

Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

**Substance Abuse and HIV Prevention
Ready-To-Respond Initiative in Communities Highly
Impacted by Substance Use and HIV Infection**

Short Title: Ready-To-Respond Initiative

Request for Applications (RFA) No. SP-10-003

Catalog of Federal Domestic Assistance (CFDA) No.: 93.243

Key Dates:

Application Deadline	Applications are due by February 23, 2010.
Intergovernmental Review (E.O. 12372)	Applicants must comply with E.O. 12372 if their State(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	Applicants must send the PHSIS to appropriate State and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.

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Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) is accepting applications for fiscal year (FY) 2010 grants for the Substance Abuse and HIV Prevention Ready-To-Respond Initiative in Communities Highly Impacted by Substance Use and HIV Infection, hereinafter called, “Ready-To-Respond Initiative.” The Ready-To-Respond Initiative (RTR) is one of CSAP’s Minority AIDS Initiative (MAI) programs. The purpose of the MAI is to provide substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The RTR program builds on previous accomplishments of MAI grantees in providing evidence-based prevention services by expanding knowledge and experience in developing blended substance abuse and HIV prevention practices for these populations. Intended for experienced CSAP grantees funded under *Substance Abuse (SA), HIV, and Hepatitis prevention for Minority Populations and Minority Reentry Populations in Communities of Color* (SP-05-001), this initiative will develop a comprehensive strategy for creating best practices in combining SA/HIV prevention practices. These grantees are those who are “ready to respond” to this effort.

Funding Opportunity Title:	Substance Abuse and HIV Prevention Ready-To-Respond Initiative in Communities Highly Impacted by Substance Use and HIV Infection
Funding Opportunity Number:	SP-10-003
Due Date for Applications:	February 23, 2010
Anticipated Total Available Funding:	\$10.8 million
Estimated Number of Awards:	36 awards
Estimated Award Amount:	Up to \$300,000 per year
Length of Project Period:	Up to 5 years
Eligible Applicants:	SAMHSA/CSAP grantees previously funded under SP-05-001 [See Section III-1 of this RFA for complete eligibility information.]

I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) is accepting applications for fiscal year (FY) 2010 grants for the Substance Abuse and HIV Prevention Ready-To-Respond Initiative in Communities Highly Impacted by Substance Use and HIV Infection, hereinafter called, “Ready-To-Respond Initiative.” The Ready-To-Respond Initiative (RTR) is one of CSAP’s Minority AIDS Initiative (MAI) programs. The purpose of the MAI is to provide substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The RTR program builds on previous accomplishments of MAI grantees in providing evidence-based prevention services by expanding knowledge and experience in developing blended substance abuse and HIV prevention practices for these populations. Intended for experienced CSAP grantees funded under *Substance Abuse (SA), HIV, and Hepatitis prevention for Minority Populations and Minority Reentry Populations in Communities of Color* (SP-05-001), this initiative will develop a comprehensive strategy for creating best practices in combining SA/HIV prevention practices. These grantees are those who are “ready to respond” to this effort.

This cohort of grantees was SAMHSA’s first to use the Strategic Prevention Framework to implement the combination of evidence-based substance abuse prevention programs with evidence-based HIV prevention programs to produce measurable outcomes and changes in SA and HIV rates. They have demonstrated success in combining the Centers for Disease Control and Prevention’s (CDC) Replicating Effective Programs Plus (REP+) and Diffusion of Effective Behavioral Interventions (DEBI) research projects with substance abuse prevention programs from SAMHSA’s National Registry of Effective Programs and Practices (NREPP) to achieve measurable changes in known risk factors associated with substance abuse and HIV infection. The RTR program will further refine these practices so that they may be disseminated to new service providers.

Entities that are not eligible to apply for these awards have the opportunity to apply for SAMHSA’s FY 2010 HIV Capacity Building Initiative (SP-10-004).

CSAP has identified specific subpopulations most at risk for HIV/AIDS (see Section I-1.1 below). Applicants who previously provided services under SP-05-001 will now have the opportunity to expand their services to include a new high-risk subpopulation group. Applicants must choose a different subpopulation from the one served under SP-05-001. When selecting a new high-risk subpopulation group, applicants are asked to consider the subpopulations identified on the list below. Grantees may serve a new subpopulation in a new catchment area. However, the new catchment area served must be included in the Metropolitan Statistical Area (MSA) previously served under SP-05-001.

The Ready-To-Respond Initiative Cooperative Agreements are authorized under Section 516 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2010 focus area 26 (Substance Abuse).

1.1 HIV Data on Racial/Ethnic Minority Subpopulations

HIV/AIDS remains a persistent and pervasive threat to the health and well being of minority communities. The Ready-To-Respond Initiative is designed to alleviate the impact that substance use has on minority populations and reduce the incidence of new HIV infection. The goal of the program is to engage experienced community-level domestic public and private nonprofit entities in preventing the onset and reducing SA and HIV infection among at-risk racial/ethnic minority subpopulations in communities of color disproportionately affected by SA and HIV.

The distribution of AIDS diagnoses among racial and ethnic groups has changed since the beginning of the epidemic. While the prevalence of AIDS diagnoses has decreased among Whites, it has increased among Black/African American and Hispanic/Latino populations. Black/African American populations account for 12% of the population of the 50 states and the District of Columbia. Yet, from the beginning of the epidemic through 2007, the CDC reported that they accounted for 42% of the total number of AIDS cases.

The growing epidemic and new HIV/AIDS infection rates and cases among the subpopulations described below are located in high-risk communities across the United States that are disproportionately impacted and underserved. CSAP is intensifying its efforts to address the urgent need for additional interventions designed and tailored to the specific needs of racial/ethnic minority subpopulations at greatest risk by focusing on risk reduction behaviors using evidenced-based interventions.

When selecting a new racial/ethnic minority subpopulation, applicants should consider the minority subpopulations identified below:

- **Reentry Populations (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years)** – Studies show that inmates are nearly five times more likely to acquire HIV than the U.S. general population. The vast majority of inmates with HIV became infected before entering the correctional system. Because most inmates are ultimately released back into the community, a critical goal of HIV prevention program is to provide HIV testing and education on risk and protective factors to recently released inmates, their spouses, significant partners, and family members. Additional information can be found at: <http://www.ojp.usdoj.gov/bjs/pub/pdf/dudsfp04.pdf>.
- **Men Having Sex with Men (MSM)** - According to the CDC, the largest number of HIV/AIDS diagnoses in 2007 were men who have sex with men. Additionally, racial disparities exist with regard to HIV diagnoses within the MSM population. Approximately half of the HIV/AIDS cases among non-Hispanic Black and Hispanic males reported by 33 States using name-based HIV surveillance during 2001-2005 were among men who have sex with men. Additional information can be found at: <http://www.cdc.gov/hiv/topics/msm/index.htm>.

- **African American Women** – Increased prevention services must be directed to address the impact of HIV on Black/African American women. Black/African American women are at great risk of HIV infection through heterosexual contact. From the beginning of the epidemic through 2007, the CDC reported that among Blacks/African Americans with AIDS, 60 % are women and 59 % are heterosexuals. AIDS is now the leading cause of death for African American women, ages 25-34. Additional information can be found at: <http://www.womenshealth.gov/minority/africanamerican/index.cfm>.
- **Latina or Hispanic Women** – U.S. Census Bureau data from 2005 indicate that together, Black and Hispanic women represent 24 % of all U.S. women. However, women in these two groups accounted for 82 % of the estimated total AIDS diagnoses for women. Additional information can be found at: <http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm>.
- **Adolescents (age 12-17)** - Black/African American adolescents have been disproportionately affected by the HIV/AIDS epidemic. In 2007, in the 34 states with long-term confidential name-based HIV infection reporting, 17 % of adolescents 13 to 19 years of age were Black/African American, yet 72 % of HIV/AIDS diagnoses in 13 to 19 year olds were in Black/African American adolescents. Adolescent and young adult male AIDS cases are attributed to MSM. Additional information can be found at: <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>.
- **Young Adults (age 18-24)** - Racial disparities in HIV diagnoses are particularly severe among young people. Overall, Blacks made up over half (51 %) of all new HIV diagnoses between 2001 and 2005. However, among youth and young adults aged 13-24, Blacks accounted for 61 % of diagnoses. Young adults under the age of 25 and teens continue to be at greatest risk. Most young people are infected through sex. The majority of AIDS cases among adolescent and young adult females were attributed to high risk heterosexual contact. Adolescent and young adult male AIDS cases are primarily attributed to MSM. Additional information can be found at: <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>
- **Older Adults (age 50 and over)** – The CDC reported that the annual number of new HIV infections among older Americans is increasing. Based on HIV diagnosis data alone, this group may have been infected recently while others were infected many years ago. AIDS is now the fourth leading cause of death among African American women ages 45-54. Additional information can be found at: <http://www.womenshealth.gov/hiv/women-at-risk/#d>.

2. EXPECTATIONS

Applicants to the Ready-To-Respond grant program must provide a modified strategic plan that expands the efforts and lessons learned to work with a new targeted subpopulation implementing similar SA and HIV prevention strategies to those previously funded under SP-05-001.

Grantees will be expected to provide the following services and prevention strategies:

- HIV testing services (rapid and/or blood);
- Substance abuse and HIV prevention evidence based practices (EBPs); and
- Environmental strategies

Outcomes based, data-driven plans funded through this grant should address not only the local substance abuse and HIV problems, but also address the associated risk or casual factors identified through a needs assessment process. Local data should be gathered and monitored by local epidemiological data collection and/or focus groups.

Direct prevention services for the new subpopulation selected for this program must begin within 6 months of receipt of the Notice of Award (NoA). Grantees' selection of a new subpopulation should be based on their current needs assessment. Incidence and prevalence data for substance abuse and HIV infections should be clearly delineated in the updated needs assessment plan. The assessment should also include the associated risk and protective factors for the problems identified. Expanded prevention services may be provided in a different catchment area from that served under SP-05-001. However, the new catchment area served must be included in the Metropolitan Statistical Area (MSA) previously served under SP-05-001.

Although grantees will have flexibility in designing their comprehensive strategies for their programs, Ready-To-Respond Initiative applicants must develop and submit a budget that includes the services and budget restrictions outlined below.

Applicants **must** budget for the following required activities:

- At least 50% *of the total grant award* for direct prevention services
- Up to 10% *of the total grant award* for HIV testing
- Up to 15% *of the total grant award* for data collection and performance assessment
- Up to 15% *of the total grant award* for environmental strategies

Applicants **may** also include limited infrastructure development activities as follows:

- Up to 10% *of the total grant award* for infrastructure development activities. If infrastructure development is not needed, the applicant may use this remaining 10% for additional direct services. [See [Section I- 2.6](#) for allowable infrastructure development activities.]

As of February 2009, approximately 1.89 million men and women have been deployed to serve in support of overseas contingency operations, including Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Individuals returning from Iraq and Afghanistan are at increased risk for suffering post-traumatic stress and other related disorders. Experts estimate that up to one-third of returning veterans will need mental health and/or substance abuse treatment and related services. In addition, the family members of returning veterans have an increased need for related support services. To address these concerns, SAMHSA strongly encourages all applicants to consider the unique needs of returning veterans and their families in developing their proposed project.

2.1 Required HIV Testing and Counseling

In addition to implementing substance abuse and HIV prevention services, grantees are required to use up to 10% of the total direct award to conduct HIV testing services. Grantees must provide either rapid testing or blood testing to at-risk minority subpopulations. Grantees may elect to provide HIV testing services on-site or off-site through a Memorandum of Agreement (MOA) with another organization. Grantees are required to provide appropriate referrals to pre/post counseling, linkages to medical care and other supportive services for participants with a confirmed HIV positive result, and referrals to counseling for persons who test negative to decrease their risk of acquiring HIV.

Grantees should plan the number of participants that will be tested each year and over the 5 year period of the grant. Additional information regarding types of HIV testing can be found at: <http://www.cdc.gov/hiv/topics/testing/rapid/rt-comparison.htm>

2.2 Using Evidence-Based Practices

SAMHSA/CSAP's services grants are intended to fund prevention services or practices that have a demonstrated evidence base and that are culturally appropriate for the population of focus. An evidence-based practice, also called EBP, refers to services/practices that are validated by some form of documented research evidence.

In **Section B**, Proposed Evidence-Based Service/Practice of your project narrative, you will need to:

- Identify the evidence-based practice(s) you propose to implement for the specific population of focus for substance abuse and HIV prevention services.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective.
- If you are proposing to use more than one evidence-based practice, or a combined substance abuse and HIV curriculum prevention strategy, please provide the name of the specific evidence-based strategy, the proposed number of sessions, frequency of sessions, and length of sessions, and the anticipated number of sessions and number of participants to be served during each session and annually and over the course of the five year project.
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your subpopulation(s) of focus. [See note below].

Note: SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain interventions for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other interventions that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with an intervention that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. You may describe your experience either with the population of focus or in managing similar programs. Information in support of your proposed practice needs to be sufficient to demonstrate the appropriateness of your practice to the individuals reviewing your application.

- strategy(ies) that will be implemented and its relatedness to the risk Document the evidence that the practice(s) you have chosen is appropriate for the outcomes you want to achieve
- Explain how the practice you have chosen meets SAMHSA's goals for this grant program.
- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population of focus or your program, or to allow you to use resources more efficiently. You must describe any changes to the proposed service(s)/practice(s) that you believe are necessary for these purposes. You may describe your own experience either with the population of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.
- Explain why you chose this evidence-based practice over other evidence-based practices.
- If applicable, justify the use of multiple evidence-based practices.
- Discuss in the logic model and related narrative how use of multiple evidence-based practices will be integrated into the program, while maintaining an appropriate level of fidelity for each practice. Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.
- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).
- Discuss the environmental and causal factors identified in your needs assessment.

Additional Resources for Evidence-Based Practices:

You will find information on evidence-based practices in SAMHSA's *Guide to Evidence-Based Practices on the Web* at <http://www.samhsa.gov/ebpwebguide/index.asp>. SAMHSA has developed this Web site to provide a simple and direct connection to Web sites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Guide* provides a short description and a link to dozens of Web sites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

Please note that SAMHSA's Guide to Evidence-based Practices also references another SAMHSA Web site, the National Registry of Evidence-Based Programs and Practices (NREPP). NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. NREPP is intended to serve as a decision support tool, not as an authoritative list of effective interventions. *Being included in NREPP, or in any other resource listed in the Guide, does not mean an intervention is "recommended" or that it has been demonstrated to achieve positive results in all circumstances.* You must document that the selected practice is appropriate for the specific population of focus and purposes of your project.

Additionally, the CDC's 2009 Compendium of Evidence-Based HIV Prevention Interventions includes 96 evidence-based HIV behavioral interventions identified from the scientific literature published through June 2009. Interventions in this compendium include programs from the CDC's Replicating Effective Programs Plus (REP+) and Diffusion of Effective Behavioral Interventions (DEBI) research projects. The Compendium contains tested, science-based behavioral interventions with demonstrated evidence of effectiveness in reducing risky behaviors, such as unprotected sex, or in encouraging safer ones, such as using condoms and other methods of practicing safer sex. <http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm>.

In addition to the Web site noted above, you may provide information on research studies to show that the services/practices you plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, you may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

2.3 Program Design

While grantees will have substantial flexibility in designing their grant projects, all are required to base their projects on the five steps of the SPF to build state of the science substance abuse and HIV prevention capacity for the at-risk racial/ethnic minority population of focus. CSAP recommends that when developing a comprehensive prevention plan, the grantee should target multiple strategies that impact the individual, their family and friends, their peer groups, their school climate and the shared environment, and norms and social policies of the community where they live. Multiple sectors of the community must be engaged in an active prevention process together to leverage many sources of funding and a variety of resources that can implement such complex strategies.

2.4 Service Delivery

At least half of the funding provided by this grant should fund evidence-based substance abuse and HIV programs and activities designed to change individual risk behaviors that lead to substance abuse and increase the risk of HIV infection. Direct service programs include those identified through the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) and the CDC Replicating Effective Programs Plus (REP+) and Diffusion of Effective Behavioral Interventions (DEBI) program listings.

In addition, direct services should be part of a comprehensive approach of creating and sustaining behavior change by providing services that support and enhance the overall prevention plan. This includes the following services:

1. Providing information and educational presentations, workshops, and seminars; conducting social marketing campaigns; using Web-based communications such as Twitter, Myspace, Facebook, and podcasts; distributing educational and information materials such as brochures, pamphlets, and fact sheets; conducting public forums or town hall meetings, etc.
2. Enhancing skills through workshops, seminars, training, distance learning, curricula implementation, etc.
3. Providing social support through referrals, support groups, alternative activities, mentoring, clubs, etc.

2.5 Environmental Prevention Strategies

Grantees are required to use up to 15% of the total grant award to implement environmental strategies based on a community systems perspective. Research has shown that to effectively change attitudes, perceptions, and ultimately behavior, prevention strategies must include a comprehensive approach that addresses both the individual and the environment where the individual lives. Substance abuse prevention practices that include environmental strategies are the most effective in producing these changes.

Individuals do not engage in substance abuse or risk behaviors solely on the basis of personal characteristics, but rather as a result of a complex set of factors in the environment. These include the rules and regulations of the social institutions to which individuals belong, the norms of the communities in which they live, the mass media messages to which they are exposed, and the accessibility of alcohol, tobacco and illicit drugs. Therefore, effective prevention requires “intervention” in various facets of community life that are designed to change individuals and the environment in which they live. More specifically, environmental strategies seek to:

1. Increase or decrease the probability of a specific behavior through rewards and recognition or disincentives such as citations, fines, penalties, loss of privileges, random drug testing, distribution or promotion of sexually transmitted disease protective products, etc.

2. Modify or change policies including formal changes in written procedures, proclamations, rules or laws such as drug free zones, prescription drug monitoring, criminal penalties or sanctions, appropriate and consistent law enforcement and judicial actions, workplace policies, etc.
3. Changing the physical design or structure of the environment to reduce risk or enhance protection such as regulating sales or restricting consumption in public places or event, placement of drug related products, paraphernalia, designer drugs or stimulate products, sexually transmitted disease protective products, etc.
4. Alter access to substance abuse and HIV related health systems or services including; parent or family education, court services, after school or workplace programs, etc.

Grantees are more likely to be successful in meeting the goal of the Ready-To-Respond Initiative if they work together collaboratively with their local partners to utilize environmental strategies to combat their community substance abuse and HIV problems.

NOTE: See Appendix J for additional information on Environmental Strategies.

2.6 Infrastructure Development

Grantees may use up to 10% of the total grant award for infrastructure issues that may need to be addressed in order to implement or improve substance abuse and HIV service delivery. Grantees may implement one or more of the following types of infrastructure development strategies:

- Develop systems that aid in a smoother transition planning process for affected persons, establish referrals and access to intensive case management for HIV diagnosed participants, establish referral and access to care and treatment, aid in the development of family strengthening prevention systems that promote seamless and coordinated cross-organizational level strategies that set policy, practices and procedures.
- Promote organizational collaboration and coordination between agencies, such as housing, HIV/AIDS services/prevention, and mental health and substance abuse treatment and substance abuse prevention services.
- Encourage communities to establish approaches to create a coordinated, comprehensive seamless system of services to address substance abuse and HIV prevention. Such approaches may include establishing an infrastructure that forges systemic relationships among prevention providers for effective identification and referral to treatment services, more effective leveraging of fiscal and human resources, cross-system training of prevention providers, laypersons and others to identify substance abuse and HIV risks of minority subpopulations.
- Provide workforce development training to help your staff or other providers in the community identify early warning signs of substance abuse issues.
- Enhance access/reduce barriers to improve provider network and service systems and processes to increase their ability and opportunity to utilize prevention systems and services (e.g., addressing literacy issues, referral to healthcare, childcare, transportation, housing, criminal justice, education, safety, special needs, cultural and language sensitivity).

- Expand HIV prevention planning for risk behavior reduction, educational outreach and HIV testing in non-traditional settings.
- Enhance data collection, performance evaluation and outcomes measurement and reporting capabilities.

2.7 Data Collection and Performance Measurement

All of SAMHSA/CSAP grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). Applicants must describe their current capacity for collecting and reporting direct service participant and community level data as appropriate for their project, as well as plans for ensuring that SAMHSA’s National Outcome Measures (NOMs) can be collected and reported at the participant and community level in time for the implementation phase of the proposed project. The NOMs have been defined by SAMHSA as key priority areas relating to substance abuse. All applicants must document their ability to collect and report these data in “[Section E: Performance Assessment and Data](#)” of their application.

The CSAP individual and community level National Outcome Measures (NOMs), which include the GPRA measures, are listed in Table 1 and select CDC HIV prevention performance measures are listed in Table 2. Grantees should use these measures to assess performance of their individual and environmental community level evidence-based programs. These performance assessment data are currently reported in the aggregate to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA’s budget request.

TABLE 1: CSAP COMMUNITY – PROGRAM-PARTICIPANT LEVEL DATA REPORTING

	DOMAINS	NATIONAL OUTCOMES	SUBSTANCE ABUSE PREVENTION MEASURES
I.	Reduced Morbidity	Abstinence from drug use/alcohol abuse.	<ul style="list-style-type: none"> • 30-day substance use (non use/reduction in use). • Perceived risk/harm of use. • Age of first use. • Perception of disapproval /attitude.
II.	Employment/Education	Increased/Retained Employment or Return to/Stay in School.	<ul style="list-style-type: none"> • Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment.
III.	Crime and Criminal Justice	Decreased Criminal Justice Involvement.	<ul style="list-style-type: none"> • Alcohol-related car crashes and injuries; alcohol- and drug-related crime.
IV.	Social Connectedness	Increased Social Supports/Social Connectedness.	<ul style="list-style-type: none"> • Family communication around drug use.
V.	Access/Capacity	Increased Access	<ul style="list-style-type: none"> • Number of persons served by age,

	DOMAINS	NATIONAL OUTCOMES	SUBSTANCE ABUSE PREVENTION MEASURES
		to Prevention Services (Service Capacity).	gender, race and ethnicity who engage in prevention services and environmental strategies.
VI.	Retention	Increased Retention.	<ul style="list-style-type: none"> Total number of evidence-based programs and strategies; percentage of youth seeing, reading, watching, or listening to a prevention message.
VII.	Cost Efficiency	Number of participants improved.	<ul style="list-style-type: none"> Total number of persons improved divided by the years/ divided by costs.

TABLE 2: SELECT CDC HIV PREVENTION GOALS

	GOALS	HIV PREVENTION MEASURES
I.	Decrease the rate of HIV transmission by HIV - infected persons.	<ul style="list-style-type: none"> Perceived risk/harm of risky sexual behavior. Sex under the influence of drugs and/or alcohol. Sexual self-efficacy.
II.	Decrease risky sexual and drug using behaviors among persons at risk for acquiring HIV.	<ul style="list-style-type: none"> Perceived risk/harm of risky sexual behavior. Sex under the influence of drugs and/or alcohol. Sexual self-efficacy.
III.	Increase the proportion of persons at risk for HIV who received HIV prevention interventions.	<ul style="list-style-type: none"> Increase the number of persons receiving HIV evidence-based prevention programs.

Grantees are required to collect data on the CSAP NOMs and HIV prevention measures, as well as additional measures related to the goals of the program. These measures include HIV testing data, and substance abuse and HIV risk and protective factor data. This information will be used to assess each grantee’s performance as well as contribute to the cross site evaluation on the overall MAI Initiative. The CSAP Prevention Management Reporting and Training Tool (PMRT) will be used to collect this information. This tool provides access to two instruments, the MAI NOMs survey and the Management Reporting Tool (MRT) progress report. The NOMs survey instrument will be used to collect direct service data.

For programs lasting 30 days or more, applicants must collect data at **baseline, exit and 3 months post exit**. For programs lasting between 2 and 29 days, applicants must collect baseline and exit data. For programs lasting one day, applicants must collect participant demographic data. Applicants must also collect environmental strategy performance data. These data should be collected by community surveys fielded before and after implementation of the environmental strategy. Community surveys could include, at a minimum, the following:

1. The SPF-SIG Community Level NOMs instrument; (CLI)
2. The Communities that Care Survey, or
3. A locally developed survey.

The PMRT serves as the progress report which should be submitted twice a year. Grantees will report on the SPF as well as on their screening and testing data. These data should include the number of persons tested for HIV by demographics, number of first time testers by demographics, and number of SA and HIV evidence-based programs provided to the sub-populations of focus.

CSAP Prevention Management Reporting and Training System (PMRT)

The CSAP Prevention Management Reporting and Training System (PMRT) is designed to collect programmatic data to meet Federal government reporting requirements. The PMRT system is a Web-based system designed around the SPF. Grantees will be required to collect and submit their progress data on each of the five SPF steps (Assessment, Capacity, Planning, Implementation, and Performance Assessment). Applicants will also be expected to enter their program data on their goals and objectives into the PMRT, which will be monitored by the Government Project Officer (GPO). Mandatory progress reports submitted through the PMRT system are required twice a year. In addition to submitting reports, grantees will be able to use the PMRT data system to monitor and manage their grants, monitor progress and provide feedback to their communities and other key stakeholders.

Additional information on the programmatic data system can be found at: <https://www.pmrts.samhsa.gov/csams/tools.aspx> along with instructions for completing it. Hard copies are available in the application kits available by calling the SAMHSA Health Information Network at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

NOTE: Further information on data collection and reporting and the PMRT system will be provided after the grant is awarded.

Grantees will be required to participate in a community cross-site evaluation and will select one community change outcome they propose to change over the five years of the grant. Grantees will work with the SAMHSA Government Project Officer (GPO) and data contractors on developing tools and resources that will best capture community change efforts.

2.8 Performance Assessment

Grantees must periodically review the performance data submitted to SAMHSA and assess their progress and use this information to improve quality management of their grant projects. The assessment should be designed to help them determine whether they are achieving the program goals and whether adjustments need to be made to their projects. Grantees are required to report on their NOMs and community survey results, barriers encountered, and efforts to overcome these barriers with the PMRT described above. At a minimum, the performance assessment should include the required performance measures identified above under Section 2.7.

In addition, grantees may also consider additional process and outcome questions, such as the following:

Process Questions:

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What led to the changes in the original plan?
- What effect did the changes 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)?

Outcome Questions:

- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity?
- How durable were the effects?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

NOTE: Performance assessments should be completed at the end of each fiscal year to address discrepancies in program implementation. This information will be reviewed annually by CSAP Staff.

Up to 15% of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in [Section I-2.7](#) and [Section I-2.8](#) above.

2.9 Grantee Meetings

Grantees must plan to send a minimum of two people (including the Project Director and Evaluator) to at least two grantee meetings in each year of the grant. You must include a detailed budget and narrative 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 up to 3 days and possible attendance at co-sponsored national conferences may be required. These meeting locations will be determined each year and attendance is mandatory. **For planning purposes, applicants should plan to attend one of these 3 day meetings in the Washington, DC area and the second one in Dallas, TX.**

II. AWARD INFORMATION

Funding Mechanism:	Cooperative Agreement
Anticipated Total Available Funding:	\$10.8 million
Estimated Number of Awards:	36 Awards
Estimated Award Amount:	Up to Up to \$300,000 per year
Length of Project Period:	Up to 5 years

Proposed budgets cannot exceed \$300,000 in total costs (direct and indirect) in any year of the 5 year 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 compliance with all terms and conditions of award.

Cooperative Agreement

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

Role of Grantee:

Grantees must comply with the terms of the Ready-To-Respond Initiative including implementation of all required activities described in Section I-2, of this RFA. Grantees must agree to provide SAMHSA with all required performance data, collaborate with SAMHSA/CSAP staff in all aspects of the grant program, and participate in the cross-site evaluation (including submission of all required forms, data, and reports).

Role of SAMHSA Staff:

The design of this program necessitates participation of the Government Project Officer (GPO) in several key aspects of the Ready-To-Respond Initiative. The GPO provides ongoing monitoring of the award recipient's project to assure adherence to the approved goals and objectives stated in their application. Site visit(s) are conducted and reports are developed with corrective action plans and/or technical assistance recommendations. The GPO reviews and evaluates progress reports and requires corrective action and/or makes technical assistance recommendations. When the GPO finds or is alerted to serious deficiencies in the award recipient's performance, temporary staff intervention is provided to correct or ameliorate the conditions causing or contributing to the unsatisfactory performance. The GPO ensures compliance with legislative, regulatory, and administrative requirements, and other terms and conditions of the award. The GPO will coordinate all data collection activities on SAMHSA's NOMs, GPRA, and other performance measures related to this RFA. Following completion of the project, the GPO analyzes and assesses the overall performance of the award recipient's project with respect to whether the goals and objectives of the program have been achieved.

Role of the Grants Management Specialist:

The Grants Management Specialist (GMS) is responsible for all business management aspects of grant negotiation, award, and financial and administrative aspects of this cooperative agreement. The GMS will utilize information from site visits, reviews of expenditure and audit reports, and other appropriate means to ensure that the project is operated in compliance with all applicable Federal laws, regulations, guidelines, grant eligibility requirements, and terms and conditions of award. Questions concerning the applicability of regulations and policies of this grant program, and all required prior approvals such as requests for permission to expend funds for certain items, should be directed to the GMS (see Section VII for the GMS's contact information). The GMS is the only person who may grant such required approvals. All changes in the terms of the award must be in writing by the GMS.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligibility is limited to grantees previously funded under SAMHSA/CSAP's RFA No. SP-05-001, *Substance Abuse (SA), HIV, and Hepatitis Prevention for Minority Populations and Minority Reentry Populations in Communities of Color*. SAMHSA is restricting eligibility to these grantees because of their demonstrated successes in implementing the Strategic Prevention Framework (SPF) and combining evidence-based substance abuse prevention programs with evidence-based HIV prevention programs to achieve more robust outcomes. Only these grantees have the requisite experience and are now "ready to respond" to the substance abuse and HIV problems in a new subpopulation of focus and achieve similar outcomes based on their data collection efforts, and experience with adapting and implementing combined SA and HIV evidence-based programs to achieve measurable outcomes.

Entities that are not eligible to apply for these awards have the opportunity to apply for SAMHSA's FY 2010 HIV Capacity Building Initiative (SP-10-004).

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

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 form; application submission requirements in [Section IV-3](#) of this document; and formatting requirements provided in [Appendix A](#) of this document.

3.2 Evidence of Experience and Credentials

Applicants funded under this program must be ready to build on the successes already accomplished and adapt their strategic plans to address a new subpopulation based on a current needs assessment and updated data. The selected evidence-based strategies to be implemented should be appropriate for the community of focus and new subpopulation selected. It is expected that direct services will begin within 6 months after receipt of Notice of Award (NoA).

Grantees must meet the requirements identified below in order to be eligible to provide prevention services.

The requirements are:

- You must be a prevention provider organization already providing HIV and substance abuse prevention services and have experience with identifying risk and protective factors of subpopulations and designing programs that meet the needs of the population of focus;
- You must have 4 or more years experience (as of the due date of the application) providing substance abuse and HIV evidence-based prevention services using the SPF process for minority subpopulations in the geographic area(s) in which services are to be provided (official documents must establish that the organization has provided relevant services for the last 4 years);
- You must have the appropriate organizational capacity to continue the direct services funded under SAMHSA/CSAP's RFA No. SP-05-001 grant program and be able to update or revise your needs assessment to implement combined substance abuse and HIV services to a new subpopulation based on your previous experience and lessons learned.
- You must meet the Clinical Laboratory Improvement Amendments (CLIA) requirements (include certification in Attachment 1) if you plan to provide HIV testing services, or you must establish a Memorandum of Agreement (MOA) with an appropriate certified HIV testing provider (include MOA in Attachment 1) in your State.

In **Attachment 1** of your application, you must: (1) if applicable, submit a MOA from a CLIA certified State regulatory HIV testing provider organization and a provider of substance abuse prevention services; (2) include a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency if the applicant is a prevention service provider organization; also include other Federal funding resources provided through the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), and Office of Minority Health (OMH), and any in-kind or shared resources that will be brought to bear on this project through partnering relationships; and (3) include the Statement of Assurance (provided in [Appendix C](#) of this announcement), signed by the authorized representative of the applicant organization identified on the face-page (SF 424 v2) of the application, attesting that all participating service provider organizations:

- meet the 4-year requirement for providing substance abuse and HIV EBP programs;
- meet applicable SPF experience in SA and HIV direct services;

In addition, if, following application review, your application's score is within the funding range, you will be required to submit the following documentation prior to the issue of the Notice of Award (NoA):

- a letter of commitment from every service provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all participating organizations have been providing relevant dual substance abuse and HIV prevention services for a minimum of 4 years before the date of the application in the area(s) in which the services are to be provided; and
- official documentation that all participating service provider organizations comply with all applicable local (city and county) and State/tribal requirements for licensing, accreditation, and certification, where applicable, to provide substance abuse and/or HIV prevention services and programs.

NOTE: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license.

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the SAMHSA Health Information Network 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 grant writing 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 GRANT APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page (SF 424 v2), 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 a description of the program, specific information about the availability of funds, and 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/index.aspx>) and a synopsis of the RFA is available on the Federal grants Web site (<http://www.Grants.gov>).

You must use all of the above documents in completing your application. A complete list of documents included in the application kit is available at:

<http://www.samhsa.gov/Grants/ApplicationKit.aspx>.

2.2 Required Application Components

Applications must include the required application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Attachments, Project/Performance Site Location(s) Form, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page** – SF 424 v2 is the face page. This form 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 <http://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 attachment.
- **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. (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 – 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.” Supporting documentation should be submitted in black and white (no color).

- **Attachments 1 through 5** – Use only the attachments listed below. If your application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1, 3 and 4 combined. There are no page limitations for Attachments 2 and 5. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.
 1. *Attachment 1:* (1) Identification of at least one experienced, service provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency and prevention service provider organization with 4 years of SPF experience; (3) the Statement of Assurance (provided in [Appendix C](#) of this announcement) signed by the authorized representative of the applicant organization identified on the face page of the application, that assures SAMHSA that all listed providers meet the 4-year experience requirement, are appropriately licensed, accredited, and certified; (4) letters of commitment from community organizations supporting the project; (5) signed Memoranda of Agreement (MOA) that demonstrate established referral networks for participants needing appropriate treatment and support services.
 2. *Attachment 2:* Data Collection Instruments/Interview Protocols
 3. *Attachment 3:* Sample Consent Forms
 4. *Attachment 4:* Letter to the SSA (if applicable; see [Section IV-4](#) of this document)
 5. *Attachment 5:* A copy of the State or county strategic plan, a State or county needs assessment, or a letter from the State or county indicating that the proposed project addresses a State- or county-identified priority.

- **Project/Performance Site Location(s) Form** – This form is part of the PHS 5161-1. The purpose of this form is to collect location information on the site(s) where work funded under this grant announcement will be performed.
- **Assurances** – Non-Construction Programs. You must read the list of assurances provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application. 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 kit.
- **Certifications** – You must read the list of certifications provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.
- **Disclosure of Lobbying Activities** – You must submit 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. If no lobbying is to be disclosed, mark N/A on the form.
- **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications. If you are submitting a paper application, the Checklist should be the last page.

2.3 Application Formatting Requirements

Please refer to [Appendix A](#), *Checklist for Formatting Requirements and Screen out 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 **February 23, 2010**. Hard copy applications are due by 5:00 PM (Eastern Time). Electronic applications are due by 11:59 PM (Eastern Time). **Applications may be shipped using only, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

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

SAMHSA will not accept or consider any applications that are hand carried or sent by facsimile.

Your application must be received by the application deadline or it will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. You are responsible for ensuring that you submit your application so that it will arrive by the application due date and time.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application and, as a result, the designated office does not receive your application by the deadline, your application will be considered late and ineligible for review.

SAMHSA accepts electronic submission of applications through <http://www.Grants.gov>. Please refer to [Appendix B](#) for “Guidance for Electronic Submission of Applications.” **If you plan to submit electronically through Grants.gov it is very important that you read thoroughly the application information provided in [Appendix B](#)** “Guidance for Electronic Submission of Applications.”

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

This grant program is covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, States may design their own processes for reviewing and commenting on proposed Federal assistance under covered programs. Certain jurisdictions have elected to participate in the EO process and have established State Single Points of Contact (SPOCs). A current listing of SPOCs is included in the application kit and can be downloaded from the Office of Management and Budget (OMB) Web site at http://www.whitehouse.gov/omb/grants_spoc.

- Check the list to determine whether your State participates in this program. You do not need to do this if you are an American Indian/Alaska Native Tribe or tribal organization.
- If your State participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the State’s review process.
- For proposed projects serving more than one State, you are advised to contact the SPOC of each affiliated State.
- The SPOC should send any State review process recommendations to the following address within 60 days of the application deadline. 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: SPOC – SP-10-003. Change the zip code to **20850** if you are using another delivery service.

In addition, if you are a community-based, non-governmental service provider and you are not transmitting your application through the State, you must submit a Public Health System Impact Statement (PHSIS)¹ to the head(s) of appropriate State and local health agencies in the area(s) to be affected no later than the application deadline. The PHSIS is intended to keep State and local health officials informed of proposed health services grant applications submitted by community-based, non-governmental organizations within their jurisdictions. If you are a State or local government or American Indian/Alaska Native Tribe or tribal organization, **you are not subject to these requirements.**

The PHSIS consists of the following information:

- a copy of the face page of the application (SF 424 v2); and
- a summary of the project, no longer than one page in length that provides:
 1. a description of the population to be served;
 2. a summary of the services to be provided; and
 3. a description of the coordination planned with appropriate State or local health agencies.

For SAMHSA grants, the appropriate State agencies are the Single State Agencies (SSAs) for substance abuse and mental health. A listing of the SSAs for substance abuse can be found on SAMHSA's Web site at <http://www.samhsa.gov>. A listing of the SSAs for mental health can be found on SAMHSA's Web site at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3509/page4.asp>. If the proposed project falls within the jurisdiction of more than one State, you should notify all representative SSAs.

If applicable, you must include a copy of a letter transmitting the PHSIS to the SSA in **Attachment 4, "Letter to the SSA."** The letter must notify the State that, if it wishes to comment on the proposal, its comments should be sent no later than 60 days after the application deadline to the following address. **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: SSA – Funding Announcement No. **SP-10-003**. Change the zip code to **20850** if you are using another delivery service.

In addition:

- Applicants may request that the SSA send them a copy of any State comments.
- The applicant must notify the SSA within 30 days of receipt of an award.

¹ Approved by OMB under control no. 0920-0428; Public reporting burden for the Public Health System Reporting Requirement is estimated to average 10 minutes per response, including the time for copying the face page of SF 424 v2 and the abstract and preparing the letter for mailing. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0920-0428. Send comments regarding this burden to CDC Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428).

5. 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.samhsa.gov/grants/management.aspx>:

- 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

In addition, SAMHSA's **Ready-To-Respond Initiative** cooperative agreement recipients must comply with the following funding restrictions:

- No more than 15% of the total grant award may be used for implementing environmental strategies.
- No more than 15 % of the total grant award may be used for data collection and performance assessment
- No more than 10% of the total grant award may be used for HIV testing.
- At least 50% of the total grant award must be used for direct services.
- Up to 10% of the total grant award may be used for infrastructure enhancements, if needed.

SAMHSA grantees must also comply with SAMHSA's standard funding restrictions, which are included in [Appendix F](#).

6. OTHER SUBMISSION REQUIREMENTS

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

Submission of Electronic Applications

SAMHSA accepts electronic submission of applications through <http://www.Grants.gov>. 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 <http://www.Grants.gov> apply site. You will be able to download a copy of the application package from <http://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 [Appendix B](#) for detailed instructions on submitting your application electronically.

Submission of Paper Applications

You must submit an original application and 2 copies (including attachments). 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
1 Choke Cherry Road, Room 3-1044
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 “**Ready-To-Respond Initiative - SP-10-003**” in item number 12 on the face page (SF 424 v2) of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-E below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-E.

- 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 be no longer than 30 pages.
- You must use the five sections/headings listed below in developing your Project Narrative. 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.

- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative, and will consider how well you address the cultural competence aspects of the evaluation criteria when scoring your application. SAMHSA’s guidelines for cultural competence can be found on the SAMHSA Web site at <http://www.samhsa.gov/grants/apply.aspx> at the bottom of the page under “Resources for Grant Writing.”
- The Supporting Documentation you provide in Sections F-I and Attachments 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. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall section score.

Section A: Statement of Need (10 points)

- Describe the subpopulation of focus and the geographic area to be served, and justify the selection of both with respect to the primary purpose of the grant program. Also include demographic information on the subpopulation of focus, e.g., race, ethnicity, age, socioeconomic status, and geography. Indicate the subpopulation of focus served under your previous grant and the subpopulation of focus you will serve with RTR funds.
- Describe the nature of the problem and extent of the need, (e.g., update the data with any new current prevalence rates or incidence data) for the subpopulation of focus. The statement of need should include a clearly established baseline for the project. Documentation of need may come from a variety of qualitative and quantitative sources. The quantitative data could come from local epidemiologic data or trend analyses, State data (e.g., from State Needs Assessments, SAMHSA’s National Survey on Drug Use and Health), and/or national data (e.g., from SAMHSA’s National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control reports). For data sources that are not well known, provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.
- Non-tribal applicants must show that identified needs are consistent with priorities of the State or county that has primary responsibility for the service delivery system. Tribal applicants must provide similar documentation relating to tribal priorities.
- Include, in Attachment 5, a copy of the State or county strategic plan, a State or county needs assessment, or a letter from the State or county indicating that the proposed project addresses a State- or county-identified priority. The plans should be less than five years old.

Section B: Proposed Evidence-Based Service/Practice (20 points)

- Clearly state the purpose, goals and objectives of your proposed project. Describe how achievement of the goals will produce meaningful and relevant results (e.g., increase access, availability, prevention, outreach, linkages to treatment and/or other prevention services) and support SAMHSA's goals for the program.
- Identify the evidence-based service(s)/practice(s) that you propose to implement, and the source of your information. (See [Section I-2.2](#), Using Evidence-Based Practices). Discuss the evidence that shows that this practice is effective with your subpopulation of focus. If the evidence is limited or non-existent for your subpopulation of focus, provide other information to support your selection of the intervention(s) for your subpopulation of focus.
- Document the evidence that the practice(s) you have chosen is (are) appropriate for the outcomes you want to achieve.
- Identify and justify any modifications or adaptations you think you will need to make – or have already made – to the proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes.
- Explain why you chose this evidence-based practice over other evidence-based practices. If this is not an evidence-based practice, explain why you chose this intervention over other interventions.
- Describe how the proposed project will address the following issues in the subpopulation of focus, while retaining fidelity to the chosen practice:
 - Demographics – race, ethnicity, religion, gender, age, geography, and socioeconomic status;
 - Language and literacy;
 - Sexual identity – sexual orientation and gender identity; and
 - Disability.
- Demonstrate how the proposed service(s)/practice(s) will meet your goals and objectives. Provide a logic model that links need, the services or practice to be implemented, and outcomes. (See [Appendix D](#) for a sample logic model)

Section C: Proposed Implementation Approach (30 points)

Proposed Program Design:

- Describe how the proposed service(s) or practice(s) will be implemented.
- Describe your plans to provide substance abuse and HIV risk assessment, HIV screening and HIV testing (rapid or blood). Indicate the number of participants you plan to test each year and over the 5 year grant period. **(Refer to [Appendix H](#) of this RFA to review HIV testing requirements.)**
- Describe how referrals will be made to appropriate counseling, medical treatment, and other supportive services for participants who are confirmed HIV positive.
- Describe how you will make referrals to counseling for persons who tested negative to decrease their risk for acquiring HIV and substance abuse.
- Describe how project planning, implementation and assessment will include participant input.
- Provide a realistic time line for the entire project period (chart or graph) including major activities and implementation of services within the first 6 months of Notice of Award (NoA).
- Describe how the project components will be embedded within the existing local prevention service system, including other SAMHSA-funded projects, if applicable. Identify any other Federal, State and local organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of commitment from community organizations supporting the project in **Attachment 1** and state the services that are being provided and coordinated across service providers.
- Describe the potential barriers to conduct the proposed project and how you will address these concerns.
- Describe your plan to continue the project after the funding period ends. Also describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.
- Describe any infrastructure development activities you are proposing as part of your program design. Describe how environmental strategies will be implemented and how these strategies will improve community level change.

- Describe your goal for community change in years 2-5.
- Describe how the new subpopulation of focus will be identified, recruited, and retained. Using your knowledge of the language, beliefs, norms, values and socioeconomic factors of the new subpopulation of focus, discuss how the proposed approach addresses these issues in outreaching, engaging and delivering programs to this subpopulation, e.g., collaborating with community gatekeepers.

Documented Outcomes:

- Describe the successes achieved and problems encountered in providing your evidence-based program with the subpopulation you previously served, including its efficacy with meeting the goals of your program.
- Describe the risk factors associated with the subpopulation you served and the strategies you implemented to reduce the risk of HIV infection and prevent further substance use.
- Describe lessons learned about your work with this subpopulation and what you would do differently if given the opportunity under this grant announcement.
- Describe the outcomes of your sustainability plan for your previous project.
- Discuss significant community changes or improvements that resulted from your previous project.

Section D: Staff and Organizational Experience (20 points)

- Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations. Demonstrate that the applicant organization and other participating organizations have linkages to the subpopulation of focus and ties to grassroots/community-based organizations that are rooted in the culture and language of the subpopulation of focus.
- Provide a complete list of staff positions for the project, showing the role of each and their level of effort and qualifications. Include the Project Director and other key prevention personnel (e.g.; Project Coordinator and Evaluator).
- Discuss how key staff have four or more years of experience in implementing SAMHSA's SPF in serving high-risk minority populations and are familiar with the culture and language of the subpopulation of focus. If the subpopulation of focus is multicultural and multilinguistic, describe how staff is qualified to serve this population.

- Describe the resources available for the proposed project (e.g., facilities, equipment), and provide evidence that services will be provided in a location that is adequate, accessible, compliant with the Americans with Disabilities Act (ADA), and amenable to the subpopulation of focus. If the ADA does not apply to your organization, please explain why.

Section E: Performance Assessment and Data (20 points)

- Document your ability to collect and report on the required performance measures as specified in [Section I-2.7](#) of this RFA. Describe your plan for data collection, management, analysis and reporting. Specify and justify any additional measures or instruments you plan to use for your grant project.
- Describe how data will be used to manage the project and assure continuous quality improvement, including consideration of disparate outcomes for different racial/ethnic groups. Describe how information related to process and outcomes will be routinely communicated to program staff.
- Describe your plan for conducting the performance assessment as specified in [Section I-2.8](#) of this RFA and document your ability to conduct the assessment.

Documented Outcomes:

- Provide data that show outcomes achieved for your subpopulation of focus served over the past four years that result from the substance abuse prevention, HIV prevention, environmental strategies or infrastructure development activities you implemented.

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. Be sure to show that no more than 10 % of the total grant award will be used for infrastructure development, no more than 15 % of the total grant award will be used for environmental strategies, no more than 15 % of the total grant award will be used for data collection and performance assessment, and no more than 10% of the total grant award will be used for HIV testing. An illustration of a budget and narrative justification is included in [Appendix G](#) of this document.

Please describe the following in your budget justification:

- Type of HIV testing and purchasing mechanism (e.g., bulk, direct, wholesale retail costs) for the test kits.
- Explain the additional costs needed for rapid and confirmatory test results, supplies and other administrative costs (e.g., lab services and reports).
- Staffing costs for administering the HIV testing and providing counseling.

More information on HIV testing methodologies and apparatus related costs is available at <http://www.cdc.gov/hiv/topics/testing/rapid/index.htm>.

NOTE: Although the budget for the proposed project is not a scored 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.

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 on the SAMHSA Web site.

Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects: You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of your application, using the guidelines provided below.

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 elements 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 elements, 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 must be resolved prior to funding.

1. Protect Participants 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 population(s) of focus 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, and 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.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an “undue inducement” which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed \$20.
- 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 **Attachment 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 participant 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 participants from these risks.
- Explain how you will get consent for youth, the elderly, and 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 **Attachment 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

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 for research involving human subjects. For assistance in determining if your proposed performance assessment meets the criteria in 45 CFR 46, Protection of Human Subjects Regulations, refer to the SAMHSA decision tree on the SAMHSA Web site, under "Applying for a New SAMHSA Grant," <http://www.samhsa.gov/grants/apply.aspx>.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must 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 participants 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 evaluation 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 Prevention National Advisory Council;
- availability of funds; and
- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size.

VI. 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 through postal mail, the Notice of Award (NoA), signed by SAMHSA's Grants Management Officer. The Notice of Award is the sole obligating document that allows you to receive Federal funding for work on the grant project.

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

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- If your application is funded, you 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 <http://www.samhsa.gov/grants/management.aspx>.
- If your application is funded, you 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/management.aspx>).

- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you 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;
 - requirements to address problems identified in review of the application; or
 - revised budget and narrative justification.

- If your application is funded, you 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 at: <http://www.samhsa.gov/grants/downloads/SurveyEnsuringEqualOpp.pdf>. You are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in [Section I-2.7](#), and [Section I-2.8](#) you must comply with the following reporting requirements:

3.1 Progress and Financial Reports

- You will be required to submit quarterly workplans, SPF progress reports (Needs Assessment, Capacity Building and Strategic Plan), subsequent monthly progress reports and a final progress report at the end of the grant period. In addition, grantees will be expected to submit annual and final financial status reports.
- Because SAMHSA is extremely interested in ensuring that prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this grant.
- If your application is funded, SAMHSA will provide you with guidelines and requirements for these reports 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 your progress toward meeting its goals.

3.2 Government Performance and Results Act (GPRA)

The Government Performance and Results Act (GPRA) mandate accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., “GPRA data”) from grantees. The performance requirements for SAMHSA’s **Ready-To-Respond Initiative** grant program are described in [Section I-2.7: Data Collection and Performance Measurement](#), and [Section I-2.8: Performance Assessment](#) of this document.

3.3 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:

Claudia Richards, MSW, LICSW
Division of Community Programs, Center for Substance Abuse Prevention,
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 4-1115
Rockville, Maryland 20857
Helpline: (240) 276-0469
Email inquiries to: 2010RTR@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Eileen Bermudez
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1079
Rockville, Maryland 20857
(240) 276-1412
eileen.bermudez@samhsa.hhs.gov

Appendix A – Checklist for Formatting Requirements and Screen out 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 form.
- Applications must be received by the application due date and time, as detailed in [Section IV-3](#) of this grant announcement.
- Information provided must be sufficient for review.
- Text must be legible. Pages must be typed in black ink, single-spaced, using a font of Times New Roman 12, with all margins (left, right, top, bottom) at least one inch each. (For Project Narratives submitted electronically, see separate requirements in [Section IV-6](#) of this announcement under “Submission of Electronic Applications.”)
- To ensure equity among applications, page limits for the Project Narrative cannot be exceeded.
- Paper must be white paper and 8.5 inches by 11.0 inches in size.

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 application components required for SAMHSA applications should be included and submitted in the following order:
 - 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
 - Attachments
 - Project/Performance Site Location(s) Form

- 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.
 - Pages should be numbered consecutively from beginning to end so that information can be located easily during review of the application. The abstract page should be page 1, the table of contents should be page 2, etc. The four pages of Standard form 424 v2 are not to be numbered. Attachments 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 Attachments stated in [Section IV-2.2](#) of this 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 B – Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search <http://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 <http://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 Grants.gov Contact Center is available 24 hours a day, 7 days a week, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete three 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; and 3) Grants.gov registration (Get username and password.). **REMINDER: CCR registration expires each year and must be updated annually.**

Please also allow sufficient time for enter your application into Grants.gov. When you submit your application you will receive a notice that your application is being processed and that you will receive two e-mails from Grants.gov. within the next 24-48 hours. One will confirm receipt of the application in Grants.gov and the other will indicate that the application was either successfully validated by the system (with a tracking number) or rejected due to errors. It will also provide instructions that if you do not receive a receipt confirmation **and** a validation confirmation or a rejection e-mail within 48 hours, you must contact Grants.gov directly. Please note that it is incumbent on the applicant to monitor their application to ensure that it is successfully received and validated by Grants.gov. **If your application is not successfully validated by Grants.gov it will not be forwarded to SAMHSA as the receiving institution.**

It is strongly recommended that you submit your grant application using Microsoft Office 2003 products (e.g., Microsoft Word 2003, Microsoft Excel, etc.). The new Microsoft Vista operating system and Microsoft Word 2007 products are not currently accepted by Grants.gov. If you do not have access to Microsoft Office 2003 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 A](#) 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 infection 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 at least one inch each. Adhering to these standards will help to ensure the accurate infection of your document.
- *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, the application will be screened out and will not be reviewed.** To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

Keep the Project Narrative as a separate document. Please consolidate all other materials in your application to ensure the fewest possible number of attachments. Be sure to label each file according to its contents, e.g., “Attachments 1-3”, “Attachments 4-5.”

Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. **Documents containing scanned images must also contain page numbers to continue the sequence.** Failure to comply with these requirements may affect the successful infection 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. 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. **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.**

If you are submitting any documentation that cannot be submitted electronically, please send a hard copy to the address below. [SAMHSA no longer requires submission of a signed paper original of the face page (SF 424 v2) or the assurances (SF 424B)]. **You must include the Grants.gov tracking number for your application on these documents. 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
1 Choke Cherry Road, Room 3-1044

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.

Appendix C – Statement of Assurance

As the authorized representative of [*insert name of applicant organization*]

_____, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment from every service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all service provider organizations participating in the project have been providing relevant services for a minimum of 4 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 4 years; and
- official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

Signature of Authorized Representative

Date

Appendix D – Sample Logic Model

A logic model is a *picture* of your project. It graphically shows the planning approach of activities and chronology of tasks, and strategies of progression for moving forward the goals of the project. A logic model is a tool to show how your proposed project is supposed to work by explaining why the strategy is a good solution to the problem at hand and making an explicit, visual, statement of activities and results.

A logic model should depict how your proposed project connects the local problems with appropriate strategies (programs, practices and policies) that over time produce changes in behaviors and ultimately in the identified problems. It should create a visual display of the connection, or logic, between the goals, consequences, intervening variables, or risk and protective factors, the strategies, and the ultimate outcomes.

It should also describe the relationships among the resources you put in it and what you do (strategies), and what happens or results (outcomes). Your logic model should form a logical chain of “if-then” relationships that enables you to demonstrate how you will get to your desired outcomes with your available resources and other community key stakeholders’ involvement. Because your logic model requires you to be specific about your intended outcomes, it can be a valuable resource in assessing performance and rallying support by declaring what will be accomplished by your project and how by providing specific goals and outcomes that can be measured over time during the project grant period.

The graphic on the following page provides an example of a logic model that links the goals, consequences, and intervening variables to program strategies and outcomes.

Your logic model should be based on the data presented in your Needs Assessment, in which you document the substance abuse and HIV problems in your minority subpopulation of focus. A properly targeted logic model will show a logical pathway from the problem to solution or from the goals to the intended outcomes.

Goals - Planning begins with the end in mind. The goals restate the identified problems in measurable terms of the problems that will be improved as a result of the project. Related problems often provide an associated social indicator that can better quantify the problem.

As an example, underage drinking is an identified problem and related problems often are linked to social problems caused by underage drinking, such as high DWI rates. The goal then would be to reduce underage drinking and decrease the incidence of DWI.

Consequences - The consequences are the social results of substance abuse and its related problems. In the example presented above, the consequences of underage drinking and DWIs include increased assaults, and hospital E.R. admissions due to accidents, falls, assaults and teen car crashes, deaths and injuries. Each of these consequences have social indicator data sets that track rates and can provide measures of change.

Intervening Variables – The intervening variables are underlying causes or conditions that allow the problem to exist. These are often described in terms of risk and protective factors and also have associated measures. Again in the example above, intervening variables for underage drinking include easy access and availability of alcohol, perceptions of approval or disapproval, perceptions of risk from harm, etc.

Strategies - Strategies are the combination of programs, practices and policies that are put in place to address the identified intervening variables and ultimately effect the social consequences and improve the identified problems. The strategies implemented should be based on the science and have demonstrated evidence of effectiveness. In the underage drinking example, effective strategies include: engaging law enforcement practices to reduce access and availability such as controlled underage purchases, increasing policies that mandate alcohol sales I.D. and provide random compliance checks, educational programs and social marketing campaigns on I.D. checks, adult and peer disapproval of use, and examples of physical or legal harm or risks associated with use.

Outcomes – The outcomes include short term, long term and behavioral measured changes over time and they should be “logically” connected to various points of the plan or logic model. The behavioral changes are measures related to the identified changes in the intervening variables or risk and protective factors. The short term outcomes are measures related to identified consequences and the long term measures or the ultimate outcomes are related to measured changes in the identified problems or goals.

To demonstrate the measures with the underage drinking example, think in terms of the “if/then” concept and work the problem backwards across the logic model to answer the “if/then” questions beginning with the strategies. If we provide education and social marketing campaigns along with law enforcement compliance checks and improve retailer ID practices, then we will achieve decreased access and availability, increased perceptions of risk and increased disapproval. These will then lead to decreased car crashes and hospital E.R. admissions and also over the long term reduce underage drinking

In the evaluation plan, appropriate measures can be identified and tracked over time to demonstrate improved outcomes and ultimately goal accomplishment. The measures do not have to be depicted on the logic model itself.

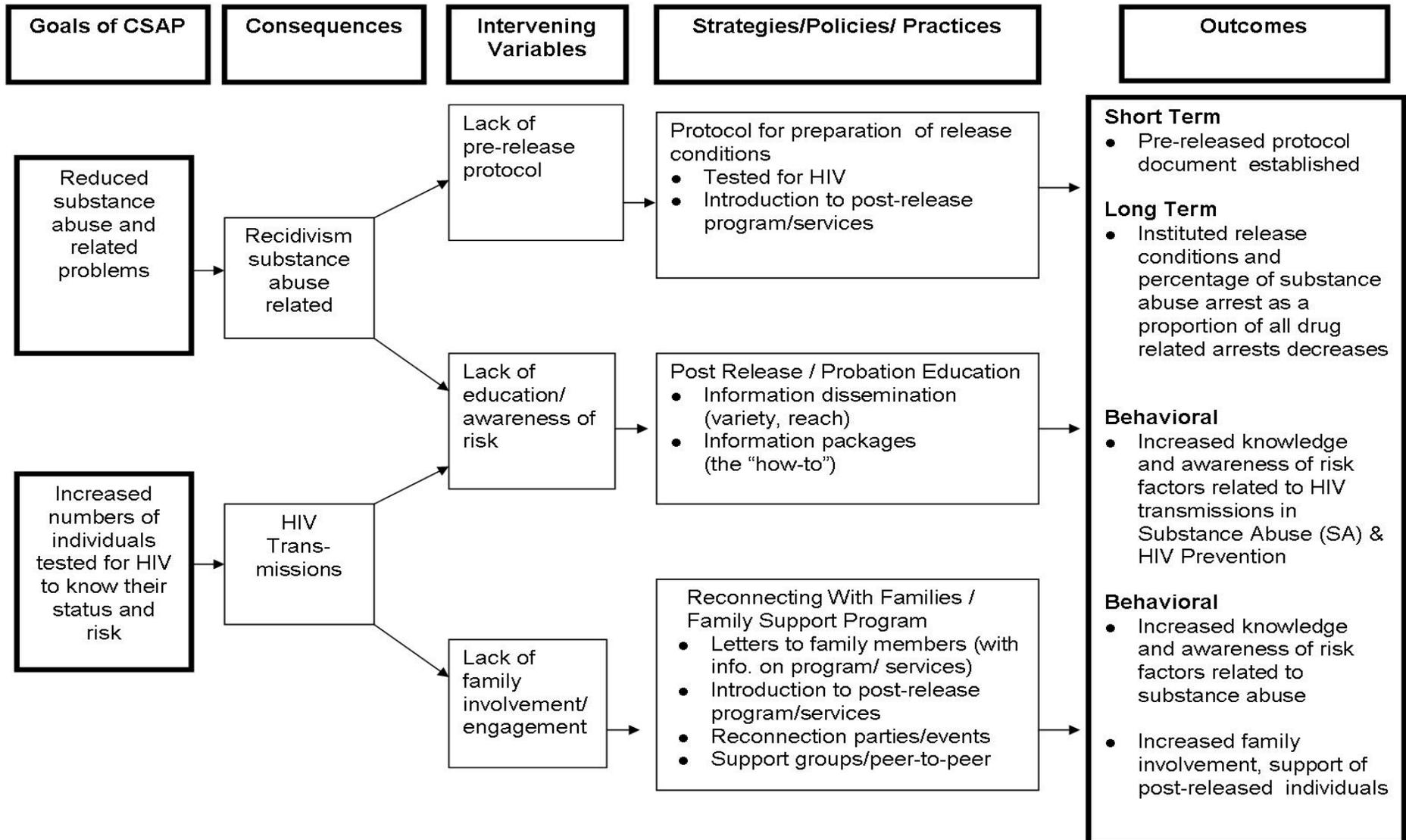
The sample logic model provides a similar example for substance abuse and HIV prevention for minority re-entry populations. Examine the sample to follow the logical planning process presented in this scenario and use the “if/then” thinking to work backwards to validate if there is a logical connection between the outcomes and the strategies, intervening variables, consequences and goals. Use the sample to develop a similar logic model that depicts your planning process, goals and outcomes.

NOTE: The logic model presented is not a required format and SAMHSA does not expect strict adherence to this format. It is presented only as a sample of how you can present a logic model in your application.

FIGURE 1: SAMPLE LOGIC MODEL FOR DATA-DRIVEN OUTCOMES PLANNING

SAMPLE LOGIC MODEL FOR DATA-DRIVEN OUTCOMES PLANNING

(POPULATION OF FOCUS: MINORITY REENTRY SUBPOPULATIONS)



Description of the Above Sample Logic Model For Data-Driven Outcomes Planning

The above logic model ([Figure 1](#)) is a sample of data-driven outcomes planning for a Substance Abuse and HIV Prevention program serving minority re-entry subpopulations.

Re-entry programs are designed to help newly released prisoners with making a seamless transition back into society and to equip them with knowledge and effective tools and strategies to prevent them from engaging in substance abuse and other risky behaviors that can lead to HIV transmission.

[Figure 1](#) consists of stated goals, stated consequences, intervening variables, strategies, policies, and practices, and a list of desired outcomes.

Phase 1 of the logic model is to list the goals which in this case are:

1. Reduced substance abuse and related problems, and
2. Increased numbers of individuals tested for HIV so they are aware of their HIV status and risk.

Phase 2 of the logic model provides a list of the consequences:

1. Recidivism as a result of substance abuse related crimes, and,
2. Increased number of HIV transmissions

Phase 3 of the model describes the intervening variables. In other words, what are some factors that play into helping or hindering a program from reaching its goals?

1. Lack of a pre-release protocol document
2. Lack of education or awareness of the risks of HIV infection, and
3. Lack of family involvement or family engagement.

Remember, these are examples ONLY. There may be many more variables you can identify during the planning phase of the project (SPF, Step 3).

Phase 4 of the logic model involves listing strategies, policies and/or practices that can be employed to reach the desired goals. The examples listed are as follows:

- **Establish protocols for preparation of release conditions** including testing re-entry subpopulations upon release for HIV; and providing information to them on post-release programs or related services.
- **Provide Post Release / Probation Education** by establish an agreement with the prison to disseminate comprehensive post release and probation education and other helpful information packages (the “how to”) to your target population.
- **Develop strategies to reconnect reentry population with families /develop family support program.** Some strategies you can use are:
 - Writing letters to family members about your program and its services,
 - Introducing them to the post-release program and services,
 - Conducting re-connection events such as parties so that families can get re-acquainted, and

- Establishing support groups or peer to peer support.

The fifth and last phase of the logic model displays a list of the desired outcomes including short term, long term and behavioral measured changes over time that are “logically” connected to various points of the plan or logic model.

Listed below are short-term, long-term, and behavioral measured change outcomes:

- **Short-term outcome** (measures related to the identified consequences):
 - Established a pre-release protocol document that will be useful in identifying and recruiting members of the re-entry population to participate in our program.
- **Long-term outcome** (ultimate outcome related to the measured changes in the identified problems or goals):
 - Instituted release conditions and percentage of substance abuse arrests (as a proportion of all drug-related arrests) decrease.
- **Behavioral measured change outcomes** (measures related to the identified changes in the intervening variables or risk and protective factors):
 - Increased knowledge and awareness of HIV risk factors resulting from Substance Abuse and HIV prevention education.
 - Increased family involvement and support for reentry populations.

Appendix E – Logic Model Resources

Chen, W.W., Cato, B.M., & Rainford, N. (1998-9). Using a logic model to plan and evaluate a community intervention program: A case study. *International Quarterly of Community Health Education*, 18(4), 449-458.

Edwards, E.D., Seaman, J.R., Drews, J., & Edwards, M.E. (1995). A community approach for Native American drug and alcohol prevention programs: A logic model framework. *Alcoholism Treatment Quarterly*, 13(2), 43-62.

Hernandez, M. & Hodges, S. (2003). *Crafting Logic Models for Systems of Care: Ideas into Action*. [Making children's mental health services successful series, volume 1]. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. <http://cfs.fmhi.usf.edu> or phone (813) 974-4651.

Hernandez, M. & Hodges, S. (2001). Theory-based accountability. In M. Hernandez & S. Hodges (Eds.), *Developing Outcome Strategies in Children's Mental Health*, pp. 21-40. Baltimore: Brookes.

Julian, D.A. (1997). Utilization of the logic model as a system level planning and evaluation device. *Evaluation and Planning*, 20(3), 251-257.

Julian, D.A., Jones, A., & Deyo, D. (1995). Open systems evaluation and the logic model: Program planning and evaluation tools. *Evaluation and Program Planning*, 18(4), 333-341.

Patton, M.Q. (1997). *Utilization-Focused Evaluation* (3rd Ed.), pp. 19, 22, 241. Thousand Oaks, CA: Sage.

Wholey, J.S., Hatry, H.P., Newcome, K.E. (Eds.) (1994). *Handbook of Practical Program Evaluation*. San Francisco, CA: Jossey-Bass Inc.

W.K. Kellogg Foundation, (2004). *Logic Model Development Guide*. Battle Creek, MI. To receive additional copies of the Logic Model Development Guide, call (800) 819-9997 and request item #1209.

Appendix F – Funding Restrictions

SAMHSA 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.
- Make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA discretionary grant funds may be used for non-clinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.
- Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, SAMHSA discretionary grant funds may be used for non-cash incentives of up to \$20 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to \$20 cash 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.
- Food is generally unallowable unless it's an integral part of a conference grant or program specific, e.g., children's program, residential.

- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.
- Pay for pharmacist for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C Vaccine, or for treatment after medical diagnosis from a qualified medical practitioner 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.

Appendix G – Sample Budget and Justification (no match required)

THIS IS AN ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION WITH GUIDANCE FOR COMPLETING SF 424A: SECTION B FOR THE BUDGET PERIOD

A. Personnel: an employee of the applying agency whose work is tied to the application

TABLE 3: FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Project Director	John Doe	\$64,890	10%	\$ 6,489
Coordinator	To be selected	\$46,276	100%	\$46,276
			TOTAL	\$52,765

JUSTIFICATION: Describe the role and responsibilities of each position.

The Project Director will provide daily oversight of the grant and will be considered a key staff member. The coordinator will coordinate project services and project activities, including training, communication, and information dissemination. Key staff positions require prior approval of resume and job description.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form SF424A) **\$52,765**

B. Fringe Benefits: List all components of fringe benefits rate

TABLE 4: FEDERAL REQUEST

Component	Rate	Wage	Cost
FICA	7.65%	\$52,765	\$4,037
Workers Compensation	2.5%	\$52,765	\$1,319
Insurance	10.5%	\$52,765	\$5,540
		TOTAL	\$10,896

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF424A) **\$10,896**

C. Travel: Explain need for all travel other than that required by this application. Local travel policies prevail.

TABLE 5: FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
Grantee Conference	Washington, DC	Airfare	\$200/flight x 2 persons	\$400
		Hotel	\$180/night x 2 persons x 2 nights	\$720
		Per Diem (meals)	\$46/day x 2 persons x 2 days	\$184
Local travel		Mileage	3,000 miles@ .38/mile	\$1,140
		TOTAL		\$2,444

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

Cost for two staff to attend a grantee meeting in Washington, DC. Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on agency's policies and procedures privately owned vehicle (POV) reimbursement rate.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF424A) **\$2,444**

D. Equipment: an article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit – federal definition.

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF424A) **\$ 0**

E. Supplies: materials costing less than \$5,000 per unit and often having one-time use

TABLE 6: FEDERAL REQUEST

Item(s)	Rate	Cost
General office supplies	\$50/mo. x 12 mo.	\$600
Postage	\$37/mo. x 8 mo.	\$296
Laptop Computer*	\$900	\$900
Printer*	\$300	\$300
Projector*	\$900	\$900
Copies	8000 copies x .10/copy	\$800
TOTAL		\$3,796

JUSTIFICATION: Describe need and include explanation of how costs were estimated.

Office supplies, copies, and postage are needed for general operation of the project. The laptop computer is needed for both project work and presentations. The projector is needed for presentations and workshops. All costs were based on retail values at the time the application was written.

*Provide adequate justification for purchases.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF424A) **\$ 3,796**

F. Contract: A consultant is an individual retained to provide professional advice or services for a fee but usually not as an employee of the organization. The grantee must have policies and procedures governing their use of consultants that are consistently applied among all organization’s agreements.

TABLE 7: FEDERAL REQUEST

Name	Service	Rate	Other	Cost
Joan Doe	Training staff	\$150/day	15 days	\$2,250
	Travel	.38/mile	360 miles	\$137
TOTAL				\$2,387

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.

This person will advise staff on ways to increase the number of participants and participant services. Consultant is expected to make up to 6 trips (each trip a total of 60 miles) to meet with staff and other local and government experts. Mileage rate is based on grantee’s POV reimbursement rate.

TABLE 8: FEDERAL REQUEST

Entity	Product/Service	Cost
To Be Announced	Marketing Coordinator \$25/hour x 115 hours	\$2,875
ABC, Inc.	Evaluation \$65/hr x 70 days	\$4,550
TOTAL		\$7,425

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.

The Marketing Coordinator will develop a marketing plan to include public education and outreach efforts to engage participants of the community about grantee activities, provision of presentations at public meetings, and community events to stakeholders, community civic organizations, churches, agencies, family groups, and schools. Information disseminated by written or oral communication and electronic resources. A local evaluator will be contracted to produce the outcomes and report input of GPRA data.

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF424A) **\$ 9,812**
(combine the total of consultant and contact)

G. Construction: NOT ALLOWED – Leave Section B columns 1&2 line 6g on SF424A blank.

H. Other: expenses not covered in any of the previous budget categories

TABLE 9: FEDERAL REQUEST

Item	Rate	Cost
Rent*	\$15/sq.ft x 700 sq. feet	\$10,500
Telephone	\$100/mo. x 12 mo.	\$1,200
Participant Incentives	\$10/participant follow up x 278 participants	\$2,780
Brochures	.89/brochure X 1500 brochures	\$1,335
	TOTAL	\$15,815

JUSTIFICATION: Break down costs into cost/unit, i.e. cost/square foot. Explain the use of each item requested.

Office space is included in the indirect cost rate agreement; however, other rental costs are necessary for the project as well as telephone service to operate the project. The rent is calculated by square footage and reflects SAMHSA’s share of the space. The monthly telephone costs reflect the percent of effort for the personnel listed in this application for the SAMHSA project only. Survey copyright requires the purchase of the ATOD surveys. Brochures will be used at various community functions (health fairs and exhibits).

*If rent is requested (direct or indirect), provide the name of the owner(s) of the space/facility. If anyone related to the project owns the building which is less than an arms length arrangement, provide cost of ownership/use allowance calculations since mortgage costs are unallowable.

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF424A) **\$ 15,815**

Indirect cost rate: Indirect costs can only be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. For information on applying for the indirect rate go to: www.samhsa.gov then click on Grants – Grants Management – HHS Division of Cost Allocation – Regional Offices.

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF424A)
8 % of personnel and fringe (.08 x \$63,661) **\$5,093**

BUDGET SUMMARY: (identical to SF-424A)

TABLE 10: BUDGET SUMMARY

Category	Federal Request
Personnel	\$52,765
Fringe	\$10,896
Travel	\$2,444
Equipment	0
Supplies	\$3,796
Contractual	\$9,812
Other	\$15,815
Total Direct Costs*	\$95,528
Indirect Costs	\$5,093
Total Project Costs	\$100,621

*** TOTAL DIRECT COSTS:**

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF424A) **\$95,528**

TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF424A) **\$100,621**

Appendix H – HIV Testing Requirements

Grantees that meet the requirements delineated below for rapid HIV testing may **use up to 10% of the total direct costs to purchase rapid HIV antibody test kits, control kits, confirmatory kits, and/or confirmation laboratory services to test participants enrolled in the program. Please refer to the note at the end of this Appendix referencing budget justification for standard or rapid HIV testing.** Award recipients with MOAs in place with local Rapid HIV testing provider(s) for participants enrolled in this program may use up to 10% of their award to purchase HIV rapid antibody test kits or standard test kits, control kits, confirmatory kits, and/or confirmation laboratory services for providers to conduct on- and off-site Rapid HIV testing services.

Grantees must obtain the following trainings:

- Basic fundamentals of HIV/AIDS training, as recognized by the State.
- State-certified HIV Counseling, Testing, and Reporting (CTR) Services.
- Fundamentals of HIV rapid testing and Pre/Post Test Prevention Counseling with Rapid HIV-1 Antibody Test.

- **CLIA Certificate of Waiver:** Trained award recipients must obtain a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver. Instructions on how to obtain this waiver are available on CDC's Web site at:<http://www.cms.hhs.gov/CLIA/downloads/HowObtainCertificateofWaiver.pdf>

- **State regulations:** Grantees must adhere to their State HIV rapid testing regulatory requirements. A copy of State compliance documentation on HIV rapid testing (i.e., HIV Prevention Counseling, Partner Notification, Disease Reporting protocol) must be provided. State agency contacts are listed at:
http://www.cms.hhs.gov/clia/12_state_agency_&_regional_office_clia_contacts.asp.

- **Linkages to Care:** Trained service providers on HIV rapid testing **MUST** provide signed Memoranda of Agreement (MOAs) in **Attachment 1** of your application demonstrating established referral networks for participants needing appropriate counseling, treatment, and support services. Linkages to care must consist of, but are not limited to, partnership(s) with local health departments and AIDS service organizations to secure appropriate HIV/AIDS support resources including HIV rapid testing, laboratory services, HIV/AIDS primary and behavioral health care services, and other necessary support services (e.g., insurance, housing, food, and transportation). **Grantees with MOAs in place with local HIV rapid testing provider(s) for testing on participants enrolled in this program may use up to 10% of the total direct costs of the award to purchase HIV rapid test kits for providers to conduct on- and off-site Rapid HIV testing services.**

- **HIV Rapid Testing Quality Assurance Plan:** Trained service providers must provide a copy of their site's rapid testing policies, procedures, and Quality Assurance (QA) plan (i.e., records management, self-monitoring protocol, test reliability and validity, and use

of control kits). For information on CDC's QA guidelines, visit: http://www.cdc.gov/hiv/rapid_testing/materials/QA-Guide.htm.

- **Policies & Procedures:** Grantees must provide a copy of the following policies and procedures before initiating our agency rapid testing protocol:
 - *Informed Consent Form* – Grantees must have an informed consent form for participants to give consent to confidential or anonymous testing and HIV prevention and risk reduction counseling.
 - *Legal/Ethical Policies* - Grantees must know their State laws regarding who may implement Counseling, Testing, and Referral (CTR) procedures and disclosure of an individual's HIV status (whether positive or negative) to partners and other parties. Organizations are also obligated to inform participants about State laws regarding the reporting of child abuse, sexual abuse of minors, and elder abuse.
 - *HIPAA Compliance/Participant Protection and Confidentiality* – Grantees must maintain the confidentiality of participant records according to the provisions of Title 42 of the Code of Federal Regulations, Part II. For information on HIPAA compliance, visit: www.hhs.gov/ocr/hipaa.
 - *Safety* – Grantees must have guidelines for personal safety and security in non-traditional settings, for ensuring minimal safety standards (including biohazard waste disposal) as outlined by the Occupational Safety and Health Administration.
 - *Volunteers* – Grantees using volunteers must follow State requirements.
 - *Data Security* - Grantees must collect and report data consistent with SAMHSA/CDC requirements to ensure data security and confidentiality. This includes written protocols on how to collect and analyze CTR data according to State and local policies.

Additional information regarding FDA's HIV testing requirements can be found at: <http://www.cdc.gov/hiv/topics/testing/rapid/rt-comparison.htm>

Appendix I – State Epidemiological Outcomes Workgroup (SEOW) Coordinator Listing

TABLE 11: STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP (SEOW) COORDINATOR LISTING

Name	Company	Job Title	Street Address	City	State	Zip Code	Work Phone	Work Email
Kristopher Vilamaa	Alabama Department of Mental Health/Mental Retardation	Director of Information Services	100 North Union St. Suite 430	Montgomery	AL	36104	(334) 242-3969	kristopher.vilamaa@mh.alab.gov
Stephanie McCladdie	Alabama Prevention Contact	Chief Office of Prevention	100 North Union Street Room 430	Montgomery	AL	36104-1410	(334) 242-3954	stephanie.mccladdie@mh.a
Steve Wirtz	Epidemiology and Prevention for Injury Control (EPIC) Branch California Department of Health Services	Research Scientist	MS 7214 P.O. Box 997413	Sacramento	CA	95899-7413	(916) 552-9844	swirtz@dhs.ca.gov
Judith Donovan	Addiction Prevention and Recovery Administration APRA/Office of Prevention Services (OPS):	Director of Prevention	3720 Martin Luther King, Jr. Ave. S.E.	Washington	DC	20032	202-645-0326	judith.donovan@dc.gov
Mariam Madanat	APRA/Office of Prevention Services (OPS)	CSAP Prevention Fellow	3720 Martin Luther King, Jr. Ave. S.E.	Washington	DC	20032	202-645-0335	Mariam.madanat@dc.gov
Bruce Points	APRA/Office of Prevention Services (OPS)	Prevention Coordinator	3720 Martin Luther King, Jr. Ave. S.E.	Washington	DC	20032	202-645-0333	Bruce.points@dc.gov
Thomas Randolph	APRA/Office of Prevention Services (OPS)	Prevention Coordinator	3720 Martin Luther King, Jr. Ave. S.E.	Washington	DC	20032	202-645-0334	Thomas.randolph@dc.gov
Isabel Rivera-Green	Division of Substance Abuse and Mental Health	Prevention Specialist	1901 N. DuPont Highway Main Building 1st. Floor	New Castle	DE	19720	302-255-4722	Isabel.Rivera-Green@state.

Name	Company	Job Title	Street Address	City	State	Zip Code	Work Phone	Work Email
Steven Martin	University of Delaware	Senior Scientist & Epidemiologist/Delaware SEOW	Center for Drug and Alcohol Studies University of Delaware 77E. Main Street	Newark	DE	19716-2582	(302) 831-1564	martin@udel.edu
Erin Artigiani	University of Maryland Center for Substance Abuse Research (CESAR)	Deputy Director for Policy	4321 Hartwick Rd Suite 501	College Park	MD	20740	(301) 405-9794	erin@cesar.umd.edu
Kathy Dixon	NYS OASAS	Research Scientist	1450 Western Ave.	Albany	NY	12203	(518) 485-1664	kathydixon@oasas.state.ny.us
Nina Gargon	New York State Office of Substance Abuse Services (OASAS)	Research Scientist	501 7th Avenue	New York	NY	10018	(646) 728-4608	ninagargon@oasas.state.ny.us
Sanford Starr	Division of Planning Outcomes and Research Ohio Department of Alcohol and Drug Addiction Services	SEOW Team Member	280 Plaza 280 N. High Street 12th Floor	Columbus	OH	43215	(614) 644-8316	starr@ada.state.oh.us
Molly					OH			Stone@ada.ohio.gov
Jessica Hawkins	Oklahoma Dept. of Mental Health and Substance Abuse Services	Director	1200 NE 13th	Oklahoma City	OK	73152	(405) 522-5952	jhawkins@odmhsas.org
Geralyn Brennan	Oregon Addictions & Mental Health Division DHS and Addiction Services	Epidemiologist	500 Summer St. NE E86	Salem	OR	97301	(503) 947-2319	geralyn.brennan@state.or.us
Lillian Albite	Mental Health and Anti-Addiction Services Administration	SEOW Program Manager	422 Bonafoux St .El Vedado Hato Rey	San Juan	PR	00918-3021	(787) 759-6943	lalbite@assmca.gobierno.pr
Julia Delgado	Prevention and Mental Health Promotion Assistant Administration	Assistant Administrator	Mental Health and Anti-Addiction Services Administration P.O. Box 21414	San Juan	PR	00928-1414	(787) 763-3133	juliad@assmca.gobierno.pr

Name	Company	Job Title	Street Address	City	State	Zip Code	Work Phone	Work Email
Hector Colon	Centro de Estudios en Adiccion Universidad Central del Caribe	SEOW Epidemiologist	PO Box 60327	Bayamon	PR	00960-6032	(787) 288-0200	HColon@uccaribe.edu
Crystal Gordon	Pacific Institute for Research and Evaluation c/o South Carolina Department of Alcohol and Other Drug Abuse Services	SEOW Manager	101 Executive Center Drive Suite 215	Columbia	SC	29210	(803) 896-7228	cgordon@pire.org
Michelle Nienhius		Prevention Consultant	101 Executive Center Drive Suite 215	Columbia	SC	29210	(803) 896-1184	mnienhius@daodas.state.sc
Hope Merrick	Virginia Prevention Contact	Manager Prevention Services	Jefferson Building 1220 Bank Street 10th Floor	Richmond	VA	23219	(804) 786-1411	Hope.Merrick@co.dmhmsa
Susan Gholston	Governor's Office for Substance Abuse Prevention	Community Data Director	P.O. Box 1475202 North Ninth Street 4th Floor	Richmond	VA	23218	(804) 786-9072 Ext. 4	susan.gholston@governor.v
Eugene Tull	Division of Bioterrorism		Virgin Islands Department of Health Charles Harwood Complex 3500 Richmond	Christiansted	VI	00820-4370	(340) 773-1311 X3241	eugene.tull@usvi-doh.org

Appendix J – Prevention Strategies

The following are descriptions of the types of programs, practices, and policies that can be used in combination to develop the prevention strategy to be implemented through this grant. The design of the strategy should be such that it will have an impact on changing the risk and protective factors for the individuals receiving the direct services and change the underlying conditions of the community that allow substance abuse problems to occur.

Direct Services

- **Information Dissemination** – These services focus on building awareness and knowledge of the nature and extent of substance use, abuse, and addiction, and its effects on individuals, families, and communities, as well as dissemination of information about prevention programs and resources. Examples include community educational presentations, workshops, presentations of data, public announcements, brochures, dissemination, community meetings, forums, and web-based communications. Grantees who choose this strategy will be expected to provide quantitative data on the number of persons reached and develop a qualitative analysis of the setting in which information dissemination was given and a synopsis of the community environment acceptability of the information (e.g., feedback to the host of information, acknowledgement of having been educated by the information, and other nuances that are present that relate to the information given).
- **Skills Building Education** – These services focus on improving the skills of individual participants including youth, adults, parents, teachers, coaches, campus residence staff, law enforcement officers, and healthcare staff, community leaders needed to achieve population level outcomes. Examples include training, technical assistance, distance learning, strategic planning meetings/retreats, and curricula implementation. Grantees will be expected to report on pre-post evaluation of their target population.
- **Pro-social Support** – These services create opportunities to support people participating in activities that reduce risk or enhance protection. This includes developing relationships with non-substance-using peers. Examples include mentoring, screenings and referrals, support groups, clubs, and alternative activities. Grantees must identify in their evaluation plan how these activities will be evaluated.

Environmental Practices and Policies

- **Rewards and Consequences** – These practices focus on increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior. Examples include; public recognition for deserved behavior, low-cost individual or business rewards, revocations or loss of privileges, penalties, citations, and fines. Grantees must identify in their evaluation plan how these activities will be evaluated.
- **Physical Design** – These practices focus on changing the physical design or structure of the environment to reduce risk or enhance protection. Examples include changes in signage,

improved lighting in high-risk area, placement of products and promotional displays, and outlet density. Grantees must identify in their evaluation plan how these activities will be evaluated.

- **Modifying or Changing Policies** – This approach focuses on formal changes in written procedures, bylaws, proclamations, rules, or laws with written documentation or voting procedures. Examples include; workplace policies, law enforcement procedures and practices, public policy actions, and systems change within government, communities and organizations.
- **Enhancing Service Access or Reducing Barriers to Services** – These policies or practices improve systems and established processes to increase the ease, ability, and opportunity to utilize those systems and services. Examples include ensuring availability and easy access to healthcare, treatment, childcare, transportation, housing, justice, education, safety, special needs, and cultural and language sensitivity.

Appendix K – Acronyms and Definitions

AIDS – Acquired Immunodeficiency Syndrome
ATOD – Alcohol, Tobacco, and Other Drugs
CBO – Community-Based Organization
CDC – Centers for Disease Control and Prevention
CFR – Code of Federal Regulations
CSAP – Center for Substance Abuse Prevention
DHHS – Department of Health and Human Services
FDA – Food and Drug Administration
FY – Fiscal Year
GPO – Government Project Officer
GMO – Grants Management Officer
GPRA – Government Performance and Results Act
HIV – Human Immunodeficiency Virus
HRSA – Health Resources and Services Administration
IRB – Institutional Review Board
MSA – Metropolitan Statistical Area
NOMs - National Outcome Measures
OMH – Office of Minority Health
PMRT – Prevention Management Reporting and Training Tool
SAMHSA – Substance Abuse and Mental Health Services Administration
SEOW – State Epidemiological Outcome Workgroup
SIGs – State Incentive Grants
SPF – Strategic Prevention Framework
SSA – Single State Agency
STDs – Sexually Transmitted Diseases
STIs – Sexually Transmitted Infections

Appendix L – Glossary

Abstinence: Voluntary restraint from indulging a desire or appetite for certain bodily activities that are widely experienced as giving pleasure. Most frequently, the term refers to abstinence from sexual intercourse, alcohol, illicit drugs, or food.

Abuse: The intentional or unintentional misuse of substances despite negative consequences or the threat of physical damage to the health of the user that imposes social and personal costs.

Adaptation: The degree to which a program undergoes change in its implementation to fit the needs of a particular delivery situation. Adaptation can be deliberate or unplanned; can alter program integrity if it is so great that the program is not delivered as intended; and can increase a program's cultural sensitivity and its fit within an implementation setting.

Baseline Data: The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

CDC: The Centers for Disease Control and Prevention. For more information, visit www.cdc.gov.

Community Indicators: A defined, measurable variables used to monitor the quality of a community.

Cooperative Agreement: A legal instrument reflecting a relationship between the United States Government and a State, a local government, or other recipient when (1) the principal purpose of the relationship is to transfer a thing of value to the State, local government, or other recipient to carry out a public purpose of support or stimulation authorized by a law of the United States instead of acquiring (by purchase, lease, or barter) property or services for the direct benefit or use by the United States Government; **AND** (2) substantial involvement is expected between the funding agency and the State, local government, or other recipient when carrying out the activity contemplated in the agreement. (31 U.S.C. 6305)

Cost-Effectiveness Analysis (CEA): A systematic method for valuing over time the monetary costs and non monetary consequences of producing and consuming substance abuse program services. Results from a CEA are often shown in terms of total costs and total levels of effectiveness (e.g., total quality adjusted life-years saved or total numbers of substance abuse cases avoided), or in terms of cost per unit of effectiveness. These data are used by employers to determine contents of a benefits package.

Cultural Competency: Cultural competence integrates the culture, values, and traditions of individuals, families, and communities into services that reduce disparities based on the following:

- Demographics—race, ethnicity, religion, gender, age, geography, and socio-economic status
- Language and literacy
- Sexual identity—sexual orientation and gender identity

- Disability

This is a quality improvement process that promotes effective policies, programs, and practices that build on the strengths of diverse cultures and their evolving needs.

Data Analysis: The systematic process of applying statistical and logical techniques to describe, summarize, and compare data.

Demographics: Physical characteristics of a population such as age, sex, marital status, family size, education, geographic location, and occupation.

Diffusion of Effective Behavioral Interventions (DEBI): Designed to bring science-based, community, group, and individual-level HIV prevention interventions to community-based service providers and State and local health departments. The goal is to enhance the capacity to implement effective interventions at the State and local levels, to reduce the spread of HIV and STDs, and to promote healthy behaviors. For more information, visit http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm.

Environmental Strategies: In the public health model, the environment is the context in which the host and the agent exist. The environment creates conditions that increase or decrease the chance that the host will become susceptible and the agent more effective. Environmental strategies refer to targeting the societal climate that encourages, supports, reinforces, or sustains problematic behavior.

Evidence Based Interventions: Interventions based on a strong theory or conceptual framework that comprises activities grounded in that theory or framework and that produce empirically verifiable positive outcomes when well implemented.

Faith Based Organizations: A community that includes religious groups or churches.

Fidelity: The degree to which a specific implementation of a program or practice resembles, adheres to, or is faithful to the evidence-based model on which it is based. Fidelity is formally assessed using rating scales of the major elements of the evidence-based model. A toolkit on how to develop and use fidelity instruments is available through SAMHSA's Evaluation Technical Assistance Center at <http://tecathsri.org> or by calling (617) 876-0426.

Government Performance Rating Assessment (GPRA): Mandates accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., "GPRA data") from grantees.

Grant: A funding mechanism used by the Federal government when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant is the public, as opposed to the Federal government.

HIV Screening Test: In most cases the EIA (enzyme immunoassay), used on blood drawn from a vein, this is the most common screening test used to look for antibodies to HIV. A positive (reactive) EIA must be used with a follow-up (confirmatory) test such as the Western blot to make a positive diagnosis. There are EIA tests that use other body fluids to look for antibodies to HIV. These include:

- **Oral Fluid Tests** – use oral fluid (not saliva) that is collected from the mouth using a special collection device. This is an EIA antibody test similar to the standard blood EIA test. A follow-up confirmatory Western Blot uses the same oral fluid sample.
- **Urine Tests** – use urine instead of blood. The sensitivity and specificity (accuracy) are somewhat less than that of the blood and oral fluid tests. This is also an EIA antibody test similar to blood EIA tests and requires a follow-up confirmatory Western Blot using the same urine sample.

Illegal Drugs: Drugs whose use, possession, or sale is illegal.

Independent Review Group (IRG): The first level of review is carried out by a peer Review Group composed primarily of non-federal individuals who have expertise in relevant substance abuse, HIV/AIDS prevention disciplines. The second level of review is performed by the Center for Substance Abuse and Prevention (CSAP) National Advisory Council that provides oversight to the IRG. This Council is composed of lay members chosen for their expertise, interest, or activity in matters related to substance abuse and HIV/AIDS prevention. Only applications that are favorably recommended by both the IRG and the Advisory Council may be considered for funding.

Logic Model: A diagrammatic representation of a theoretical framework that describes logical linkages among program resources, activities, outputs, audiences, and short-, intermediate-, and long-term outcomes related to a specific problem or situation.

Measure: An assessment item or ordered set of items. Measures are the tools used to obtain the information or evidence needed to answer a research question. They are similar to indicators, but more concrete and specific. Often an indicator will have multiple measures. Indicators are statements about what will be measured; measures answer the question about exactly how will it be measured.

Metropolitan Statistical Areas (MSA): A metropolitan statistical area is defined as a county or group of counties that has at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. This definition is not significantly different from the 1990 definition.

Minorities: A subset of the U.S. population distinguished by racial, ethnic, or cultural heritage. The Office of Management and Budget Directive No. 15 defines racial and ethnic as American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian and other Pacific Islander.

National Registry of Evidence-based Programs and Practices (NREPP): A searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people, agencies, and organizations implement programs and practices in their communities. For more information about NREPP, visit <http://www.nrepp.samhsa.gov/>.

National Outcome Measures (NOM): NOMs are a set of domains and measures that SAMHSA uses to accomplish its vision and to meet all of its Federal reporting requirements, thus reducing burden and redundancy for grantees. For more information about NOMs, visit <http://www.nationaloutcomemeasures.samhsa.gov./index.aspx?menuID=1&font=>

Performance Assessment: The act of collecting information about individual or groups of individuals in order to better understand them. For this award, recipients will assess program effectiveness, ensure service delivery quality, identify successes, encourage needed improvement, and promote sustainability of effective policies, programs, and practices.

Prevention Management Reporting and Training Tool System (PMRT):

The PMRT is a web-based system designed to help your organization use SAMHSA's SPF. Progress data on each of SPF's five steps on your accomplishments (Needs Assessment, Capacity Building, Strategic Planning, Implementation and Assess Performance) will need to be entered and submitted in the PMRT. For more information, visit <https://www.pmrts.samhsa.gov/pmrts/>.

Program Participants: Refers to the students that will participate in this initiative.

Protective Factors: Conditions that build resilience to substance abuse and can serve to buffer the negative effects of risks.

Quantitative Data: Data which are measurable, quantifiable, or tangible. They involve counting of people, behaviors, conditions, or other events; classifying those events into categories; and using math and statistics to answer questions.

Risk Factors: Characteristics, variables, and/or conditions present in individuals or groups that increase the likelihood of that individual or group developing a disorder or adverse outcome.

SAMHSA: The Substance Abuse and Mental Health Service Administration. For more information, visit www.samhsa.gov.

Selective Preventive Interventions: Interventions that are targeted to individuals or a subgroup of the population whose risk of developing adverse disorders is significantly higher than average. The risk may be imminent or it may be a lifetime risk (Institute of Medicine, Mrazek & Haggerty, 1994).

- **Universal:** Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. For example, it would include the

general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs.

- **Selective:** Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment - for example, children of adult alcoholics, dropouts, or students who are failing academically. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (Institute of Medicine (IOM) 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.
- **Indicated:** Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem. Indicated prevention programs address risk factors associated with the individual, such as conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs.

State Epidemiological Outcome Workgroups (SEOW): A State Epidemiological Outcome Workgroup (SEOW) is a network of people and organizations that bring analytical and other data competencies to substance abuse prevention. The purpose of SEOW is to collect, analyze, report, and utilize the NOMs data in a manner aligned with SAMHSA's SPF guiding framework for prevention.

Strategic Prevention Framework (SPF): A series of guiding principles to prevention that is built on community-based risk and protective factors and can be utilized at the Federal, State/tribal, and community levels. For more information, visit www.samhsa.gov/Matrix/matrix_prevention.aspx

Stakeholder: An individual, organization, constituent group, or other entity that has an interest in and will be affected by a proposed project.

Subpopulations: A subset of the U.S. population distinguished by racial, ethnic, geographic origins, national origins, and/or cultural differences.

Sustainability: The ability to continue a program or practice after funding has ended.

Target Population: A specific population of people whom a particular program or practice is designed to serve or reach.

Validity: Getting results that accurately reflect the concept being measured.

Young Adult: Individuals ages 18-24 years old.