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Opioid Overdose Community Preparedness Planning

For

Opioid State Targeted Response (STR): Services Expansion
Community Preparedness Planning – Opioid Overdose

Release Date: July 23, 2018

Completed Plans Must be submitted to: opioidstrgrant@health.nv.gov
with the following in the subject line of the email:

**Opioid State Targeted Response: Service Expansion
Community Preparedness Plan – Opioid Overdose**

Technical Assistance Webinar: August 14, 2018 at 1:00pm

Join from PC, Mac, Linux, iOS or Android: <https://zoom.us/j/479749916>

Or iPhone one-tap :

US: +16468769923,,479749916# or +16699006833,,479749916#

Or Telephone:

Dial(for higher quality, dial a number based on your current location):

US: +1 646 876 9923 or +1 669 900 6833

Meeting ID: 479 749 916

International numbers available: <https://zoom.us/j/479749916>

**Deadline for Selection of Lead Applicant Organization and Submission of Appendices C, D, and E:
September 14, 2018**

For additional information, please contact:

Dennis Humphrey, Bureau of Behavioral Health Wellness and Prevention
Division of Public and Behavioral Health, Department of Health and Human Services
4126 Technology Way, Suite 200 Carson City, NV 89706 | Phone: (775) 684-2212 |
Email address: dhumphrey@health.nv.gov

Dear Interested Parties and Potential Subgrantees:

In April 2017, Nevada was awarded a Fiscal Year (FY) 2017 State Targeted Response to the Opioid Crisis Grant (Short Title: Opioid STR). The program was aimed at addressing the opioid crisis (including misuse of prescription opioids as well as other illicit drugs) by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of overdose prevention, treatment, and recovery activities for opioid use disorders.

As an Opioid STR Grantee, the State of Nevada is required to expand access to treatment and recovery services. Nevada expects to meet the goals of the Opioid STR Grant through the following activities:

- Implement system design models that will most rapidly address the gaps in their systems of care to deliver evidence-based treatment interventions, including induction and maintenance of medication assisted treatment services (MAT) and psychosocial interventions;
- Implement or expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of medication assisted treatment (MAT), i.e., the use of FDA-approved medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine) in combination with psychosocial interventions. (For more relevant resources: <https://www.samhsa.gov/medication-assisted-treatment>.)
- Provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings.
- Report progress toward increasing availability of treatment for OUD and reducing opioid-related overdose deaths based on measures developed in collaboration with the Department of Health and Human Services (DHHS); and
- Ensure individuals have opportunities for engagement in treatment and recovery supports throughout the continuum of care and increase retention in care.
- Enhance or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.

For the period of August 2018 – April 30, 2019, an RFA to promote MAT Expansion services across the state by increasing Nevada’s service and referral network was released in May. Activities and services will build upon the work accomplished during the 2017-2018 funding cycle that established three Integrated Opioid Treatment and Recovery Centers (IOTRC) across the State of Nevada. The Integrated Opioid Treatment and Recovery Center’s (IOTRC) serve as the regional consultants and subject matter experts on opioid use disorder treatment, provide Medication Assisted Treatment (MAT) and clinically appropriated evidence-based interventions for the treatment of OUD, and recovery services for adult and adolescent populations.

The goal of this RFA, Opioid State Targeted Response (STR): Services Expansion Community Preparedness Planning – Opioid Overdose, is to solicit Opioid Overdose Community Preparedness Plans for each county in Nevada, administered by the community coalitions, Health Department, or local EMS.

Funding Opportunity Title:	State of Nevada Opioid STR: Community Preparedness Plan – Opioid Overdose
Funding Opportunity Number:	NV STR-03
Due Date for Lead Organization Applications:	September 14, 2018
Anticipated Total Funding Available:	See Table below; Half of the funds will be distributed upfront and the remainder upon completion of the plan. <i>(Funding to counties will be administered by the local Community Coalition, Health Department, or local EMS).</i>
Estimated Number of Award(s):	17
Estimated Award Amount:	See Table below; Half of the funds will be distributed upfront and the remainder upon completion of the plan. <i>(Funding for the Opioid Overdose Community Preparedness Plans for each county in Nevada, can be lead/administered by community coalitions, the Health District, and/or EMS within the counties).</i>
Cost Sharing/Match Required:	None
Project Period:	Upon approval through February 2019

Completed Opioid Overdose Community Preparedness Plans must be received no later than Thursday, November 15, 2018 4:00 PM (PST).

Funding for the Opioid Overdose Community Preparedness Plans for each county in Nevada, can be administered by the community coalitions, the Health District, and/or EMS within the counties. In the case that the community coalition takes leadership, it is asked that the local EMS and health authority endorses the coalition to provide support and participate. The agency who takes the lead role in the distribution of funds will be required to complete the Letter for Intent for Lead Agency template found in Appendix C.

The following table outlines amounts available per county. Please note that half of the funds will be distributed upfront and the remainder upon completion of the plan.

Award Amounts

County	Amount
<u>Clark County</u>	\$20,000
<u>Washoe County</u>	\$15,000
<u>Carson City</u>	\$15,000
<u>Lyon County</u>	\$10,000
<u>Elko County</u>	\$10,000
<u>Douglas County</u>	\$10,000
<u>Nye County</u>	\$10,000
<u>Churchill County</u>	\$7,000
<u>Humboldt County</u>	\$7,000
<u>White Pine County</u>	\$7,000
<u>Pershing County</u>	\$7,000
<u>Lander County</u>	\$7,000
<u>Lincoln County</u>	\$7,000
<u>Mineral County</u>	\$7,000
<u>Storey County</u>	\$7,000
<u>Eureka County</u>	\$7,000
<u>Esmeralda County</u>	\$7,000

Opioid Overdose Community Preparedness Plans Timeline

NOTE: These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time, with appropriate notice to prospective

TASK	DUE DATE & TIME
SAPTA distributes the Request Opioid Overdose Community Preparedness Plans with all submission forms	July 23, 2018
Q&A Written Questions due to SAPTA	August 10, 2018
Informational Webinar to address questions	<p>August 14, 2018 (1:00pm –2:00pm) Join from PC, Mac, Linux, iOS or Android: https://zoom.us/j/479749916</p> <p>Or iPhone one-tap : US: +16468769923,,479749916# or +16699006833,,479749916#</p> <p>Or Telephone: Dial(for higher quality, dial a number based on your current location): US: +1 646 876 9923 or +1 669 900 6833</p> <p>Meeting ID: 479 749 916 International numbers available: https://zoom.us/u/xw7EuDR6</p>
Deadline for Selection of Lead Applicant Organization and Submission of Appendices C, D, and E	September 14, 2018
Release of first half of funds	October 2018
Deadline for submission of plans	February 2019
SAPTA will notify organizations that have discrepancies within their plans.	Upon Receipt of Plans
Evaluation Period: Content review of Plans	Upon Receipt of Plans
Release of second half of funds based on content review	February/March 2019

Submission of Opioid Overdose Community Preparedness Plans

The Community Preparedness Plans must be completed on the Community Preparedness Plan Template. The template packet must be emailed to Dennis Humphrey in original files (Word) and must be received **on or before the deadline of November 15, 2018 by 4:00 p.m.**

Dennis Humphrey, Program Manager

Must be submitted to: opioidstrgrant@health.nv.gov and dhumphrey@health.nv.gov with **RFA Opioid State Targeted Response: Service Expansion Community Preparedness Plan – Opioid Overdose** in the subject line of the email.

Attachments are required to be in Microsoft Word format.

Questions must be submitted to: opioidstrgrant@health.nv.gov by 4:00 pm on August 10, 2018. Responses will be provided via the informational webinar session on August 14, 2018 from 1pm – 2pm. In addition a follow-up Frequently Asked Questions (FAQ) document will be provided capturing all questions asked and will be distributed on the DHHS Website.

Submissions should be in Times New Roman font using only 11-point. Submissions must abide by the maximum page limitations and exceeding identified limits may be cause for disqualification for review. Any documents or questions that are not applicable, identify the question and reflect NA.

Page Limit	No page limit
Submission Format	Emailed, Microsoft word or excel format
Font Size	11 pt., Times New Roman
Margins	1 inch on all sides
Spacing	Single Spaced
Headers	Mandatory and Identical to RFA Request
Attachments	Attachments such as maps are permitted.

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COMMUNITY PREPAREDNESS PLANNING – Response to Opioid Overdose

The goal of implementing community preparedness planning measures is to reduce injury or death related to overdose by facilitating the development and implementation of coordinated response strategies using existing resources. Public Health/Emergency Awareness in response to the opiate crisis is designed to occur in communities in an effort to address local needs regarding substance use misuse and abuse trends, community access to resources, and facilitate interaction between programs including but not limited to Opioid Use Disorder (OUD) treatment centers, health care centers, community centers, social service programs, and law enforcement.

Required Format:

Each submitted Community Preparedness Plan **must** contain the following sections:

PLAN DEVELOPMENT

Steps that are recommended in developing the framework for an action plan will be based on the resources that are available within your own communities. The following steps will assist in that development:

- Each community will need to identify and implement a real time overdose mapping system. This system will be utilized to track information that guides activities pre-overdose spikes, during an overdose spikes, and post overdose spikes.
- Identify the stakeholders (e.g. EMS, Law Enforcement, Health Department, Coroners, treatment centers, etc.) that will be integral to your plan. Each stakeholder will need clear definitions of their role and responsibility.
- Select leaders that will assist with coordinating the action plan with the stakeholders. This group of leaders will assign responsibilities among the stakeholders based upon the community's resources and needs. This may include the coalitions, Health Department, and/or local EMS
- Create a clear definition as to what a spike of opioid overdoses will be in your community. A spike is the number of suspected overdoses in a certain timeframe that will trigger the response plan. To best develop this definition, historical data in your community will be needed to understand what constitutes a spike.
- Establish and determine pre-opioid spike, during opioid crisis spike and post-opioid spike activities.
- Communicate with the community to best identify local contributors to overdose risk. Factors may include local drug trends and use, availability and access to treatment, evaluation of current outreach strategies or materials.
- Establish line of communication with the press in the event of a spike in OD deaths, especially if due to fentanyl and/or carfentanyl in an area.
- Identify local resources and what assistance may be needed.
- Implement a system of evaluation to assess the effectiveness of the current plan and adjust as needed to remain operative.

ENGAGEMENT

Community engagement is an important component to address both those individuals who are at risk of overdose and community members who are likely to engage with those who are at risk including family and friends. A system of information delivery of community resources will need to be developed. Communities will need access to information regarding services beyond treatment including:

- Establishment of naloxone distribution centers that are accessible to community members.
- Provide drug disposal and unused prescription medication drop off sites.
- Support meetings available for those who are at risk (i.e. NA, AA, SMART Recovery, etc) as well those who support those individuals (i.e. Al-Anon, Nar-Anon, etc).
- Provide continued education on Good Samaritan Law protections and provisions.
- Deliver education on harm reduction strategies that can help prevent overdoses.
- Provide school and community education programs to raise awareness and educate about the risk of opioid misuse, opioid overdose, and opioid overdose rescue training

Stakeholders

Some common agencies that may be utilized as stakeholders include local health departments, state health departments, first responders, coroner or medical examiner's offices, hospital emergency departments, community coalitions, treatment facilities, parole & probation, correctional facilities, social services, schools, and media. Each agency can play an important role in community response and development.

Health Departments are important in coordinating between stakeholders and the Response Plan Team. They are in the best position to evaluate local plans following overdose spikes and provide feedback. Recommended actions for Health Departments include:

Pre-Overdose Spike:

- Work with the Response Plan Team and stakeholders to develop a local Overdose Spike Response Plan. It will likely be beneficial to coordinate with the State Health Department or your local health department to reduce duplicate efforts.
- Develop a public service announcement (PSA) template that can be easily implemented if an overdose spike occurs.
- Analyze historic data to define an overdose spike at the local level
- Establish an information delivery system coordinating with media groups and develop a plan to distribute PSAs in the event of a spike
- Provide training on criminal investigations (criminal/epidemiologic investigations course)
- Provide Crisis Intervention Team (CIT) Training

During a Spike:

- During a spike, Health Departments will be responsible to implement local response plans, issue PSA if appropriate, and coordinate with local stakeholders
- Confirm ODMAP spike with syndromic surveillance
- Conduct epidemiologic investigation

Post-Spike:

- Evaluate data and distribute findings to stake holders to improve response strategies
- Debrief for lessons learned

First responders (including fire departments, EMS, and law enforcement) are often the first to encounter those experiencing an overdose. During periods of overdose spikes, first responders will need to prepare for increased volume of cases. Recommended actions for first responders include:

Pre-Overdose Spike:

- Identify necessary information to be disseminated during an overdose spike.
- Supervisors will be responsible for developing a plan to reduce first responder burnout (e.g. access to employee assistance programs or critical incident stress management).
- Provide continuing education for first responders in overdose reversals and safe handling guidelines and epidemiologic investigations (criminal/epidemiologic investigations course)
- Plan engagement activities to improve community view of law enforcement.
- Provide CIT Training

During a Spike:

- Contact Overdose Spike Response Plan Team.
- Coordinate with local emergency departments to ensure appropriate treatment for overdose reversal and concerns of unusual symptoms.
- Increase law enforcement presence in known hotspots to increase naloxone availability.
- Deploy investigative plan.
- Promote information sharing across jurisdictions.
- Maintain an appropriate supply of naloxone to account for spikes.
- Establish field narcotic detection testing of product.

Post-Spike:

- Coordinate with coroner/medical examiners to expedite analysis in the event of a spike.

- Implement employee assistance/critical incident stress management plan, as needed.
- Debrief for lessons learned.

[Coroner's or medical examiners offices](#) assist law enforcement agencies in investigating overdose spikes through analysis of evidence. This assists in identifying substance trends and contributing concerns to better guide Response Plans. Recommended actions for forensics include:

Pre-Overdose Spike:

- Develop coordinated plans for expediting evidence during spikes.
- Develop a communication plan with law enforcement.
- Collect necessary evidence to better understand and address possible public health threats. (Should this be under the next tab during a spike?)
- Provide training for epidemiologic investigations (criminal/epidemiologic investigations)

During a Spike:

- Prioritize evidence analysis based upon plan.
- Implement communication plan with law enforcement.

Post-spike:

- Debrief for lessons learned.

[Hospital emergency departments](#) will likely be a point of contact for individuals who have experienced an overdose. They are in a position to educate individuals and connect them to available resources. Recommended actions for emergency departments include:

Pre-Overdose Spike:

- Establish discharge protocols to expedite connection to treatment services.
- Establish a follow up process and a point of contact.
- Develop a resource contact list and contact plan in the event of a spike. (Contact mobile response team, if a team exists within your local jurisdiction. If no mobile response team create a plan to coordinate with community paramedicine providers).
- Identify detox resources.
- Identify staff that are responsible for educating patients at discharge and provide take home education and naloxone.
- Prepare HIPPA compliant release of information paperwork for any 3rd party follow-up or referrals.
- Provide CIT Training.

During a Spike:

- Implement Overdose Spike Response Plan.

- Maintain an appropriate supply of naloxone to account for spikes.
- Report increased trend to local health department (as appropriate).
- Follow discharge protocols based upon plan.

Post-spike:

- Debrief for lessons learned.

Parole and Probation officers are regular points of contact with individuals that offers opportunity for brief intervention for those who may be at risk of overdose or family members of those who are. Harm reduction messages and treatment encouragement may decrease risk or help others respond appropriately when they observe an overdose.

Pre-Overdose Spikes:

- Provide access to and promotion of educational materials (e.g. Naloxone training and distribution, Good Samaritan Law awareness, treatment resources, etc.).
- Coordinate with Response Plan Team.
- Identify information to be shared during a spike to those on probation/parole and their families.

During a Spike:

- Implement Overdose Spike Response Plan
- Reinforce best practices for reducing overdoses.
- Inform friends and families of those on probation/parole of spikes and promote evidence-based practices.

Post-spike:

- Debrief for lessons learned.

Individuals with a history of opioid use are at an increased risk of overdose following release from a correctional facility. **Correctional facilities** may become a resource to enforce harm reduction for individuals prior to and at the time of release regarding reduced tolerance levels and provide overdose education. Recommended actions for correctional facilities include:

Pre-Overdose Spike:

- Identify information to be shared with inmates upon release (e.g. overdose education, and reduced tolerance after periods of abstinence).
- Investigate opportunities to provide naloxone kits upon release.
- Identify a list of resources for OUD treatment.
- Identify support group resources.
- Provide CIT Training.

During a Spike:

- Implement Overdose Spike Response Plan.

Post-spike:

- Debrief for lessons learned.

OD Treatment Facilities will likely see an increase in referrals during or immediately following a spike. They should remain in communication with referral sources such as emergency rooms and law enforcement regarding their current capacity. They also can provide education and outreach resources. Recommended actions for treatment facilities include:

Pre-Overdose Spike:

- Establish protocol for communicating resource availability to referral sources and appropriate members of the Response Plan Team.
- Identify information to be shared with existing clients during a spike (e.g. increased risk for overdose, resource cards, self-help meeting schedules, etc.).
- Provide info to LE/PH as appropriate of any awareness of increased OD activity or bad batch info.
- Provide CIT Training.

During a Spike:

- Implement Overdose Spike Response Plan.

Post-spike:

- Debrief for lessons learned.

Community coalitions are often organized stakeholders in the community that have established relationships within the community and have more accessibility for organizing outreach events. They tend to know where high risk populations are and have established rapport with these individuals. Recommended actions for community coalitions include:

Pre-Overdose Spikes:

- Assist with overdose prevention measures (e.g. naloxone trainings, Good Samaritan Law promotions, Public Service Announcements, etc.).
- Identify information sharing channels that can be utilized during spikes.
- Share information about the community and needs with the Response Plan Team.
- Provide info to LE/PH as appropriate of any awareness of increased OD activity or bad batch info.

During a Spike:

- Implement Overdose Spike Response Plan.

Post-spike

- Debrief for lessons learned.

[Social services and schools](#) are able to address the needs of younger populations that may be impacted by overdose spikes. Recommended actions include:

Pre-Overdose Spikes:

- Ensure first responders are trained and aware of protocols for overdose incidents that involve a child.
- Identify information to be shared from first responders to Child Protective Services.
- Identify process for notifying a school resource officer, counselors, or appropriate staff during an overdose spike.
- Provide CIT Training.

During a Spike:

- Implement Overdose Spike Response Plan.
- Notify appropriate staff of overdose spike

Post-spike:

- Debrief for lessons learned.

[Media outlets](#) are a resource to effectively communicate messages to prevent overdoses. Recommended actions regarding media include:

Pre-Overdose Spike:

- Designate a Public Information Officer within the Response Plan Team to coordinate with media.
- Develop a protocol of how and when to use the media to disseminate messages to the public regarding overdose spikes.
- Prepare templates or scripts that can be swiftly tailored in the event of an overdose spike warranting messaging to the public.

During a Spike:

- Release prepared messages outlined in plan.

Post-spike

- Debrief for lessons learned.

Plans may be annexed under existing community public health emergency preparedness plans.

Plan Evaluation Criteria

Applicants must provide evidence of their capacity to successfully execute all proposed strategies and activities to meet the objectives outlined within the template.

APPENDICES

APPLICATION SUBMITTAL PACKAGE (REQUIRED)

APPENDIX A

COVER PAGE

Nevada Division of Public and Behavioral Health
Bureau of Behavioral Health Prevention and Wellness

In response to:

STR Service Expansion: Community Preparedness Planning – Opioid Crisis

Release Date: July 23, 2018

Deadline for Submission and Time: November 15, 2018 at 4:00 PM (PST)

Our application is respectfully submitted as follows:

Community Name			
Community Coalition or Lead Address			
Mailing Address: (If different)			
Phone:		Fax:	
Planning Committee Members and Affiliate Organizations			
Name of Primary Contact for Proposal:			

Proposal Primary Contact Email Address:	
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As a duly authorized representative, I hereby certify that I have read, understand, and agree to all terms and conditions contained within this request for applications and that information included in our organization's application hereby submitted is accurate and complete.

Signed:

Date:

Print Name:

Title:

APPENDIX B

CONFLICT OF INTEREST POLICY ACKNOWLEDGMENT

Clinic/Agency must have a conflict of interest policy designed to foster public confidence in our integrity and to protect our interest when we are contemplating entering a transaction or arrangement that might benefit the private interest of a director, a corporate officer, our top management official, and top financial official, any of our key employees, or other interested persons.

I hereby acknowledge that **[INSERT NAME OF AGENCY]**, has a conflict of interest policy on file and that all employees, contractors, and volunteers have read and understood it, and agree to comply with its terms.

Authorized Agency Title / Signature

Date

APPENDIX C
LETTER OF INTENT FOR LEAD AGENCY (TEMPLATE)

This letter of intent for the lead agency serves to establish who the lead agency responsible for the convening of members and development of this plan. The identify lead organization will further coordinate on Opioid Overdose Community Preparedness Response Plan with community stakeholders to address local needs regarding substance use misuse and abuse trends, community access to resources, and facilitate interaction between programs in accordance with the terms set forth below. The purpose of this Agreement is to set forth the parties' understanding regarding their collaborative community preparedness planning and care coordination activities.

I. Identified Lead Organization:

In the case that the community coalition takes leadership, it is asked that the local EMS and health authority endorses the coalition to provide support and participate.

II. County Represented:

III. Funding and Budget:

1. Those identified as the lead organization will be responsible for administering funding to stakeholders in the community. Opioid Overdose Community Preparedness Plans for the county in Nevada, can be administered by the community coalitions, the Health District, and/or EMS within the counties. The Opioid Community Preparedness Leadership Team will work closely with the stakeholder to develop the budget necessary to fulfill the responsibilities listed above. Lead organization will be responsible for submitting the budget documents outlined in Appendices D & E.

Lead Organization: _____

Representative: _____ Date: _____

Signature: _____

APPENDIX D

PROPOSED BUDGET PLAN – INSTRUCTIONS & BUDGET EXAMPLE

The following budget development instructions and budget example have been prepared to help you develop a complete and clear budget to ensure delays in processing awards are minimized.

Funding Details and Requirements:

This funding announcement is for the STR Service Expansion. The subgrant period for this application will be for **the project period of 12 months** and will start **October 1, 2018** and continue through **September 30, 2019**.

1. Apply for the project period. Complete an individual scope of work (SOW), budget and budget narrative for each budget cycle of the ten-month project period.
2. Unspent funding will be returned to the state. No exceptions.
3. All funding is subject to the availability of funding.

Detailed Budget Building Instructions by Line Item:

Budget building is a critical component of the application process. The budget in the application is going to be the budget used for the subgrant. The budget must be error free and developed and documented as described in the instructions.

1. **Under the “Category” section of the line item;** there is nothing to be filled out or completed by the applicant. **Please see the Example Budget for reference**
2. **Under the “Total Cost” section of the line item;** the total cost identified should represent the sum of all costs represented in the “Detailed Cost” section associated to the line item. **Please see the Example Budget for reference**
3. **Under the “Detailed Cost” section of the line item;** the detailed costs identified should represent the sum of all costs represented in the “Details of expected expenses” section associated to the line item. **Please see the Example Budget for reference**

Under the “Details of Expected Expenses” section of the line item; the details of expected expenses identified here should represent the fiscal/mathematical representation of all costs that are outlined in the budget narrative. The expenses should represent a projection of the expenses that will be charged to the subgrant that directly support the work necessary to complete the tasks that are required to meet the goals and objectives as outlined in the scope of work (SOW) for this subgrant.

Example Budget for reference.

<u>Category</u>	<u>Total Cost</u>	<u>Detailed Cost</u>	<u>Details of Expected Expenses</u>
1. Personnel	\$ 77,280		<p>Personnel: The costs that are allowable in this budget line item are personnel costs only. This does not include any form of temporary staff, contract employees and/or volunteers.</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> 1. The positions title must be included. NOTE: Do not put an individual name. 2. The number of staff that will be charged to the grant under a specific position title. NOTE: If your organization charges multiple staff that share the same projected allocation of time, then group them together. See Project Coordinators NOTE: If your organization charges multiple staff that do not share the same projected allocation of time, then separate them. See Administrative Assistant 3. The total annual salary of the position per year. 4. The percentage of time they will be contributing to the project. 5. The sum total of 1 through 4. 6. The fringe benefits line must be represented as an average percent of the total salaries being charged to the grant. Example: \$7,000 + \$22,500 + \$35,000 + \$3,000 + \$1,500 = \$69,000. The average cost of fringe benefits for all staff being charged to the grant is 12%. Fringe benefits are calculated as \$69,000 X 12% (0.12) = \$8,280. Salaries: (FTE X Annual Salary X % of Effort = Salary Charged) Fringe: (Total Salary Charged X Average Fringe Benefit Rate = Fringe Benefit Cost) NOTE: Please see the example below.
		<p>\$ 7,000</p> <p>22,500</p> <p>35,000</p> <p>3,000</p> <p>1,500</p> <p>8,280</p>	<p>Executive Director, 1 X \$70,000 per year X 10% = \$7,000</p> <p>Project Manager, 1 X \$45,000 per year X 50% = \$22,500</p> <p>Project Coordinators, 2 X 35,000 per year X 50% = \$35,000</p> <p>Administrative Assist, 1 X \$15,000 per year X 20% = \$3,000</p> <p>Administrative Assist, 1 X \$15,000 per year X 10% = \$1,500</p> <p>Fringe Benefits equals 12% of total salaries charged - \$69,000 X 12% = \$8,280</p>

2. Travel	\$ 8,160	<p>Travel: The costs that are allowable in this budget line item are all travel costs.</p> <p>The following details must be included in the details of expected expenses sections of the line item. All rates must be reflective of actual GSA approved rates at the time budget development.</p> <ol style="list-style-type: none"> 1. Mileage should reflect GSA approved rate and total projected miles to be driven. 2. A brief description of the trip. 3. The destination of the trip. 4. The number of staff that will be traveling. 5. An estimated trip cost per staff traveling. 6. The projected trip total. <p>Mileage: (GSA Rate X Number of Miles = Cost)</p> <p>Trips: (Number of staff X estimated cost per staff X number of trips = Cost)</p> <p>NOTE: Please see the example below</p>	
	\$ 1,070 3,000 4,000 90	<p>Mileage for local meeting and events - \$.535 X 2000 miles = \$1,070</p> <p>1 SAMHSA Conference, Washington DC, April 2017, 2 Staff, \$1,500 each = \$3,000</p> <p>4 Quarterly Meetings, Statewide, 2 Staff, \$500 each = \$4,000</p> <p>1 "Prevention Training" travel only, Reno, 6 staff, \$15 each = \$90</p>	
3. Operating	\$ 7,075	<p>Operating: The costs that are allowable in this budget line item are all operating costs. Operating costs may include but are not limited to; building space, utilities, telephone, postage, printing and copying, publication, desktop/consumable office supplies, drugs, biologicals, certification fees and insurance costs. If applicable, indirect costs are not included in this section. Organizational costs that do not reasonably contribute the accomplishments of project tasks, goals and objectives of the scope of work cannot not be charged to the grant.</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> 1. A brief description of the item being charged. 1. The monthly average cost of the item. 2. The number of months that the budget encompasses. 3. If the item of cost is split between funding sources, then include the percentage of split being charged to this grant. 	

		<p>NOTE: if one item of cost is split at 25% then all other items of cost should share the same percent of the split.</p> <p>Supplies: (Per Month Cost X number of months charged X Rate of Allocation = Cost)</p> <p>NOTE: Please see the example below</p>
	<p>\$ 900</p> <p>4,500</p> <p>300</p> <p>375</p> <p>1,000</p>	<p>Office Supplies (paper, pencils, pens, etc.) - \$75 per month X 12 months = \$900</p> <p>Rent - \$1,500 per month X 12 Months = \$18,000 X 25% allocation.</p> <p>Phone - \$100 per month X 12 months = \$1,200 X 25% allocation.</p> <p>E-mail - \$125 per month X 12 months = \$1,500 X 25% allocation.</p> <p>1 Computer for the project manager X \$1000 per computer</p>
4. Equipment	\$ 16,500	<p>Equipment: The costs that are allowable in this budget line item are equipment costs. Per federal regulation; §200.33 Equipment. Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or \$5,000 per unit</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> 1. Include a brief description of the item being charged. 2. Include the cost of the item, per unit. 3. Include the number of units that are being purchased. 4. If the item of cost is split between funding sources, then include the percentage of split being charged to this grant. <p>NOTE: if one item of cost is split at 25% then all other items of cost should share the same percent of the split.</p> <p>Equipment: (Per Unit Cost X Number of Units = Cost)</p> <p>NOTE: Please see the example below</p>
	\$ 16,500	<p>Examination Table, \$5,500 per unit X 3 units – 16,500 (<i>this is almost never used; most expenditures will fall under Operating costs</i>)</p>

5. Contractual Consultant	\$ 99,575	<p>Contractual: The costs that are allowable in this budget line item are contract costs. List all sub-grants, consultants, contract, personnel/temporary employees and/or vendors that will be procured through a competitive process. (Travel and expenses of consultants and contractor should be incorporated into the contracts and included in this section as a part of the estimate contract cost.)</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> 1. Include a brief description of the intended future contract that is being considered. 2. Include the estimated cost of the contract. 3. If applicable, include the cost of and number of deliverables that will be the result of the completed contract. 4. If applicable, include the per hour rate of the contract and the number of hours the project is going to take. 5. For subgrant funding; provide a brief description of the sub-grant project or projects and the total estimated pass-through amount. <p>NOTE: Do not list the actual names of contractors, consultants, vendors or subgrantees in the budget.</p> <p>NOTE: Please see the example below</p>
	<p>\$ 20,000</p> <p>4,375</p> <p>15,200</p> <p>60,000</p>	<p>Contract to provide 4 regional prevention training courses; \$5,000 X 4 Courses = \$20,000</p> <p>Media consultant - \$35 per hour X 125 hours = \$4,375</p> <p>Contract for the development of a community needs assessment = \$95.00 per hour X 160 hours - \$15,200</p> <p>Sub-grants for community primary prevention programs = \$60,000</p>
6. Training	\$ 1,650	<p>Training: The costs that are allowable in this budget line item are training costs. This line item may include registration fees/conference fees and training costs. This line item can be used to budget for training that will be attended by staff and for the costs of training and educational materials being provided to targeted populations as identified in accordance to the proposed SOW.</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> 1. Include a brief description of the intended training cost being considered. 2. Include the estimated cost of the training. 3. If developing educational materials for hosting a training. 4. Include the “per unit” cost and number of units being developed for the training.

		NOTE: Please see the example below	
		\$ 500	SAMSHA Conference registration fees, 2 staff X \$250 each = \$500
		150	Prevention Training registration fees, 6 staff X \$25 each = \$150
		1,000	Printing cost for education books for addiction prevention seminar = \$20 per book X 50 books = \$1000
7. Other/Indirect	\$ 27,469	<p>Other/Indirect: The costs that are allowable in this budget line item are indirect costs and if applicable audit costs.</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> 1. Include a brief description of the intended cost being considered. 1. For audit costs include the total annual of the audit and the rate of allocation. NOTE: the rate of allocation should be the same as the rates of allocation in the operating section. If not, provide a justification as why the rate of allocation is different. 2. If applicable, include the total direct costs being charged for indirect. 3. If applicable, include the federally approved indirect rate total direct costs being charged for indirect. <p>Audit Cost: (Annual audit cost X Rate of Allocation = Cost)</p> <p>Indirect Cost: (Total Direct Costs being charged x Federally Approved Indirect Rate = Indirect Cost)</p> <p>NOTE: Please see the example below</p>	
		\$ 2,000	Annual audit cost: \$8,000 X 25% = \$2,000
		25,469	Indirect Costs: \$210,228 X 12% = 25,468.80
Total Cost	\$ 237,709		
Note #1: Totals listed must match totals on Cover Page.			

Please use the Excel template provided with the announcement package to complete and submit.

Review and complete the included Excel budget form. Please refer to the Instructions for Proposed Budget Plan(s) and/or Subcontracting Budget Plan provided (APPENDIX D).

Develop a line item budget for the project. For each itemized category, specify the total project costs (including subcontracting cost), description of expense, and the amount requested from Nevada Division of Public and Behavioral Health (DPBH) funding. A line item expense under a category **must** include a description of the line item expense in the detail description.

See Proposed Budget Template on the next page...

APPENDIX E
PROPOSED BUDGET TEMPLATE

Click to insert the Organizations Name			
BUDGET NARRATIVE			
July 1, 2018 through June 30, 2019			
Detailed Budget Year 1 – July 1, 2018 through June 30, 2019			
Category	Total cost	Detailed cost	Details of expected expenses
1. Personnel	\$		
		\$	# and type (position type; FTE type) of staff to be hired
2. Travel	\$		
		\$	# traveling, positions traveling, location, dates of travel, purpose, reimbursement made in accordance with SAM
3. Operating	\$		
		\$	To include: xxxx
4. Equipment	\$		
		\$	Itemize expenses allowed within this category
5. Contractual Consultant	\$		
		\$	Itemize expenses allowed within this category
6. Training	\$		
		\$	Type of training, location, # attending, benefit to Subgrantee and implementation of subgrant
7. Other	\$		
		\$	Itemize expenses allowed within this category
Total Cost	\$		

APPENDIX F SPENDING PLAN Template

Sub-grant Time Period		Aug-18		To		Jul-19									
Total Budget Requested															
Category	Total Requested Budget	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Total of Months	
Personnel	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Travel	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Operating	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Equipment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Contract/Consultant	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Training	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Total:	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
Percent of Total	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

Instructions:

Please fill out the following spending plan using the budgeted amounts from your sub grant budget. All amounts must match the budget categories in your budget justification. All fields in the template are locked except for those requiring your input as follows:

- In cell C3, please enter the name of your organization.
- In cell C4, select the start month and year of your subgrant by using the drop-down box. After you make your month and year selection, the rest of the dates will be filled in automatically for a 12-month time period.
- In cell C5, enter the total amount of your sub-grant award.
- In cells B7 to B 13, put the total amount of the categorical costs in the appropriate section. These amounts must match the amounts in the same categories in you budget justification.
- In cells C7 to N7, enter your expected total personnel costs for each month.
- In Cells C8 to N8, please enter your expected travel costs for each month as appropriate.
- In Cells C9 to N9, please enter operating costs you expect to spend for each month.
- In Cells C10 to N10, please enter any planned equipment purchases and place those costs in the month(s) you expect to incur the costs.
- In Cell C11 to N11, place the total expected costs for Contracts/Consultants in the months you plan on using such services.
- In Cell C12 to N12, please note any expected training costs in the months you expect the training activities to occur.
- In Cell C13 to N13, please specify any other costs that are planned in the months they will occur.

While you are entering this information, you will observe that cells for the "Total" and "Total Percentage" will be auto calculated and will reflect one of three colors. If the cell is yellow, it indicates that the amount is below the total awarded amount; if the color is green, it indicates the amount is the same as the total awarded amount; and if the cell turns red, it indicates that the amount is above the total awarded amount. All applicable cells must reflect green once you are finished filling in your spending plan for each month.

In the same way, you will notice the end column (O7 thru O15) will also change colors. Once again, yellow indicates that the total amount for the total of all months for the category is under the total budgeted amount (reflected in the "B" column), the green indicates that the monthly total for the category matches the total categorical budget, and red indicates that the monthly total exceeds the categorical budget. All cells must be green before submitting the spending plan. At the bottom of each column, a monthly percentage of the total budget is also calculated. The sum of all monthly percentages must equal 100% of the total award.

APPENDIX G

BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION PROGRAM REQUIREMENTS

In addition to the Division of Public and Behavioral Health Subaward Grant Assurances, the subrecipient and all organizations or individuals to whom the sub-grantee passes through funding must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines, and policies and procedures. The terms and conditions of this State subaward flow down to the subrecipient's pass through entities unless a particular section specifically indicates otherwise.

GENERAL REQUIREMENTS

Applicability

This section is applicable to all subrecipients who receive funding from the Division of Public and Behavioral Health through the Bureau of Behavioral Health Wellness and Prevention (BBHWP). The subrecipient agrees to abide by and remain in compliance with the following:

1. 2 CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards
2. 45 CFR 96 - Block Grants as it applies to the subrecipient and per Division policy.
3. 42 CFR 54 and 42 CFR 54A Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention & Treatment Block Grants and/or Projects for Assistance in Transition from Homelessness Grants
4. NRS 218G - Legislative Audits
5. NRS 458 - Abuse of Alcohol & Drugs
6. NRS 616 A through D Industrial Insurance
7. GAAP – [Generally Accepted Accounting Principles] and/or GAGAS [Generally Accepted Government Auditing Standards]
8. GSA – [General Services Administration] guidelines for travel

9. The Division of Public and Behavioral Health, BBHWP policies and guidelines.

10. State Licensure and certification
 - a. The subrecipient is required to be in compliance with all State licensure and/or certification requirements.
 - b. The subrecipient's certification must be current and fees paid prior to release of certificate in order to receive funding from the Division. Subawards cannot be issued unless certifications are current.

11. The Subgrantee shall carry and maintain commercial general liability coverage for bodily injury and property damage as provided for by NRS 41.038 and NRS 334.060. In addition, Subgrantee shall maintain coverage for its employees in accordance with NRS Chapter 616A. The parties acknowledge that Subgrantee has adopted a self-insurance program with liability coverage up to \$2,000,000 and has excess liability coverage up to \$20,000,000 for bodily injury (automobile and general liability), property damage (automobile and general liability), professional liability, and personal injury liability. The parties further acknowledge that Subgrantee is self-insured for workers' compensation liability. Subgrantee warrants that its participation in the plan is in full force and effect and that there have been no material modifications thereof. If, at any time, Subgrantee is no longer a participant in the self-insurance program, then Subgrantee shall immediately become a participant in a comparable self-insurance program or immediately obtain a policy of commercial insurance. The parties acknowledge that any Subgrantee liability is limited by NRS 41.0305 through NRS 41.035.

12. The subrecipient shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.

13. The subrecipient agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed.

14. The subrecipient will report within 24 hours the occurrence of an incident, following Division policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).

15. The subrecipient shall maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years were conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the subrecipient serves minors with funds awarded through this subaward.

16. Application to 2-1-1

- As of October 1, 2017, the Sub-grantee will be required to submit an application to register with the Nevada 2-1-1 system.
17. The subrecipient agrees to cooperate fully with all BBHWP sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.
 18. The subrecipient must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.
 19. The subrecipient acknowledges that to better address the needs of Nevada, funds identified in this subaward may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The BBHWP may reallocate funds to other programs to ensure that gaps in service are addressed.
 20. The subrecipient acknowledges that if the scope of work is NOT being met, the subrecipient will be provided an opportunity to develop an action plan on how the scope of work will be met and technical assistance will be provided by BBHWP staff or specified subcontractor. The subrecipient will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, BBHWP will provide written notice identifying the reduction of funds and the necessary steps.
 21. The subrecipient will NOT expend BBHWP funds, including Federal Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Funds for any of the following purposes:
 - a. To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
 - b. To purchase equipment over \$1,000 without approval from the Division.
 - c. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
 - d. To provide in-patient hospital services.
 - e. To make payments to intended recipients of health services.
 - f. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstrated needle exchange program would be effective in reducing drug abuse and there is no substantial risk that the public will become infected with the etiologic agent for AIDS.
 - g. To provide treatment services in penal or correctional institutions of the State.
 22. Failure to meet any condition listed within the subaward award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current

funding.

Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

23. Subrecipients of the program who expend less than \$750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.
24. Subrecipients of the program who expend \$750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Division Audit policy.

Year-End Financial Report

25. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.
26. The non-federal entity financial statements may also include departments, agencies, and other organizational units.
27. Year-End Financial Report must be signed by the CEO or Chairman of the Board.
28. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.
29. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:
 - a. List individual federal and State programs by agency and provide the applicable federal agency name.
 - b. Include the name of the pass-through entity (State Program).
 - c. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
 - d. Include the total amount provided to the non-federal entity from each federal and State program.
30. The Year-End Financial Report must be submitted to the Division 90 days after fiscal year end at

the following address:

Behavioral Health Wellness and Prevention
4126 Technology Way, Second Floor Carson City, NV 89706

Limited Scope Audits

31. The auditor must:

- a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
- b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
- c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program;
- d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding;
- e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.

32. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.

33. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:

- a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies;
- b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests;
- c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and
- d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).

34. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day. The Audit Report must be sent to:

Behavioral Health Wellness & Prevention
4126 Technology Way, Second Floor
Carson City, NV 89706

Amendments

35. The Division of Public and Behavioral Health policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the BBHWP through the assigned analyst prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via email.
36. For any budgetary changes that are in excess of 10 percent of the total award, an official amendment is required. Requests for such amendments must be made to BBHWP in writing.
37. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.
38. Any significant changes to the scope of work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all scope of work amendments.
39. The subrecipient acknowledges that requests to revise the approved subaward must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.
40. Final changes to the approved subaward that will result in an amendment must be received 60 days prior to the end of the subaward period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60-day deadline will be denied.

Remedies for Noncompliance

41. The Division reserves the right to hold reimbursement under this subaward until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

SUBSTANCE USE TREATMENT SERVICES

Applicability

This section applies to all sub-grants that support direct services to persons being treated for substance use.

1. The subrecipient, as applicable, if identifying as Faith-Based Organizations must comply with 42 USC § 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b)), Charitable Choice provisions and regulations.
 - a. The subrecipient must post a notice to advise all clients and potential clients that if the client objects to the religious character of the Sub-grantee's organization as applicable.
 - b. The client has the right to be referred to another Division-funded provider that is not faith-based or that has a different religious orientation.
2. Priority Groups – The subrecipient agrees to prioritize and expedite access to appropriate treatment, except for Civil Protective Custody Services, for priority populations in the following order:
 - a. Pregnant injecting drug users;
 - b. Pregnant substance abusers;
 - c. Injection drug users;
 - d. Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
 - e. All others.
3. The subrecipient agrees to report within 24 hours to the Bureau of Behavioral Health Wellness and Prevention when any level of service reaches 90 percent capacity or greater in accord with the Division's Wait List and Capacity Management policy.
4. A subrecipient who provides residential services agrees to report bed capacity in the HavBed system or a successor system for residential services daily in accord with the Division's Wait List and Capacity Management policy.
5. Programs will make continuing education in alcohol and other drug treatment available to all employees who provide services.
6. The subrecipient must post a notice, where clients, visitors, and persons requesting services may easily view it, that no persons may be denied services due to inability to pay. This notice may stipulate that the organization is authorized to deny services to those who are able to pay but refuse to do so.
7. The subrecipient is required to implement the National Institute of Drug Abuse (NIDA) 13 principles of treatment.

8. The subrecipient is required to participate, if selected to be reviewed by the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (AADAPTS) annual peer review process.

Capacity of Treatment for Intravenous Substance Abusers

9. A subrecipient must admit an individual who requests and needs treatment for intravenous drug use to a treatment program. If unable to provide services, the subrecipient must contact the BBHWP according to the Division's Capacity Management and Wait List policy.

10. The subrecipient who treats persons who inject drugs agrees to carry out activities to encourage individuals in need of treatment for injection drug use to undergo such treatment. The subrecipient must use outreach models that are scientifically sound or an alternate outreach method that is reasonably expected to be effective and has been approved by the BBHWP. All outreach activities will be reported to the Division quarterly. The model shall require that outreach efforts include the following at a minimum:
 - a. Selecting, training and supervising outreach workers;
 - b. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2;
 - c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
 - d. Recommend steps that can be taken to ensure that HIV transmission does not occur; and
 - e. Encouraging entry into treatment.

Treatment services for pregnant women (45 CFR § 96.131)

11. All subrecipient who treat women agree to provide immediate comprehensive treatment services to pregnant women, or if the sub-grantee is unable to do so, the sub-grantee must immediately contact the Bureau of Behavioral Health Wellness and Prevention in accord to the Divisions Capacity Management and Wait List policy.

12. Subrecipients who do not treat women and who receive a request for treatment services from a pregnant woman must provide a referral to an appropriate treatment provider within 48 hours of the request for services and must immediately notify the Bureau of Behavioral Health Wellness and Prevention of the need for such services.

13. Subrecipients who provide services to women agree to publicize the availability of services to women in priority populations and the admission priority granted to pregnant women. The publication of services for women in priority populations may be achieved by means of street outreach programs, ongoing public service announcements, regular advertisements, posters placed

in target areas, and frequent notification of availability of such treatment services distributed to the network of community-based organizations, health care providers, and social services agencies.

Records

14. All subrecipients will have in effect a system to protect from inappropriate disclosure of client records, compliant with all applicable State and federal laws and regulations, including 42 CFR, Part 2.
15. The system to protect confidentiality shall include, but not be limited to, the following provisions:
 - a. Employee education about the confidentiality requirements, to be provided annually;
 - b. Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.

Reporting

16. The subrecipient is required to submit monthly Treatment Episode Data Set (TEDS) admissions files and TEDS discharges files in accordance with current block grant requirements. The subrecipient is also required to submit any other reporting as defined and requested by the BBHWP.
17. The subrecipient agrees to participate in reporting all required data and information through the authorized BBHWP data reporting system and to the evaluation team as required; or, if applicable, another qualified Electronic Health Record (EHR) reporting system.

Fee for Service requirements

18. Subrecipients that have been awarded a fee for service subaward must comply with the Division's Utilization Management policy and the following billing and eligibility rules for claims processing.
 - a. The service must be delivered at a Division certified facility.
 - b. The certifications must cover the service levels under which the qualified service was delivered.
 - c. The service must be provided by an appropriately licensed/certified staff member.
 - d. The service delivered must be a Division qualified service which is **NOT** reimbursable by Medicaid or other third-party insurance carrier.
 - e. The rate of reimbursement will be based on the Division approved rates (available upon request).
 - f. The subrecipient agrees to accept the Division reimbursement rate as full payment for any program eligible services provided.
 - g. The subrecipient is responsible for ensuring that all third-party liabilities are billed and collected from the third party payers and are **NOT** billed to the Division.
 - h. Division funds will **NOT** be used to fund the services for self-pay clients or clients who elect not to use their insurance coverages. This includes clients that elect not sign up for insurance under the ACA [Affordable Care Act] or clients that have existing insurance and

choose not to use their insurance for treatment services. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.

- i. Division funds will **NOT** be used to reimburse Medicare claims.
- j. Division funds will **NOT** be used to reimburse claims for which the client is pending eligible for insurance coverage.
- k. Division funds will **NOT** be used to reimburse for claims denied by Medicaid or other insurance carriers unless the claim was denied as “not a covered benefit”.
 - i. Claims denied as “not a covered benefit” and billed to the Division must have the accompanying denial attached in order to guarantee payment.
- l. Division funds will **NOT** be used to cover any unpaid costs that Medicaid and/or other insurance carriers may not reimburse (i.e. copayments, deductibles).
- m. The subrecipient agrees to use Division funds as the “payer of last resort” for all services provided to clients. If an undue barrier to treatment exist, a written request to the Division may be submitted for review and some services may be covered upon written permission from the Division.

19. The subrecipient must establish policies, procedures, and the systems for eligibility determination, billing, and collection to:
- a. Ensure that all eligible clients are insured and/or enrolled in Medicaid in accord with the ACA;
 - b. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical assistance, any grant program, any private health insurance, or any other benefit program; and secure from client’s payment for services in accordance with their ability to pay; and
 - c. Prohibits billing the Division for a service that is covered by Medicaid or any other insurance carrier. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.

BILLING THE DIVISION

Fee-for-service only

20. The subrecipient agrees to submit a monthly billing invoice, along with back-up documentation via the Secure File Transfer Protocol (SFTP) site to the Division; the Sub-grantee agrees to notify the treatment analyst once the invoice has been posted to the SFTP site.

21. Upon official written notification from the BBHWP, prior authorizations will be required for all residential and transitional housing services being billed to the Division.

22. The subrecipient agrees to include an explanation of benefits for all charges requested for services that have been denied by Medicaid or any other third-party payer due to non-coverage of that benefit.
23. The subrecipient understands that charges greater than 90 days from the date of service will be considered stale dated and may not be paid.
24. The subrecipient understands that quarterly Medicaid audits will be conducted by Division and recouping of funds may occur.
25. The subrecipient understands that they are required to produce an invoice that breaks out the total number of services provided by level of care and CPT or HCPCS code. The invoice must, at a minimum meet the following conditions.
 - a. The invoice must contain, company information (Name, address, City, State and Zip), Date, unique Invoice #, vendor #, PA or HD#.
 - b. The invoice must contain contact name, phone number, e-mail and identify the invoice period.
 - c. The invoice must contain: Billed To: The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention, 4126 Technology Way, Suite 200, Carson City, NV 89706.
 - d. The invoice must show the total number of services by CPT or HCPS code, the rate being charged, the total amount charged to that CPT or HCPS code line and summarize the totals by level of care.
 - e. The invoice must also show the total number of services provided, the total number of unique clients served for the invoice and the total amount charged to the invoice.
 - f. The invoice must be signed and dated by the organizations fiscal officer and include the following certification, "By submitting this invoice, we certify that all billing is correct and no Medicaid or other insurance eligible services have been charged to this invoice."

REQUESTS FOR REIMBURSEMENTS (All non-fee-for-service subawards)

1. Request for Reimbursement is due, at a minimum, on a monthly basis, based on the terms of the sub-grant agreement, no later than the 15th of the month. If there has been no fiscal activity in a given month, a Request for Reimbursement claiming zero dollars is required to be submitted for the month.
2. Reimbursement is based on actual expenditures incurred during the period being reported.
3. Requests for advance of payment will not be considered or allowed by the Division.
4. Reimbursement must be submitted with all Division required supporting back up documentation. The Division has the authority to ask for additional supporting documentation at any time and the information must be provided to Division staff within 10 business days of the request.

5. Payment will not be processed without all programmatic reporting being current.
6. Reimbursement may only be claimed for allowable expenditures approved within the sub-grant award.
7. The subrecipient is required to submit a complete financial accounting of all expenditures to the Division within 30 days of the **CLOSE OF THE SUBAWARD PERIOD**. All remaining balances of a federally funded sub-grant revert back to the Division 30 days after the close of the subaward period.
8. The Request for Reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 25 days after the close of the SFY which occurs on June 30. All remaining balances of the State funded subawards revert back to the State after the close of the SFY.
9. The subrecipient must retain copies of approved travel requests and claims, consultant invoices, payroll register indicating title, receipts for goods purchased, and any other relevant source documentation in support of reimbursement requests for a period of three years from the date of submission of the State's final financial expenditure report submitted to the governing federal agency.

The subrecipient agrees that any failure to meet any of the conditions listed within the above Program Requirements may result in the withholding of reimbursement for payment, termination of current contract and/or the disqualification of future funding.

