Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Prevention of Substance Abuse (SA) and HIV for At-Risk Racial/Ethnic Minority Subpopulations Cooperative Agreements

Short Title: Minority SA/HIV Prevention Initiative

(Initial Announcement)

Request for Applications (RFA) No. SP-08-001

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

Key Dates:

Application Deadline	**Applications are due by April 1, 2008.**
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.**

Anna Marsh, Ph.D.
Acting Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health
Services Administration

Terry L. Cline, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration

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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) 2008 for Prevention of Substance Abuse (SA) and HIV for At-Risk Racial/Ethnic Minority Subpopulations (Short Title: Minority SA/HIV Prevention Initiative) cooperative agreements. The purpose of this 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 community-level domestic public and private non-profit entities to prevent and reduce the onset of SA and transmission of HIV/AIDS among the following at-risk racial/ethnic minority subpopulations: reentry populations (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years); men having sex with men (MSM); Black, Latina, or Hispanic women; adolescents (age 12-17); young adults (age 18-24); and older adults, age 50 and over in communities of color disproportionately affected by SA and HIV/AIDS.

Funding Opportunity Title:	Prevention of Substance Abuse (SA) and HIV for At-Risk Racial/Ethnic Minority Subpopulations Cooperative Agreements
Funding Opportunity Number:	SP-08-001
Due Date for Applications:	April 1, 2008
Anticipated Total Available Funding:	$17.89 million
Estimated Number of Awards:	46
Estimated Award Amount:	Up to $400,000 per year
Length of Project Period:	Up to 5 years
Eligible Applicants:	Community-level domestic public and private nonprofit entities. [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) 2008 for Prevention of Substance Abuse (SA) and HIV for At-Risk Racial/Ethnic Minority Subpopulations (Short Title: Minority SA/HIV Prevention Initiative) cooperative agreements. The purpose of this 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 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 subpopulations that are described below.

The Centers for Disease Control and Prevention (CDC) estimates that the number of people infected with HIV in the United States ranges from 800,000 to 900,000. The HIV/AIDS sub-epidemics not only vary by region and community but also by population, risk behavior, and geography. Elimination of such disparities among certain racial and ethnic groups, particularly African American and Hispanic populations, remains a challenge.

Since the AIDS epidemic began, injection drug use (IDU) has accounted for more than one-third of AIDS cases in the United States. Of the 43,517 new cases of AIDS reported in 2000, 25 percent were injection drug use (IDU)-associated[1]. Racial/ethnic minorities in the U.S. are most heavily affected by IDU-associated AIDS. In 2000, African American adults and adolescents accounted for 26 percent of IDU-associated AIDS cases and Hispanic adults and adolescents accounted for 31 percent, as compared to 19 percent of all IDU-associated AIDS cases among their white counterparts. IDU-associated AIDS accounts for a larger proportion of cases among women than among men. Fifty-seven (57) percent of all AIDS cases reported among women have been attributed to injection drug use or sex with partners who inject drugs as compared with 31 percent of cases among men.

Despite the decline in AIDS cases in certain populations and regions resulting from improved HIV treatment, 2003 data reported by CDC indicate that more people are living with HIV/AIDS than ever before[2]. CDC estimates that about 1 million people in the United States are living with HIV or AIDS and about one quarter of these people are unaware of their infection, which puts them and others at risk. Groups at highest risk since the beginning of the epidemic include men having sex with men (MSM) and IDUs. Other groups who are also at high risk for HIV transmission include people of color, women (particularly Black and Latina/Hispanic women), and youth[13].

SAMHSA, therefore, is particularly interested in eliciting the interest of providers who can offer quality services to the following at-risk racial/ethnic minority subpopulations residing in a geographic area(s) with high SA and HIV/AIDS prevalence. Applicants are required to indicate <u>one</u> racial/ethnic minority subpopulation from the following list that they propose to target in their eligible catchment area:

1) reentry populations (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years);
2) men having sex with men (MSM);
3) Black, Latina or Hispanic women;
4) adolescents (age 12-17);
5) young adults (age 18-24); and
6) older adults, age 50 and over.

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) to build state of the science SA and HIV/AIDS prevention capacity for their targeted at-risk racial/ethnic minority population.

Minority SA/HIV Prevention Initiative cooperative agreements are authorized under Section 516 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2010 focus area 26 (Substance Abuse).

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

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 a racial/ethnic minority subpopulation within their community. This initiative is under girded by 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. Grantees are expected to provide direct services to their select target subpopulation but may elect to implement environmental strategies.

As of fall 2007, approximately 1.4 million men and women have been deployed to serve in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) in support of the Global War on Terror. 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 substance abuse prevention 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. Minority SA/HIV Prevention Initiative funds must be used primarily to support the implementation of the following <u>required</u> 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. Local drug use and HIV/AIDS risk-behavior patterns must be tracked to refine program approaches over time and to evaluate program outcomes. Grantees are, therefore, required to conduct an in-depth community (e.g., tribal jurisdictions, towns, cities, counties) needs assessment in areas reporting high rates of SA and HIV/AIDS on one target subpopulation. (SAMHSA's targeted racial/ethnic minority subpopulations are discussed below.) 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 catchment area;
   - Assessment of risk and protective factors associated with SA and HIV in the catchment 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 of 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 catchment 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 on-going monitoring and evaluation throughout the five-year project period, as described in Step 5 (below). Again, applicants are required to target one of the following at-risk racial/ethnic minority subpopulation of greatest need in their catchment area: reentry populations (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years); men having sex with men (MSM); Black, Latina or Hispanic women; adolescents (age 12-17); young adults (age 18-24); and older adults, age 50 and over in communities of color disproportionately affected by SA and HIV/AIDS.

   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 in **Appendix 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 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 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 subpopulations. Grantees must, therefore, engage in activities that include but are not limited to: training community stakeholders and service providers; formalizing linkages to care through Memoranda of Understanding (MOUs); 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 Minority SA/HIV Prevention Initiative, 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:

- HIV Prevention Community Planning Groups funded by the Centers for Disease Control and Prevention, 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 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 expected to develop a strategic plan resulting from the documented community needs assessment that articulates a vision for the Minority SA/HIV Prevention Initiative. Grantees must plan to provide culturally and age appropriate services to the one at-risk racial/ethnic minority subpopulation of greatest need. The comprehensive strategic plan must be designed based on documented needs and include an identified evidence-based practice for the target group (refer to SAMHSA's *Guide to Evidence-Based Practices on the Web* at www.samhsa.gov/ebpwebguide), 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 approved within the first 6 months of the Minority HIV/SA Prevention Initiative project. A detailed strategic plan must be approved by the SAMHSA GPO prior to beginning implementation of services – Step 4 of the SPF.]

Grantees are expected to provide direct prevention services to their selected target subpopulation and may elect to implement environmental strategies with approval from their Project Officer. Planning should include the following considerations from the Principles of HIV Prevention in Drug-Using Populations developed by the National Institute on Drug Abuse (NIDA) (http://www.drugabuse.gov/POHP/principles.html):

- 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**:
Grantees are expected to implement SA and HIV evidence-based practices (refer to SAMHSA's *Guide to Evidence-Based Practices on the Web* at www.samhsa.gov/ebpwebguide) to prevent and reduce the onset of substance abuse and HIV transmission in their local community with high prevalence of SA and HIV, as determined through the needs assessment. Key services supported by Minority SA/HIV Prevention Initiative cooperative agreement funds include:
   - Outreach to identified racial/ethnic minority subpopulations at high risk of acquiring a SA disorder and HIV;
   - Direct services to the selected target subpopulation. In addition, grantees may elect to implement environmental strategies.
   - SA and HIV risk assessment, HIV screening and HIV testing (standard or rapid). Applicants that provide rapid HIV testing services must refer to Appendix J 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 subpopulations, 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 Minority SA/HIV Prevention Initiative project. Grantees are, therefore, expected to play a critical role in providing on-going monitoring and performance assessment of all Minority SA/HIV Prevention Initiative 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 2.3, Data Collection and Performance Measurement. Grantees must be prepared to adjust their implementation plans based on the results of their performance assessment activities.

In addition, SAMHSA strongly encourages grantees to submit data and performance assessment results, when completed, to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) for review and rating of scientific rigor.

2.2 Data Supporting Target Racial/Ethnic Minority Subpopulations

As discussed in the Introduction section, applicants must choose one of the following racial/ethnic minority subpopulations that they propose to target in their catchment area.

1. **Reentry Populations (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years).** Since 1999, approximately 600,000 individuals per year are released from State and Federal prisons back into the community, and an estimated 33 percent of these individuals have drug abuse problems[3], HIV and other infectious diseases, and other medical and mental health disorders. At the end of 2003, an estimated 774,588 adults in the United States were released on parole. Out of those parolees, 13 percent and 41 percent were women and Blacks, respectively, which the CDC has indicated as groups at highest risk for HIV transmission since the beginning of the epidemic. People who had committed drug-related offenses accounted for 40 percent of those released on parole[4]. Data indicate that upon release, few have connections in the community to help them access local substance abuse and HIV/AIDS prevention and treatment programs.

2. **Men having Sex with Men (MSM).** According to the CDC, approximately half of the HIV/AIDS cases among non-Hispanic Black and Hispanic males reported by 33 States using name-based HIV surveillance during 2001-2005 were among men who have sex with men.

   In the year 2003, 17,969 AIDS cases in MSM were diagnosed, compared with 6,353 cases in men who acquired their infection through injection drug use, 5,133 through sex with women, and 1,877 through having sex with men and injecting drugs. CDC data from the 2004 National HIV Behavioral Surveillance (NHBS) system show across five US cities that many HIV-infected MSM were younger, Black, and unaware of their infection[5].

3. **Black, Latina or Hispanic Women.** The CDC reported that Hispanics and Blacks in the United States are disproportionately affected by HIV infection and AIDS. In 2005, Hispanics accounted for 14.4 percent of the U.S. population of which 18.9 percent received an AIDS diagnosis[6,7]. According to the 2000 census, Blacks make up approximately 13 percent of the US population. However, in 2005, Blacks accounted for 18,121 (49 percent) of the estimated 37,331 new HIV/AIDS diagnoses in the United States across 33 states with long-term, confidential name-based HIV reporting[8].

Moreover, the epidemic has increased most dramatically among Black, Latina and Hispanic women. In 2004, they represented an estimated 50 percent of persons newly diagnosed with HIV/AIDS[9]. To date, Black and Hispanic women together represent about one fourth of all US women, but they account for more than 75 percent of estimated AIDS cases diagnosed among US women[9,10]. The most common exposures in both groups were reported as high-risk heterosexual contact and injection drug use[7,8].

4. **Adolescents (age 12-17) and**
5. **Young Adults (age 18-24)**

   Teens today are engaging in substance abuse at younger ages. Data reveal that younger African American teens (8th grade) are using marijuana as much as their white counterparts: 13 percent of African Americans as compared to 14.5 percent of white teens reported having used marijuana in the past year[11]. Adolescents and young adults who use marijuana weekly have double the risk of depression later in life[12, 13]. Moreover, an estimated 9,789 young people (aged 15–24 years) with AIDS have died since the beginning of the epidemic through 2003[9]. Fortunately, from 1989 through 2003, deaths from AIDS have declined in this age group[7]. However, challenges still persist in addressing disparities in preventing substance abuse and primary/secondary transmission of HIV, treatment, and social and medical needs of at-risk young persons and those living with HIV/AIDS.

6. **Older Adults (age 50 and over).** The 2000 NHSDUH indicated that an estimated 568,000 adults aged 55 or older, or 1 percent of all older adults in the United States, had used illicit drugs in the past month[15]. The illicit drugs most commonly used by older adults were psychotherapeutics (an estimated 300,000 past month users) and marijuana (an estimated 221,000 past month users). The rate of past month illicit drug use was highest for those aged 55 to 59, and rates declined dramatically with increasing age. The number of new AIDS cases among persons 50 and over today has risen twice as fast as compared to persons aged 13-49[16]. Other reports have indicated that approximately 75,270 people older than age 50 years have been diagnosed with AIDS in the United States and account for 11 percent of the cases of AIDS[18]. The mortality among older individuals who contract HIV is extremely high, with 37 percent of those over the age of 80 years dying within 1 month of diagnosis[19].

   Older individuals particularly at risk for HIV, AIDS, or STDs are those who have had unprotected sex, shared needles when using drugs, received blood transfusions prior to 1986, or are men who engage in homosexual activities.

   Despite the fact that older adults engage in risky behaviors that put them at risk for HIV transmission, they are less likely to perceive themselves as “at-risk” and less likely to adopt safer behaviors. Several reasons have been identified as to why older individuals do not protect themselves against exposure to HIV or other STDs including[17]:

   - Most women are past menopause and do not fear getting pregnant.
   - While the safe sex battles of the 1980s were raging, many of today's seniors were settled in marriages and perceive STD as “something that happened to somebody else".
   - Women outnumber their male counterparts, resulting in men having many partners from which to choose. Women are, therefore, willing to remain unprotected based on male preference.

- Older adults grew up at a time when men made many decisions in most relationships, and if the male does not want to use "protection", then it is not used.

The rise of HIV transmission is on the rise among older adults. Those with HIV are more likely to be diagnosed late in the disease, experience progression more quickly, and survive for a shorter period than their younger counterparts. Additionally, comorbidities (SA and HIV) are frequent in older adults with HIV infection and can complicate the disease process and management.

2.3 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). You must document your ability to collect and report the required data in "Section D: Performance Assessment and Data" of your application. This information will be gathered using the CSAP Services Accountability Monitoring System (CSAMS), which can be found at https://www.csapdccc-csams.samhsa.gov/tools/publictools.aspx?sp=5, along with instructions for completing it. Hard copies are available in the application kits available by calling the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889]. Data will be collected at baseline, at exit and at 6 months post exit. The collection of these data will enable CSAP to report on the following National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to substance abuse:

DOMAIN		NATIONAL OUTCOMES	SUBSTANCE ABUSE PREVENTION MEASURES
I.	Reduced Morbidity	Abstinence from drug use/alcohol abuse	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	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
III.	Crime and Criminal Justice	Decreased Criminal Justice Involvement	Alcohol-related car crashes and injuries; alcohol and drug-related crime
IV.	Social Connectedness	Increased Social Supports/Social Connectedness	Family communication around drug use
V.	Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity
VI.	Retention	Increased Retention in Treatment	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
VII.	Cost Effectiveness	Cost Effectiveness	Services provided within Cost Bands*****

DOMAIN		NATIONAL OUTCOMES	SUBSTANCE ABUSE PREVENTION MEASURES
		(Average Cost)	
VIII.	Use of Evidence Based Practices	Use of Evidence Based Practices	Total number of evidence-based programs and strategies

*Grantees are required to collect data on cost band measures during the project period.

Grantees will also be expected to report on additional HIV-specific measures which are pending OMB approval.

In addition to these measures, grantees will be expected to collect and submit testing and counseling data for all participants receiving services provided with grant funds. These data include, but are not limited to: rapid and confirmatory test results; past HIV test results; reason for referral; risky behaviors; and referrals. The data will be reported using the standard GPRA data collection tool and entered through CSAMs.

Grantees who are conducting environmental strategies will be required to use the SAMHSA Community NOMs instrument and report their data on at least an annual basis.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

2.4 Performance Assessment

Grantees must assess their projects, addressing the performance measures described in Section I-2.3. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project based on the results of the community needs assessment, on-going work of key stakeholders, the development of the comprehensive strategic plan, and GPO feedback on progress.

In addition to assessing progress against the performance measures required for this program, your performance assessment must also consider outcome and process questions, such as the following, that measure change related to project goals and objectives over time and compared with baseline data.

Outcome Questions:

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

Process Questions:

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

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

In addition to conducting a site-specific performance assessment, grantees must participate in multi-site performance activities conducted by CSAP. The multi-site evaluation may include the use of common data collection instruments and routine data reporting procedures. Applicants must explicitly state their willingness to participate in the multi-site evaluation in Section D, Performance Assessment and Data, of their applications, including their willingness to provide required forms, data and reports related to the multi-site evaluation.

No more than 20% of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.3 and 2.4 above.

2.5 Grantee Meetings

Grantees must budget to send a minimum of two people (including the Program Director or Principal Investigator and Evaluator) to attend a minimum of three (3) mandatory meetings each year of the project. Meetings are usually held in the Washington, D.C., metropolitan area. At these meetings, grantees will present their projects, network with other grantees, and receive extensive technical assistance from Federal staff and contractors.

II. AWARD INFORMATION

Funding Mechanism:	Cooperative Agreement
Anticipated Total Available Funding:	$17.89 million
Estimated Number of Awards:	46
Estimated Award Amount:	Up to $400,000 per year
Length of Project Period:	Up to 5 years

Proposed budgets cannot exceed $400,000 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 Minority SA/HIV Prevention 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 Minority SA/HIV Prevention 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 target population. The GPO also will provide on-going monitoring and technical assistance and coordinate the collection and data analysis of GPRA and other performance measurement requirements.

Role of the Grants Management Officer:
The Grants Management Officer (GMO) is responsible for all business management aspects of grant negotiation, award, financial and administrative aspects of this cooperative agreement. The GMO 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 GMO (see Section VII for the GMO's contact information). The GMO is the only person who may grant such required approvals. All changes in the terms of the award must be in writing by the GMO.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are community-level domestic public and private nonprofit entities. For example, non-profit community-based organizations, faith-based organizations, colleges and universities, health care delivery organizations, local governments, tribal governments, tribal organizations and tribal urban Indian entities are eligible to apply. Since the purpose of this RFA is to expand the capacity of community-level domestic public and private non-profit entities, State government agencies and national organizations are not eligible to apply.

Eligibility is limited to applicants from geographic areas with high AIDS case rates. Eligible applicants must be located in and proposing to provide services in a State, MSA, the Virgin Islands, Puerto Rico, or the District of Columbia with an annual AIDs case rate of 10 or greater per 100,000 population.

See Appendix I of this document for States and MSAs that meet the above criteria based on data from the Centers for Disease Control and Prevention (CDC). **Only applicants serving geographic areas listed in Appendix I may apply.** Applicants must specify in **Appendix 6** of their application the geographic area where services will be provided.

The eligibility criteria above were based on the most recent AIDS data (2005) among racial/ethnic minority populations provided by CDC. SAMHSA is limiting eligibility to applicants listed in Appendix I because, in the absence of consistent data reporting by all jurisdictions, the best indicator of the magnitude of the epidemic is AIDS case rates derived from the CDC HIV/AIDS surveillance reports.

Instructions for Current Grantees under SAMHSA's RFA No. SP-05-001:

Current grantees under SAMHSA's RFA # SP-05-001 (*Substance Abuse (SA), HIV, & Hepatitis Prevention for Minority Reentry Populations in Communities of Color*) may apply, but are required to:

- serve one of the target subpopulations listed above in Section I-2.2, Data Supporting of Target Racial/Ethnic Minority Subpopulations. You may serve the same target subpopulation (as long as it is one chosen from the list) that you are currently serving under RFA # SP-05-001 in a different catchment area or serve a different subpopulation (chosen from the list) in the same catchment area under RFA # SP-05-001. Your catchment area must be within an eligible geographic area listed in Appendix I of this RFA.

- describe your target populations, demographics, and catchment areas currently being served under RFA # SP-05-001. This information must be provided on the form provided in Appendix K of this RFA, and the completed form must be provided in **Appendix 6** of your application.

Applications from grantees funded under RFA # SP-05-001 that are found out of compliance with these requirements will be screened out and returned without review.

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.

3.2 Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct substance abuse and HIV prevention services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;

- Each direct service provider organization must have at least 2 years experience (as of the due date of the application) providing relevant prevention services; and

- Each direct service provider organization must comply with all applicable local (city, county) and State/tribal licensing, accreditation, and certification requirements, as of the due date of the application.

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

In **Appendix 7** of your application, you must: (1) identify at least one provider of direct substance abuse prevention services; (2) include a list of all direct service provider organizations that have agreed to participate in the proposed project, including the type of service each provides; and (3) include the Statement of Assurance (provided in Appendix C of this announcement), signed by the authorized representative of the applicant organization identified on the face-page (SF 424 v2) of the application, attesting that all participating service provider organizations:

- meet the 2-year experience requirement;
- meet applicable licensing, accreditation, and certification requirements; and
- if the application is within the funding range for grant award, the applicant will provide the Government Project Officer (GPO) with the required documentation within the time specified.

In addition, if, following application review, your application's score is within the funding range, the GPO will call you and request that the following documentation be sent by overnight mail:

- a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization that has agreed to participate in the project;

- official documentation that all participating organizations have been providing relevant prevention services for a minimum of 2 years before the date of the application; and

- official documentation that all participating service provider organizations comply with all applicable 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.

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

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

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

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

Additional materials available on this Web site include:

- Frequently Asked Questions for the Minority SA/HIV Prevention 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 FORM OF APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page (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 (www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants Web site (www.Grants.gov).

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

2.2 Required Application Components

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

- **Face Page –** 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 www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]

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

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

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

- **Appendices 1 through 7 –** Use only the appendices listed below. If your application includes any appendices not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Appendices 1, 3, 4, 6 and 7 combined. There are no page limitations for Appendices 2 and 5. Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Pease label the appendices as: Appendix 1, Appendix 2, etc.

  - *Appendix 1*: Memoranda of Understanding/letters of commitment/support from service provider organizations that have agreed to participate in the Minority SA/HIV Prevention Initiative project in your proposed catchment area. Applicants must also submit MOUs with hepatitis treatment providers.
  - *Appendix 2*: Data Collection Instruments/Interview Protocols
  - *Appendix 3*: Sample Consent Forms
  - *Appendix 4*: Letter to the Single State Agency (SSA) (if applicable; see Section IV-4 of this document)
  - *Appendix 5*: A copy of an existing community-wide (i.e., town, city, county) needs assessment
  - *Appendix 6*: Only current grantees under SAMHSA's SP-05-001 must include the completed form in Appendix K of this RFA as **Appendix 6** of the application. If you are a current SP-05-001 grantee and you do not include the form provided in Appendix K of this RFA as **Appendix 6** of your application, your application will be returned without begin reviewed. All other applicants must specify the geographical area where activities are proposed in **Appendix 6** of their applications.
  - *Appendix 7*: Credentialing
    - Identification of at least one provider of direct substance abuse prevention services;
    - A list of all direct service provider organizations that have agreed to participate in the proposed project, including type of services each one provides;
    - Statement of Assurance (provided in Appendix C of this announcement), signed by the authorized representative of the applicant organization identified on the face-page of the application, that assures SAMHSA: 1) that all listed providers meet the 2-year experience requirement and meet applicable licensing, accreditation, certification requirements; and 2) that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the time specified.

- **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 **April 1, 2008**. Hard copy applications are due by 5:00 PM (EST). Electronic applications are due by 11:59 PM (EST). **Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).** You will be notified by postal mail that your application has been received.

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 will not accept or consider any applications sent by facsimile.

SAMHSA accepts electronic submission of applications through www.Grants.gov. Please refer to Appendix B for "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 www.whitehouse.gov/omb/grants/spoc.html.

- 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-08-001**. 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)[*] to the head(s) of appropriate State, county and local health agencies in the area(s) to be affected no later than the application deadline. The PHSIS is intended to keep State, county and local health officials informed of proposed health services grant applications submitted by community-based, non-governmental organizations within their jurisdictions. If

[*] 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).

you are a State, county 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 can be found on SAMHSA's Web site at www.samhsa.gov. 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 **Appendix 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 not 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-08-001**. 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 www.samhsa.gov/grants/management.aspx:

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

In addition, SAMHSA's Minority SA/HIV Initiative cooperative agreement recipients must comply with the following funding restrictions:

- No more than 20% of the total grant award may be used for data collection and performance assessment, including incentives for participating in the required data collection follow-up.

SAMHSA grantees must also comply with SAMHSA's standard funding restrictions, which are included in Appendix G of this RFA.

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

Please refer to Appendix B for detailed instructions on submitting your application electronically.

Submission of Paper Applications

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

Send applications to the address below:

For United States Postal Service:

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

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

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include "**Minority SA/HIV Prevention Initiative – SP-08-001**" 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.

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

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

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

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 www.samhsa.gov. Click on "Grants/Applying for a New SAMHSA Grant/Guidelines for Assessing Cultural Competence."

- The Supporting Documentation you provide in Sections E-H and Appendices 1-7 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, applicants are encouraged to respond to each bulleted statement.

Section A: Statement of Need (15 points)

- **Documentation of AIDS Case Rate in Target Area/Population – Applicants must document that the AIDS case rate in the city/county where services will be provided meet the eligibility requirements in Section III, Eligibility Information, of this RFA.** Specifically, applicants must:

  - Identify the geographic area where services will be provided, the city or county in which that area is located, and document the AIDS case rate in that city/county, using data from the CDC, city/county public health department/agency or other reliable source. [NOTE: Applicants from geographic areas listed in Appendix I may use the rate for minority populations listed in Appendix I.]

  - Identify which <u>one</u> of the following racial/ethnic minority subpopulations you will target within your geographic service area:

    - Reentry populations (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years);
    - Men having sex with men (MSM);
    - Black, Latina or Hispanic women;
    - Adolescents (age 12-17);
    - Young adults (age 18-24); or
    - Older adults (age 50 and over).

  - Document the AIDS case rate for the target racial/ethnic subpopulation, if the data are available. (If the data are not available, state that fact in the application.)

  [NOTE: If neither city/county data are available, applicants may use data from the closest equivalent for which data are available. In some instances, this may be the State. Rural applicants may combine data from multiple counties in order to build a large enough population to document an AIDS case rate.]

  For Current Grantees under SAMHSA's RFA No. SP-05-001 ONLY:
  Current grantees funded under RFA # SP-05-001 (*Substance Abuse (SA), HIV, & Hepatitis Prevention for Minority Reentry Populations in Communities of Color*) may apply, but are <u>required</u> to:

  Serve <u>one</u> of the target subpopulations listed above. You may serve the same target subpopulation that you are currently serving under RFA # SP-05-001 in a different catchment area (as long as it is one from the above list) <u>or</u> serve a different subpopulation (chosen from the above list) in the same catchment area under RFA # SP-05-001. You must describe your target populations, demographics, and catchment areas currently being served under RFA # SP-05-001. Please provide this information on the form provided in Appendix K of this RFA and submit it as **Appendix 6** of your application.

Applications from grantees funded under RFA # SP-05-001 that are found out of compliance with these requirements will be screened out and returned without review.

- **Documentation of Other Factors Contributing to Need in the Target Area/Subpopulation – In this section of the Project Narrative, applicants must document that there are other factors (aside from a high AIDS case rate) that create a compelling need for substance abuse (SA) and HIV prevention services in the target area/subpopulation. Specifically, applicants must discuss and (where appropriate) provide data to document other major factors contributing to need in the target area/subpopulation. 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 target area/subpopulation. These factors may also include related health/social problems in the target area and experienced by the target racial/ethnic minority subpopulation, including substance abuse rates (especially rates of injection drug use), homelessness, criminal activity, etc. Finally, these factors may include community, cultural or social norms, values and beliefs in the target area/target racial/ethnic subpopulation that may influence HIV risk and protective behaviors and, therefore, limit the effectiveness of HIV/AIDS and substance abuse prevention. All applicants <u>must</u> specifically discuss the needs of <u>one</u> subpopulation within the target area.**

  [NOTE: All grantees will be required to complete a comprehensive community needs assessment reflecting the selected subpopulation after award. This section of the Project Narrative does not constitute a comprehensive community needs assessment. However, applicants who have recently completed a comprehensive community needs assessment should submit a copy of it in **Appendix 5** of their application. Successful applicants with an approved needs assessment focused on one of SAMHSA's racial/ethnic minority subpopulations may be able to receive up to five years of funding to carry out Steps 2-5 of the SPF. Successful applicants lacking an assessment of SA and HIV prevention service needs for their target racial/ethnic minority subpopulation, will be required to begin at Step 1 of the SPF to conduct an in depth assessment.]

Section B: Proposed Implementation Approach (45 points)

- Clearly state the purpose of the proposed project, including goals and objectives. Describe how implementation of selected evidence-based interventions (direct services and environmental strategies) will lead to achieving the goals and objectives, and how this will increase capacity to address SA and HIV prevention in communities reporting high SA and HIV/AIDS rates among your target racial/ethnic minority subpopulation. [NOTE: Applicants are strongly encouraged to refer to SAMHSA's *Guide to Evidence-Based Practices on the Web* at www.samhsa.gov/ebpwebguide to select an appropriate intervention for their target subpopulation.]

- Clearly state the unduplicated number of individuals you propose to serve annually and over the entire project period.

- Discuss your plans for implementing each step of SAMHSA's Strategic Prevention Framework (SPF) in the proposed Minority SA/HIV Prevention Initiative project.

- Provide a logic model that demonstrates the linkage between the identified need, the proposed approach, and outcomes. [NOTE: Appendix D of this RFA contains a sample logic model or you may submit a similar model of your own design. Appendix E provides logic model resources.]

- Describe plans for forming and mobilizing a workgroup of key stakeholders that also includes, but is not limited to, representatives from the list of planning groups and programs (see Section I-2.1.1 - Step 2). Include a description of their roles and functions, and frequency of meetings. Demonstrate key stakeholders' commitment to the project by including in **Appendix 1** of your application, letters of commitment, coordination, and support. These letters from key stakeholders must describe commitment to providing referral sources and linkages to care.

- Provide an outreach strategy to identify and provide services to the target racial/ethnic minority subpopulation for HIV transmission resulting from substance abuse.

- Describe plans to implement culturally appropriate policies, programs and practices related to the proposed project. Describe how activities will improve SA and HIV prevention services in the proposed catchment area.

- 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.

- Describe how members of your target racial/ethnic minority subpopulation were involved in the preparation of the application, and how they will be involved in all the SPF steps of the project.

Section C: Staff and Organizational Experience (20 points)

- Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and subpopulations. Demonstrate that the applicant organization and other participating organizations have linkages to the target racial/ethnic subpopulation and ties to grassroots/community-based organizations that are rooted in the culture and language of the target racial/ethnic subpopulation.

- 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 target racial/ethnic minority subpopulation and are familiar with the culture and language of the target subpopulation. If the target racial/ethnic minority subpopulation is multicultural and multilinguistic, describe how the staff are qualified to serve this subpopulation.

- 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 target racial/ethnic minority subpopulation. If the ADA does not apply to your organization, please explain why.

Section D: Performance Assessment and Data (20 points)

- Document your ability to collect and report on the required performance measures as specified in Section I-2.3, Data Collection and Performance Measurement, of this RFA. Describe your plan for data collection, management, analysis and reporting. Specify and justify any additional measures or instruments you plan to use for your project.

- Describe how data will be used to manage the project and assure continuous quality improvement.

- 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 20% for data and performance assessment; 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-2.4 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.

In reviewing applications, peer reviewers can rate and make comments on the items listed above for reasonable merit. Program staff can negotiate specific targets with applicants during the pre-award or post-award phase using the applicant's information noted above and peer review comments, as applicable.

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 H of this document.

Applicants **must** budget (up to 5% of total direct costs of the award) for standard or rapid HIV testing. Please describe the following in your budget justification:

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. Explain the additional costs needed for rapid and confirmatory test results, supplies and other administrative costs (e.g., lab services and reports not to exceed 5% of total direct costs of the award).
3. Provide an estimate on 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 H of your application, using the guidelines provided below. More detailed guidance for completing this section can be found in Appendix F of this RFA.

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the eight bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these eight bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining

Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

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

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

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

- State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate participants, specify the type (e.g., money, gifts, coupons), and the value of any such incentives. 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 to be 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. (See Appendix F: Confidentiality and Participant Protection.)

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

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

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

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

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria of research involving human subjects. 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.

Applicants whose projects must comply with the Human Subjects Regulations must, in addition to the bullets above, fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling clients in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp, or ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the 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 target racial/ethnic minority subpopulations 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 Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant 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).

- If your application is funded, you must provide a copy of your Notice of Grant Award and the grant abstract to the head(s) of appropriate State, county and local public health agencies in the area(s) to be affected.

- 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; or
  - requirements to address problems identified in review of the application.

- 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. 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-2.3, 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. Progress reports must be submitted electronically through CSAP's Minority AIDS Initiative Strategic Prevention Framework Management Reporting Tool (MAI SPF MRT). The MAI SPF MRT is a Web-based system that is accessible through CSAP's Service Accountability Monitoring System (CSAMS) and is designed to assist grantees with implementing the SPF effectively.

- Because SAMHSA is extremely interested in ensuring that SA and HIV 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 and NOMs data") from grantees. The performance requirements for this grant program are described in Section I-2.3 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) 276-2409
Email inquiries to: fy08mairfa@samhsa.hhs.gov

For questions on grants management issues contact:

Edna Frazier
Grants Management Specialist
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1087
Rockville, Maryland 20857
(240) 276-1405
edna.frazier@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.

- ❑ Current grantees under SAMHSA/CSAP's RFA No. SP-05-001 will be screened out if they propose to serve one of the SAME target subpopulations with the SAME demographics (i.e., gender, age, sexual orientation) in the SAME catchment area as proposed under RFA No. SP-05-001. **Refer to the requirements in Section I-2.2, Data Supporting Target Racial/Ethnic Minority Subpopulations, in this RFA.**

- ❑ Current grantees under SAMHSA/CSAP's RFA No. SP-05-001 will be screened out if they fail to complete and submit the form provided in Appendix K of this RFA in **Appendix 6** of their application.

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

- ❑ The 10 application components required for SAMHSA applications should be included 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
- $ Appendices
- $ Assurances (Standard Form 424B, which is in PHS 5161-1)
- $ Certifications
- $ Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
- $ Checklist (a form in PHS 5161-1)

- ❑ Applications should comply with the following requirements:

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

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

- ❑ 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. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- ❑ The page limits for Appendices stated in 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 www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

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

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

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

It is strongly recommended that you submit your grant application using Microsoft Office 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 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., "Appendices 1-3", "Appendices 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. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV-3 of this announcement. The paper submission must be clearly marked: **"Back-up for electronic submission."** The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Include the Grants.gov tracking number in the top right corner of the face page (SF 424 v2) for any paper submission. Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

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

For United States Postal Service:

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

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

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

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 that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in **Appendix 1** of the application, that has agreed to participate in the project;

- 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 <u>does not</u> constitute adequate documentation.)

_____ _____

Signature of Authorized Representative Date

Appendix D – Sample Logic Model

A Logic Model is a tool to show how your proposed project links the purpose, goals, objectives, and tasks stated with the activities and expected outcomes or "change" and can help to plan, implement, and assess your project. The model also links the purpose, goals, objectives, and activities back into planning and evaluation. A Logic Model is a *picture* of your project. It graphically shows the activities and progression of the project. It should also describe the relationships among what resources you put in (inputs), what you do (outputs), and what happens or results (outcomes). Based on both your planning and evaluating activities, you can then make a "logical" chain of "if-then" relationships.

Look at the graphic on the following page to see the chain of events that links the inputs to program components, the program components to outputs, and the outputs to outcomes (goals).

The framework you set up to build your model is based on a review of your Statement of Need, in which you state the conditions that gave rise to the project with your target group. Then you look at the **Inputs,** which are the resources, contributions, time, staff, materials**,** and equipment you will invest to change these conditions. These inputs then are organized into the **Program Components**, which are the activities, services, interventions and tasks that will reach the target population. These outputs then are intended to create **Outputs** such as changes or benefits for the consumer, families, groups, communities, organizations and SAMHSA. The understanding and further evidence of what works and what does not work will be shown in the **Outcomes**, which include achievements that occur along the path of project operation.

*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.

Sample Logic Model*

Resources (Inputs)	→	Program Components (Activities)	→	Outputs (Objectives)	→	Outcomes (Goals)
Examples		**Examples**		**Examples**		**Examples**
People Staff – hours Volunteer – hours Funds Other resources Facilities Equipment Community services		Outreach Intake/Assessment Client Interview Treatment Planning Treatment by type: Methadone maintenance Weekly 12-step meetings Detoxification Counseling sessions Relapse prevention Crisis intervention Special Training Vocational skills Social skills Nutrition Child care Literacy Tutoring Safer sex practices Other Services Placement in employment Prenatal care Child care Aftercare Program Support Fundraising Long-range planning Administration Public Relations		Waiting list length Waiting list change Client attendance Client participation Number of Clients: Admitted Terminated Inprogram Graduated Placed Number of Sessions: Per month Per client/month Funds raised Number of volunteer hours/month Other resources required		Inprogram: Client satisfaction Client retention In or postprogram: Reduced drug use – self reports, urine, hair Employment/school progress Psychological status Vocational skills Social skills Safer sexual practices Nutritional practices Child care practices Reduced delinquency/crime

Appendix E – Logic Model Resources

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

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

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

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

Julian, D.A. (l997). Utilization of the logic model as a system level planning and evaluation device. *Evaluation and Planning*, *20*(3), 251-257.

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

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

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

Appendix F – Confidentiality and Participant Protection

1. Protect Clients and Staff from Potential Risks

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

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

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

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

2. Fair Selection of Participants

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

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

   - Explain the reasons for including or excluding participants.

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

3. Absence of Coercion

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

   - If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by

consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $20.

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

4. Data Collection

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

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

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

5. Privacy and Confidentiality

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

   - Describe:

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

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

6. Adequate Consent Procedures

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

- State:

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

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

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

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

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

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

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

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

7. Risk/Benefit Discussion

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

Protection of Human Subjects Regulations

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

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

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

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

Appendix G – Funding Restrictions

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

- Support more than 20% of the total direct cost of the award for data collection and performance assessment, including incentives for participating in the required data collection follow-up.

- Spend in excess of 5% of the total direct cost of the award for purchasing rapid HIV antibody test kits, control kits, confirmatory kits, and/or confirmation laboratory services to test clients enrolled in this program. Those with MOUs in place with local HIV testing provider(s) for clients enrolled in this program may use up to five percent (5%) 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.

- Pay for substance abuse treatment and HIV treatment. 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 and other medications;

- Pay for hepatitis, TB and sexually transmitted infections (other than HIV) screening, testing, and treatment services under this initiative. Grantees are required to make referrals for these services through Memoranda of Understanding with local health providers.

- 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.

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

Appendix H – Sample Budget and Justification

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

OBJECT CLASS CATEGORIES

Personnel

Job Title	Name	Annual Salary	Level of Effort	SAMHSA Funded	Non-Federal Sources	TOTAL
Project Director	J. Doe	$30,000	1.0	$30,000	$-0-	
Clinical Director	J. Doe			$-0-	In-Kind	
Secretary	Unnamed	$18,000	0.5	$-0-	$ 9,000	
Counselor	R. Down	$25,000	1.0	$25,000	$-0-	
SUBTOTAL				**$55,000**	**$9,000**	
Enter Personnel subtotal on 424A, Section B, 6.a.						**$64,000**
Fringe Benefits (24%)				$15,360	$-0-	
SUBTOTAL				**$15,360**	**$-0-**	
Enter Fringe Benefits subtotal on 424A, Section B, 6.b.						**$15,360**

Travel

2 trips for SAMHSA Meetings for 2 Attendees (Airfare @ $600 x 4 = $2,400) + (per diem @ $120 x 4 x 6 days = $2,880)	$5,280	$-0-
Local Travel (500 miles x .24 per mile)	$-0-	$120
SUBTOTAL	**$5,280**	**$120**
Enter Travel subtotal on 424A, Section B, 6.c.		**$ 5,400**

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

Equipment (List Individually)

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

SUBTOTAL	**$-0-**	**$-0-**
Enter Equipment subtotal on 424A, Section B, 6.d.		**$-0-**

Supplies

Office Supplies	$500	$-0-
Computer Software – Microsoft Word	$-0-	500

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

CONTRACTUAL COSTS

Evaluation

Job Title	Name	Annual Salary	Level of Effort	SAMHSA Funded	Non-Federal Sources	TOTAL
Evaluator	J. Wilson	$48,000	.05	$24,000	$-0-	
Other Staff		$18,000	1.0	$18,000	$-0-	
Fringe Benefits (25%)				$10,500	$-0-	
Travel						
2 trips x 1 Evaluator ($600 x 2)				$ 1,200	$-0-	
Per Diem @ $120 x 6				720	$-0-	
Supplies (General Office)				500	$-0-	
Evaluation Contractual Direct Costs				$54,920	$-0-	
Evaluation Contractual Indirect Costs (19%)				$10,435	$-0-	
Evaluation Contract Subtotal				**$65,355**		
SUBTOTAL				**$65,355**	**$-0-**	**$65,355**

Training

Job Title	Name	Annual Salary	Level of Effort	SAMHSA Funded	Non-Federal Sources	TOTAL
Coordinator	M. Smith	$ 12,000	0.5	$12,000	$-0-	
Admin. Asst.	N. Jones	9,000	0.5	9,000	$-0-	
Fringe Benefits (25%)				5,250	$-0-	
Travel						
2 Trips for Training						
Airfare @ $600 x 2				$1,200	$-0-	
Per Diem $120 x 2 x 2 days				480	$-0-	
Local (500 miles x .24/mile)				120	$-0-	
Supplies						
Office Supplies				$500	$-0-	
Software (Microsoft Word)				$500	$-0-	
Training Contractual Direct Costs Subtotal				$40,025	$-0-	**$40,025**
Training Contractual Indirect Costs Subtotal				$-0-	$-0-	**$-0-**

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

SUBTOTAL	**$105,380**	**$-0-**	**$105,380**
Enter Contractual subtotal on 424A, Section B, 6.f.			**$105,380**

	SAMHSA Funded	**Non-Federal Sources**	**TOTAL**
OTHER			
Rent (500 Sq. Ft. x $9.95)	$ 4,975	$-0-	
Telephone	$ 500	$-0-	
Maintenance (e.g., van)	$-0-	$ 2,500	
Audit	$-0-	$ 3,000	
Consultants = Expert @ $250/day X 6 day (If expert is known, should list by name)	$ 1,500	$-0-	
SUBTOTAL	**$6,957**	**$5,500**	
Enter Other subtotal on 424A, Section B, 6.h.			**$12,475**
TOTAL DIRECT CHARGES (sum of 6.a-6.h)			
Enter Total Direct on 424A, Section B, 6.i.			**$192,640**
INDIRECT CHARGES			
15% of Salary and Wages (copy of negotiated Indirect Cost Rate Agreement attached) [$64,000 X 15% = $9,600]			
Enter Indirect Costs subtotal of 424A, Section B, 6.j.			**$9,600**
Enter TOTALS on 424A, Section B, 6.k. (sum of 6i and 6j)			**$202,240**

JUSTIFICATION

PERSONNEL - Describe the role and responsibilities of each position.

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

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

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

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

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

OTHER - Generally self-explanatory. If consultants are included in this category, explain the need and how the consultant's rate has been determined. If rent is requested, provide the name of the owner of the building/facility. If anyone related to the project owns the building which is a less than arms length arrangement, provide cost of ownership/use allowance.

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

OTHER SOURCES – If other non-Federal sources of funding, including match or cost sharing as a total operating budget is included, provide the name of the source, e.g., in-kind, foundation, program income, Medicaid, State funds, applicant organization, etc., and explain its use.

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

Review and verify the accuracy of future year budget estimates. Increases or decreases in the future years must be explained and justified. (NOTE: salary cap of $186,600 is effective for all FY 2008 awards.)

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

*Increased from 50% to 100% effort in 02 through 03 budget periods.

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

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

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

***Increased amounts in 02 and 03 years reflect the increase in client data collection.

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

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

Appendix I – Eligible States and MSAs

ELIGIBLE STATES

States with 10 AIDS Case Rates and Greater per 100,000 People, reported through December 2005	
State	**Rate**
Alabama	11.4
Arizona	10.8
California	11.3
Connecticut	19
Delaware	20.9
District of Columbia	128.4
Florida	27.9
Georgia	25.7
Illinois	15.1
Louisiana	21.2
Maryland	28.5
Massachusetts	10.8
Mississippi	13.2
Nevada	12.3
New Jersey	14.7
New York	32.7
North Carolina	10.9
Pennsylvania	12.1
South Carolina	15.7
Tennessee	14.1
Texas	13.6
Puerto Rico	26.4
Virgin Islands, U.S.	15.6

CDC reported AIDS cases and annual rates (per 100,000 population), by area of residence and age category, cumulative through 2005-United States, HIV/AIDS Surveillance Report 2005 Vol. 17, U.S. Department of Health and Human services, Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS, Prevention, Surveillance, and Epidemiology. Single copies of the report are available through the CDC National Prevention Information Network, 1-800-458-5231 or 301-562-1098 or http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/table14.htm

ELIGIBLE METROPOLITAN STATISTICAL AREAS (MSAs)

50 states and D.C. and Puerto Rico **Reported AIDS cases and rates *(per 100,000 population) among minorities* in 2005**		
Area of residence	**No.**	**Rate**
Akron, OH	38	36.1
Albany-Schenectady-Troy, NY	62	55.6
Allentown-Bethlehem-Easton, PA-NJ	54	43.8
Atlanta-Sandy Springs-Marietta, GA	1,296	60.2
Augusta-Richmond County, GA-SC	96	45.2
Austin-Round Rock, TX	133	22.1
Bakersfield, CA	66	15.9
Baltimore-Towson, MD	928	98.8
Baton Rouge, LA	204	71.8
Birmingham-Hoover, AL	112	32.1
Boston-Cambridge-Quincy, MA-NH *	294	32.8
Bridgeport-Stamford-Norwalk, CT	119	46.1
Buffalo-Niagara Falls, NY	77	37.8
Cape Coral-Fort Myers, FL	26	20.8
Charleston-North Charleston, SC	62	29.6
Charlotte-Gastonia-Concord, NC-SC	167	32.4
Chicago-Naperville-Joliet, IL-IN-WI	1,271	31.8
Cincinnati-Middletown, OH-KY-IN	61	19.1
Cleveland-Elyria-Mentor, OH	171	31.2
Columbia, SC	128	47.8
Columbus, OH	82	23.7
Dallas-Fort Worth-Arlington, TX	552	21.1
Dayton, OH	31	19.6
Denver-Aurora, CO	143	19.2
Des Moines, IA	12	18.8
Detroit-Warren-Livonia, MI	441	32.4
Grand Rapids-Wyoming, MI	23	16.6
Greensboro-High Point, NC	40	17.9
Greenville, SC	47	33.6
Harrisburg-Carlisle, PA	18	22.1

ELIGIBLE METROPOLITAN STATISTICAL AREAS (MSAs)

50 states and D.C. and Puerto Rico **Reported AIDS cases and rates *(per 100,000 population) among minorities* in 2005**		
Area of residence	**No.**	**Rate**
Hartford-West Hartford-East Hartford, CT	189	66.6
Houston-Baytown-Sugar Land, TX	837	28.9
Indianapolis, IN	98	28.6
Jackson, MS	125	48.9
Jacksonville, FL	230	60.1
Kansas City, MO-KS	107	25.3
Knoxville, TN	14	21.3
Lakeland, FL	58	36.8
Las Vegas-Paradise, NV	133	17.5
Little Rock-North Little Rock, AR	51	29.8
Los Angeles-Long Beach-Santa Ana, CA	1,040	12.3
Louisville, KY-IN	61	28.9
Memphis, TN-MS-AR	365	57.6
Miami-Fort Lauderdale-Miami Beach, FL	2,006	61.9
Milwaukee-Waukesha-West Allis, WI	46	11.1
Minneapolis-St. Paul-Bloomington, MN-WI	115	21.7
Nashville-Davidson--Murfreesboro, TN	128	40.2
New Haven-Milford, CT	119	51.1
New Orleans-Metairie-Kenner, LA	315	51.9
New York-Newark-Edison, NY-NJ-PA	5,332	59.6
Oklahoma City, OK	54	17.3
Omaha-Council Bluffs, NE-IA	17	12
Orlando, FL	385	49.8
Oxnard-Thousand Oaks-Ventura, CA	36	10
Palm Bay-Melbourne-Titusville, FL	28	29.6
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	992	55
Phoenix-Mesa-Scottsdale, AZ	221	15
Pittsburgh, PA	70	27.1
Portland-Vancouver-Beaverton, OR-WA	50	12.3
Poughkeepsie-Newburgh-Middletown, NY	107	65.4

ELIGIBLE METROPOLITAN STATISTICAL AREAS (MSAs)

50 states and D.C. and Puerto Rico **Reported AIDS cases and rates *(per 100,000 population) among minorities* in 2005**		
Area of residence	**No.**	**Rate**
Providence-New Bedford-Fall River, RI-MA	59	22.3
Raleigh-Cary, NC	111	36.4
Richmond, VA	95	22.1
Rochester, NY	92	47.8
Sacramento--Arden-Arcade--Roseville, CA	78	10
St. Louis, MO-IL	119	19.1
San Antonio, TX	153	13.4
San Diego-Carlsbad-San Marcos, CA	241	17.7
San Francisco-Oakland-Fremont, CA	446	20.6
Sarasota-Bradenton-Venice, FL	33	29.7
Scranton--Wilkes-Barre, PA	7	23.9
Seattle-Tacoma-Bellevue, WA	140	17.4
Springfield, MA	82	55.7
Syracuse, NY	25	30.3
Tampa-St. Petersburg-Clearwater, FL	336	46.9
Toledo, OH	17	13.4
Tucson, AZ	53	14.1
Tulsa, OK	36	16.1
Virginia Beach-Norfolk-Newport News, VA-NC	149	23
Washington-Arlington-Alexandria, DC-VA-MD-WV	1,233	50.9
Wichita, KS	21	16.9
Worcester, MA	57	48.3
Youngstown-Warren-Boardman, OH-PA	16	19.6

Notes:
Reported AIDS cases and annual rates (per 100,000 population) by area of residence and age category, cumulative through 2005-United States, HIV/AIDS Surveillance Report 2005 Vol. 17, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS, Prevention, Surveillance, and Epidemiology. CDC conducted a "special data run" for purposes of assisting SAMHSA/CSAP with this RFA.
Cases with unknown and multiple races are included in the table.
***Includes a metropolitan division with population of <500,000.**

Appendix J – SAMHSA's Rapid HIV Testing Requirements

Grantees that meet the requirements delineated below for rapid HIV testing **may use up to five percent (5%)** 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 five percent (5%) 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 **Appendix 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 five percent (5%)** 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: 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 K – Disclosure of Target Minority Subpopulations, Demographics, & Catchment Areas

(FOR CURRENT RECIPIENTS OF SAMHSA'S RFA NO. SP-05-001 ONLY)

Please answer the following questions if you are currently an award recipient of SAMHSA/CSAP's Request for Applications (RFA) No. SP-05-001, entitled: *"Substance Abuse (SA), HIV, & Hepatitis Prevention for Minority Populations and Minority Reentry Populations in Communities of Color"*

1. **Identify your target Minority and Reentry populations being served in your SP-05-001 grant.**

2. **Provide detailed demographics (i.e., age, gender, sexual orientation) on your current target populations**

3. **Identify the geographic area(s)/catchment area(s) where services are being provided.**

Appendix L – Acronyms and Definitions

AIDS – Acquired Immunodeficiency Syndrome
ATOD – Alcohol, Tobacco, and other Drugs
CBO – Community-Based Organization
CDC – Centers for Disease Control and Prevention
CFR – Code of Federal Regulations
CSAM –Center Services Accountability and Monitoring System
CSAP – Center for Substance Abuse Prevention
DHHS – Department of Health and Human Services
FY – Fiscal Year
GPO – Government Project Officer
GMO – Grants Management Officer
GPRA – Government Performance and Results Act
HIV – Human Immunodeficiency Virus
IDU – Injection Drug Use
IDUs – Injection Drug Users
IRB – Institutional Review Board
MSA – Metropolitan Statistical Area
NIDA – National Institute on Drug Abuse
NOMs - National Outcome Measures
PART - Program Assessment Ratings Tool
SAMHSA – Substance Abuse and Mental Health Services Administration
SIGs – State Incentive Grants
SPF – Strategic Prevention Framework
SPP – SAMHSA Participant Protection
SSA – Single State Agency
STDs – Sexually Transmitted Diseases
STIs – Sexually Transmitted Infections

Appendix M – 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.

Adolescents:
Individuals aged 12-17 years

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 exists when a group of people agree to abide by a set of behaviors, attitudes, and policies. This agreement, in turn, allows them to work effectively in cross-cultural situations.

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.

Metropolitan Statistical Areas (MSAs):
Whole counties (or equivalent entities) that have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. (Source: **U.S. Office of Management and Budget:** http://www.whitehouse.gov/omb/bulletins/fy2007/b07-01.pdf)

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: (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

Youth
Individuals, aged 18-24 years.

Appendix N – References

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