

Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

**Capacity Building Initiative for Substance Abuse (SA) and
HIV Prevention Services for At-Risk Racial/Ethnic Minority
Young Adults**

**Short Title: Capacity Building Initiative (CBI)
(Initial Announcement)**

Request for Applications (RFA) No. SP-10-004

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

Key Dates:

Application Deadline	Applications are due by May 15, 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 *Capacity Building for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Young Adults* (Short Title: *Capacity Building Initiative*) grants. The Capacity Building Initiative (CBI) is one of CSAP's programs under SAMHSA's Minority AIDS Initiative (MAI). 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 CBI will support an array of activities to assist grantees in building a solid foundation for delivering and sustaining quality and accessible state of the science substance abuse and HIV prevention services. Specifically, the program aims to engage colleges, universities, and community-level domestic public and private non-profit entities to prevent and reduce the onset of SA and transmission of HIV/AIDS among at-risk racial/ethnic minority young adults, ages 18-24, including minority college students.

Funding Opportunity Title:	Capacity Building for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Young Adults (Short Title: Capacity Building Initiative)
Funding Opportunity Number:	SP-10-004
Due Date for Applications:	May 15, 2010
Anticipated Total Available Funding:	\$8 million
Estimated Number of Awards:	Up to 27
Estimated Award Amount:	Up to \$300,000 per year
Length of Project Period:	Up to 5 years
Eligible Applicants:	Colleges, universities, community-level domestic public and private nonprofit entities, Federally recognized tribes, and tribal organizations. [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 *Capacity Building for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Young Adults* (Short Title: *Capacity Building Initiative*) grants. The Capacity Building Initiative (CBI) 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 purpose of the CBI program is to support an array of activities to assist grantees in building a solid foundation for delivering and sustaining quality and accessible state of the science substance abuse and HIV prevention services. Specifically, the program aims to engage colleges, universities and community-level domestic public and private non-profit entities to prevent and reduce the onset of SA and transmission of HIV/AIDS among at-risk racial/ethnic minority young adults, ages 18-24.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Over the years, SAMHSA - in collaboration with other Federal agencies, States, local organizations, and individuals including consumers and the recovery community - has demonstrated that prevention works, treatment is effective, and people recover from mental and substance use disorders. To continue to improve the delivery and financing of prevention, treatment, and recovery support services, SAMHSA has identified 10 Strategic Initiatives to focus the Agency's work on people and emerging opportunities. SAMHSA expects CBI grantees to address the following Strategic Initiative: **Prevention of Substance Abuse and Mental Illness**. SAMHSA's initiative will prepare and enable communities to learn skills, strategies, and programs to better understand and recognize the behaviors that connect substance abuse and mental illness in overall health and wellness.

[NOTE: Complete references for statements followed by numerals in footnote format throughout this document can be found in [Appendix K, References](#).]

HIV remains a major health concern that disproportionately affects young, minority populations. In 2007, there were 571,378 people living with HIV/AIDS in the U.S. However, people of color accounted for 70% of all HIV cases in the U.S. that year. African Americans make up the largest U.S. population affected by HIV, with 21,509 cases of the 42,318 HIV cases reported in 2007. African Americans comprise about 13% of the U.S. population, yet they account for 50% of new HIV infection diagnoses (1).

In addition, in 2007, there were 1,703 HIV infections reported among 15-19 years olds, and 4,907 infections reported among 20-24 year olds. Among persons 13-24 years old, African Americans account for 55% of all HIV infections. Among women ages 13-24, African American and Hispanic females account for over 75% of reported HIV infections. Together, they represent only 26% of the U.S. women in this age group (1).

One factor contributing to these disproportionate numbers is health care disparities for youth of color, especially reduced access to health services. Approximately 20% of African Americans are uninsured compared to 11% of whites (2). Among all Hispanics, about 33% lack health insurance (the highest rate of any group). People who lack adequate health care are less likely to be tested for HIV and, thus, less likely to know their HIV status. People who do not know they are HIV-positive may fail to take appropriate precautions against spreading the disease.

College students, who comprise of one-third of the 18-24 year old population in the United States, are particularly at risk. According to data from SAMHSA's National Survey on Drug Use and Health, college students in America are more likely to use alcohol in the past month, binge drink, and drink more heavily than their peers not enrolled in school. A recent peer reviewed journal article written by leading alcohol researchers, entitled *Magnitude of Alcohol-Related Mortality and Morbidity among U.S. College Students Ages 18-24*, indicated that frequent, heavy, episodic drinkers were 21 times more likely than were other drinkers to experience five or more of 12 alcohol-related problems, including risk behaviors associated with sexual activity (3). In this study, which focused on heavy episodic or binge drinking among college students, 44% reported at least one heavy drinking episode in the past year. About one fourth (23%) drank this way frequently (three or more times in the past 2 weeks).

In a 2004, the U.S. Centers for Disease Control and Prevention (CDC) and the North Carolina Department of Health conducted an epidemiological investigation on the characteristics of HIV-positive and HIV-negative college student groups compared to non-college peers. This was the first investigation conducted on young black college men who have sex with men (MSM) outside of large urban settings. The study indicated that black college students who are MSM and non-students in North Carolina had high rates of HIV risk behaviors, underscoring the need for enhanced HIV-prevention programs for young black MSM both on and off campus (4).

The study indicated the following characteristics of the participants: both HIV-positive and HIV-negative college student participant groups (hereinafter called college student groups) were younger than the HIV-negative non-student participant group; the mean number of lifetime sex partners was lower for the college student groups as compared to the non-student group; the majority of both steady and casual sexual partners for all three groups were black and aged 18-30 years; approximately 20% of study participants had a female sex partner during the preceding 12 months; nearly one third of HIV-positive college students met sex partners on college campuses as compared to the majority who met their sex partners at gay nightclubs or over the Internet; fewer college students than non-students identified themselves as gay or disclosed their sexual identity to everyone or to most people. Nearly 70% of study participants previously had been tested for HIV, and 70% believed they were unlikely to have been infected with HIV at the time of their most recent HIV test.

Both MSM study participants and college student discussion group participants provided similar explanations for why MSM specifically, and young black people in general, continue to engage in high-risk sexual behavior. The most common reasons were 1) lack of sustained prevention messages targeting young blacks, 2) feeling personally disconnected from the reality that they might contract HIV, and 3) believing that physical characteristics and appearance can inform one about their partner's HIV status.

SAMHSA, therefore, is particularly interested in eliciting the interest of college and university clinics/wellness centers and community-based providers who can provide comprehensive substance abuse and HIV prevention strategies. These strategies must combine education and awareness programs, social marketing campaigns, and HIV testing services in non-traditional settings with substance abuse and HIV prevention programming for at-risk racial/ethnic minority young adults, ages 18-24.

The Capacity Building Initiative (CBI) is authorized under Section 516 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2010 focus area 26 (Substance Abuse).

2. EXPECTATIONS

Grantees will be funded for up to five years (based on the availability of funds) to provide leadership and coordination on the planning and implementation of their projects to address the high prevalence of SA and HIV/AIDS impacting racial/ethnic minority young adults, ages 18-24, within their communities. While grantees will have substantial flexibility in designing their grant projects, all are required to base their projects on the five steps of SAMHSA's Strategic Prevention Framework (SPF), which is an effective prevention process that provides direction, a common set of goals, expectations, and accountabilities to be adapted and integrated at the community level. (See Section I-2.1, Required Activities, below.)

Applicants must submit a comprehensive strategic plan (based on relevant data that identify the SA and HIV problems in their communities), that proposes to provide direct services, environmental strategies, HIV testing services, and if necessary, infrastructure enhancements. The plan should focus on changing policies and practices related to substance abuse and HIV prevention. Grantees are expected to provide access to HIV testing in non-traditional settings, and engage at-risk racial/ethnic minority young adults, ages 18-24, to seek HIV testing.

Although grantees will have flexibility in designing their comprehensive strategies for their project, applicants must develop and submit a budget that complies with the activities/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 20% of the total grant award for data collection and performance assessment.
- Up to 10% of the total grant award for environmental strategies.

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

- Up to 10% of the total grant award for infrastructure development activities. If infrastructure development is not needed, the applicant must use the remaining 10% for additional direct prevention services. [See [Section I- 2.5](#) 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 Activities

Moving SAMHSA's SPF from vision to practice is a strategic process that community stakeholders must undertake in partnership with multiple agencies and levels of government. Funds must be used primarily to support the implementation of the following required five steps of the SPF:

1. Conduct a community needs assessment:

Because the nature and extent of drug abuse and the HIV/AIDS epidemic vary widely, prevention strategies must be adapted to local community needs and resources. Applicants should present data that describe the local substance abuse and HIV problems within the community of focus and how this information is being used to select evidence-based practices and strategies to address the presenting problems. Local drug use and HIV/AIDS risk-behavior patterns must be clearly defined and tracked over time to achieve the anticipated outcomes of the program and ensure that the strategies being implemented fit the local conditions and ultimately change the risk-behavior patterns. Grantees are, therefore, required to conduct an in-depth community needs assessment as part of the first 6 months of their grant program. Applicants are required to target at-risk racial/ethnic minority young adults, ages 18-24, of greatest need in communities disproportionately affected by SA and HIV/AIDS. Community needs assessments should be based on collection and analysis of epidemiological data that include:

- Assessment of the magnitude of SA and HIV in the geographic area;
- Assessment of risk and protective factors associated with SA and HIV in the geographic area;
- Assessment of the number of individuals at risk for HIV due to substance abuse;
- Assessment of community assets and resources;
- Identification of gaps in services and capacity;
- Assessment of readiness to act;
- Identification of priorities based on the epidemiological analyses, including the identification of target populations in greatest need to implement the SPF and specification of baseline data.

In order to complete the community needs assessment, grantees must form and manage a workgroup with key stakeholders or work with an existing epidemiological workgroup. The needs assessment should be broad enough to encompass the entire specified geographic area

for the proposed project. If the grantee is already engaged in a needs assessment effort, they should work with a local or State epidemiological workgroup (i.e., SAMHSA's SPF State Incentive Grant Epidemiological Workgroup) to enhance and supplement the current process and its findings. SAMHSA expects that these data collection efforts will support ongoing monitoring and evaluation throughout the five-year project period, as described in Step 5 (below).

NOTE: Applicants who have completed a comprehensive community needs assessment within the last two years should submit a copy of their needs assessment on their target group as [Attachment 5](#) of their application. Successful applicants will be required to further conduct a needs assessment on their target group if documentation provided is deemed insufficient by SAMHSA. The SAMHSA Government Project Officer (GPO) will review and approve the needs assessment. Successful applicants with a completed needs assessment may be approved to carry out Steps 2-5 of the SPF.

2. Mobilize and/or build capacity to address SA and HIV prevention needs:

Involving the local community increases the likelihood that grantees will develop and implement culturally appropriate SA/HIV/AIDS prevention strategies that the community accepts and that can effectively reach drug users and their sexual partners in their natural environments. It is important for grantees to develop and enhance local capacity and mobilize community resources in order to implement effective programs, practices, and strategies to prevent and reduce the onset of SA and HIV transmission among at-risk minority, young adult populations. Grantees must, therefore, engage in activities that may include but are not limited to: training community stakeholders and service providers; formalizing collaborations and partnerships that increase the access to HIV testing in non-traditional settings; and leveraging resources for program and outcome sustainability. Grantees are required to demonstrate planning and coordination of services with a local or State epidemiological workgroup (identified through their Single State Agency). To ensure coordination and successful implementation of the CBI, grantees are also required to collaborate and coordinate with key stakeholders or representatives from State governmental agencies and community level programs, including those listed below, as applicable. Key stakeholders must be willing to commit to providing referral sources and linkages to care.

- HIV Prevention Community Planning Groups funded by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, STD, TB Prevention (NCHSTP);
- Health Resources and Services Administration (HRSA) Ryan White Planning Councils;
- Juvenile and adult criminal justice, correctional, parole systems and reentry programs;
- National Immunization Program, and other HIV/AIDS CDC funded projects;
- American Indian/Alaska Native tribal councils, Tribal community-based organizations, tribal governments, and Indian Health Service-funded programs; and
- Support service programs for persons with HIV/AIDS and other infectious diseases.

3. Develop a comprehensive strategic plan:

Grantees are required to develop a strategic plan resulting from the documented community needs assessment that articulates a vision for the Capacity Building Initiative. Grantees must

plan to provide culturally and age-appropriate services to at-risk racial/ethnic minority young adults, ages 18-24.

The comprehensive strategic plan must be designed based on documented needs and include an identified evidence-based practice for the target population (refer to [SAMHSA's Guide to Evidence-Based Practices](#) available at <http://www.samhsa.gov/ebpwebguide/index.asp>). It should also include resources/strengths, set measurable objectives, and include the performance measures and baseline data against which progress will be monitored. [NOTE: It is anticipated that the required community needs assessment and the strategic plan will be finalized and submitted to CSAP for review and approval within the first 6 months of the Capacity Building Initiative project. A detailed strategic plan must be approved by the assigned CSAP GPO prior to implementation of services.]

As additional resources to address documented needs, SAMHSA encourages applicants to incorporate the National Institute on Drug Abuse (NIDA) [substance abuse prevention principles](#) (available at <http://www.drugabuse.gov/pdf/prevention/RedBook.pdf>) and [HIV prevention principles for drug-using populations](#) (available at <http://www.drugabuse.gov/POHP/principles.html>) in the development of their strategic plan. The following HIV prevention principles for drug-using populations serve as a basis for program planning and development:

- HIV prevention services can most effectively reach drug-using populations when they are available in a variety of locations and at a range of operating times.
- HIV prevention and treatment efforts should target drug users who already have the HIV infection, as well as their sex partners.
- HIV prevention efforts must target not only individuals, but also couples, social networks, and the broader community of drug users and their sex partners.
- HIV community-based outreach is an essential component of HIV/AIDS prevention and must be directed to drug users in their own neighborhoods.
- HIV prevention interventions must be personalized for each person at risk. Drug users and their sex partners must be treated with dignity, respect, and sensitivity to cultural, racial/ethnic, age, and gender-based characteristics.

4. Implement evidence-based prevention programs and infrastructure development activities (if necessary):

Grantees are required to implement SA and HIV evidence-based practices to prevent and reduce the onset of substance abuse and HIV transmission in their local communities with at-risk racial/ethnic minority young adults, ages 18-24, as determined through the needs assessment. Some of the key activities supported through this initiative include:

- Outreach to identified racial/ethnic minority young adults, ages 18-24, at risk of acquiring a SA disorder and HIV;
- Direct SA and HIV prevention services to the selected population of focus;
- Environmental strategies that focus on policies and practices such as access to HIV testing;
- SA and HIV risk assessment, HIV screening, and HIV testing (standard or rapid). Applicants that provide rapid HIV testing services must refer to Appendix H of this RFA to review SAMHSA's rapid HIV testing requirements and funding limitations for the

purchase of rapid HIV testing kits, control kits, confirmatory kits, and/or confirmation laboratory services. Applicants that provide standard testing must adhere to their State HIV testing regulations;

- Pre/Post SA and HIV counseling [**NOTE:** Applicants that provide rapid HIV testing must provide counseling before the administration of the rapid HIV test, during the waiting period for preliminary results, and after preliminary results have been provided.];
- SA and HIV/AIDS education and prevention interventions for at-risk racial/ethnic minority populations, their significant other(s), and family members;
- Referrals to appropriate counseling, medical treatment (including hepatitis treatment), and other supportive services for clients who are confirmed HIV positive;
- Referrals to effective counseling for persons who tested negative to decrease their risk of acquiring HIV and engaging in substance use and abuse.

5. Assess performance:

Grantees will be accountable for the results of their Capacity Building Initiative project. Grantees are, therefore, expected to play a critical role in providing on-going monitoring and performance assessment of all project activities. Through these efforts, grantees will assess program effectiveness, ensure service delivery quality, identify successes, encourage needed improvement, and promote sustainability of effective policies, programs, and practices. Grantees will be expected to provide performance data to SAMHSA and the Single State Agency SPF State Incentive Grant Epidemiological Workgroup (if available in their State) on a regular basis, as described below in [Section I-2.6, Data Collection and Performance Measurement](#). Grantees must be prepared to adjust their implementation plans based on the results of their performance assessment activities.

2.2 Using Evidence-Based Practices (Required)

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 Approach](#) 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 strategies, please provide the name of the specific evidence-based strategy, the proposed number of sessions, frequency of sessions, length of sessions, and the anticipated 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 population(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.

- 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 strategy(ies) that will be implemented and its relatedness to the risk 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*](http://www.samhsa.gov/ebpwebguide/index.asp) 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 Center for Disease Control’s (CDC) [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.

In addition, you should 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 HIV Testing and Counseling (Required)

In addition to implementing substance abuse and HIV prevention services, grantees are required to use up to 10% of the total grant award to conduct HIV testing services. Grantees must provide either rapid testing or blood testing to at-risk minority populations. 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 ensure 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>.

2.4 Environmental Strategies (*Required*)

Grantees are required to use up to 10% of the total grant award to implement environmental strategies based on their risk-behavior assessment findings post award. Environmental strategies that target a universal population may include social marketing approaches or wide scale education efforts that seek to change attitudes and beliefs regarding substance abuse and HIV. These approaches should also be designed to motivate the population of focus to seek HIV testing and to change local conditions to allow greater access to testing.

2.5 Infrastructure Development (*Optional*)

Where gaps exist as identified in their community needs assessments, grantees may use up to 10% of the total grant award for infrastructure enhancements to improve substance abuse and HIV service delivery. If infrastructure enhancements are not needed, the applicant must use the remaining 10% of grant funds for additional direct prevention services.

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 among agencies, such as those that handle 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, and cross-system training of prevention providers, laypersons, and others to identify substance abuse and HIV risks of minority populations.
- 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.

2.6 Data Collection and Performance Measurement

All 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 D: Performance Assessment and Data” of their applications.

The CSAP individual and community level NOMs, which include the GPRA measures, are listed in Table 1 and select CDC HIV prevention performance measures are listed in Table 2. These NOMs are subject to change. However, in the interim, grantees should use the measures provided below to assess performance of their individual and environmental community level evidence-based programs. Performance assessment data will be reported 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 to Prevention Services (Service Capacity).	<ul style="list-style-type: none"> • Number of persons served by age, gender, race and ethnicity who engage in prevention services and environmental strategies.
VI.	Retention	Increased	<ul style="list-style-type: none"> • Total number of evidence-based

	DOMAINS	NATIONAL OUTCOMES	SUBSTANCE ABUSE PREVENTION MEASURES
		Retention.	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 System (PMRTS) 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 using OMB approved instruments, such as community surveys that are fielded before

and after implementation of the environmental strategy. Examples of community surveys for use to collect environmental strategy performance data are as follows:

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

The PMRTS 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 populations of focus.

CSAP Prevention Management Reporting and Training System (PMRTS)

The CSAP Prevention Management Reporting and Training System (PMRTS) is designed to collect programmatic data to meet Federal government reporting requirements. The PMRTS 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 Building, Planning, Implementation, and Performance Assessment). Applicants will also be expected to enter program data on their goals and objectives into PMRTS, which will be monitored by the Government Project Officer (GPO). Mandatory progress reports submitted through PMRTS are required twice a year. In addition to submitting reports, grantees will be able to use the PMRTS 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 PMRTS will be provided after the grant is awarded.

Grantees will be required to participate in a community cross-site evaluation focused on one proposed community change outcome. Grantees will work with the SAMHSA GPO and data contractors on developing tools and resources that will best capture community change efforts.

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 via the PMRTS (described above). At a minimum, the performance assessment should include the required performance measures identified above in this Section of the RFA.

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.

2.7 Grantee Meetings

Grantees must plan to send a minimum of two people (including the Project Director or Principal Investigator and Evaluator) to a minimum of three mandatory meetings each year of the project. You must include a detailed budget and narrative for this travel in your budget. At these meetings, grantees will present their projects, network with other grantees, and receive extensive technical assistance from Federal staff and contractors. These meetings are usually held in the Washington, D.C. area.

II. AWARD INFORMATION

Funding Mechanism: Cooperative Agreement

Anticipated Total Available Funding: \$8 million

Estimated Number of Awards: Up to 27

Estimated Award Amount: 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 proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and 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 grantees and SAMHSA staff are:

Role of Grantee:

Grantees must comply with the terms of the Capacity Building Initiative including implementation of all required SPF activities described in [Section I-2, Expectations](#), of this RFA. Grantees must agree to provide SAMHSA with all required performance data, collaborate with SAMHSA/CSAP staff in all aspects of the Capacity Building Initiative, and participate in the multi-site evaluation (including submission of all required forms, data, and reports).

Role of Federal Staff:

The design of this program necessitates participation of the Government Project Officer (GPO) in two key aspects of the cooperative agreement projects: 1) review and approval of the needs assessment to ensure that the grant activities will be directed to those areas with the greatest need for substance abuse and HIV prevention; and 2) review and approval of the strategic plan to ensure that the identified evidence-based SA and HIV practice or program is appropriate for the population of focus. The GPO also will provide ongoing monitoring and technical assistance and coordinate the collection and data analysis of GPRA and other performance measurement requirements.

Role of the Grants Management Specialist:

The Grants Management Specialist (GMS) is responsible for all business management aspects of grant negotiation, award, 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 assure 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

Eligible applicants are colleges and universities, and community-level domestic public and private nonprofit entities. For example, non-profit community-based organizations, faith-based organizations, health care delivery organizations, local governments, federally recognized American Indian/Alaska Native Tribes and tribal organizations, and urban Indian organizations are eligible to apply. Tribal organization means the recognized body of any AI/AN Tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. Consortia of tribal organizations are eligible to apply, but each participating entity must indicate its approval.

Since the purpose of this RFA is to expand the capacity of community-level domestic public and private non-profit entities, State and national organizations are not eligible to apply.

The statutory authority for this program prohibits grants to for-profit agencies.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match are 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.

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:

- Frequently Asked Questions for Capacity Building Initiative;
- 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, 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 D. Sections A-D 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 E through H. There are no page limits for these sections, except for Section G, 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. 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.

- *Attachment 1:* Memoranda of Understanding/letters of commitment/support from service provider organizations that have agreed to participate in the Capacity Building Initiative project in your proposed geographic area
 - *Attachment 2:* Data Collection Instruments/Interview Protocols
 - *Attachment 3:* Sample Consent Forms
 - *Attachment 4:* Letter to the SSA (if applicable; see [Section IV-4](#) of this document)
 - *Attachment 5:* A copy of a community-wide (i.e., town, city, county) needs assessment
- **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 kits.
 - **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 Screenout Criteria for SAMHSA Grant Applications*, for SAMHSA's basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **May 15, 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 – Funding Announcement No. **SP-10-004**. 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->

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).

[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-10-004**. 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.

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, the Capacity Building Initiative grantees must comply with the following funding restrictions:

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 20% *of the total grant award* for data collection and performance assessment.
- Up to 10% of the total grant award for environmental strategies.

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

- Up to 10% *of the total grant award* for infrastructure development activities. If infrastructure development is not needed, the applicant must use the remaining 10% for additional direct prevention services.

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

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
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**

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

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include “**Capacity Building Initiative – SP-10-004**” 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-D below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-D.

- 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-D) together may be no longer than 30 pages.
- You must use the four 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 E-H 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 (15 points)

- Describe the substance abuse problems in the population of focus. This should include available local data such as substance abuse rates, age of onset, past 30 day use, etc.
- Describe the HIV problems in the population of focus.
- Describe the underlying risk factors that contribute to the substance abuse and HIV problems in the population of focus. This should include risk behaviors associated with substance abuse and sexually transmitted diseases, specifically, HIV.

- Describe other factors that create a compelling need for substance abuse and HIV prevention services in the population of focus. Specifically, applicants must discuss and (where appropriate) provide data to document other major factors contributing to need in the area/population of focus. These factors may include current service gaps/barriers, gaps in funding for services, and demographic trends suggesting a growing risk of HIV/AIDS in the area/population of focus. These factors may also include related health/social problems in the geographic area of focus that are experienced by the racial/ethnic minority population of focus, including substance abuse rates (especially rates of injection drug use), homelessness, criminal activity, etc. Finally, these factors must include community, cultural or social norms, values and beliefs in the area/ racial/ethnic population of focus that may influence substance abuse and HIV risk and protective behaviors and, therefore, limit the effectiveness of substance abuse and HIV/AIDS prevention.

[NOTE: All grantees will be required to complete a more comprehensive community needs assessment after award to establish baseline measures for both substance abuse and HIV problems, as well as their associated risk factors.]

Section B: Proposed Approach (35 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, pre-services, and/or intervention) 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 population of focus. If the evidence is limited or non-existent for your population of focus, provide other information to support your selection of the intervention(s) for your population of focus. [NOTE: Applicants are strongly encouraged to refer to SAMHSA’s Guide to Evidence-Based Practices (EBP) on the Web at <http://www.samhsa.gov/ebpwebguide> to select an appropriate intervention for their population of focus.]
- 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. [NOTE: *Applicants are not expected to have completed a needs assessment at the time of application. Grantees may find that a different EPB is more suitable to meet the goals of their CBI project.*]
- 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 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.

- Discuss any infrastructure enhancements that will be made as part of the proposed project or indicate if none are planned.
- Describe how the proposed project will address the following issues in the population 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. [NOTE: [Appendix D](#) of this RFA contains a sample logic model. You may use this sample as a template or submit a similar model of your own design. [Appendix E](#) provides logic model resources.]
- Describe potential barriers related to the implementation of the proposed project and how you will overcome them.
- 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.

Section C: Staff, Management, and Relevant 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 population of focus and ties to grassroots/community-based organizations that are rooted in the culture and language of the population 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 personnel, such as treatment/prevention personnel.
- Discuss how key staff have demonstrated experience in serving the racial/ethnic minority population of focus and are familiar with the culture and language of the population of focus. If the population of focus is multicultural and multilingual, describe how the staff are 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 population of focus. If the ADA does not apply to your organization, please explain why.

Section D: Performance Assessment and Data (30 points)

- Document your ability to collect and report on the required performance measures as specified in [Section I-2.6](#) of this document, including data required by SAMHSA to meet GPRA requirements. Specify and justify any additional measures 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.
- Provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the cooperative agreement and subtracting up to 20% for data collection and performance assessment, and up to 10% for infrastructure development activities; 2) dividing this number by the total unduplicated number of persons to be served.
- Describe your plan for conducting the performance assessment as specified in [Section I-2.6](#) of this RFA and document your ability to conduct the assessment. Indicate your willingness to participate in and provide all the required forms, data, and reports for the multi-site evaluation.

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.

2. SUPPORTING DOCUMENTATION

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

Section F: 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 20% of the total grant award will be used for data collection and performance assessment. An illustration of a budget and narrative justification is included in [Appendix G](#) of this document.

Applicants must use up to 10% of the total grant award for standard or rapid HIV testing: Please describe in your budget justification how you plan to use grant funds for HIV testing, including:

1. Type of HIV testing (e.g., standard HIV testing, rapid HIV testing) and purchasing mechanism (e.g., bulk, direct, wholesale/retail costs) for the test kits.
2. The costs of rapid and confirmatory test results, supplies, and other administrative costs (e.g., lab services and reports).
3. Estimate of the number of persons that will be tested annually and over the entire project period.

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

Section G: 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 H: 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 of 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’s 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-2.6](#), you must comply with the following reporting requirements:

3.1 Progress and Financial Reports

- You will be required to submit quarterly, annual and final progress reports, as well as annual and final financial status reports, and dosage data. Progress reports must be submitted electronically through the Prevention Management Reporting and Training System (PMRTS), and your financial status reports to Division of Grants Management each fiscal year every 30 days.
- Because SAMHSA is extremely interested in ensuring that treatment and prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this grant.
- 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) 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. The performance requirements for this grant program are described in [Section I-2.6](#) of this document under “Data Collection and Performance Measurement.”

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
Chief, Community Grants and Program Development Branch
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: 2010CBI@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 Screenout Criteria for SAMHSA Grant Applications

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

- Use the PHS 5161-1 application 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 transmission and equitable treatment of applications.

- *Text legibility*: Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of at least one inch each. Adhering to these standards will help to ensure the accurate transmission 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 transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. 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 242B)]. **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
Room 3-1044

1 Choke Cherry Road
Rockville, MD **20857**
ATTN: Electronic Applications

For other delivery services, change the zip code to 20850.

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

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 2 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 2 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.

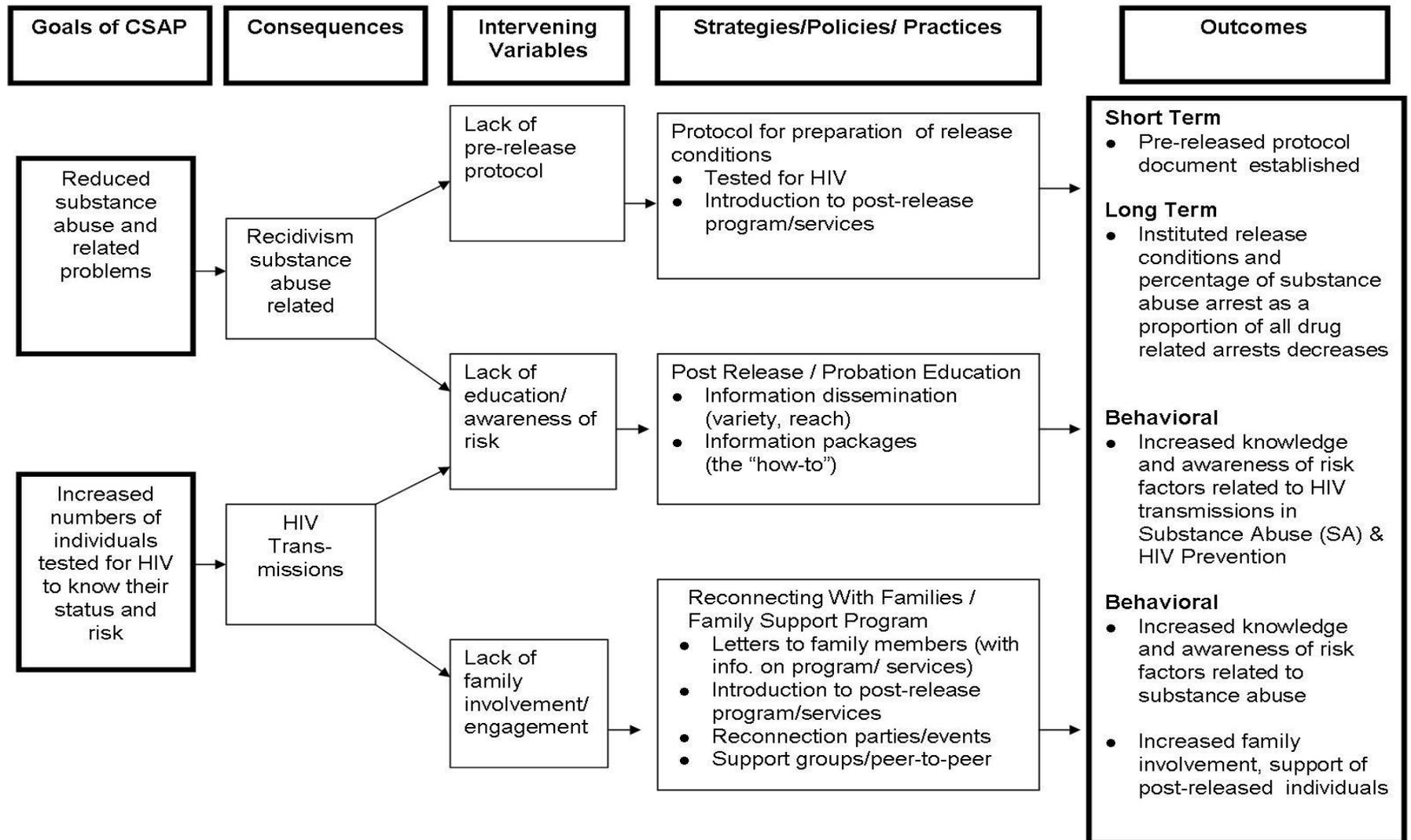
The sample logic model provides a similar example for substance abuse and HIV prevention for minority re-entry populations. Examine the sample to follow the logical planning process presented in this scenario and use the “if/then” thinking to work backwards to validate if there is a logical connection 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)



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.

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

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

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

FEDERAL REQUEST: PERSONNEL

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 position. The coordinator will coordinate project services and project activities, including training, communication and information dissemination. Key staff positions requires 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

FEDERAL REQUEST: FRINGE BENEFITS

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.

FEDERAL REQUEST: TRAVEL

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. (Be as specific as possible regarding events and conference names and locations.) Local travel rate is based on the grantee organization’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

FEDERAL REQUEST: SUPPLIES

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 and need 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 for a fee. A contract provides services for a fee. The grantee must have procurement policies and procedures governing their use of consultants and contracts that are consistently applied among all the organization’s projects.

FEDERAL REQUEST: CONTRACT

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 clients and client 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.

FEDERAL REQUEST: CONTRACT

Entity	Product/Service	Cost
To Be Announced	Marketing Coordinator \$25/hour x 115 hours	\$2,300
ABC, Inc.	Evaluation \$65/hr x 70 days	\$4,500
TOTAL		\$6,800

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 clients 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, electronic resources, etc. 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) **\$ 9,187**
 (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

FEDERAL REQUEST: OTHER

Item	Rate	Cost
Rent*	\$15/sq.ft x 700 sq. feet	\$10,500
Telephone	\$100/mo. x 12 mo.	\$1,200
Client Incentives	\$10/client follow up x 278 clients	\$2,784
Brochures	.89/brochure X 1500 brochures	\$1,335
	TOTAL	\$15,819

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 service site 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 % of effort for the personnel listed in this application for the SAMHSA project only. Brochures will be used at various community functions (health fairs and exhibits) once per month throughout the service area.

*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) **\$ 15,819**

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 indirect cost rate agreement. For information on applying for the indirect rate go to: 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 salaries and wages and fringe benefits (.08 x \$63,661) **\$5,093**

BUDGET SUMMARY: (identical to SF-424A)

BUDGET SUMMARY

Category	Federal Request
Salaries & Wages	\$52,765
Fringe Benefits	\$10,896
Travel	\$2,444
Equipment	0
Supplies	\$3,796
Contractual	\$9,187
Other	\$15,819
Total Direct Costs*	\$94,907
Indirect Costs	\$5,093
Total Project Costs	\$100,000

*** TOTAL DIRECT COSTS:**

FEDERAL REQUEST (enter in Section B column 1 line 6i of form SF424A) \$94,907

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

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF424A) **\$100,000**

Appendix H – SAMHSA’s Rapid HIV Testing Requirements

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

A. 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 Rapid HIV Testing and Pre/Post Test Prevention Counseling with the OraQuick® Rapid HIV-1 Antibody Test (*provided by SAMHSA or CDC, and State training, as required*).

B. 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/08_certificate_of_%20waiver_laboratory_project.asp.

C. State regulations: Grantees must adhere to their State HIV testing regulatory requirements. A copy of State compliance documentation on rapid HIV 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#topofpage.

D. Linkages to Care: Trained service providers on Rapid HIV testing **MUST** provide signed Memoranda of Understanding (MOUs) or Agreement (MOAs) in Attachment 1 of your application demonstrating established referral networks for clients 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 testing, laboratory services, HIV/AIDS primary and behavioral health care services, and other necessary support services (e.g., insurance, housing, food, transportation). **Grantees with MOUs in place with local HIV testing provider(s) for HIV testing on clients enrolled in this program may use up to ten percent (10%) of the total direct costs of the award to purchase rapid HIV test kits for providers to conduct on- and off-site HIV testing services.**

E. Rapid HIV 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.

F. Policies & Procedures: Grantees must provide a copy of the following policies and procedures before initiating SAMHSA's new rapid testing protocol:

- *Informed Consent Form* – Grantees must have an informed consent form for clients 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 clients 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 client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II. For information on HIPAA compliance, visit: <http://www.hhs.gov/ocr/hipaa>.
- *Safety* – Grantees must have guidelines for personal safety and security in non-traditional settings, for assuring 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.

Appendix I – Acronyms and Definitions

AIDS – Acquired Immunodeficiency Syndrome
CBO – Community-Based Organization
CDC – Centers for Disease Control and Prevention
CFR – Code of Federal Regulations
CLI - Community level instrument
CSAP – Center for Substance Abuse Prevention
DHHS – Department of Health and Human Services
EIA –Enzyme immunoassay
EPB - Evidence-based practices
FY – Fiscal Year
GPO – Government Project Officer
GMS – Grants Management Specialist
GPRA – Government Performance and Results Act
HIPAA – Health Insurance Portability and Accountability Act
HIV – Human Immunodeficiency Virus
HRSA – Health Resources and Services Administration
IRB – Institutional Review Board
MOA – Memorandum of Agreement
MSM – Men having sex with men
NIDA – National Institute on Drug Abuse
NOMs - National Outcome Measures
NREPP - National Registry of Evidence-based Programs and Practices
OMB – Office of Management and Budget
PMRTS - Prevention Management Reporting and Training System
SAMHSA – Substance Abuse and Mental Health Services Administration
SPF – Strategic Prevention Framework
SPP – SAMHSA Participant Protection
SSA – Single State Agency
STDs – Sexually Transmitted Diseases
STIs – Sexually Transmitted Infections

Appendix J – Glossary

A

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 abstention 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.

B

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.

C

Community Indicators:

A defined, measurable variable 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 of 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.

D

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.

E

Evidence Based Interventions:

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

http://download.ncadi.samhsa.gov/csap/spfsig/Final_SPFGuidance_Jan04_2007.pdf)

F

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.

G

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.

H

Healthy People 2010:

The prevention agenda for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. This agenda was established with a great deal of input from public and private organizations and will be carefully monitored throughout the present decade. A number of prevention goals have been established with respect to substance abuse.

HIV Screening Test:

In most cases the EIA (enzyme immunoassay), used on blood drawn from a vein, 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.

I

Illegal Drugs:

Drugs whose use, possession, or sale is illegal.

L

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.

M

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 exactly how will it be measured.

Minorities

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

N

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/>.

P

Performance Assessment:

The act of collecting information about individuals 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.

Protective Factors:

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

Q

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.

R

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.

S

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).

School Survey:

A process, most often using a specially designed instrument, to collect information relevant to school administration, student attitudes and behavior, and/or student performance

Strategic Prevention Framework:

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 about the Strategic Prevention Framework, visit:

http://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.

T

Target Population:

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

V

Validity:

Getting results that accurately reflect the concept being measured.

Y

Young Adult:

Individuals, aged 18-24 years.

Appendix K – References

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4. CDC. *HIV Transmission Among Black College Student and Non-Student Men Who Have Sex With Men—North Carolina, 2003*. *MMWR*. 2004;53:731-734
5. US Census Bureau. Annual estimates of the population by sex, race and Hispanic or Latino origin for the United States: April 1, 2000 to July 1, 2006. Available at <http://www.census.gov/popest/national/asrh/NC-EST2006-srh.html>.
6. National Center for Health Statistics, National Vital Statistics Report, Vol. 53, No. 17, March 2005.
7. SAMHSA's 2006 National Survey on Drug Use & Health (NSDUH)