**Exhibit B – SUD Px Application Packet**

(This application packet is for Applicants applying for programs funded SUD Px Funds)

**Attachment 1 – SUD Px - Application Cover Page**

(Mandatory/Not Scored\* Bonus Point Available)

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| 1. **Applicant type**   See Section 1 *Definitions* of RFA2023HCA8 for Applicant Type Details. | **Applicant Type A – Requesting funding for new services**  **Applicant Type A – Requesting funding to expand existing services**  **Applicant Type A – Requesting funding to continue existing services**  **Applicant Type B – Requesting funding for new services** | |
| 1. **Organization Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. **Fund Source(s) Applying For**   (Select All That Apply) | Opioid Prevention Services  Dedicated Cannabis Account (DCA) | |
| 1. **Community(ies) Served by Applicant’s Programs**   Community is identified as High Risk/High Need per Exhibit - E [Yes  No ]  Bonus Points (5 regardless of total High Risk/High Need communities served.): | (Type in Community) | (Type in Community) |
| (Type in Community) | (Type in Community) |
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| (Type in Community) | (Type in Community) |
| 1. **County(ies) Served by Applicant’s Programs**   (Select All That Apply) | (Select County) | (Select County) |
| (Select County) | (Select County) |
| (Select County) | (Select County) |
| (Select County) | (Select County) |
| (Select County) | (Select County) |
| 1. **School District(s) Served by Applicant’s Programs**   (Select All that Apply) | (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| 1. **Can Program Implementation begin within 30 days of contract execution?** | Yes  No | |
| 1. **Total Amount of Funding Requested**   (For two (2) year period) | Opioid Prevention Services  Year 1 $\_\_\_\_\_\_\_\_\_\_  Year 2 $\_\_\_\_\_\_\_\_\_\_  DCA  Year 1 $\_\_\_\_\_\_\_\_\_\_  Year 2 $\_\_\_\_\_\_\_\_\_\_ | |
| 1. **Are you collaborating with a Community Coalition?** Bonus Points(5) | Yes  No *(Skip to #10)*   * 1. If yes, how is this coalition funded?   HCA/DBHR CPWI  Drug Free Communities,  Other existing Community Coalitions  Other state funded prevention efforts  DCYF, Family and Youth support Prevention Programs  DOH Youth Cannabis and Commercial Tobacco Programs   * 1. If yes, please identify the community coalition contact person and email address.   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * 1. If yes, provide a letter of support from the community coalition(s) separate from this document. (Bonus points: 5) | |
| 1. **Is your application complete? Please check box indicating that your application includes the following:** | Application Cover Page - Attachment 1  Program Selection Form - Attachment 2  Action Plan - Attachment 3  Project Narrative - Attachment 4 | |

Dedicated Cannabis Account (DCA): To address RCW 69.50.540 HCA will provide grants to entities to implement youth cannabis misuse and abuse prevention services. HCA intends to increase capacity to implement direct and environmental substance use disorder prevention services in communities.

Opioid Prevention Services: (this and any variations of) means State and/or Federal funding granted to provide opioid prevention services. Funding for Prevention Capacity Expansion is provided to fund prevention services for youth, young adults, and families through community-based (CBO) grants.

Return the entire Application Packet as part of your submittal to Procurement Coordinator at:  
[HCAProcurements@hca.wa.gov](mailto:HCAProcurements@hca.wa.gov)

Attachment 2- Program Selection Form

(Mandatory/Not Scored)

This program selection form is a list of all possible evidence-based programs and strategies that an Applicant can choose from to address their local conditions. The selected program(s) will be used by the Applicant to create their Action Plan and Budget. Applicants must select the box next to each program they plan to implement. Program selection should reflect the Applicant’s capacity and budget.

Community Based Organizations applying for Opioid Prevention Services are required to use the following guidance when implementing services each year under the contract:

* + 1. Must implement at least the following Information Dissemination Strategies:

Participate in the National Drug Take-Back Days, held in April and October each year, or at least twice annually based on local implementation. Participation in a Take Back Day could entail:

* + - Partnering and following DEA regulations on hosting an event.
    - Partnering with an existing community Take Back Day (not organized by the CBO), ensuring CBO staff are present at the event, and promoting the event on various platforms to encourage participation from the community.
    - Promoting the National Drug Take Back Days, sharing Take Back resources with the community such as [www.medproject.org](http://www.medproject.org), and implementing the Starts with One Take Back campaign messages.

Implementation of the Starts with One opioid prevention public education campaign. Implementation means having a recurring cycle (at least once monthly) of media reach, through one or more mediums (social media, ads, radio, billboards, traditional media). Local implementation and/or translations may occur in consultation with HCA/DBHR. Information on the Starts with One campaign can be found at <https://getthefactsrx.com/>.

* + 1. Implement at least one Direct Service Program or Strategy on the list below. The program is expected to be implemented on a regular annual schedule over the course of the grant year, which may mean implementing multiple series or cycles of a program. For example, if Guiding Good Choices is selected, which is a five-week program, this must be implemented at least twice during each fiscal year.

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| Opioid Prevention Services Funded Direct Service Programs or Strategies | |
| **Evidence-Based (EB) Programs for Opioid Prevention Services** | |
| Athletes Training and Learning to Avoid Steroids (ATLAS)  Community-based Mentoring (Across Ages, Big Brothers Big Sisters Community Based, Career Beginnings, or innovative design – must be approved by Mentoring Works WA)  Communities that Care (CTC)  Familias Unidas  Good Behavior Game   * Approved versions: American Institutes for Research (AIR) GBG, PAXIS Institute (PAX) GBG   Guiding Good Choices | LifeSkills Training (LST) – Botvin Middle School Version  Nurse Family Partnership (NFP)  Positive Action  Project Northland (Class Action may be done as a booster)  Project Towards No Drug Abuse  PROSPER  Raising Healthy Children  SPORT Prevention Plus Wellness  Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14, Iowa version)  Strong African American Families Program  Strong African American Families - Teen |
| **Promising - Information Dissemination Strategy (Optional)** | **Promising – Environmental Strategy (Optional)** |
| Social Norms | Prescription Drug Monitoring Program (PMP) use promotion  Prescriber/Provider Education  School Policy |

Community Based Organizations applying for Dedicated Cannabis Account (DCA) are required to use the following guidance when implementing services each year under the grant:

1. Implement at least one Direct Service Program or Strategy on the list below. The program is expected to be implemented on a regular annual schedule over the course of the grant year, which may mean implementing multiple series or cycles of a program. For example, if Guiding Good Choices is selected, which is a five-week program, this must be implemented at least twice during each fiscal year.
2. If an Applicant is applying for Dedicated Cannabis Account (DCA) funds, once two (2) or more Evidence-Based Programs are selected, an Applicant may select one (1) Promising Program.

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| **Dedicated Cannabis Account (DCA) Funded Direct Service Programs or Strategies** | |
| **Evidence-Based (EB) & Research-Based (RB) Programs for Dedicated Cannabis Account** | |
| Community-based Mentoring (Across Ages, Big Brothers Big Sisters Community Based, Career Beginnings, or innovative design – must be approved by Mentoring Works WA)  Communities that Care  Familias Unidas  Family Matters (Adapted for Marijuana)  Good Behavior Game   * Approved versions: American Institutes for Research (AIR) GBG, PAXIS Institute (PAX) GBG   Guiding Good Choices  Incredible Years   * Approved versions: Parent BASICS – (toddler, preschool, and/or School Age); Teacher Classroom management\*   Lifeskills Training (LST) – Middle School – Approved version: Botvin Middle School Version; Grades 6, 7, and 8 | Lions Quest Skills for Adolescence  Nurse Family Partnership (NFP)  Positive Action  Project Northland (Class Action may be done as a booster)  Project STAR (Formerly Midwestern Prevention Project)  Project Towards No Drug Abuse  Project Towards No Tobacco Use (adapted for marijuana)  PROSPER  Raising Healthy Children (using Seattle Social Development Project model)  SPORT Prevention Plus Wellness  Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14, Iowa Version)  Strong African American Families Program  Strong African American Families Program – Teen |
| **Promising Program (Optional):** | **Promising Environmental Strategy (Optional):** |
| Athletes Training and Learning to Avoid Steroids (ATLAS) | Community Trials Intervention to Reduce High-Risk Drinking (adapted for marijuana)  Policy Review and Development  Purchase Surveys coupled with Reward and Reminder  Restrictions at Community Events  Social Norms |

\*Each listed Incredible Years version may be implemented as a stand-alone program: more than one version is not required.

Attachment 3 – Action Plan (20 points scored)

Directions: Complete an Action Plan using the template provided below. In order to fully complete the Action Plan for submission, fill in responses to all prompts beneath all Goals/Objectives, outlining the programs and strategies you are planning on implementing. Please include the program name(s), the number of participants being served, number of sessions, months the program(s) will be implemented, and the responsible party(ies) within the community or organization who will be running the programs/services. These programs/activities should correspond with the required programs/activities as outlined in Attachment 2. If you cannot answer a specific section on the Action Plan, you must indicate the reason within the table. Applicants may add as many tables for Goals and Objectives as needed.

**Goal:** Write the goal you are looking to achieve within your community with the program / strategy you are choosing. Goals should be written in SMART (Specific, Measurable, Actionable, Realistic, Timely) goal form.

**Objective:** Write the specific and measurable outcomes(s) you will strive to achieve to accomplish your stated goal. Objectives should be written in SMART (Specific, Measurable, Actionable, Realistic, Timely) goal form.

**CSAP:** Choose the appropriate CSAP category that your program / strategy fits within. CSAP categories can be found in the definitions section of this RFA.

**Program / Strategy:** Write the name(s) of program / strategy(ies) from Program Selection List that you have selected to implement.

**Community Name:** Write the name of community(ies) each program will serve.

**IOM Category:** Indicate the appropriate IOM Category (Universal Direct, Universal Indirect, Selected, Indicated). IOM Categories can be found in the definitions section of this RFA.

**How much? How often?:** Write how many groups of people will be receiving the program / strategy, and how many series will be offered.

**When:** List all of the implementation months of the program.

**Who & How many:** Write who is this service for, and how many people reached.

**Survey:** Type A Applicants should indicate which survey they will implement using the survey selection guide posted on Athena, Type B Applicants should indicate N/A (Successful type B applicants will receive guidance in survey selection after award).

**Responsible party(ies) and Program Lead:** Write who (Name and/or title) within the organization will be responsible to ensure all set up for the program / strategy, and who will be the Lead in implementing it. If this is the same person, please indicate.

This template is for use with the September 1, 2023 – June 30, 2025 HCA/DHBR CBO MHPP Grants . Please complete an Action Plan for Direct Service Programs and Strategies for the first fiscal year only. If Applicant is awarded a contract, the Action Plan for Year 2 Direct Service Programs and Strategies will be resubmitted for review with HCA by June 15, 2024.

Applicants may use as many tables as needed.

Prevention Services Action Plan Template

**Action Plan for First Year: September 1, 2023 - June 30, 2024:**

***Goal 1:***



***CSAP Strategy:***Choose an item.*(See definitions in RFA)*

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| Fund Source | Program/ Strategy | Community Name | IOM Category | How much?  How often? | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *DCA*  *or*  *Opioid* | *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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***Goal 2:***

***Objective 2.1:***

***CSAP Strategy:***Choose an item. *(See definitions in RFA)*

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| Fund Source | Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Lead |
| *DCA*  *or*  *Opioid* | *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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**Action Plan for Second Year: July 1, 2024 - June 30, 2025:**

***Goal 1:***



***CSAP Strategy:***Choose an item. *(See definitions in RFA)*

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| Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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***Goal 2:***

***Objective 2.1:***

***CSAP Strategy:***Choose an item. *(See definitions in RFA)*

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| Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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**Attachment 4 – Project Narrative** (55 Points Scored)

Instructions for Project Narrative

A complete Project Narrative is required for the Application to be considered complete.

Please provide complete responses to the following questions to describe the proposed program(s) selected. Please remember: The Project Narrative will be scored according to how well the Applicant answers each question. Each narrative question will be assessed when determining the score for each question. If an Applicant cannot answer a specific question, then the reason for this must be explained within the answer to the question.

All required responses must be submitted using the template provided. Each response may not exceed the number of pages listed in the questions described below, and any pages that exceed this limit will be deleted prior to the Health Care Authority (HCA) forwarding the applications to the evaluators. Applicants are not required to utilize the full-page allotment if not needed, as long as the Applicant ensures that the answer is complete.

*Optional:* Applicant *may use the checklist below to track their response progress*

Section 1 -Overview (20 points)

Question 1.

Question 2.

Question 3.

Question 4.

Section 2- Plan for Advancing Health Equity (10 Points)

Question 5.

Question 6.

Section 3 – Implementation (25 Points)

Question 7.

Question 8.

Question 9.

Question 10.

Question 11.

1. **Describe the community(ies) that will be served with your program(s), and if the community(ies) is/are on the Communities Experiencing the Highest Need and Risk from Opioid Use Disorder (OUD) and / or Cannabis Use Disorder (CUD) list as described in Exhibit E of this RFA. Briefly describe the demographics of the community(ies) you intend to serve, including specifically who will be served with these funds** 5 Points (Maximum 1 Page)
2. **Provide data (such as a high-level summary with references, demographics, or Healthy Youth Survey data) to support the substance use disorder needs in the communities identified.** 5 Points (Maximum 1 Page)
3. **Provide a brief overview of how your program addresses prevention of substance use and the proposed strategies to be implemented in the community you intend to serve. Explain your understanding of the factors in identified the community that’s likely increasing the need for substance use prevention services.** 5 Points (Maximum 1 Page)
4. **Describe your ability and experience with providing Substance Use Disorder prevention services. Describe your ability and experience serving populations experiencing the highest need and risk, including youth and families.** 5 Points (Maximum 1 Page)
5. **Explain how your organization will provide culturally competent and appropriate services, using specific details that demonstrate this capacity.** 5 Points (Maximum 1 Page)
6. **Explain how your organization will be actively involved with reducing health disparities and promoting health equity, using specific details that describe strategies used and/or steps taken.** 5 Points (Maximum 1 Page)
7. **Provide a brief description of how your organization will implement the chosen approved Program(s), from the Program Selection Page(s). Please indicate how you** **plan to repeat implementation throughout the years of service, if you plan to implement programs according to program implementation requirements. If you have any planned adaptations or cultural considerations, please describe these.** 5 Points No Page Max
8. **Describe how these programs were selected for implementation in your community. Describe the overall goal(s) of the program(s). Discuss the expected changes in either behavior, attitudes, beliefs and/or knowledge of participants that will demonstrate the effectiveness of the program(s) in addressing your community’s need(s).** 5 Points (Maximum 1 Page)
9. **Discuss the process of selecting and recruiting participants to the identified program and tools you will use to assess the effectiveness of the identified program(s).** 5 Points (Maximum 1 Page)
10. **Describe your capacity to fulfill the scope of the services described for the proposed number of participants.** **Describe staffing levels needed to implement the program with fidelity and** **identify what staff position or positions will be the lead on ensuring supervision and implementation.** 5 Points (Maximum 1 Page)
11. **Describe the specific technical assistance and training you will need to implement this scope of work and your plan to address these needs.** 5 Points (Maximum 1 Page)

**{End of Exhibit B – SUD Px Application Packet }**