abuse clinical treatment and recovery support services under this program. Examples of topics for which technical assistance may be provided include, but are not limited to:

- Developing and maintaining a voucher system.
- Eligibility determinations for clinical treatment and recovery support service providers and for which service in the continuum of recovery will be included in the voucher reimbursement system.
- Eligibility determinations for clients, including management of a system for assessment and service determinations.
- Identifying and determining eligibility of new clinical treatment and recovery support service providers.
- Fiscal/cost accounting mechanisms that can track voucher implementation.
- Management of information systems to track performance and outcomes.
- Development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support service providers.
- Oversight of standards and fraud and abuse.
- Outreach to grass-roots community- and faith-based organizations and other entities unknown to the State.
- Linkage to the criminal justice system including, but not limited to, State Departments of Corrections, probation, parole and jail authorities.
- Linkage to housing programs and initiatives including, but not limited to, those supported with funding from State and local governments and the U.S. Department of Housing and Urban Development.

2.1 Data and Performance Measurement

The Government Performance and Results Act of 1993 (P.L.103-62, or "GPRA") requires all Federal agencies to set program performance targets and report annually on the degree to which the previous year's targets were met. Agencies are expected to evaluate their programs regularly and to use results of these evaluations to explain their successes and failures and justify requests for funding. SAMHSA has established the performance targets for the ATR program. (See Appendix M of this RFA.) The 2008-2010 targets are estimates based on past grantee performance. These targets will be reviewed, and may be revised, based on information provided in funded grantees' applications. Grantees will be expected to contribute to achievement of these targets.

To meet the GPRA requirements, SAMHSA must collect performance data from grantees. ATR Grantees will be required to submit the performance data described below to SAMHSA. Grantees must submit these data for the program as a whole, as well as for the relevant methamphetamine-related components of the program (e.g., the total number of people served and the number of people receiving methamphetamine-related services; the total number of vouchers issued and the number of vouchers issued for methamphetamine-related services). For the ATR program, SAMHSA will assess program performance through accountability measures as well as through outcome measures. GPRA data must be collected in a face-to-face interview at baseline (i.e., the client's entry into the project), six months post baseline and at discharge (or exit from ATR services). Grantees are also expected to submit voucher and transaction data via the tool provided. Grantees will be required to obtain a minimum 80% six-month follow-up rate. GPRA data must be entered into the GPRA Data Entry and Reporting System (www.samhsa-gpra.samhsa.gov) within 7 business days of the interview forms (intake and discharge) or transaction forms being completed. Grantees are expected to take action necessary to ensure data are valid and reliable, and are submitted in a timely manner. Data reporting is required to commence upon admission of the first client.

Accountability Measures

SAMHSA will assess grantee performance using the following accountability measures:[2]

- Target number of clients to be served
- Number of vouchers issued and redeemed
- Number of eligible clinical treatment providers – total number of providers, providers identified as grass-roots providers, providers identified as faith-based and providers identified as secular
- Number of eligible recovery support service providers – total number of providers, providers identified as grass-roots providers, providers identified as faith-based and providers identified as secular
- Clinical treatment services – total clients served, clients served by grass-roots organizations, clients served by faith-based organizations and clients served by secular organizations
- Recovery support services – total clients served, clients served by grass-roots organizations, clients served by faith-based organizations and clients served by secular organizations
- Combined services – total clients served, clients served by grass-roots organizations, clients served by faith-based organizations, and clients served by secular organizations
- Grant draw down
- Expenditures for clinical treatment services – total expenditures, clients served by grass-roots organizations, expenditures for services provided by faith-based organizations, and expenditures for services provided by secular organizations
- Percentage of clients provided services directly referred from the criminal justice system including but not limited to prisons and jails.

[2] Several performance measures will be reported for all providers, grass-roots providers, providers identified as faith-based and providers identified as secular. Grantees will receive training on how to provide this information using the provider ID number included in the Voucher Information Tool and Voucher Transaction Tool. The categories of providers are not mutually exclusive. That is, grass-roots providers are all providers with an annual operating budget of $500,000 or less; they may be faith-based or secular. Faith-based and secular providers may have operating budgets that exceed $500,000 per year.

- Expenditures for recovery support services – total expenditures, expenditures for grass-roots organizations, expenditures for faith-based organizations, and expenditures for secular organizations
- Combined expenditures for clinical treatment and recovery support services – total expenditures, expenditures for grass-roots organizations, expenditures for faith-based organizations, and expenditures for secular organizations
- Administrative expenditures

Information should be provided on the type of service, date of service, and the days, partial days, or hour(s) of service provided. Each State should submit data on reimbursement rate per service (clinical treatment or recovery support service) per day, partial day, or hour(s) for the voucher program.

Outcome Measures

SAMHSA will assess outcomes for the ATR program through the National Outcome Measures (NOMs) for substance abuse treatment that SAMHSA has developed in partnership with the States. Grantees will be required to report performance in several areas relating to the client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment and criminal justice status. Grantees must collect and report data using the Discretionary Services Client Level GPRA tool (Appendix I), which can be found at www.samhsa-gpra.samhsa.gov (click on 'Data Collection Tools/Instructions'), along with instructions for completing it. There are two other tools grantees are responsible to report to CSAT: the voucher information tool and a voucher transaction tool that are in Appendices J and K. Grantees use the voucher information tool to report the amount for which the voucher was issued, and the voucher transaction tool is used to report the amount for which a specific provider redeemed the voucher. These two tools are used primarily for tracking the status of each voucher that is issued to an ATR client. It is important to note that these two tools are not asked of the client. It is the responsibility of program staff to report this programmatic information. Grantees can retain responsibility for transmitting data submitted by providers to SAMHSA. However, grantees (States/Tribes) can choose to allow providers to directly enter the required data.

Outcome data must be collected at the time of entry to and at exit from an episode of care and six months post entry. (For the purposes of the ATR program, an episode of care means the period of time from entry to exit from a paid service, whether it be a clinical treatment service or a recovery support service.) In the case of brief interventions, only drug/alcohol use should be reported. In addition, rather than reporting on retention for brief interventions, grantees should report on completion. Please note that the substance use domain is framed in terms of rates of frequency of use; however, the primary outcome measure for this program is abstinence from substance use, and successful completion of an episode of care should be established by randomly collected samples that are free of these substances.

Outcome data will be collected by individual service providers and given to the grantees (i.e., States/Territories/Tribes). In a situation where a client is concurrently using multiple services, a single provider may be delegated the responsibility to collect data on client outcomes. Grantees (i.e.,

States/Territories/Tribes) will be responsible for transmitting the outcome data and other performance data to SAMHSA. Data will be submitted on an ongoing basis. As stated previously, grantees (States/Territories/Tribes) can retain responsibility for transmitting data submitted by providers to SAMHSA or they can choose to allow providers to enter the required data directly.

Applicants are strongly encouraged to review the required data collection forms in Appendices I, J and K of this grant announcement to determine what changes, if any, will be necessary to the data collection/management information systems within the State/Territory/Tribe, so that these changes can be factored into the proposed project. For example, it will be necessary for States to uniquely identify clients through the course of a clinical treatment/recovery support episode of care and provide basic demographic information. Client IDs should be client specific and should also allow for clients to be tracked though multiple episodes of care.

The terms and conditions of the ATR grant award will include these data collection requirements. Grantees will be required to adhere to these terms and conditions. Grantee ability to demonstrate improvement in the above domains will be a factor in determining funding levels in years after year 1 of the grant. Grantees must propose a plan for collecting 6-month post-exit data from a paid service on a sample basis by the third year of the grant.

Training and technical assistance on data collecting, tracking, and follow-up, as well as data entry, will be provided by CSAT.

2.2 Performance Assessment

Grantees must assess their projects, addressing the performance measures described in Section I-2.1 (above). The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

In addition to assessing progress against the performance measures required for this program, you may also want to consider outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of intervention on participants?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects?

Process Questions:

- How closely did implementation match the plan?
- What types of deviation from the plan occurred?
- What led to the deviations?

- What effect did the deviations have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

Applicants should be aware that SAMHSA will be conducting a cross-site evaluation of the ATR program. The evaluation will be designed to comply with OMB expectations regarding independence, scope, and quality. Grantees will be required to provide performance data to the evaluator as well as to SAMHSA. In addition, it is possible the evaluation design may necessitate changes in the required data elements and/or timing of data collection or reporting. Grantees will be required to comply with any changes in data collection requirements. SAMHSA will work in collaboration with the States in developing any changes in data collection requirements.

2.3 Grantee Meetings

Applicants must plan to send a minimum of three people (including the Project Director) to at least one joint grantee meeting in each year of the grant, and you must include funding for this travel in your budget. At these meetings, grantees will present the results of their projects and Federal staff will provide technical assistance. Each meeting will be 3 days. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

II. AWARD INFORMATION

1. AWARD AMOUNT

It is expected that up to $96 million will be available in fiscal year 2007 through Access to Recovery (ATR) to fund approximately 18 awards. Applicants may request up to, but no more than, $7,000,000 in total costs (direct and indirect) per year in any year of the grant project. Based on past experience, it is expected that grant awards will range from $1,000,000 to $7,000,000 per year. Grants will be awarded for a period of up to 3 years. The actual award amount in any one year will depend on the availability of funds. Awards may be adjusted based on the number of individuals proposed to be served per year and SAMHSA's ability to reach the $25 million target for methamphetamine-related treatment and recovery support services. Applicants should be aware that the amount to be awarded for continuation awards in year 3 is expected to be 95% of the amount available awarded for continuation awards in year 2. This is being done to create a pool of funds for supplemental performance based awards (described below). [Note: Applicants should not reduce their requested third year amounts relative to year 2; this adjustment will be made by SAMHSA at the time the year 3 continuation awards are negotiated.]

Proposed budgets cannot exceed $7,000,000 in any year of the proposed project.

Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and grant expenditures.

Supplemental Awards Based on Performance: Section VI-2, Administrative and National Policy Requirements, of this RFA discusses a grantee's proposed performance targets and explains that failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in the reduction or withholding of continuation awards. Conversely, an ATR grantee that exceeds its performance targets or demonstrates efficiencies may receive a supplemental award based on performance to maintain its high level of performance.

For year 3 of the ATR grant program, CSAT will review each grantee's Government Performance and Results Act (GPRA) data submissions and assess whether a grantee has: 1) met or exceeded its target for the number of clients served by 25 percent or more, 2) met or exceeded its target for 6-month follow-ups[3], and 3) provided services within approved cost-bands. Any grantee that has demonstrated appropriate financial management of the grant and has exceeded its targets for the number of clients served by 25 percent or more, exceeded its target for 6-month follow-ups, and provided services within allowable cost bands, may receive a supplemental award of up to 5 percent of the third year requested amount based on performance. Supplemental award amounts will be determined on a sliding scale based on availability of funds and the grantee's achievement of performance goals and demonstration of sound fiscal management. **Applicants should be aware that SAMHSA/CSAT does not plan to make supplemental awards to all grantees, and that it is possible that no grantees will receive supplemental awards based on performance.**

Eligible grantees will be asked to submit a narrative and budget justification for the supplemental award that maintains the increase in its targets during the final year of the project. The supplemental award based on performance is for the purpose of the grantee maintaining, at a minimum, the additional number of clients for the remainder the project.

A grantee receiving a supplemental award based on performance may be subject to additional site visits and/or audits to verify the accuracy of the client data reported.

2. FUNDING MECHANISM

Awards will be made as grants to States that, in turn, must distribute funds to clients through vouchers.

3. GRANTEE ADMINISTRATIVE COSTS

A list of services considered to be administrative costs is contained in Appendix B of this RFA. The direct and indirect costs of administration of the program are to include the management of information systems for tracking outcomes and costs, including the cost of data collection and reporting. These are to be held to as low a percentage of the total grant expenditures as possible. For new grantees, administrative costs are not to exceed 15% of the total grant expenditures over the three-year grant period. However, the percentage for the first year may exceed 15% to cover startup expenditures for such activities as establishing new voucher systems, provider networks, and State standards for recovery support services, as long as the 15% average is maintained over the life of the grant.

[3] The follow-up rate must be at least 80 percent of the number of clients actually served.

Current ATR grantees with established voucher and administrative systems are expected to demonstrate improved efficiencies over the course of the grant. Current ATR grantees proposing to continue services in the same geographic areas and/or populations, should set a target for administrative costs of 10% of the total grant expenditures annually. The percentage of administrative costs for current grantees that successfully compete for a new award will be negotiated between 10-15%, depending on the justification and rationale for exceeding the 10% target for administrative expenses. For example, administrative expenses may need to be greater than 10% for current grantees proposing to expand services in order to cover such startup costs as:

- Establishing a voucher system in new areas;
- Establishing an ATR provider network in areas where it does not now exist; and
- Establishing and implementing data collection and tracking systems in new areas.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligibility for ATR grants is limited to the immediate office of the Chief Executive (e.g., Governor) in the States, Territories, District of Columbia; or the highest ranking official and/or the duly authorized official of a federally recognized American Indian/Alaska Native Tribe or Tribal Organization. Tribal Organization means the recognized governing body of any American Indian/Alaska Native tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. **The Chief Executive of the State, Territory, or District of Columbia, or the highest ranking official and/or the duly authorized official of the Tribe/Tribal Organization must sign the application.**[4]

Eligibility is limited to these applicants because only they have the authority to coordinate funding across the State/Tribe, implement the necessary policy changes, manage the fiscal responsibilities, and coordinate the range of programs necessary for successful implementation of the voucher programs to be funded through these grants.

No more than one ATR application from any one Chief Executive or head of a Tribe/Tribal Organization will be funded.

Current ATR grantees are eligible to apply for an ATR grant in 2007.

[4] Following the initial award, the Governor may delegate responsibility of the ATR project, including signatory authority for continuation applications, to a State Agency or State official.

2. COST SHARING

Cost sharing is not required in this program. However, grantees must use these funds to supplement, and not supplant, current funding for substance abuse clinical treatment and recovery support services and maximize existing resources.

3. OTHER

3.1 Additional Eligibility Requirements

You must comply with the following requirements, or your application will be screened out and will not be reviewed: use of the PHS 5161-1 application; application submission requirements in Section IV-3 of this document; and formatting requirements provided in Appendix F of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

To ensure that you have met all submission requirements, a checklist is provided for your use in Appendix F of this document.

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

You also may download the required documents from the SAMHSA Web site at http://www.samhsa.gov/grants/apply.aspx.

Additional materials available on this Web site include:

- a technical assistance manual for potential applicants;
- standard terms and conditions for SAMHSA grants;
- guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation, and evaluation); and
- a list of certifications and assurances referenced in item 21 of the (SF) 424 v2.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page, budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not**

submitted on the required application form will be screened out and will not be reviewed.

- Request for Applications (RFA) – Provides specific information about the availability of funds along with instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA Web site (http://www.samhsa.gov/Grants/2007/fy2007.aspx) and a synopsis of the RFA is available on the Federal grants Web site (www.Grants.gov).

You must use all of the above documents in completing your application

2.2 Required Application Components

Applications must include the required ten application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Appendices, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page –** Use Standard Form (SF) 424 v2, which is part of the PHS 5161-1. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]

- **Abstract** – Your total abstract should not be longer than 35 lines. It should include the project name, population to be served (demographics and clinical characteristics), strategies/interventions, project goals and measurable objectives, including the number of people to be served annually and throughout the lifetime of the project, etc. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

- **Table of Contents** – Include page numbers for each of the major sections of your application and for each appendix.

- **Budget Form** – Use SF 424A, which is part of the PHS 5161-1. Fill out Sections B, C, and E of the SF 424A. A sample budget and justification is included in Appendix G of this document.

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be longer than 30 pages. (For example, remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing

each section of the Project Narrative are provided in "Section V-1 – Application Review Information" of this document.

The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in Sections F through I. There are no page limits for these sections, except for Section H, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation."

- **Appendices 1 through 5** –Use only the appendices listed below. If your application includes any appendices not required in this document, they will be disregarded. Do not use more than 30 pages for Appendices 1, 3, and 4 combined. There are no page limitations for Appendices 2 and 5. Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do.

  - *Appendix 1*: Letters of Commitment
  - *Appendix 2*: Data Collection Instruments/Interview Protocols
  - *Appendix 3*: Sample Consent Forms
  - *Appendix 4*: Non Supplantation letter
  - *Appendix 5*: Implementation Plan

- **Assurances** – Non-Construction Programs. Use Standard Form 424B found in PHS 5161-1. You are also required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form will be posted on SAMHSA's web site with the RFA and provided in the application kits.

- **Certifications** – Use the "Certifications" forms found in PHS 5161-1.

- **Disclosure of Lobbying Activities** – Use Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes, or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way.

- **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications and is the last page of your application.

2.3 Application Formatting Requirements

Please refer to Appendix F, *Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications*, for SAMHSA's basic application formatting requirements.

Applications that do not comply with these requirements will be screened out and will not be reviewed.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **June 7, 2007**. **Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

Your application must be received by the application deadline, or you must have proof of its timely submission as specified below.

- **For packages submitted via DHL, Federal Express (FedEx), or United Parcel Service (UPS), proof of timely submission shall be the date on the tracking label affixed to the package by the carrier upon receipt by the carrier. That date must be at least 24 hours prior to the application deadline. The date affixed to the package by the applicant will not be sufficient evidence of timely submission.**

- For packages submitted via the United States Postal Service (USPS), proof of timely submission shall be a postmark not later than 1 week prior to the application deadline, and the following upon request by SAMHSA:
    - proof of mailing using USPS Form 3817 (Certificate of Mailing), or
    - a receipt from the Post Office containing the post office name, location, and date and time of mailing.

You will be notified by postal mail that your application has been received.

Applications not meeting the timely submission requirements above will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. Allow sufficient time for your package to be delivered.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application, and that results in the designated office not receiving your application in accordance with the requirements for timely submission, it will cause the application to be considered late and ineligible for review.

SAMHSA will not accept or consider any applications sent by facsimile.

Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

You must follow the instructions in the User Guide available at the www.Grants.gov apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete four separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: 1) DUNS Number registration; 2) Central Contractor Registry (CCR) registration; 3) Credential Provider registration; and 4) Grants.gov registration.

It is strongly recommended that you submit your grant application using Microsoft Office products (e.g., Microsoft Word, Microsoft Excel, etc.). If you do not have access to Microsoft Office products, you may submit PDF files. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described in Appendix F of this announcement. These requirements also apply to applications submitted electronically, with the following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help ensure the accurate transmission and equitable treatment of applications.

- *Text legibility*: Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of one inch each. Adhering to these standards will help to ensure the accurate transmission of your document. If the type size in the Project Narrative of an electronic submission exceeds 15 characters per inch, or the text exceeds 6 lines per vertical inch, SAMHSA will reformat the document to Times New Roman 12, with line spacing of single space. Please note that this may alter the formatting of your document, especially for charts, tables, graphs, and footnotes.

- *Amount of space allowed for Project Narrative*: The Project Narrative for an electronic submission may not exceed 15,450 words. If the Project Narrative for an electronic submission exceeds the word limit and exceeds the allowed space as defined in Appendix F, then **any part of the Project Narrative in excess of these limits will not be submitted to review**. To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

While keeping the Project Narrative as a separate document, please consolidate all other materials in your application to ensure the fewest possible number of attachments. Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. Please name and number your attachments, indicating the order in which they

should be assembled. Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed above. The paper submission must be clearly marked: **"Back-up for electronic submission."** The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Include the Grants.gov tracking number in the top right corner of the face page for any paper submission. Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

The Grants.gov Web site does not accept electronic signatures at this time. Therefore, you must submit a signed paper original of the face page (SF 424 v2), the assurances (SF 424B), and hard copy of any other required documentation that cannot be submitted electronically. **You must include the Grants.gov tracking number for your application on these documents with original signatures, on the top right corner of the face page, and send the documents to the following address. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**
ATTN: Electronic Applications
For other delivery services, change the zip code to 20850.

If you require a phone number for delivery, you may use (240) 276-1199.

4. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at http://www.hhs.gov/grantsnet/roadmap/index.html:

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments and Federally Recognized Indian Tribal Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Hospitals: 45 CFR Part 74, Appendix E

ATR grant funds must be used for purposes supported by the program and may not be used to:

- Pay for any lease beyond the project period.

- Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).

- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)

- Pay for housing other than residential mental health and/or substance abuse treatment.

- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

- Pay for incentives to induce individuals to enter treatment. However, a grantee or treatment provider may provide up to $20 or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow-up. This amount may be paid for participation in each required interview.

- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.

- Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.

SAMHSA will not accept a "research" indirect cost rate. The grantee must use the "other sponsored program rate" or the lowest rate available.

5. OTHER SUBMISSION REQUIREMENTS

You may submit your application in either electronic or paper format:

Submission of Electronic Applications

SAMHSA is collaborating with www.Grants.gov to accept electronic submission of applications. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether you use the electronic or paper format.

To submit an application electronically, you must use the www.Grants.gov apply site. You will be able to download a copy of the application package from www.Grants.gov, complete it off-line, and then upload and submit the application via the Grants.gov site. E-mail submissions will not be accepted.

Please refer to Section IV-3 above for detailed instructions on submitting your application electronically.

Submission of Paper Applications

You must submit an original application and 2 copies (including appendices). The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Send applications to the address below:

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**

Change the zip code to **20850** if you are using another delivery service.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include the title of this program **(ATR Program)** and the funding announcement number (**TI-07-005)** in item number 12 on the face page of any paper applications:

If you require a phone number for delivery, you may use (240) 276-1199.

Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

SAMHSA will not accept or consider any applications sent by facsimile.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

Your application will be reviewed and scored according to the quality of your responses to the requirements listed below for developing the Project Narrative (Sections A-E). These sections describe what you intend to do with the project.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program. **These are to be used instead of the "Program Narrative" instructions found in the PHS 5161-1**.

- The Project Narrative (Sections A-E) together may not be longer than 30 pages.

- You must use the five sections/headings listed below in developing your Project Narrative(s). Be sure to place the required information in the correct section, **or it will not be considered**. Your application will be scored according to how well you address the requirements for each section of the Project Narrative(s).

- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative. Points will be assigned based on how well you address the cultural competence aspects of the evaluation criteria. SAMHSA's guidelines for cultural competence can be found on the SAMHSA web site at www.samhsa.gov. Click on "Grants/Applying for a New SAMHSA Grant/Guidelines for Assessing Cultural Competence."

- The Supporting Documentation you provide in Sections F-I and Appendices 1-5 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.

- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Bullet statements in each section do not have points assigned to them. They are provided to invite the attention of applicants and reviewers to important areas within the criterion.

Project Narrative

Section A: Statement of Need (15 points)

- Describe the current substance abuse clinical treatment system in the proposed target area (i.e., the State, Territory or Tribe, or subsection of the State, Territory or Tribe). Include the number of clinical treatment providers currently funded by the State/Territory/Tribal Organization, gaps in service delivery, and barriers to service access.

- Describe the current recovery support service system in the proposed target area. Include the number of recovery support services providers currently funded by the State/Territory/Tribal Organization, gaps in service delivery, and barriers to service access.

- Describe the nature and prevalence of substance abuse problems in the target area, including that of persons returning to the target area following incarceration. Quantify the need for services, capacity of the service system to provide services, and the difference between the two.

- Specifically describe the nature and prevalence of problems related to methamphetamine use in the target area. Quantify the need for methamphetamine-related treatment and recover support services, the capacity of the service system to provide these services, and the difference between the two.

- Explicitly state whether or not the State, Territory or Tribal Organization already has a voucher system in place to pay for substance abuse treatment and recovery support services. Discuss how the proposed project would help address the difference between system capacity and service need, including how and by how much capacity would be increased for each year of the grant. Clearly state the number of clients who would be served under the proposed project in each year of the grant. Clearly state the number of clients requiring methamphetamine-related treatment and/or recovery support services who would be served under the proposed project in each year of the grant.

Section B: Project Plans to Meet Original ATR Program Goals (30 points)

- Provide evidence that voucher recipients will have a genuine, free, and independent choice among eligible clinical treatment and recovery support service options. Evidence is defined as at least 2 providers for each service to be provided using vouchers, one of which must be secular.

- Describe the process to enable clinical treatment providers previously unable to compete effectively for Federal funds to participate in the voucher program (including faith-based and community providers). Describe the process to enable recovery support service providers previously unable to compete effectively for Federal funds to participate in the voucher program (including faith-based and community providers). Clearly state how many of such clinical treatment and recovery support service providers are expected to be designated under this program and the timeframe in which this will occur. Affirm that faith-based organizations that otherwise satisfy program requirements will not be discriminated against on the basis of religious character or affiliation.

- Provide plans for increasing capacity over the period of the voucher program, particularly for recovery support services.

- Provide plans for monitoring the operation and the effectiveness of the voucher program jurisdiction through the timely reporting of data.

Section C: Proposed Approach (20 points)

- Clearly state the three year goal of your proposed project. Describe how achievement of the three year goal will increase client choice with regard to services and increase access to/availability of prevention, outreach, pre-treatment, treatment, and recovery support services. Clearly indicate whether the proposed project will address methamphetamine use and, if so, how methamphetamine use will be incorporated into the goals for the project. For applicants that have already received ATR grants, indicate whether the proposed project differs in scope from the previous project and describe the differences, if appropriate. Applicants that have already received ATR grants should also discuss how the proposed project will build upon the lessons learned through the previous ATR grant.

- Describe the approach that will be used to implement or expand (depending on applicant level of readiness) vouchers to pay for substance abuse treatment and recovery support services (including methamphetamine-related treatment and recovery support services, if appropriate) in the State, Territory or Tribe. If you are a previous ATR grantee, you must discuss how the current program will be expanded under this grant. You must also document that the current program will be maintained. Include the following:

  - Implementation model (e.g., State, sub-State agency including State Departments of Corrections and Probation and Parole authorities, public/private partnership or other model).

  - Infrastructure enhancements needed to accelerate implementation of vouchers, if the State/Territory/Tribal Organization does not already have a voucher system in place.

  - Eligibility criteria for clients to receive vouchers for clinical treatment and recovery support services. Clearly state the number of clients who would be successfully treated under the proposed program.

  - Procedures/policies for screening, assessment, and level of care determinations to identify appropriate clinical treatment and recovery support services options and to place clients with the eligible provider of their choice.

  - Process to ensure that clients receive a comprehensive assessment, using an instrument that assesses need for clinical treatment and recovery support services (See Appendix A for a discussion of clinical treatment and recovery support services, and Appendix D for information on screening, assessment, and level of care determination).

  - Process to ensure that clients receive vouchers for the most appropriate services and are transitioned between services based on established criteria. (See Appendices C and D for more information and resources about criteria.)

- Steps to ensure that clients successfully enter clinical treatment and/or recovery support services following receipt of a voucher, regardless of where the client is seen for screening, assessment, and referral.

- Eligibility criteria for provider organizations, including: (1) standards for all eligible provider organizations and/or processes to ensure individuals receive appropriate services in safe settings from appropriate individuals, including plans to enforce those standards and processes; and (2) reporting requirements. (See Appendix C for SAMHSA's expectations regarding standards for States.)

- Method/process for designating providers as eligible participants in the voucher program and for maintaining an up-to-date, client friendly information service to ensure client choice is always available and clients are aware of their choices (e.g., a website or 24-hour staffed help line).
- Method/process for measuring client satisfaction in management of the voucher program.

- Unbundling of services, if the State intends to use this strategy to achieve the best outcomes at the lowest cost.

- Provide a three-year plan for implementing the project in Appendix 5 of the application. The plan must include specific milestones with target dates for their achievement and must identify the party(ies) responsible for achieving milestones.

Section D: Readiness to Implement/Expand the Voucher System (15 points)

- Describe the timeframe by which the proposed voucher system would be fully operational (for applicants proposing new voucher systems) or expanded (for applicants proposing to expand an existing system).

- Document which of the following capabilities the State **currently possesses** to implement or expand the voucher system:

  - Ability to make eligibility determinations for clients and providers.
  - Ability to manage and monitor a voucher program.
  - Ability to set reimbursement rates and monitor costs per person served.
  - Ability to collect and report data (either through an existing or planned system).
  - Ability to implement quality improvement activities including technical assistance and training.
  - Ability to establish and implement standards for clinical treatment and/or recovery support service providers.
  - Capability to conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.
  - Capability to provide a list of eligible providers for anyone to whom a voucher is issued.

- Describe anticipated potential operational problems, if any, and propose feasible solutions to them. Examples include:

- Ensuring clients genuine, free, and independent choice of clinical treatment and/or recovery support providers in situations in which the range and number of providers are limited.
- Handling significant numbers of clients eligible for vouchers who may exceed the State's ability to fund vouchers, and ensuring that resources are appropriately allocated during the course of the year.
- Preventing potential conflict-of-interest among those conducting screening, assessment, level of care determination, and service provision.

- Describe other organizations/entities partnering in the project, including their roles in implementing the voucher program. In Appendix 1 of the application, provide letters of commitment showing that identified partner organizations are ready and able to fulfill their roles.

Section E: Management, Staffing and Cost Controls (20 points)

- Describe how the lead agency will manage the voucher program, including steps that will be taken to ensure quality of care; prevent waste, fraud and abuse; and prevent supplantation of funds.

- Describe the resources available for the project. Document that resources will be appropriately allocated throughout the project period to ensure against funding shortfalls.

- If you previously received an ATR grant, discuss how the proposed project will achieve improved efficiencies over the course of the project.

- Describe how the lead agency will work with other agencies with roles and responsibilities related to identifying clients and implementing and administering the voucher program.

- Describe how the provider performance issues will be addressed through the process of determining provider eligibility and through monitoring/oversight.

- Describe the State's and other participating entities' experience managing other voucher-type programs (e.g., Temporary Assistance for Needy Families (TANF), HUD/housing, daycare), if any, and discuss how these experiences will be applied to the proposed voucher program.

- Describe qualifications of the key staff to effectively implement and manage the proposed project.

- Document the ability or present a plan for developing the ability of the State/Territory/Tribal Organization to collect and report all necessary GPRA data, including data on costs and outcomes, to SAMHSA.

- Describe the process the State will use to regularly monitor implementation of the voucher program (including costs and outcomes) and make adjustments to the program (including the introduction of evidence-based practices) in order to achieve the intended outcomes in the most

cost-effective manner. Specify how the State will create incentives for positive outcomes (e.g., adjusting provider eligibility reimbursement based on such outcomes). The extent to which evidence supports abstinence from substance use is of the utmost importance in assessing provider performance.

- Describe the process for establishing reimbursement rates for services provided through vouchers.

- Describe how the State will manage the program on the basis of reasonable costs. Include a justification if the applicant proposes to deviate from the cost ranges outlined in Appendix H.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

Supporting Documentation

Section F: Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

Section G: Budget Justification, Existing Resources, Other Support.

- You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project.

- You must identify administrative expenses and justify the percent of the budget that will be allocated to administrative expenses.

- <u>If your project will include methamphetamine-related treatment and recovery support services, you must identify and justify the expenses associated with those services.</u>

- You should justify your proposed budget on the basis of a variety of factors, including specification of the direct and indirect costs of the project and the relationship of those costs to the number of people to be served, the number of to be issued, the size and complexity of the service delivery system to be converted to a voucher program, and the nature of the barriers which must be addressed in order to successfully implement a voucher program.

- You should be mindful of the need to demonstrate that the proposed project will implement the most cost effective mix of clinical treatment and recovery support services necessary to achieve the intended outcomes of the project.

- An illustration of a budget and narrative justification is included in Appendix G of this document.

Section H: Biographical Sketches and Job Descriptions**.**

- Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a position description and/or a letter of commitment with a current biographical sketch from the individual.

- Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.

- Information on what should be included in biographical sketches and job descriptions can be found on page 22, Item 6, in the Program Narrative section of the PHS 5161-1 instruction page, available at www.hhs.gov/forms/PHS-5161-1.doc.

Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects: Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of the application, using the guidelines provided below and in Appendix L of this document.

*Confidentiality and Participant Protection***:**

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the eight bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these eight bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application may result in the delay of funding.

- Identify foreseeable risks or adverse effects due to participation in the project and/or in the data collection (performance assessment) activities (including physical, medical, psychological, social, legal, and confidentiality) and provide your procedures for minimizing or protecting participants from these risks.

- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

- Describe the target population and explain why you are including or excluding certain subgroups. Explain how and who will recruit and select participants.

- State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate victims, specify the type (e.g., money, gifts, coupons), and the value of any such incentives.

- Describe data collection procedures, including sources (e.g., participants, school records) and the data collecting setting (e.g., clinic, school). Provide copies of proposed data collection instruments and interview protocols in **Appendix 2** of your application, "Data Collection Instruments/Interview Protocols." State whether specimens such as urine and/or blood will be obtained and the purpose for collecting. If applicable, describe how the specimens and process will be monitored to ensure the safety of participants.

- Explain how you will ensure privacy and confidentiality of participants' records, data collected, interviews, and group discussions. Describe where the data will be stored, safeguards (e.g., locked, coding systems, storing identifiers separate from data), and who will have access to the information.

- Describe the process for obtaining and documenting consent from adult participants and assent from minors along with consent from their parents or legal guardians. Provide copies of all consent forms in **Appendix 3** of your application, "Sample Consent Forms." If needed, give English translations.

- Discuss why the risks are reasonable compared to expected benefits from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria of research involving human subjects. Applicants whose projects must comply with the Human Subjects Regulations must, in addition to the bullets above, fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling clients in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp, or ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the review criteria listed above. For those programs where the individual award is over $100,000, applications also must be reviewed by the appropriate National Advisory Council.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers and, when applicable, approved by the Center for Substance Abuse Treatment National Advisory Council;

- availability of funds;

- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among target populations and program size; and

- ability to reach the $25 million target for methamphetamine-related treatment and recovery support services.

VI. AWARD ADMINISTRATION INFORMATION

1. AWARD NOTICES

After your application has been reviewed, you will receive a letter from SAMHSA through postal mail that describes the general results of the review, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice, the Notice of Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant Award is the sole obligating document that allows the grantee to receive Federal funding for work on the grant project. It is sent by postal mail and is addressed to the contact person listed on the face page of the application.

If you are not funded, you can re-apply if there is another receipt date for the program.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- Successful applicants must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA web site at www.samhsa.gov/grants/generalinfo/grants_management.aspx.

- Successful applicants must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA web site (http://www.samhsa.gov/Grants/generalinfo/grant_reqs.aspx).

- Depending on the nature of the specific funding opportunity and/or the proposed project as identified during review, additional terms and conditions may be negotiated with the grantee prior to grant award. These may include, for example:

- actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
- requirements relating to additional data collection and reporting;
- requirements relating to participation in a cross-site evaluation; or
- requirements to address problems identified in review of the application.

- Successful applicants will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a Federal grant.

- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services "Survey on Ensuring Equal Opportunity for Applicants." This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA web site. Applicants are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

3.1 Progress and Financial Reports

- Grantees must submit required financial information and information not included in GPRA data on a monthly basis. The GPRA data will be submitted on an ongoing basis. Additionally, grantees are responsible for quarterly progress reporting to grants management.

- The monthly progress reports must include the performance data described in Section I-2.1 of this announcement, as well as information about fraud and abuse monitoring and examples of client success, until the grantee develops the capability to upload data through CSAT's GPRA Data Entry and Reporting System (www.samhsa-gpra.samhsa.gov). After that time, the monthly progress reports will include only the performance information not captured in the GPRA Data Entry and Reporting System (e.g., information about fraud and abuse monitoring and examples of client success).

- Because SAMHSA is extremely interested in ensuring that treatment and prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this grant.

- SAMHSA will provide guidelines and requirements for these reports to grantees at the time of award and at the initial grantee orientation meeting after award. SAMHSA staff will use

the information contained in the reports to determine the grantee's progress toward meeting its goals.

3.2 Publications

If you are funded under this grant program, you are required to notify the Government Project Officer (GPO) and SAMHSA's Publications Clearance Officer (240-276-2130) of any materials based on the SAMHSA-funded grant project that are accepted for publication.

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.
- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.

- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

For questions about program issues contact:

Andrea Kopstein
Practice Improvement Branch, Division of Service Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd., Room 5-1095
Rockville, MD 20857
(240) 276-1575
andrea.kopstein@samhsa.hhs.gov

For questions on grants management issues contact:

Kimberly Pendleton
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
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Appendix A: Comprehensive Array of Clinical Treatment and Recovery Support Services

Overview:

Research has established that there are many paths to recovery from alcohol and drug problems. Indeed, many resolve their alcohol and drug problems naturally, without any outside intervention. Others recover with the support of self-help groups such as Alcoholics Anonymous, and/or the faith community. Still others have found recovery through formal clinical treatment interventions. A variety of factors can influence which of these paths is taken successfully. For example, individuals with moderate problems and social support/stability are more apt to recover naturally or with minimal interventions. In contrast, people who seek treatment tend to have more serious problems.

To achieve the best outcomes at the lowest cost, SAMHSA encourages States to provide access to a comprehensive array of clinical treatment and recovery support services as described below. Both components – clinical treatment services and recovery support services–are appropriate for many, if not all, individuals who meet the DSM-IV diagnostic criteria for substance dependence. However, not all services and/or interventions are needed by every individual in treatment for or in recovery from substance dependence. Those who meet the diagnostic criteria for substance abuse may require a less comprehensive range of services. In addition, the array of services described below need not be provided by a single entity but can be provided by a consortium of addiction treatment, health, and human service providers.

This array is not specific to any particular philosophy of clinical treatment and recovery, modality, or setting. It is a generic framework within which potential applicants can conceptualize service arrays, service capabilities, and appropriate managerial and administrative processes, including evaluation.

Methods of implementing the components of this array, the staff who deliver each service, the manner and setting in which different services are delivered, etc., should be based on individual assessment and level of care determination that considers 1) the needs of the individual; 2) the extent to which there are clinical treatment services, recovery support services, health, human services, housing, criminal justice supervision, and labor training alternatives in the jurisdiction of authority; and 3) the extent of available resources and agencies linked through coordinated case management.

In many cases, it will be desirable to provide various components of the array simultaneously, with the emphasis changing throughout the clinical treatment and recovery process. For example, in the earlier, acute phase of clinical treatment, heavier emphasis may be placed on clinical treatment services; the emphasis may switch toward recovery support as individuals move through rehabilitation and enter a maintenance phase of clinical treatment and recovery. In some cases, recovery support services alone will suffice.

Examples of Clinical Treatment and Recovery Support Services

Clinical treatment services are provided by individuals who are licensed, certified, or otherwise credentialed to provide clinical treatment services in the State, often in settings that address specific treatment needs. Examples of clinical treatment services include the following:

- Screening/assessment
- Brief intervention
- Treatment planning
- Detoxification
- Medical care
- Substance abuse education
- Individual counseling
- Group counseling
- Residential treatment
- Pharmacological interventions
- Co-occurring treatment services
- Family/marital counseling
- Case management
- Relapse prevention
- Continuing care (including face-to-face and telephone-based continuing care counseling)
- Alcohol/drug testing
- Family services, including family/marriage counseling and parenting and child development services
- Employment services and job training
- Outreach

Recovery support services are typically provided by paid staff or volunteers familiar with how their communities can support people seeking to live free of alcohol and drugs, and are often peers of those seeking recovery. Some of these services may require reimbursement while others may be available in the community free of charge. Examples of recovery support services include the following:

- Transportation to and from treatment, recovery support activities, employment, etc.
- Employment services and job training
- Case management/individual services coordination, providing linkages with other services (legal services, TANF, social services, food stamps, etc.)
- Outreach
- Relapse prevention
- Housing assistance and services
- Child care
- Family/marriage education
- Peer-to-peer services, mentoring, coaching
- Self-help and support groups, such as 12-step groups, SMART Recovery, Women for Sobriety, etc.
- Life skills
- Spiritual and faith-based support

- Education
- Parent education and child development
- Substance abuse education

Definitions for Recovery Support Services

Transportation

Commuting services are provided to clients who are engaged in treatment- and/or recovery support-related appointments and activities and who have no other means of obtaining transportation. Forms of transportation services may include public transportation or a licensed and insured driver who is affiliated with an eligible program provider.

Employment Services and Job Training

These activities are directed toward improving and maintaining employment. Services include skills assessment and development, job coaching, career exploration or placement, job shadowing or internships, résumé writing, interviewing skills, and tips for retaining a job. Other services include training in a specific skill or trade to assist individuals to prepare for, find, and obtain competitive employment such as skills training, technical skills, vocational assessment, and job referral.

Case Management

Comprehensive medical and social care coordination is provided to clients to identify their needs, plan services, link the services system with the client, monitor service delivery, and evaluate the effort.

Relapse Prevention

These services include identifying a client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

Housing Assistance and Services

These services include transitional housing, recovery living centers or homes, supported independent living, sober housing, short-term and emergency or temporary housing, and housing assistance or management. These services provide a safe, clean, and sober environment for adults with substance use disorders. Lengths of stay may vary depending on the form of housing. This assistance also includes helping families in locating and securing affordable and safe housing, as needed. Assistance may include accessing a housing referral service, relocation, tenant/landlord counseling, repair mediation, and other identified housing needs.

Child Care

These services include care and supervision provided to a client's child(ren), less than 14 years of age and for less than 24 hours per day, while the client is participating in treatment and/or recovery support activities. These services must be provided in a manner that complies with State law regarding child care facilities.

Family/Marriage Counseling and Education

Services provided to engage the whole family system to address interpersonal communication, codependency, conflict, marital issues and concerns, parenting issues, family reunification, and strategies to reduce or minimize the negative effects of substance abuse use on the relationship.

Peer-to-Peer Services, Mentoring, Coaching

Mutual assistance in promoting recovery may be offered by other persons who have experienced similar substance abuse challenges. These services focus more on wellness than illness. Mentoring and coaching may include assistance from a professional who provides the client counsel and/or spiritual support, friendship, reinforcement, and constructive example. Mentoring also includes peer mentoring which refers to services that support recovery and are designed and delivered by peers—people who have shared the experiences of addiction recovery. *Recovery support* is included here as an array of activities, resources, relationships, and services designed to assist an individual's integration into the community, participation in treatment, improved functioning or recovery.

Life Skills

Life skills services address activities of daily living, such as budgeting, time management, interpersonal relations, household management, anger management, and other issues.

Spiritual and Faith-based Support

These services assist an individual or group to develop spiritually. Activities might include, but are not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, and achieving serenity and peace of mind. Faith-based services include those provided to clients and using spiritual resources designed to help persons in recovery to integrate better their faith and recovery. Such services are usually provided in a religious or spiritual setting by spiritual leaders or other staff who are knowledgeable about the spiritual values of the community and are equipped to assist individuals in finding spirituality. Services include, but are not limited to, social support and community-engagement services, faith, or spirituality to assist clients with drawing on the resources of their faith tradition and community to support their recovery; mentoring and role modeling; and pastoral or spiritual counseling and guidance.

Education

Supported education services are defined as educational counseling and may include academic counseling, assistance with academic and financial applications, and aptitude and achievement testing to assist in planning services and support. Vocational training and education also provide support for clients pursuing adult basic education, i.e., general education development (GED) and college education.

Parent Education and Child Development

An intervention or treatment provided in a psycho-educational group setting that involves clients and/or their families and facilitates the instruction of evidence-based parenting or child development knowledge skills. Parenting assistance is a service to assist with parenting skills; teach, monitor, and model appropriate discipline strategies and techniques; and provide information and advocacy on child development, age appropriate needs and expectations, parent groups, and other related issues.

Examples of Recovery Support Service Rate Ranges

Table 1. Rate ranges for selected recovery support service types

Recovery support service type	Unit of service	Range
Most common types		
Transportation	Round trip	$10–$14 bus pass
Employment services or job training	Hour	$10–$46.79
Case management	Hour	$10–$56.89
Housing assistance or services	Daily transitional Recovery House (monthly)	$25–$33 $1,359–$2,000
Child care	Hour	$3.85–$12
Family, marriage counseling, and education	Hour (individual)	$5–$81.98
Peer-to-peer services, mentoring, coaching	Hour (individual) Hour (group)	$10–$56.89 $15–$20.50
Other		
Life skills	Hour	$25–$30
Spiritual and faith-based support	Hour	$5–$10
Education	Hour (individual)	$20–$25

Appendix B: Services Included as Administrative Expenses

- Eligibility determinations for clinical treatment and recovery services providers and for which services in the comprehensive array of clinical treatment and recovery support services will be included in the voucher reimbursement system
- Management of a system for client eligibility determination and assessment for appropriate level of care
- Fiscal/cost accounting mechanisms that can track voucher implementation
- Management of information systems for tracking outcomes and costs, including the costs of data collection and reporting
- Development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support providers
- Marketing of vouchers to client and provider organizations
- Oversight of standards and fraud and abuse issues

Appendix C: Standards For The Access To Recovery (ATR) Program

Grantees will be expected to administer their ATR projects in a manner consistent with good management practices. Grantees will have flexibility in establishing standards appropriate and feasible for their service delivery system and target population. However, once Grantees have established standards for participating provider organizations, they are expected to enforce such standards.

In its application, the State should demonstrate how it intends to:

1. Ensure that clients receive a genuine, free, and independent choice among assessment, placement, clinical treatment, and recovery support services.

a. For purposes of this program, choice is defined as a client being able to select among at least two providers which are qualified to provide the services needed by the client, among them at least one provider to which the client has no religious objection.

2. Ensure that clients receive a clinical assessment and a level of care determination from a qualified person and/or provider organization.

a. States should describe the qualifications they require of individuals and/or providers that perform assessments and level of care determinations.

b. States should describe steps they will take to prevent potential conflicts of interest among practitioners and/or provider organizations conducting screening, assessment and referral to clinical treatment and/or recovery support services.

3. Ensure that clients receive appropriate services from clinical treatment and recovery support programs.

a. To be eligible for voucher reimbursement, clinical treatment and recovery support programs should meet standards that are required by the State for other providers that provide the same type of services (e.g. residential, outpatient, family support services, etc.).

b. Each State should document the eligibility requirements and program standards the State intends to use for each of the services proposed to be reimbursed under the voucher program. Eligibility requirements and standards should be documented for services across the entire array of recovery, as described in Appendix A, including eligibility requirements and standards for clinical treatment services and recovery support services. (For example, the State should document its eligibility requirements and standards for specific types of providers such as residential, outpatient, methadone, recovery support services, etc.) In the case of services for which no standards currently exist, the State must describe the process to be used to ensure that individuals receive appropriate

services in safe settings from appropriate individuals. States must also describe how they intend to monitor compliance with these standards and/or processes.

4. Expand the range of clinical treatment and recovery support services providers that meet appropriate standards.

a. States should describe how they intend to provide technical assistance and training to providers of clinical treatment and recovery services as described in Appendix A in order for them to meet State standards.

5. Ensure that outcome and financial data is reported in a timely manner.

a. States should describe how they intend to ensure that outcome data are reported, as required in Section I-2.1 of the funding announcement.

Appendix D: Screening, Assessment, and Level of Care Determination

Screening

The purpose of screening is to quickly and cost-effectively rule out people without substance abuse problems and to identify the need for specialized substance abuse treatment.

The basic questions asked in the screening process are: 1) is a substance abuse problem present; and 2) does it require specialized care. Although we often think individuals seeking clinical treatment have been previously screened, some individuals seek specialized treatment directly.

If screening suggests an individual probably has a problem likely to require specialized treatment, the next step in the sequence may be thought of as the problem assessment.

Assessment

Assessment is the systematic process of interaction with an individual to observe, elicit, and subsequently assemble the relevant information required to manage his or her problems, both immediately and for the foreseeable future. An assessment gauges which of the available clinical treatment and recovery services options are likely to be most appropriate for the individual being assessed. Hence, assessment must occur prior to any referral of the individual to a particular kind of clinical treatment and/or recovery support service. When the same general approach is applied to all or most clients, assessment may have little impact.

Purpose of Assessment

- To characterize a problem –

  Substance abuse problems differ from person to person, often both in degree and in kind. What should emerge from an assessment is a detailed picture of the particular kind of substance abuse problem manifested by a particular individual at a particular point in time.

  In the absence of a clear, unambiguous picture at initial contact, appropriate decisions regarding care for the present and future may be difficult.

- To characterize an individual –

  Substance abuse problems do not occur in a vacuum. Individuals who manifest them are at least as different from one another as they are from people without substance use disorders. Some of these problems may be the result of abuse of drugs or alcohol; some may result in using drugs or alcohol; others may be independent problems. All are important in themselves, requiring assessment, (and often attention), in clinical treatment and/or recovery support programs. Individual characteristics may affect a person's acceptance (and, in consequence, the eventual outcome) of various forms of clinical treatment and/or recovery support services. Thus,

detailed knowledge of individual characteristics can help provide the client with a list of appropriate clinical treatment and/or recovery support service options.

- To identify appropriate clinical treatment and/or recovery support service options–

  Assessment prior to clinical treatment and/or recovery support forms the basis on which individuals are provided a list of clinical treatment and/or recovery support options appropriate to their needs.

  Additional information on the individual will need to be gathered by program staff following the selection of a clinical treatment and/or recovery support program to plan the individual's ongoing course of care.

Level of Care Determination

Level of care determination is achieved through the client's selection of clinical treatment and recovery support alternatives that are both available and most likely to facilitate a positive outcome in a particular individual. Level of Care Determination:

- Focuses on matching clinical treatment and/or recovery support services to individual needs within the framework of client choice

- Defines expectations for each stage of care:
  - Acute intervention, including detoxification
  - Rehabilitation
  - Maintenance and relapse prevention

While choice among the various clinical treatment and/or recovery support services options resides with the individual, the assessor is responsible to ensure that the individual is fully conversant with all of the therapeutic alternatives available from eligible providers.

The Level of Care Determination Process

Level of Care determination is a complex matter, requiring consideration of individuals and their substance abuse problems, and knowledge of available clinical treatment and recovery support services by both the assessor and the client.

The following general descriptors of clinical treatment and recovery support services represent the kinds of information most useful to help identify appropriate levels of care and clinical treatment and/or recovery support service options for individuals with substance abuse problems. When presented to clients in every-day language, the following information can assist clients in making an informed choice of the clinical treatment and/or recovery support service option(s) that may meet their needs:

- Philosophy and orientation of the program (e.g., medical model, social model, spiritual model, etc.);
- Stage of substance abuse problem or recovery at which the clinical treatment and/or recovery support service is directed (e.g., detoxification, rehabilitation, maintenance);
- Setting of the program (e.g., inpatient, outpatient, residential) and staffing; and
- Therapeutic approach/type of intervention

Additional Resources for Screening, Assessment, and Level of Care Determination

I. Resources to Implement Screening

In health care, screening is a process to identify people who have, or are at risk for, an illness or disorder. The purpose of screening is to target persons for clinical treatment and/or recovery support services, thus reducing the long-term morbidity and mortality related to the condition. In addition, by intervening early and raising the individual's level of concern about risk factors and substance-related problems, screening for drug and alcohol problems in community settings can reduce subsequent use.

Two types of screening procedures are typically used. The first includes self-report questionnaires and structured interviews; the second, clinical laboratory tests that can detect biochemical changes associated with excessive alcohol consumption or illicit drug use.

A variety of screening instruments are available. The majority of studies and implementation efforts have focused on screening for alcohol problems. The CAGE and AUDIT are the most commonly used screening tools. The DAST has also been used in conjunction with the AUDIT in several projects, where there has been an effort to implement this approach for persons with or at risk for a substance use disorder. Several new instruments have been developed, but not yet rigorously tested, to assess harmful use of either alcohol or drugs (e.g., the CAGE-D, the ASSIST, the TCUDS, the GAIN-QS, the PDES).

Brown, RL and Rounds LA. 1995. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*, 94, 135-140.

Brown R, Leonard T, Saunders LA, et al. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, 151-160.

A bibliography with descriptions and evaluations of various interview, questionnaire, and laboratory test screening approaches is available from Project Cork.

Project Cork. 2002. *CORK Bibliography: Screening Tests.* 2001-2002, 58 Citations. http://www.projectcork.org/bibliographies/data/Bibliography_Screening_Tests.html

Screening instruments have been developed or modified for use with different target populations, notably adolescents, offenders within the criminal justice system, welfare recipients, women, and the

elderly. Several have been translated into other languages and have been evaluated for cultural sensitivity. Again, SAMHSA is not requiring a specific instrument or protocol, but choice of instruments or laboratory tests must be justified.

It is well recognized that screening instruments used with adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical settings. One example of a brief substance abuse screening instrument recently developed specifically for use with adolescents is the CRAFFT test.

> Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. 2002. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med*. 156(6): 607-14.

Additional screening tests and procedures targeted at adolescents, including the PDES and the GAIN-QS, are described in these publications:

> Winters KC. 1992. Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addict Behav*. 17(5): 479-90.
>
> Winters KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.
>
> Winters KC. 1999. *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA*)* 99-3283.
>
> Winters KC. 2001. Assessing adolescent substance use problems and other areas of functioning: State of the art. In: PM Monti, SM. Colby, and TA. O'Leary (eds). *Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions.* New York, Guilford Publications, Inc., pp. 80-108.
>
> Dennis ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications. http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html
>
> Martino S, Grilo CM, and Fehon DC 2000. Development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors* 25(1): 57-70.

Screening tests and procedures targeted at the elderly are described in these publications:

> Blow, F.C. Consensus Panel Chair. 1998. *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.
>
> Blow FC and Barry KL. 1999-2000. Advances in alcohol screening and brief intervention with older adults. *Advances in Medical Psychotherapy*. 10:107-124

Screening tests and procedures targeted at persons in the criminal justice system are described in these publications:

> Inciardi JA Consensus Panel Chair 1994. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076
>
> Peters, RH, Greenbaum, PE, Steinberg, ML, Carter, CR, Ortiz, MM, Fry, BC, Valle, SK. 2000. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal Substance Abuse Treatment*: 18(4): 349-58.
>
> Simpson DD. 2001. Core set of TCU forms. Fort Worth: Texas Christian University, Institute of Behavioral Research. www.ibr.tcu.edu.

Efforts are ongoing to develop methods to better screen people with co-occurring substance use and mental disorders.

II. Assessment Instruments

Substance abuse assessment instruments are designed to determine the precise nature and severity of an individual's problems. Some instruments are also designed to help pinpoint specific diagnoses. While the results of assessment instruments do not necessarily specify the service needs of clients, the data collected from these instruments can help determine a client's level of care need and, thus, the options of eligible service providers.

- **Adult Assessment Instruments**

  Addiction Severity Index (ASI)
  ASI is a 30 to 40-minute, interviewer-administered instrument that assesses severity of alcohol and drug problems across several domains. The ASI has been tested extensively and used widely for initial client assessments and to measure client progress and outcomes. The ASI should be administered by trained clinicians.
  McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E. An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *J Nerv Ment Dis* 168:26-33, 1980.
  --and/or--
  McLellan, A.T.; Kushner, H.; Metzger, D.; Peters F.; et al. The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat* 9:199-213, 1992.

  Substance Use Disorders Diagnostic Schedule (SUDDS-IV)
  "The SUDDS-IV is a comprehensive diagnostic assessment interview providing definitive documentation for substance-specific abuse or dependence diagnoses based on DSM-IV-TR criteria. It also screens for depression and anxiety disorders. In addition to diagnostic documentation, the SUDDS-IV provides valuable information for treatment planning and patient placement." (Source: www.evinceassessment.com)

Harrison, P. & Hoffman, N. (1987). Substance Use Disorders Diagnostic Schedule (SUDDS). St. Paul, MN: Norman G. Hoffman.

Minnesota Multiphasic Personality Inventory (MMPI)

"The Minnesota Multiphasic Personality Inventory (MMPI) is an objective verbal inventory designed as a personality test for the assessment of psychopathology consisting of 550 statements, 16 of which are repeated. The replicated statements were originally included to facilitate the first attempt at scanner scoring. Though they are no longer needed for this purpose, they persist in the inventory." (Source: http://www.cps.nova.edu/~cpphelp/MMPI-2.html)

Hathaway, S. & McKinley, J. Manual for the Minnesota Multiphasic Personality Inventory. New York: Psychological Corporation; 1951, 1967, 1983.

--and/or--

Hathaway, S.; McKinley, J.; Butcher, J.; Dahlstrom, W.; Graham, J.; Tellegen, A.; et al. Minnesota Multiphasic Personality Inventory-2: manual for administration. Minneapolis: University of Minnesota Press; 1989.

The Recovery Attitude and Treatment Evaluator (RAATE)

"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)

Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.

--and/or--

Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

- **Adolescent Assessment Instruments**

Comprehensive Adolescent Severity Inventory (CASI)

CASI measures education, substance use, use of free time, leisure activities, peer relationships, family history and intrafamilial substance use, psychiatric status, and legal history. The CASI also incorporates results from urine drug screens and observations from the assessor. Psychometric studies on the CASI support the instrument's reliability and validity.

Meyers, Kathleen. *Comprehensive Adolescent Severity Inventory (CASI).* Philadelphia, PA: Penn/VA Center for Studies of Addiction, 1996. c. 176 p. [RJ 503.7 M4 1996]

Global Assessment of Individual Needs (GAIN)

Dennis, ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications. http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Winters, KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.

III. Diagnostic Criteria

***Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (DSM-IV)**
DSM-IV includes the most widely accepted criteria for diagnosing substance abuse and mental disorders. Based on data collected during an assessment, the DSM criteria for substance use disorders can be used to determine if someone has a "substance abuse" or "substance dependence" diagnosis. DSM-IV was first published in 1994 by the American Psychiatric Association, Washington D.C.

IV. Level of Care Determination, Continued Stay, and Discharge Criteria

Patient Placement Criteria for the Treatment of Substance-Related Disorders
The American Society of Addiction Medicine (ASAM) published the second edition of its *Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2) in 1996. ASAM's PPC-2R presents the criteria for determining which level of services best fits a client's needs. The PPC-2R now has both adult and adolescent criteria and the appropriate criteria should be used for each of these groups.

RAATE
"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)
Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

Appendix E: Examples of How a State Could Implement a Voucher Program

Following are two examples of how an ATR grantee could use vouchers for assessment and level of care determination, as well as for substance use clinical treatment and/or recovery support services. Applicants should be innovative in their approaches.

Please note that technical assistance is available to all applicants to assist them in the development and implementation processes. We encourage all applicants to seek such assistance.

Example 1: State of New Chester

Grant Award Date: August, 2005
Implementation Date: December 2005
Client Target for Year 1: 2,333
Client Target for Year 2: 3,696
Client Target for Year 3: 3,696

Target Area: Statewide (35 counties)

Target Populations: The State of New Chester Access to Recovery (ATR) initiative will focus on delivering services geared toward the following high-risk, underserved populations:

1. Substance abusing adolescents and young adults.
2. Low income individuals in crisis who are involved with child protective services, shelters and medical clinics as a result of drug dependence and abuse.
   Special emphasis and outreach is being placed on adult women.
3. Adults 18 and over who are involved with the criminal justice system/drug courts or those who are exiting the correctional system.

Outreach to Providers: New Chester recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. All clinical treatment organizations must meet existing State licensing and certification standards for clinical treatment and assessment. For recovery support services not currently offered through New Chester's State Department of Drug and Alcohol Substance Abuse Services (SDDASAS), ATR recovery specialists refer clients to recovery support service providers who meet grantee-established eligibility standards. Therefore, in accordance with State administrative procedures, New Chester published eligibility criteria and standards and created a list of eligible entities to provide assessment and level of care determination, as well as clinical treatment and recovery support services. New Chester makes diligent efforts to conduct outreach and marketing to providers previously unable to compete for Federal funds, including faith-based and community organizations. New Chester uses educational meetings to introduce the concept of ATR, provide enrollment information, and to give information about the recovery support services ATR vouchers will support. Enrollment meetings are utilized to enroll recovery support providers, to distribute the eligibility requirements for participation, and to offer help to providers for attaining the eligibility standards required for ATR participation.

Any provider interested in being part of the voucher program will be required to participate in a training program. Once a provider has completed the training, it will be enrolled officially in the ATR voucher program and the provider name and faith-based affiliation, if any, are added to the resource listing through the Helpline. The list of new providers is shared with county coordinators. At the outset of their voucher initiative, New Chester developed an eligibility application process and incentives to improve outcomes. As part of the application process, providers agreed to receive 90% of the reimbursement rate for their services; 10% was withheld and set aside to be used to reimburse and encourage positive client outcomes.

Fifty (50) new clinical treatment providers (Statewide) met the licensing and certification criteria already established by the State. When New Chester implemented, 28 recovery support providers, including 13 faith-based organizations, had been identified, met the eligibility criteria, and agreed to the reimbursement rates established by New Chester. The recovery support service providers agreed to the grantee established definitions of recovery support services and the reimbursement rates for these services (developed by the State). All of the aforementioned providers signed Memoranda of Understanding to provide ATR services should they be selected by a client. All received at least one GPRA training session. Outreach/recruitment activities and training is ongoing. Non-traditional providers unable to meet standards will receive technical assistance and training to help them meet the requirements. Faith-based programs who have the ability to provide clinical treatment services will receive assistance for achieving licensure. The New Chester Faith-Based Association (FBA) will have responsibility for certifying unlicensed faith-based organizations that wish to provide recovery support services

Outreach to Clients: New Chester proposed to expand its current addiction programs by offering voucher driven alcohol and drug treatment/recovery support services Statewide. The scheduled implementation date was November 1, 2004.

New Chester established a 24-hour, 7-day-a-week telephone line for their ATR project (800-FOR-HELP). This number made available a list of eligible assessment, treatment, and recovery support service providers (throughout the State) for the voucher treatment system. New Chester is committed to providing an administrative process which ensures individuals receive appropriate services in safe settings and services delivered by appropriate individuals. When the program opened it doors as scheduled, the 800 telephone number had been activated. This number, the New Chester ATR website, and a major media kick-off blitz, gave the public direct and ready access to the multiple portals of entry for both potential clients and ongoing recruitment of potential caregivers. Potential clients are also able to do a brief screening and self assessment via the telephone or online. Initial appointments can be made by telephone or sent electronically. Referrals to the ATR are provided by partners at various sites, such as the public assistance/ child welfare offices, the juvenile and adult courts, the prison and jail sites and medical hospitals and clinics.

Additionally, all key staff were in place and all Helpline call center employees had attended thorough ATR customer service orientation and training on dealing with difficult/suicidal clients.

How vouchers are issued: A critical component of New Chester's voucher program is its Electronic Information System (EIS). As clients submit a *request for services* from New Chester,

they enter an electronic voucher system. A first task is to establish a client's identity and ascertain whether she or he had previously participated in the voucher program. If a client is new to the voucher system, they receive a *unique client number* and an initial client record is created. Initial contact information includes, at a minimum, name, social security number, birth date, and – where possible- substance use problem information. When the vouchers are issued (electronically) the client acknowledges by signature that he/she invoked their right to select from a list of providers appropriate to meet their assessed treatment/recovery support needs. The intake/assessment staff does a telephone follow up after 72 hours to ascertain whether or not the client kept the appointment. A bi-monthly call is made to the facility/organization to confirm the client is still in attendance. Any client who does not present for services is terminated from the ATR rolls after 60 days of non-activity. To re-enroll, a client must repeat the intake and assessment process. Separate vouchers are issued for each type of service. Vouchers have no cash value.

New Chester specifies that payments to providers be calculated on a service-by-service basis (unbundled), using a standardized rate schedule. New Chester specified that 90% of the rate be invoiced when services were delivered, and that the additional 10% be generated following outcomes reporting. In New Chester, services allowable are determined by the particular type of voucher issued for the client and by the services offered by the submitting provider. Individual services are restricted to clearly defined minimum and maximum time limits and established reimbursement rates. New Chester provides a detailed account of the voucher and service types, rate schedule, incentive payment conditions, and restrictions in effect for their voucher program

Accountability: New Chester is managing performance of ATR providers through outcomes monitoring, including tracking outcomes in SAMHSA's seven identified domains. New Chester monitors provider reporting of outcomes information on a monthly basis. At the end of the first 6 months of the first year, New Chester recognized six providers needed technical assistance to accurately report outcomes information. New Chester provided such technical assistance in a timely manner. At the end of the first year, however, four of the six providers were still unable to provide the outcomes information in each of the seven domains. As a result, New Chester declared these four providers ineligible for the voucher program for the next year.

New Chester is utilizing a variety of administrative controls to safeguard potential fraud and abuse. An independent auditor will conduct a yearly audit pursuant to OMB Circular No. A-133. Unique client identification numbers will assure there is no duplication of services and payments. On-site audits will be done to assess the need for culturally competent services. Satisfaction surveys will be given to clients. All certified care providers will have to be recertified on a yearly basis. Program monitors will conduct random site visits twice a year to review client files and provider documentation. All patient data will be tracked electronically.

Example 2: Blue Mountain Tribal Coalition

Grant Award Date: August, 2005
Implementation Date: December 2005
Client Target for Year 1: 2,476
Client Target for Year 2: 3,596

Client Target for Year 3: 3,596

Target Area: The Blue Mountain Tribal Coalition is implementing its ATR project in five designated counties between North and South Dakota.

Target Populations: The Blue Mountain Tribal Coalition is using Access to Recovery (ATR) to expand services to rural- and urban-dwelling American Indian/Alaska Natives (AI/AN) residing in North and South Dakota.

Outreach to Providers: Prior to launching its voucher program, Blue Mountain conducted outreach to a wide range of substance abuse service providers—both those involved in clinical treatment and those involved in recovery support services. Outreach to enroll new clinical treatment and recovery support service providers included recruitment meetings, mass mailings, in-service trainings, public service announcements, and displays at conferences. Blue Mountain recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. Blue Mountain encouraged providers to become eligible organizations, explaining that the program would be most successful if clients have access to a variety of treatment and recovery service choices. Prior to implementation, Blue Mountain recruited 48 Tribal Councils and Indian Health provider organizations that provided resolutions demonstrating an interest in joining the ATR provider referral list. Clinical treatment providers must be licensed and/or certified. Recovery support service providers (such as healers or elders) must be in good standing with their respective tribal organization. Two major eligibility conditions were required of providers: 1) all providers must comply with Blue Mountain established ATR eligibility standards and 2) agreeing to provide the required outcomes (the SAMHSA required seven domains) and financial data. Nontraditional providers unable to meet eligibility standards receive technical assistance and training to help them meet the requirements. Faith-based and Native Healing programs who have the ability to provide clinical treatment services will receive assistance for achieving licensure. The Blue Mountain Spiritual Healing Association (BMSHA) will have responsibility for certifying unlicensed faith-based organizations wishing to provide recovery support services. An Outreach Coordinator position has been created to conduct outreach and marketing to providers previously unable to compete for Federal funds, including Healing and other faith-based and community organizations. Blue Mountain uses initial educational meetings to introduce the concept of ATR, provider enrollment information, and information about the recovery support services ATR vouchers will support. Enrollment meetings are utilized to enroll recovery support providers, to distribute the eligibility requirements for participation, and to offer help to providers for attaining eligibility standards required for ATR participation. Organizing these events has been an efficient way for Blue Mountain to disseminate information and to answer questions and concerns posed by recovery support service providers.

Outreach to Clients:

With ATR, clients would receive vouchers to redeem at the providers of their choice. To recruit clients, Blue Mountain is conducting significant outreach in a number of ways. Blue Mountain is using a broad range of professional and community sources including self referral, family, friends,

self-help organizations, Tribal organizations, Tribal elders, Healers, faith-based organizations, human service organizations and professionals, health care professionals and centers, community-based organizations, employers, educational institutions, substance abuse treatment facilities, and recovery management services. The Blue Mountain Coalition established an 800 information number and a 24-hour access hotline through which certified addiction professionals conduct screenings, thereby facilitating access to clinical treatment and/or recovery support services.

How vouchers are issued:

Assessment voucher: The screening yields the assessment voucher. At the scheduled time, the client is assessed by qualified and trained staff. The assessment includes the Addiction Severity Index (ASI).

Clinical treatment voucher**:** Based on the results of the comprehensive assessment, a clinical treatment voucher is generated which includes level of care recommendations and all providers that offer the type and level of care indicated by the assessment. The automated voucher system enables the assessor to help the client compare various clinical treatment providers' services and capabilities so the client can make an informed choice. The clinical treatment voucher will contain the client's and assessor's signatures along with the client's choice of provider, clear instructions for the client's next steps – admission date, transportation arrangements (if needed), pre-treatment supports, recovery supports, etc.

Recovery support service voucher: An assessment provider offers multiple choices to the client in terms of recovery supports while awaiting clinical treatment, during clinical treatment, and during extended treatment along with clear instructions about next steps. The assessment produces a recovery supports voucher which includes services that might benefit the client based upon information gathered in the assessment. After the client chooses recovery supports, the client and assessor sign the voucher. The recovery supports voucher may be updated as the need for additional services arises during the course of the recovery process and in preparation for discharge.

Accountability:

Blue Mountain put processes in place to prevent, detect, and investigate incidents of fraud and/or potential abuse. Since Blue Mountain is using electronic tracking systems, ATR clients will be cross-referenced against other public data systems to identify the receipt of duplicative services and potential payments for the same service by more than one payer. Blue Mountain plans to conduct random audits of provider billings and service data. Blue Mountain will also be conducting on-site audits to assess the need for culturally competent services. Blue Mountain required an initial review of provider service and billing practices before a provider was eligible to participate in ATR. In addition, Blue Mountain will be utilizing client satisfaction surveys and medical chart and claims payment audits to reduce the likelihood of waste, fraud and abuse.

Blue Mountain monitored provider reporting of outcomes information on a monthly basis. At the end of the first 6 months of the first year, Blue Mountain recognized ten providers needed technical

assistance to accurately report outcomes information. Blue Mountain provided such technical assistance in a timely manner. At the end of the first year, however, four of the ten providers were still unable to provide the outcomes information in each of the seven domains. As a result, Blue Mountain declared these four providers ineligible for the ATR voucher program for the next year.

Appendix F – Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. ***If you do not adhere to these requirements, your application will be screened out and returned to you without review.***

- ❑ Use the PHS 5161-1 application.

- ❑ Applications must be received by the application deadline or have proof of timely submission, as detailed in Section IV-3 of the grant announcement.

- ❑ Information provided must be sufficient for review.

- ❑ Text must be legible. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-3 of this announcement under "Guidance for Submission of Electronic Applications.")
    - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
    - Text in the Project Narrative cannot exceed 6 lines per vertical inch.

- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.

- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-3 of this announcement under "Guidance for Submission of Electronic Applications.")
    - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the page limit for the Project Narrative stated in the specific funding announcement.
    - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by the page limit. This number represents the full page less margins, multiplied by the total number of allowed pages.
    - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for

review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- ❑ The 10 application components required for SAMHSA applications should be included. These are:

  - Face Page (Standard Form 424 v2, which is in PHS 5161-1)
  - Abstract
  - Table of Contents
  - Budget Form (Standard Form 424A, which is in PHS 5161-1)
  - Project Narrative and Supporting Documentation
  - Appendices
  - Assurances (Standard Form 424B, which is in PHS 5161-1)
  - Certifications
  - Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
  - Checklist (a form in PHS 5161-1)

- ❑ Applications should comply with the following requirements:

  - Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
  - Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement.
  - Documentation of nonprofit status as required in the PHS 5161-1.

- ❑ Pages should be typed single-spaced in black ink, with one column per page. Pages should not have printing on both sides.

- ❑ Please number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- ❑ The page limits for Appendices stated in the specific funding announcement should not be exceeded.

- ❑ Send the original application and two copies to the mailing address in Section IV-6 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix G: Sample Budget and Justification

ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION TO ACCOMPANY SF 424A: SECTION B FOR 01 BUDGET PERIOD

OBJECT CLASS CATEGORIES

Personnel

Job Title	Name	Annual Salary	Level of Effort	Salary being Requested
Project Director	J. Doe	$30,000	1.0	$30,000
Secretary	Unnamed	$18,000	0.5	$ 9,000
Counselor	R. Down	$25,000	1.0	$25,000

Enter Personnel subtotal on 424A, Section B, 6.a. $64,000

Fringe Benefits (24%) $15,360

Enter Fringe Benefits subtotal on 424A, Section B, 6.b. $15,360

Travel

2 trips for SAMHSA Meetings for 2 Attendees
(Airfare @ $600 x 4 = $2,400) + (per diem
@ $120 x 4 x 6 days = $2,880) $5,280
Local Travel (500 miles x .24 per mile)
120

[Note: Current Federal Government per diem rates are available at www.gsa.gov.]

Enter Travel subtotal on 424A, Section B, 6.c. $ 5,400

Equipment (List Individually)

"Equipment" means an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals the lesser of (a) the capitalization level established by the governmental unit or nongovernmental applicant for financial statement purposes, or (b) $5000.

Enter Equipment subtotal on 424A, Section B, 6.d.

Supplies

Office Supplies $500
Computer Software - 1 WordPerfect 500

Enter Supplies subtotal on 424A, Section B, 6.e. $1,000

Contractual Costs

Evaluation

Job Title	Name	Annual Salary	Salary being Requested	Level of Effort
Evaluator	J. Wilson	$48,000	$24,000	0.5
Other Staff		$18,000	$18,000	1.0

Fringe Benefits (25%)	$10,500		
Travel			
2 trips x 1 Evaluator ($600 x 2)		$ 1,200	
per diem @ $120 x 6		720	
Supplies (General Office)		500	
Evaluation Direct			$54,920
Evaluation Indirect Costs (19%)			$10,435
Evaluation Subtotal			$65,355

Training

Job Title	Name	Level of Effort	Salary being Requested
Coordinator	M. Smith	0.5	$ 12,000
Admin. Asst.	N. Jones	0.5	$ 9,000
Fringe Benefits (25%)			$ 5,250

Travel		
2 Trips for Training		
Airfare @ $600 x 2	$ 1,200	
Per Diem $120 x 2 x 2 days	480	
Local (500 miles x .24/mile)	120	
Supplies		
Office Supplies	$ 500	
Software (WordPerfect)	500	
Other		
Rent (500 Sq. Ft. x $9.95)	$ 4,975	
Telephone	500	
Maintenance (e.g., van)	$ 2,500	
Audit	$ 3,000	
Training Direct		$ 40,025
Training Indirect		$ -0-

Enter Contractual subtotal on 424A, Section B, 6.f. $105,380

ILLUSTRATION OF DETAILED BUDGET AND NARRATIVE JUSTIFICATION (cont'd.)

Other

Consultants = Expert @ $250/day X 6 day (If expert is known, should list by name)	$ 1,500

Enter Other subtotal on 424A, Section B, 6.h.	**$ 1,500**
Total Direct Charges (sum of 6.a-6.h) **Enter Total Direct on 424A, Section B, 6.i.**	**$192,640**

Indirect Costs

15% of Salary and Wages (copy of negotiated indirect cost rate agreement attached)	
Enter Indirect subtotal of 424A, Section B, 6.j.	**$ 9,600**

TOTALS

Enter TOTAL on 424A, Section B, 6.k.	**$202,240**

JUSTIFICATION

PERSONNEL - Describe the role and responsibilities of each position.

FRINGE BENEFITS - List all components of the fringe benefit rate.

EQUIPMENT - List equipment and describe the need and the purpose of the equipment in relation to the proposed project.

SUPPLIES - Generally self-explanatory; however, if not, describe need. Include explanation of how the cost has been estimated.

TRAVEL - Explain need for all travel other than that required by SAMHSA.

CONTRACTUAL COSTS - Explain the need for each contractual arrangement and how these components relate to the overall project.

OTHER - Generally self-explanatory. If consultants are included in this category, explain the need and how the consultant's rate has been determined.

INDIRECT COST RATE - If your organization has no indirect cost rate, please indicate whether your organization plans to a) waive indirect costs if an award is issued, or b) negotiate and establish an indirect cost rate with DHHS within 90 days of award issuance.

CALCULATION OF FUTURE BUDGET PERIODS
(based on first 12-month budget period)

Review and verify the accuracy of future year budget estimates. Increases or decreases in the future years must be explained and justified and no cost of living increases will be honored. (NOTE: new salary cap of $186,600 is effective for all FY 2007 awards.) *

	First 12-month Period	Second 12-month Period	Third 12-month Period
Personnel			
Project Director	30,000	30,000	30,000
Secretary**	9,000	18,000	18,000
Counselor	25,000	25,000	25,000
TOTAL PERSONNEL	64,000	73,000	73,000

*Consistent with the requirement in the Consolidated Appropriations Act, Public Law 108-447.
**Increased from 50% to 100% effort in 02 through 03 budget periods.

Fringe Benefits (24%)	15,360	17,520	17,520
Travel	5,400	5,400	5,400
Equipment	-0-	-0-	-0-
Supplies***	1,000	520	520

***Increased amount in 01 year represents costs for software.

Contractual			
Evaluation****	65,355	67,969	70,688
Training	40,025	40,025	40,025

****Increased amounts in 02 and 03 years are reflected of the increase in client data collection.

Other	1,500	1,500	1,500
Total Direct Costs	192,640	205,934	208,653
Indirect Costs (15% S&W)	9,600	9,600	9,600
TOTAL COSTS	202,240	216,884	219,603

The Federal dollars requested for all object class categories for the first 12-month budget period are entered on Form 424A, Section B, Column (1), lines 6a-6i. The total Federal dollars requested for the second through the fifth 12-month budget periods are entered on Form 424A, Section E, Columns (b) – (e), line 20. The RFA will specify the maximum number of years of support that may be requested.

Appendix H: Managing On The Basis Of Reasonable Costs

States are encouraged to manage the program on the basis of reasonable costs. Proposed per person costs for treatment and recovery support services to be provided under this initiative should be included in the application. In cases where it is not possible to include costs that are based on prior experience, the application should include an estimate of the cost of the service, as well as a plan and timeline for developing cost data based on experience.

The following are considered reasonable ranges by treatment or modality:

- Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services - $200 to $1,200
- Outpatient (Non-Methadone) - $1,000 to $5,000
- Outpatient (Methadone) - $1,500 to $8,000
- Residential - $3,000 to $10,000

If the State deviates from these costs, it should provide a justification for doing so, in order for SAMHSA to determine reasonableness of costs. Reasonable cost is based on actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program (Center for Medicare and Medicaid Services, 2003). While cost ranges for recovery support services are not specified above, due to the great variations that exist, applicants are expected to provide costs for recovery support services that they intend to provide. Per person costs for each modality should be computed by dividing the number of persons served in each modality by the amount of the project budget used to fund that program component after subtracting out the costs of required data collection and submission.

Appendix I

Form Approved
OMB No. 0930-0208
Expiration Date 01/31/2007

CSAT GPRA Client Outcome Measures for Discretionary Programs

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Client Type:

- ○ Treatment client
- ○ Client in recovery

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake [GO TO INTERVIEW DATE]

6 month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3 month follow-up ***[ADOLESCENT PORTFOLIO ONLY]*** →
Did you conduct a follow-up interview? ○ Yes ○ No ***[IF NO, GO DIRECTLY TO SECTION I.]***

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |____|____| / |____|____| / |____|____|____|____|
Month Day Year

FOR SBIRT GRANTS ONLY: REPORTED ONLY AT INTAKE/BASELINE

How did the client screen? ○ Negative ○ Positive

What was his/her screening score?

AUDIT = |____|____|

CAGE = |____|____|

DAST = |____|____|

DAST-10 = |____|____|

NIAAA Guide = |____|____|

Other (Specify) _____ = |____|____|

Was he/she willing to continue his/her participation in the SBIRT program? ○ Yes ○ No

---

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

A. RECORD MANAGEMENT (Continued)

PLANNED SERVICES [*REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE]*

Identify the services you plan to provide to the client during the client's course of treatment/recovery. ***[CIRCLE 'Y' FOR YES OR 'N' FOR NO FOR EACH ONE.]***

Modality ***[SELECT AT LEAST ONE MODALITY.]***	**Yes**	**No**
1. Case Management	Y	N
2. Day Treatment	Y	N
3. Inpatient/Hospital (Other Than Detox)	Y	N
4. Outpatient	Y	N
5. Outreach	Y	N
6. Intensive Outpatient	Y	N
7. Methadone	Y	N
8. Residential/Rehabilitation	Y	N
9. Detoxification (Select Only One)		
A. Hospital Inpatient	Y	N
B. Free Standing Residential	Y	N
C. Ambulatory Detoxification	Y	N
10. After Care	Y	N
11. Recovery Support	Y	N
12. Other (Specify)_____	Y	N

Treatment Services ***[SBIRT GRANTS: YOU MUST CIRCLE 'Y' FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]***	**Yes**	**No**
1. Screening	Y	N
2. Brief Intervention	Y	N
3. Brief Treatment	Y	N
4. Referral to Treatment	Y	N
5. Assessment	Y	N
6. Treatment/Recovery Planning	Y	N
7. Individual Counseling	Y	N
8. Group Counseling	Y	N
9. Family/Marriage Counseling	Y	N
10. Co-Occurring Treatment/ Recovery Services	Y	N
11. Pharmacological Interventions	Y	N
12. HIV/AIDS Counseling	Y	N
13. Other Clinical Services (Specify)_____	Y	N

Case Management Services	**Yes**	**No**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Employment Service		
A. Pre-Employment	Y	N
B. Employment Coaching	Y	N
4. Individual Services Coordination	Y	N
5. Transportation	Y	N
6. HIV/AIDS Service	Y	N
7. Supportive Transitional Drug-Free Housing Services	Y	N
8. Other Case Management Services (Specify)_____	Y	N

Medical Services	**Yes**	**No**
1. Medical Care	Y	N
2. Alcohol/Drug Testing	Y	N
3. HIV/AIDS Medical Support & Testing	Y	N
4. Other Medical Services (Specify)_____	Y	N

After Care Services	**Yes**	**No**
1. Continuing Care	Y	N
2. Relapse Prevention	Y	N
3. Recovery Coaching	Y	N
4. Self-Help and Support Groups	Y	N
5. Spiritual Support	Y	N
6. Other After Care Services (Specify)_____	Y	N

Education Services	**Yes**	**No**
1. Substance Abuse Education	Y	N
2. HIV/AIDS Education	Y	N
3. Other Education Services (Specify)_____	Y	N

Peer-To-Peer Recovery Support Services	**Yes**	**No**
1. Peer Coaching or Mentoring	Y	N
2. Housing Support	Y	N
3. Alcohol- and Drug-Free Social Activities	Y	N
4. Information and Referral	Y	N
5. Other Peer-to-Peer Recovery Support Services (Specify)_____	Y	N

A. RECORD MANAGEMENT - DEMOGRAPHICS *[ASKED ONLY AT INTAKE/BASELINE]*

1. What is your gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY)_____
- ○ REFUSED

2. Are you Hispanic or Latino?

- ○ YES
- ○ NO
- ○ REFUSED

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	Yes	No	Refused
Central American	Y	N	Refused
Cuban	Y	N	Refused
Dominican	Y	N	Refused
Mexican	Y	N	Refused
Puerto Rican	Y	N	Refused
South American	Y	N	Refused
Other	Y	N	Refused *[IF YES, SPECIFY BELOW]*
	(Specify)_____		

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	Refused
Asian	Y	N	Refused
Native Hawaiian or other Pacific Islander	Y	N	Refused
Alaska Native	Y	N	Refused
White	Y	N	Refused
American Indian	Y	N	Refused

4. What is your date of birth?*

|____|____| / |____|____| /
MONTH DAY

|____|____|____|____|
YEAR

○ REFUSED

***THE SYSTEM WILL ONLY SAVE MONTH AND YEAR**. DAY IS NOT SAVED TO MAINTAIN CONFIDENTIALITY.*

		Number of Days	REFUSED	DON'T KNOW
1.	**During the past 30 days how many days have you used the following:**			
a.	Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|	○	○
b1.	Alcohol to intoxication (5+ drinks in one sitting)	|____|____|	○	○
b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|	○	○
c.	Illegal drugs	|____|____|	○	○
d.	Both alcohol and drugs (on the same day)	|____|____|	○	○

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

Number of Days	RF DK	Route*	RF DK

2. During the past 30 days, how many days have you used any of the following:

a.	Cocaine/Crack	|____|____|	○	○	|____|	○	○
b.	Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|	○	○	|____|	○	○
c.	Opiates:						
	1. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○	|____|	○	○
	2. Morphine	|____|____|	○	○	|____|	○	○
	3. Diluadid	|____|____|	○	○	|____|	○	○
	4. Demerol	|____|____|	○	○	|____|	○	○
	5. Percocet	|____|____|	○	○	|____|	○	○
	6. Darvon	|____|____|	○	○	|____|	○	○
	7. Codeine	|____|____|	○	○	|____|	○	○
	8. Tylenol 2,3,4	|____|____|	○	○	|____|	○	○
	9. Oxycontin/Oxycodone	|____|____|	○	○	|____|	○	○
d.	Non-prescription methadone	|____|____|	○	○	|____|	○	○
e.	Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline	|____|____|	○	○	|____|	○	○
f.	Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	|____|____|	○	○	|____|	○	○

B. DRUG AND ALCOHOL USE (Continued)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following:			Number of Days	RF	DK	Route*	RF	DK
g.	1.	Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol–also known as roofies, roche, and cope)	|____|____|	○	○	|____|	○	○
	2.	Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal)	|____|____|	○	○	|____|	○	○
	3.	Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)	|____|____|	○	○	|____|	○	○
	4.	Ketamine (known as Special K or Vitamin K)	|____|____|	○	○	|____|	○	○
	5.	Other tranquilizers, downers, sedatives or hypnotics	|____|____|	○	○	|____|	○	○
h.		Inhalants (poppers, snappers, rush, whippets)	|____|____|	○	○	|____|	○	○
i.		Other illegal drugs (Specify)_____	|____|____|	○	○	|____|	○	○

3. In the past 30 days have you injected drugs?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

○ Always
○ More than half the time
○ Half the time
○ Less than half the time
○ Never
○ REFUSED
○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)

- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED:
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

5. ***[IF NOT MALE,]*** **Are you currently pregnant?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

6. Do you have children?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION D.]

a. How many children do you have?

|____|____| ○ REFUSED ○ DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION D.]

c. ***[IF YES,]*** **How many of your children are living with someone else due to a child protection court order?**

|____|____| ○ REFUSED ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

d. For how many of your children have you lost parental rights? ***[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.]***

|____|____| ○ REFUSED ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED,]* Is that full time or part time?

- ○ NOT ENROLLED
- ○ ENROLLED, FULL TIME
- ○ ENROLLED, PART TIME
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- ○ NEVER ATTENDED
- ○ 1ST GRADE
- ○ 2ND GRADE
- ○ 3RD GRADE
- ○ 4TH GRADE
- ○ 5TH GRADE
- ○ 6TH GRADE
- ○ 7TH GRADE
- ○ 8TH GRADE
- ○ 9TH GRADE
- ○ 10TH GRADE
- ○ 11TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- ○ COLLEGE OR UNIVERSITY/1st YEAR COMPLETED
- ○ COLLEGE OR UNIVERSITY/2nd YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
- ○ COLLEGE OR UNIVERSITY/3rd YEAR COMPLETED
- ○ BACHELOR'S DEGREE (BA, BS) OR HIGHER
- ○ VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- ○ VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- ○ REFUSED
- ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (Continued)

3. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]*

- ○ EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from…

			RF	**DK**
a.	Wages	$ |__|__|__| , |__|__|__|	○	○
b.	Public assistance	$ |__|__|__| , |__|__|__|	○	○
c.	Retirement	$ |__|__|__| , |__|__|__|	○	○
d.	Disability	$ |__|__|__| , |__|__|__|	○	○
e.	Non-legal income	$ |__|__|__| , |__|__|__|	○	○
f.	Family and/or friends	$ |__|__|__| , |__|__|__|	○	○
g.	Other (Specify) _____	$ |__|__|__| , |__|__|__|	○	○

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF NO ARRESTS, GO TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

3. In the past 30 days, how many nights have you spent in jail/prison?

|____|____| NIGHTS ○ REFUSED ○ DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS (Continued)

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 4. ANSWER HERE IN E4 MUST BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|___|___|___| TIMES ○ REFUSED ○ DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

6. Are you currently on parole or probation?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

○ Excellent
○ Very good
○ Good
○ Fair
○ Poor
○ REFUSED
○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

		YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i.	Physical complaint	○	_____ nights	○	○	○
ii.	Mental or emotional difficulties	○	_____ nights	○	○	○
iii.	Alcohol or substance abuse	○	_____ nights	○	○	○

b. Outpatient Treatment for:

		YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i.	Physical complaint	○	_____ times	○	○	○
ii.	Mental or emotional difficulties	○	_____ times	○	○	○
iii.	Alcohol or substance abuse	○	_____ times	○	○	○

c. Emergency Room Treatment for:

		YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i.	Physical complaint	○	_____ times	○	○	○
ii.	Mental or emotional difficulties	○	_____ times	○	○	○
iii.	Alcohol or substance abuse	○	_____ times	○	○	○

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

3. During the past 30 days, did you engage in sexual activity?

- ○ Yes
- ○ No → ***[GO TO F4.]***
- ○ NOT PERMITTED TO ASK → ***[GO TO F4.]***
- ○ REFUSED → ***[GO TO F4.]***
- ○ DON'T KNOW → ***[GO TO F4.]***

[IF YES] **Altogether, how many:**

		Contacts	RF	DK
a.	Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|____|	○	○
b.	Unprotected sexual contacts did you have? ***[IF ZERO, GO TO F4.]***	|____|____|____|	○	○
c.	Unprotected sexual contacts were with an individual who is or was:			
	1. HIV positive or has AIDS	|____|____|____|	○	○
	2. An injection drug user	|____|____|____|	○	○
	3. High on some substance	|____|____|____|	○	○

4. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

		Days	RF	DK
a.	Experienced serious depression	|____|____|	○	○
b.	Experienced serious anxiety or tension	|____|____|	○	○
c.	Experienced hallucinations	|____|____|	○	○
d.	Experienced trouble understanding, concentrating, or remembering	|____|____|	○	○
e.	Experienced trouble controlling violent behavior	|____|____|	○	○
f.	Attempted suicide	|____|____|	○	○
g.	Been prescribed medication for psychological/emotional problem	|____|____|	○	○

[IF CLIENT REPORTS ZERO DAYS TO ALL ITEMS IN QUESTION 4, SKIP TO SECTION G.]

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerably
- ○ Extremely
- ○ REFUSED
- ○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES _____ ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

2. In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES _____ ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES _____ ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

5. To whom do you turn when you are having trouble? ***[SELECT ONLY ONE.]***

- ○ NO ONE
- ○ CLERGY MEMBER
- ○ FAMILY MEMBER
- ○ FRIENDS
- ○ REFUSED
- ○ DON'T KNOW
- ○ OTHER SPECIFY: _____

[IF THIS IS AN INTAKE/BASELINE INTERVIEW, STOP NOW, THE INTERVIEW IS COMPETE. REMEMBER TO FILL IN PLANNED SERVICES ON PAGE 2.]

I. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP]

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED].***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (SPECIFY) _____

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS
[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

1. On what date was the client discharged?

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? [*SELECT ONE RESPONSE*.]

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other (Specify) _____

K. SERVICES RECEIVED
[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. *[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]*

Modality	**Days**
1. Case Management	|___|___|___|
2. Day Treatment	|___|___|___|
3. Inpatient/Hospital (Other Than Detox)	|___|___|___|
4. Outpatient	|___|___|___|
5. Outreach	|___|___|___|
6. Intensive Outpatient	|___|___|___|
7. Methadone	|___|___|___|
8. Residential/Rehabilitation	|___|___|___|

9. Detoxification (Select Only One)
   A. Hospital Inpatient |___|___|___|
   B. Free Standing Residential |___|___|___|
   C. Ambulatory Detoxification |___|___|___|
10. After Care |___|___|___|
11. Recovery Support |___|___|___|
12. Other (Specify) _____ |___|___|___|

Identify the number of SESSIONS provided to the client during the client's course of treatment/ recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.]***

Treatment Services **Sessions**

[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

1. Screening |___|___|___|
2 Brief Intervention |___|___|___|
3. Brief Treatment |___|___|___|
4. Referral to Treatment |___|___|___|
5. Assessment |___|___|___|
6. Treatment/Recovery Planning |___|___|___|
7. Individual Counseling |___|___|___|
8. Group Counseling |___|___|___|
9. Family/Marriage Counseling |___|___|___|
10. Co-Occurring Treatment/Recovery Services|___|___|___|
11. Pharmacological Interventions |___|___|___|
12. HIV/AIDS Counseling |___|___|___|
13. Other Clinical Services
    (Specify) _____ |___|___|___|

Case Management Services **Sessions**

1. Family Services (Including Marriage Education, Parenting, Child Development Services) |___|___|___|
2. Child Care |___|___|___|
3. Employment Service
   A. Pre-Employment |___|___|___|
   B. Employment Coaching |___|___|___|
4. Individual Services Coordination |___|___|___|
5. Transportation |___|___|___|
6. HIV/AIDS Service |___|___|___|
7. Supportive Transitional Drug-Free Housing Services |___|___|___|
8. Other Case Management Services (Specify) |___|___|___|

Medical Services **Sessions**

1. Medical Care |___|___|___|
2. Alcohol/Drug Testing |___|___|___|
3. HIV/ AIDS Medical Support & Testing|___|___|___|
4. Other Medical Services
   (Specify) _____ |___|___|___|

After Care Services **Sessions**

1. Continuing Care |___|___|___|
2. Relapse Prevention |___|___|___|
3. Recovery Coaching |___|___|___|
4. Self-Help and Support Groups |___|___|___|
5. Spiritual Support |___|___|___|
6. Other After Care Services
   (Specify) _____ |___|___|___|

Education Services **Sessions**

1. Substance Abuse Education |___|___|___|
2. HIV/AIDS Education |___|___|___|
3. Other Education Services
   (Specify) _____ |___|___|___|

Peer-To-Peer Recovery Support Services **Sessions**

1. Peer Coaching or Mentoring |___|___|___|
2. Housing Support |___|___|___|
3. Alcohol-and Drug-Free Social Activities |___|___|___|
4. Information and Referral |___|___|___|
5. Other Peer-to-Peer Recovery Support Services
   (Specify) _____ |___|___|___|

Appendix J

Form Approved
OMB No. 0930-0266
Expiration Date 05/31/2008

VOUCHER INFORMATION
ACCESS TO RECOVERY PROGRAM

VOUCHER INFORMATION

Client ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Grant ID: __ __ __ __ __ __ __

Voucher ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Voucher Issue Date: |___|___| / |___|___| / |___|___|___|___|
Month Day Year

Voucher Amount:: $__ __ __ __ __. __ __

Voucher Service Type: (Check all that apply)

Clinical Treatment Services		Medical Services	
☐	1. Screening/assessment	☐	21. Medical Care
☐	2. Brief Intervention	☐	22. Alcohol/Drug Testing
☐	3. Treatment Planning	☐	23. HIV/AIDS Medical Support & Testing
☐	4. Individual Counseling	☐	24. Other Medical Services
☐	5. Group Counseling	**After Care/Recovery Support Services**	
☐	6. Family/Marriage Counseling		
☐	7. Co-occurring Treatment Services	☐	25. Continuing Care
☐	8. Pharmacological Interventions	☐	26. Relapse prevention
☐	9. HIV/AIDS Counseling	☐	27. Recovery Coaching
☐	10. Other Clinical Services	☐	28. Self-help and Support Groups
Case Management/Recovery Support Services		☐	29. Spiritual Support
		☐	30. Other After Care Services
☐	11. Family Services (including marriage education, parenting and child development services)	**Education/Recovery Support Services**	
☐	12. Child Care	☐	31. Substance Abuse Education
☐	13. Employment Services	☐	32. HIV/AIDS Education
☐	14. Pre-employment Services	☐	33. Other Education Services
☐	15. Employment Coaching	**Peer-to-Peer Recovery Support Services**	
☐	16. Individual Services Coordination		
☐	17. Transportation	☐	34. Peer Coaching or Mentoring
☐	18. HIV/AIDS services	☐	35. Housing Support
☐	19. Supportive transitional drug-free housing services	☐	36. Alcohol- and Drug-Free Social Activities
☐	20. Other Case Management Services	☐	37. Information and Referral
		☐	38. Other Peer-to-Peer Recovery Support Services

Appendix K

Form Approved
OMB No. 0930-0266
Expiration Date 05/31/2008

VOUCHER TRANSACTION INFORMATION
ACCESS TO RECOVERY PROGRAM

VOUCHER TRANSACTION INFORMATION

Client ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Grant ID: __ __ __ __ __ __ __

Voucher ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Transaction ID: __ __ __ __ __ __ __ __ __ __

Provider ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Voucher Redemption Date: |___|___| / |___|___| / |___|___|___|___|
Month Day Year

Amount Redeemed: $__ __ __ __ __.__ __

Number of Sessions: __ __ __ __ __

Voucher Service Type: (Indicate which service the client received for this transaction from the list below)

Clinical Treatment Services		Medical Services	
☐	1. Screening/assessment	☐	21. Medical Care
☐	2. Brief Intervention	☐	22. Alcohol/Drug Testing
☐	3. Treatment Planning	☐	23. HIV/AIDS Medical Support & Testing
☐	4. Individual Counseling	☐	24. Other Medical Services
☐	5. Group Counseling	**After Care/Recovery Support Services**	
☐	6. Family/Marriage Counseling		
☐	7. Co-occurring Treatment Services	☐	25. Continuing Care
☐	8. Pharmacological Interventions	☐	26. Relapse prevention
☐	9. HIV/AIDS Counseling	☐	27. Recovery Coaching
☐	10. Other Clinical Services	☐	28. Self-help and Support Groups
Case Management/Recovery Support Services		☐	29. Spiritual Support
		☐	30. Other After Care Services
☐	11. Family Services (including marriage education, parenting and child development services)	**Education/Recovery Support Services**	
☐	12. Child Care	☐	31. Substance Abuse Education
☐	13. Employment Services	☐	32. HIV/AIDS Education
☐	14. Pre-employment Services	☐	33. Other Education Services
☐	15. Employment Coaching	**Peer-to-Peer Recovery Support Services**	
☐	16. Individual Services Coordination		
☐	17. Transportation	☐	34. Peer Coaching or Mentoring
☐	18. HIV/AIDS services	☐	35. Housing Support

☐	19. Supportive transitional drug-free housing services	☐	36. Alcohol- and Drug-Free Social Activities
☐	20. Other Case Management Services	☐	37. Information and Referral
		☐	38. Other Peer-to-Peer Recovery Support Services

Appendix L: Confidentiality and Participant Protection

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the seven bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining IRB approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and protection of human subjects identified during peer review of the application may result in the delay of funding.

1. *Protect Clients and Staff from Potential Risks*

   - Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

   - Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.

   - Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

   - Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. *Fair Selection of Participants*

   - Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

   - Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

   - Explain the reasons for including or excluding participants.

   - Explain how you will recruit and select participants. Identify who will select participants.

3. *Absence of Coercion*

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.).

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. *Data Collection*

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Appendix 2, "Data Collection Instruments/Interview Protocols,"** copies of all available data collection instruments and interview protocols that you plan to use.

5. *Privacy and Confidentiality*

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:

  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

6. *Adequate Consent Procedures*

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

- State:

  - Whether or not their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Possible risks from participation in the project.
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Appendix 3, "Sample Consent Forms"**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

Applicants may also have to comply with the Protection of Human Subjects Regulations (45 CFR 46), depending on the evaluation and data collection procedures proposed and the population to be served.

Applicants must be aware that even if the Protection of Human Subjects Regulations do not apply to all projects funded, the specific evaluation design proposed by the applicant may require compliance with these regulations.

Applicants whose projects must comply with the Protection of Human Subjects Regulations must describe the process for obtaining Institutional Review Board (IRB) approval fully in their applications. While IRB approval is not required at the time of grant award, these applicants will be required, as a condition of award, to provide the documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP) and that IRB approval has been received prior to enrolling any clients in the proposed project.

General information about Protection of Human Subjects Regulations can be obtained on the web at http://www.hhs.gov/ohrp. You may also contact OHRP by e-mail (ohrp@osophs.dhhs.gov) or by phone (240/453-6900). SAMHSA-specific questions related to Protection of Human Subjects Regulations should be directed to the program contact listed in Section VII of this RFA.

Appendix M: Access to Recovery Performance Targets

Long Term Goal: **See CSAT/Capacity**			
Measures	FY	Target	Result
Increase the number of clients gaining access to treatment *(output)* [1]	***2010***	**55,000**	**Nov-10**
	2009	**55,000**	**Nov-09**
	2008	**25,000**	**Nov-08**
	2007	**50,000**	**Dec-07**
	2006	**50,000**	**96,959**
	2005	**Baseline**	**23,138**
Increase the percentage of adults receiving services who: *(outcome)*	***2010***	**Sep-07**	**Nov-10**
	2009	**Sep-07**	**Nov-09**
a) had no past month substance use	***2008***	**Sep-07**	**Nov-08**
	2007	**81%**	**Dec-07**
	2006	**79%**	**81.4%**
	2005	**Baseline**	**78%**
b) had improved family and living conditions	***2010***	**Sep-07**	**Nov-10**
	2009	**Sep-07**	**Nov-09**
	2008	**Sep-07**	**Nov-08**
	2007	**52%%**	**Dec-07**
	2006	**63%**	**51%**
	2005	**Baseline**	**62%**

c) had no/reduced involvement with the criminal justice system	***2010***	**Sep-07**	**Nov-10**
	2009	**Sep-07**	**Nov-09**
	2008	**Sep-07**	**Nov-08**
	2007	**97%**	**Dec-07**
	2006	**95%**	**96.8%**
	2005	**Baseline**	**95%**
d) had improved social support	***2010***	**Sep-07**	**Nov-10**
	2009	**Sep-07**	**Nov-09**
	2008	**Sep-07**	**Nov-08**
	2007	**90%**	**Dec-07**
	2006	**90%**	**90%**
	2005	**Baseline**	**89%**
e) were currently employed or engaged in productive activities	***2010***	**Sep-07**	**Nov-10**
	2009	**Sep-07**	**Nov-09**
	2008	**Sep-07**	**Nov-08**
	2007	**50%**	**Dec-07**
	2006	**57%**	**50%**
	2005	**Baseline**	**56%**
f) had improved retention in treatment	***2010***	**Sep-07**	**Nov-10**
	2009	**Sep-07**	**Nov-09**
	2008	**Sep-07**	**Nov-08**
	2007	**31%**	**Dec-07**
	2006	**24%**	**30.2%**
	2005	**Baseline**	**22.8%**
Data Source: **CSAT's Automated Services Accountability Improvement System (SAIS)**			

Data Validation: **All data are automatically checked as they are input into SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.**
Cross Reference: **HHS #1.4; Secretary's 500 day plan: Increasing the commitment to faith-and community-based grants, including Access to Recovery.**

* Initial Access to Recovery grants were made in August 2004, close to the end of FY 2004. Services are not necessarily provided in the same year Federal funds are obligated. Thus, although the baseline reported for FY 2005 will represent people served in FY 2005, most of the funding will consist of FY 2004 dollars. With the FY 2004 grants, an estimated 125,000 clients will be served over the three year grant period.

1. The first cohort of grantees ends in FY 2007. The second cohort of ATR grantees will begin in FY 2008. Targets for 2008 are lower to allow the new grantees to develop the appropriate infrastructure.