



Announcement of Funding Availability

Justice Reinvestment Act – Treatment Supervision Implementation

A partnership of the WV DHHR and the WV DMAPS



Proposal Guidance and Instructions

AFA Title: Treatment Supervision Implementation
Targeting Region: Regions 1, 2, 4 & 6
AFA Number: AFA 04-2016-JRI

West Virginia Department of Health and Human Resources
Bureau for Behavioral Health and Health Facilities
350 Capital Street, Room 350
Charleston, WV 25301-3702

For Technical Assistance please include the AFA # in the subject line and forward all inquiries in writing to:

DHHRBHHFAnnouncement@wv.gov

Key Dates:	
Date of Release:	March 27,2015
TECHNICAL ASSISTANCE MEETING:	April 13, 2015, more details to follow
Letter of Intent Deadline:	April 15, 2015, Close of Business – 5:00PM
Application Deadline:	May 8, 2015, Close of Business–5:00PM
Funding Announcement(s) To Be Made:	May18, 2015
Funding Amount Available:	See Announcement for Details

The following are requirements for the submission of proposals to the Bureau for Behavioral Health and Health Facilities (BBHFF): The document includes general contact information, program information, administrative responsibilities, and fiscal requirements. ✓Responses must be submitted using the required AFA Application Template available at DHHR.WV.GOV/BHHF/AFA. ✓Responses must be submitted electronically via email to DHHRBHHFAnnouncement@wv.gov with the AFA Title and Number in the subject line. Paper copies of the proposal *will not* be accepted. ✓All submissions must be received no later than 5:00 PM on the application deadline. It is the sole responsibility of applicant to ensure that all required documents are received by the application deadline. Notification that the proposal was received will follow. ✓A Statement of Assurance agreeing to these terms is required of all proposal submissions available at DHHR.WV.GOV/BHHF/AFA. This statement must be signed by the agency's CEO, CFO, and Project Officer. ✓Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline *will not* pass initial

LETTER OF INTENT

Organizations planning to submit a response to this Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by **April, 15, 2015, close of business (5:00pm)** to the email address: DHHRBHFAnnouncement@wv.gov prior to submission of the proposal. List the AFA Title and Number found on Page 1 of this document in the email subject line. These letters of intent shall serve to document the organization's interest in providing the type of service(s) described within this AFA and will not be considered binding until documented receipt of the proposal.

RENEWAL OF AWARD

The Bureau for Behavioral Health and Health Facilities (BBHF) may renew or continue funding beyond the initial fiscal year award for up to one (1) additional fiscal year. Future funding will be contingent on factors including, but not limited to, availability of funds, successful implementation of goals, and documented outcomes.

LEGAL REQUIREMENTS

Eligible applicants are public or private organizations with a valid West Virginia Business License and/or units of local government. If the applicant is not already registered as a vendor in the State of West Virginia, registration must either be completed by the award notification date or the vendor must demonstrate proof of such application. It is also required that the applicants have a System for Award Management (SAM) registration and have a Dun & Bradstreet or DUNS number. For more information visit: <https://www.sam.gov>

The grantee is solely responsible for all work performed under the agreement and shall assume all responsibility for services offered and products to be delivered under the terms of the award. The State shall consider the designated Grantee applicant to be the sole point of contact with regard to all contractual matters. The grantee may, with the prior written consent of the State, enter into written sub agreements for performance of work; however, the grantee shall be responsible for payment of all sub awards.

FUNDING AVAILABILITY

This funding announcement is part of a statewide Justice Reinvestment Implementation plan to expand community based services and supports for persons convicted of a felony crime who demonstrate a high risk to reoffend coupled with a need for substance use treatment. Classification as high risk with moderate to high substance use need will be determined by the Level of Service/Case Management Inventory (LS/CMI). There may be more than one grant awarded in any region, but targeted regional/county program funding availability will not exceed the amounts listed in Section Two: ***Service Description*** of this document. Funding will be awarded based on accepted proposals that meet all of the required criteria contained within this document.

Start Up Costs

Applicants who wish to request reasonable startup funds for their programs must submit a separate “startup” target funded budget (TFB) and budget narrative along with their proposals. For the purposes of this funding, startup costs are defined as non-recurring costs associated with the initiation of a program. These include costs such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup cost requests submitted by the applicant will be considered to be necessary for the development of the proposed program. If, when taken together, the startup costs and program costs exceed funding availability BBHMF will contact the applicant organization and arrange a meeting to discuss remedial action.

Funding Reimbursement

All grant funds are awarded and invoiced on a reimbursement basis. Grant invoices are to be prepared monthly and submitted with and supported by the Financial Report and Progress Report to receive grant funds. The grant total invoice should agree with amounts listed on the Financial Report and reflect actual expenses incurred during the preceding service period. All expenditures must be incurred within the approved grant project period in order to be reimbursed. Providers must maintain timesheets for grant funded personnel and activities performed should be consistent with stated program objectives.

REGIONS IN WEST VIRGINIA

The WV Bureau for Behavioral Health and Facilities utilizes a six (6) Region approach:

Region 1: Hancock, Brooke, Ohio, Marshall, and Wetzel Counties

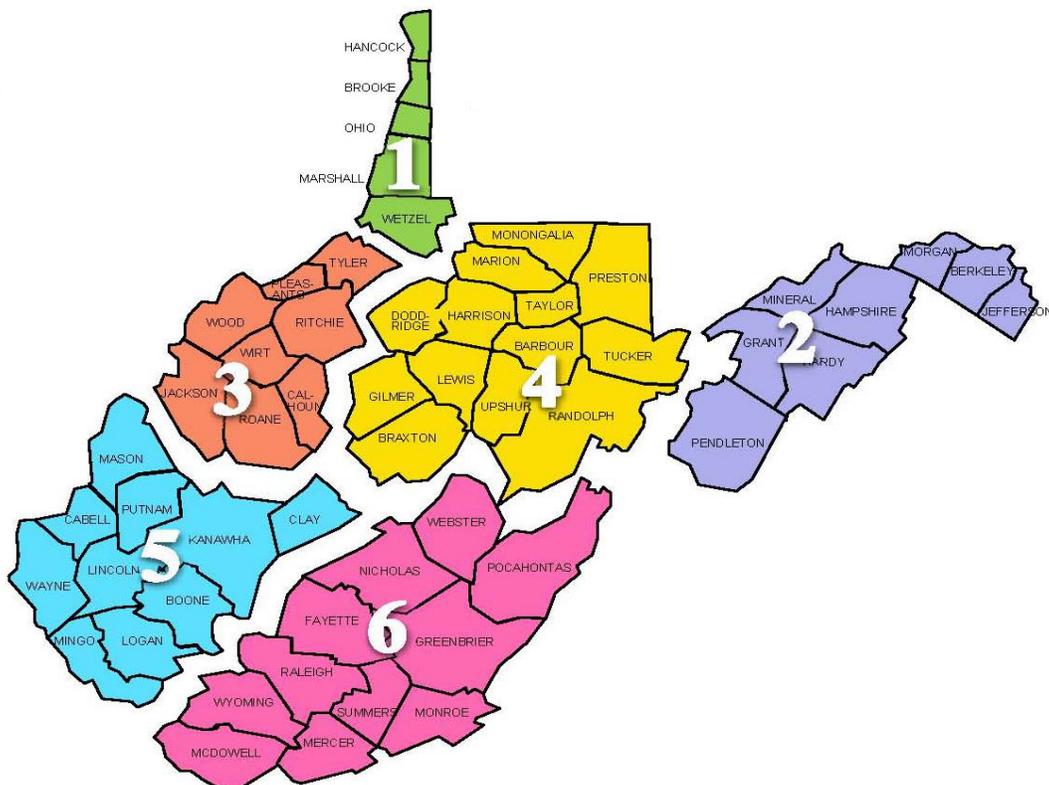
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

Region 3: Tyler, Pleasants, Wood, Ritchie, Wirt, Jackson, Roane, and Calhoun Counties

Region 4: Monongalia, Marion, Preston, Doddridge, Harrison, Taylor, Barbour, Tucker, Gilmer, Lewis, Upshur, Randolph, and Braxton Counties

Region 5: Mason, Cabell, Putnam, Kanawha, Clay, Wayne, Lincoln, Boone, Mingo, and Logan Counties

Region 6: Webster, Nicholas, Pocahontas, Fayette, Greenbrier, Raleigh, Summers, Monroe, Wyoming, McDowell, and Mercer Counties



Section One: INTRODUCTION

The West Virginia Department of Health and Human Resources' Bureau for Behavioral Health and Health Facilities (BBHFF) envisions healthy communities where integrated resources are accessible for everyone to achieve wellness, personal goals and a self-directed future. The mission of the Bureau is to ensure that West Virginians with mental health and/or substance use disorders, intellectual/developmental disabilities, chronic health conditions or long term care needs experience quality services that are comprehensive, readily accessible and tailored to meet individual, family and community needs.

Within the Bureau, the Programs and Policy Section provides oversight and coordination of policy, planning, development, funding and monitoring of statewide community behavioral health services and supports. Emphasis is placed on function rather than disability, and improving planning and cooperation between facility and community-based services. Programs and Policy includes the Division on Alcoholism and Drug Abuse, Division of Adult Mental Health, Division of Child and Adolescent Mental Health, Division of Intellectual and Developmental Disabilities, and the Office of Consumer Affairs and Community Outreach.

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are important components of the systems of care surrounding each person. The role of the Bureau is to provide leadership in the administration, integration and coordination of the public behavioral health system. The work is informed by results of a multi-year strategic planning process that includes critical partners in planning, funding and delivering services and supports.

The following Strategic Priorities guide services and service continuum development:

Behavioral Health Prevention, Treatment and Recovery System Goals	
<i>Priority 1 Assessment and Planning</i>	<i>Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.</i>
<i>Priority 2 Capacity</i>	<i>Build the capacity and competency of WV's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.</i>
<i>Priority 3 Implementation</i>	<i>Increase access to effective behavioral health prevention, early identification, treatment and recovery management that is high quality and person-centered.</i>
<i>Priority 4 Sustainability</i>	<i>Manage resources effectively by promoting good stewardship and further development of the WV behavioral health service delivery system.</i>

Section Two: FINANCIAL, LEGAL, & PROGRAMMATIC DESCRIPTION

Justice Reinvestment in West Virginia

Overview excerpted from the Justice Center, Council of State Governments website <http://csjusticecenter.org/jr/wv/>

Between 2000 and 2009, the number of people in West Virginia's prisons increased at a rate triple the national average, while the state's resident population remained flat. With the prison population expected to increase 24 percent by 2018, the state projected that accommodating this growth would cost at least \$200 million in construction costs and \$150 million in operating costs between 2013 and 2018.

In 2012, the CSG Justice Center began working with state leaders in West Virginia to develop data-driven, consensus-based policy options designed to reduce corrections spending and increase public safety. CSG Justice Center experts conducted a comprehensive analysis of West Virginia's criminal justice data and interviewed stakeholders across the criminal justice system to identify challenges facing the state:

- *The biggest driver of growth in the state's prison population between 2007 and 2011 is the number of people whose community-based supervision has been revoked, which is compounded by the length of time they spend in prison once re-incarcerated.*
- *The number of people who complete their sentence in prison and return to the community without any post-release supervision has increased significantly during the same period. Inefficiencies in correctional intake and parole decision-making processes contribute to this trend.*
- *Failure to adhere to the terms of probation or parole often stems from an individual's substance use and addiction needs and contributes to the growing prison population. Few of those under supervision receive treatment in their communities.*

West Virginia's justice reinvestment framework includes policies designed to address these challenges. Senate Bill (SB) 371, the legislation incorporating these policies, was signed into law in May 2013. Among other things, SB 371:

- *Strengthens community-based supervision by requiring supervision agencies to use risk assessments to ensure that supervision practices focus on individuals most likely to reoffend and respond to probation and parole violations with swift, certain, and more cost-effective sanctions;*
- *Increases accountability by mandating that people convicted of violent offenses receive one year of supervision upon release from prison and by permitting judges the discretion*

to order that people convicted of nonviolent offenses and not previously paroled to serve the last 180 days of their sentences under community supervision;

- *Streamlines correctional system processes by requiring the use of a pretrial screening instrument in jails that predicts risk of flight and risk of reoffending and by requiring the West Virginia Parole Board to interview parole-eligible individuals whose paperwork is not yet complete; and*
- *Expands access to substance abuse treatment by creating a new “treatment supervision” sentencing option that provides substance abuse treatment to individuals under supervision and by expanding the use of drug courts throughout the state by 2016.*

These policies are projected to avert up to an estimated \$200 million in construction costs and \$87 million in operating costs between 2014 and 2018. SB 371 also positions West Virginia to reinvest \$3 million of the projected savings into substance abuse treatment for people under community supervision in FY2014. At the state’s request, the CSG Justice Center continues to provide assistance in the implementation of these policies.

http://www.legis.state.wv.us/Bill_Text_HTML/2013_SESSIONS/RS/pdf_bills/SB371%20SUB2%20ENR%20PRINTED.pdf

Implementation Planning

The implementation of the Justice Reinvestment Act (JRA) will provide a foundation for change in serving the criminal justice population effectively and efficiently. The WV DHHR, Bureau for Behavioral Health and Health Facilities and the WV DMAPS, Division of Justice and Community Services were asked by the Office of the Governor to develop an action plan required for implementation of the treatment supervision sentencing option as outlined in the JRA. The partnership focuses on engagement of behavioral health service treatment providers, and provision of targeted training for offender populations. The increased collaboration between providers and community corrections professionals will expand effective substance use treatment services and reduce recidivism among the offender population. This collaborative approach to services development and coordination forges a long overdue partnership and avoids service system duplication. Extensive research on national best practice, key stakeholder interviews and data analysis were used to inform this treatment supervision implementation plan. It is important that national, state and local efforts be considered in the development and alignment of service systems.

The purpose of the West Virginia Justice Reinvestment Treatment Supervision Implementation Plan is to set forth strategies to reduce recidivism of offenders with substance use disorders, thus decreasing the overrepresentation of individuals with behavioral health disorders within the recidivist population. This will be accomplished through the development of a common structure for community supervision agencies and behavioral health treatment providers in an

effort to enhance collaborative partnerships and coordinate care for offenders being supervised in the community. Senate Bill 371 provides a foundation for the development of a joint plan between the Department of Military Affairs and Public Safety (DMAPS) and the Department of Health and Human Resources (DHHR) to implement an effective system of treatment supervision for high risk felons with substance use need.

Understanding the Need

According to the Substance Abuse Mental Health Services Administration (SAMHSA), Director Pam Hyde states in her presentation, Behavioral Health and Criminal Justice: Challenges and Opportunities, half of all incarcerated people have mental health problems; sixty percent have substance use disorders and one third have both. Two thirds of people in prison meet the criteria for substance use disorders yet less than fifteen percent receive treatment after admission. Twenty four percent of individuals in state prisons have a recent history of mental illness yet only thirty four percent receive treatment after admission. Over 700,000 federal and state prisoners are released to communities in the United States every year. Correctional behavioral health problems become community behavioral health problems.

The treatment supervision sentencing option was designed to address several issues identified by the Justice Center. They concluded that more intensive treatment options are needed at the community correctional level. They further identified a need for more robust sanction options for violating the terms of community supervision besides incarceration. Between 2005 and 2011, revocations from community supervision increased by 47 percent at a cost of \$150 million in incarceration costs from 2007 to 2011.

For offenders who demonstrate a high risk of recidivism, treatment supervision serves as an option of first resort. If a sentencing judge determines that substantial behavioral health issues are driving a criminal's behavior, he or she may utilize the high level of treatment services afforded by this option as an alternative to incarceration. This option may also be used for parolees who demonstrate similar behavioral health issues prior to release.

In addition, this option may also be utilized as an alternative to revocation from community supervision. If a judge or the parole board concludes that an offender's violation of their community supervision was driven by behavioral health issues, treatment supervision may serve as an alternative to revocation.

The offender population will now have greater access to healthcare coverage through health insurance exchanges and Medicaid expansion. There will be more opportunities to coordinate new health coverage with other efforts targeted at the offender population. Addressing

behavioral health needs can reduce recidivism and expenditures in the criminal justice system while increasing public health and safety outcomes.

<http://store.samhsa.gov/product/Behavioral-Health-and-Criminal-Justice-Challenges-and-Opportunities/SMA12-PHYDE072112>

Key Implementation Plan Recommendations and Strategies

To better understand the scope of work that is being undertaken at all levels within the justice system and to align and complement those efforts the following recommendations were developed. These recommendations will guide efforts to fully and effectively develop statewide capacity to serve offenders as part of reentry efforts.

1. Guide quality improvement and capture consistent process and outcomes through shared assessment, evaluation and information sharing practices across the criminal justice system by:

- Developing system and project-wide information sharing protocols among/ between justice services and community service providers
- Creating a single dashboard for capturing consistent agreed upon measures providing a readily accessible snapshot of performance and cost savings. (see example, Vermont Model)
- Building on extant DJCS: Office of Research and Strategic Planning (ORSP) quality assurance processes to ensure adherence to risk-need-responsiveness principles
- Utilizing standardized fidelity measures for implementing assessments and service delivery
- Enrolling all treatment providers in the LS/CMI online system and Online Learning Management System to administer and track (re)certifications of all training requirements
- Implement a standardized treatment planning document, to compliment and provide supplementary information for LS/CMI case plans

2. Improve person-centered, individualized care for offenders with behavioral health needs by implementing evidence-based programs and practices by:

- Administering Clinical assessments would be given to 100% of individuals prior to sentencing and release who are considered for community treatment and support services
- Providing consistent evidence based practices (EBP) training and interventions across the criminal justice and behavioral health systems
- Building on existing quality assurance systems to improve monitoring of assessment quality, case plans, provider/Day Report Center (DRC) staff credentials, and outcomes

3. *Ensure that all behavioral health and criminal justice providers/facilities (jails, prisons, drug courts, day report centers) offer a consistent continuum of assessment, treatment and community peer/recovery support services by:*

- Conducting consistent risk/needs and clinical assessments in all systems to individuals at risk for substance use/co-occurring disorders
- Offering consistent behavioral health services individuals diagnosed with substance use/co-occurring disorders
- Assigning 100% of individuals considered for community supervision a peer recovery/support specialist prior to release from any institution and/or upon placement into community corrections directly
- Providing funding targeted to engagement and out- patient services
- Providing targeted funding for community peer/recovery support services
- Providing funding targeted to recovery residences to provide safe and stable housing for individuals in community support services

4. *Improve consistency in community and peer support expansion by enhancing the monitoring and supervision of local day report centers by:*

- Developing a clear policy framework for the implementation of treatment supervision
- Co-monitor behavioral health services in coordination with BBHFF

Section Three: **SERVICE DESCRIPTION**

Justice Reinvestment Act: Treatment Supervision Implementation

Target Population: Adults men and women (ages 18+) convicted of a felony crime who demonstrate a high risk to reoffend coupled with a need for substance use treatment

Purpose

The Bureau for Behavioral Health and Health Facilities (BBHFF) supports evidence-based practices that promote social and emotional wellbeing, prevention approaches, person-centered interventions and self-directed and/or recovery driven support services. **Recovery** is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in the community, while striving to achieve their full potential.

This initiative will utilize the following service definitions to guide service development: Outpatient and Intensive Support Services, Community Support Services and Recovery Support Services. **Table 1** provides a list of eligible services for project development, while **Appendix A** provides additional service guidance.

The Bureau for Behavioral Health and Health Facilities' (BBHFF) purpose for **Justice Reinvestment Act: Treatment Supervision Implementation** throughout West Virginia is to:

1. Develop and provide access to customized, community based services and supports for the target population;
2. Reduce recidivism of the individuals who are engaged in services; as well as;
3. Develop and maintain an effective, statewide continuum of care to address the unique treatment and recovery needs of the target population.

Service Overview

Due to barriers most often associated with community re-entry, a two-phase approach has been adopted to support gradual and carefully monitored implementation; these projects represent the second phase of implementation. With over nine million individuals cycling through jails in the United States each year and two thirds of state prisoners rearrested within three years of release, this graduated process is necessary to support comprehensive systems change. Collaboration among community based behavioral health providers and community corrections professionals will be the key to successful program implementation. Through cross-training opportunities and intense technical assistance monitoring, the capacity of phase one

treatment providers has been increased. These highly trained individuals will serve as mentors and share lessons learned with phase two providers. Data collected during the first phase will also help inform and improve future and on-going practice.

The selection of pilot sites was guided by information made available through the WV Department of Military Affairs and Public Safety, Division of Justice and Community Services, Division of Corrections, Regional Jail Authority, the WV Supreme Court of Appeals and the WV Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities. Given the collaboration set forth in SB 371, §62-15-6a (d) regarding the interface between the DJCS and the Governor's Advisory Council on Substance Abuse, the Governor's six regions have been utilized to support alignment of all substance use system development initiatives.

Eligible Service Designations

Table 1 provides a list of eligible services for project development and maximum funding availability for each service, while **Appendix A** provides additional service guidance. **Table 2** identifies eligible service recommendations by region that may be proposed by applicants. Funding availability and service designations were determined based on the review of projected individuals entering community supervision, current treatment service availability and provider capacity to provide all indicated services. **Organizations may apply for one or multiple services but are encouraged to demonstrate partnership efforts in the county/region through the development of collaborative, interagency proposals.** Applicants who intend to apply for multiple projects in a county/region will only need to complete one (1) proposal when applying for multiple services.

Example1: *A Day Report Center enters into a partnership with the Substance Use Treatment Provider and a Faith Based Organization to propose development of an Out-Patient/Intensive Support site, Community Engagement Specialist position and Recovery Residence Level I. In this instance, one (1) application could be submitted for all services with a total application of \$220,000.00 based on service funding availability.*

Example2: *A Substance Use Treatment Provider is capable of offering all eligible services within the county/region. In this instance, one (1) application could be submitted for all services, however Memoranda of Understanding with the required community partners must be developed as part of the application process.*

Table 1 Eligible Service for Project Development and Funding Availability

Eligible Services for Project Development	
Outpatient & Intensive Support Services	Outpatient and Intensive Support Services site development with service capacity for those who are not Medicaid eligible/uninsured <i>See Appendix A. Service Definitions/ Credentials</i>
Maximum: \$50,000.00 per site	
Community Support Services: Community Engagement Specialists	Addition of Community Engagement Specialists to provide community support services <i>See Appendix A. Service Definitions/ Credentials</i>
Maximum: \$45,000.00 per position	
Recovery Support Services: Recovery Housing	Level II. 8-15 bed recovery facility with recovery supports Level III. 60-100 bed recovery facility with recovery supports <i>See Appendix A. Service Definitions/ Credentials; See Appendix B. Recovery Residence Standards</i>
Maximum: Level II-\$125,000.00 / Level III-\$300,000.00	
Recovery Support Services: Peer (Recovery) Coaching	Addition of Peer (Recovery) Coach staff to provide on-going recovery support services <i>See Appendix A. Service Definitions/ Credentials</i>
Maximum: \$35,000.00 per position	

Table 2 Eligible Service Recommendations by Region

Region	Preferred Site Location	Service Selection
One	Hancock	1 Recovery Residence Level III
Two	Morgan, Berkeley, Jefferson, Mineral	2 FTE Recovery Coach
Four	Monongalia	1 Site OP/IS
		1 FTE Community Engagement Specialist
		1 FTE Recovery Coach
	Harrison, Lewis, Randolph	1 Site OP/IS
Six	Greenbrier	1 Site OP/IS
		1 FTE Community Engagement Specialist

Collaborations and Memorandums of Understanding

Applicants must demonstrate that a coordinated and integrated service system is in place to meet the complex needs of the target population. In so doing, Memoranda of Understanding (MOUs) ***must*** be completed with key partnering agencies indicated (*), as well as other organizations, which may include but is not restricted to:

- Local Public Housing Authorities*
- Behavioral Health (Substance Use, Mental Health, I/DD)*
- Primary Health / Health Departments*
- Hospitals
- Obstetric/Gynecological, if applicable*
- Pediatric, if applicable
- Childcare, if applicable*
- Medication Assisted Treatment (MAT) Providers, if applicable
- Family Assistance Programs
- Early Intervention and Home Visiting Programs
- Family and/or Drug Courts*
- Criminal Justice Systems*
- Employment, Education and/or Vocational programs
- Recovery Support Network/Community/Services*

Training Requirements

According to SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, there are specific evidence-based programs and practices which have been deemed effective for treating substance use and dependence among the offender population. Cross-training among criminal justice and behavioral health providers who share responsibility for supervision and treatment of offenders in the community is critical. An offender population has unique characteristics that contribute to their risk for reoffending and it is important that community behavioral health providers are well-versed in the principles and treatment strategies associated with effective correctional intervention.

All awarded applicants will be required to participate in grantee orientation training and will also attend training in a minimum of one (1) evidenced based curriculum to be determined by the planning and implementation team. Travel costs for essential program staff attending the required grantee training ***must*** be included in the budget for five (5) days in Charleston, not to exceed more than \$1075 per person. Additional trainings will be covered by the funding organizations. Required trainings include:

- Cognitive Behavioral Therapy

- Offender Risk Assessment
- Motivational Interviewing
- Relapse Prevention
- Medication Assisted Treatment
- Offender Case Coordination
- Clinical Assessment
- Criminogenic Risk/Need & Principles of Effective Correctional Intervention
- Community and Peer Based Supports

Section Four: **PROPOSAL INSTRUCTIONS / REQUIREMENTS**

Eligible applicants must provide proof of a valid West Virginia business license and comply with all requirements provided within this AFA. All proposals will be reviewed by the BBHF staff for administrative compliance. Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline will not be reviewed. A Statement of Assurance agreeing to these terms is required of all proposal submissions to BBHF. This statement must be signed by the applicant organization's CEO, CFO, and Project Officer. All applications passing the administrative review will be subsequently forwarded to an independent grant review team which will score the proposal narrative consisting of five areas:

- A. Population of Focus and Statement of Need (10 points)
- B. Proposed Evidence-Based Service/Practice (20 points)
- C. Proposed Implementation Approach (50 points)
- D. Staff and Organizational Experience (10 points)
- E. Data Collection and Performance Measurement (10 points)

Proposal Abstract – All proposals must include a one-page proposal abstract. The abstract should include the project name, description of the population to be served, planned strategies/interventions, and a general overview of service goals and measurable objectives, including the number of people projected to be served annually. Proposal abstracts may be used for governmental reports and public release. As such, all applicants are encouraged to provide a well-developed abstract document that does not exceed the line limit; see **Table 3** for guidelines.

Proposal Narrative – The Proposal Narrative describes your project. It consists of Sections A through E. Sections A-E together may not exceed the page limit; see **Table 3** for guidelines. Applicants ***must utilize*** 12pt. Arial or Times New Roman font, single line spacing, and one (1) inch margins. Page numbers must also be included as a footer.

Supporting Documentation – The Supporting Documentation provides additional information necessary for the review of your proposal. It consists of Sections F and G. These documents and/or attachments will not be counted towards the Proposal Narrative page limit; however, Section F and G together may not exceed the page limit; see **Table 3** for guidelines.

Maximum number of pages permitted for proposal submission is provided in **Table 3**; limits for the Proposal Narrative and Supporting Documentation must also be upheld. All pages submit as part of the proposal submission will count toward this maximum limit. Materials not requested within this AFA such as cover/heading pages, additional supporting documentation, etc. will be counted. Proposals that exceed this maximum limit and/or the limits established for the Proposal Narrative and Supporting Documentation will not pass the initial administrative review.

Table 3 Formatting Requirements

	Single Service Proposed	Multiple Services Proposed
Abstract	Max. 35 Line	Max. 50 Line
Project Narrative (Section A – E)	Max. 15 Page	Max. 30 Pages
Supporting Documentation (Section F – G)	Max. 20 Page	Max. 40 Page

Section Five: **PROPOSAL OUTLINE**

All proposal submissions must include the following components without exception to be reviewed.

Abstract:

Provide a brief description of the proposed service as earlier set forth in this document.

Proposal Narrative:

A. Population of Focus and Statement of Need: (10 Points)

- Provide a comprehensive demographic profile of the target population in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy, citing relevant data. Identify the source of all data referenced.
- Clearly indicate the proposed geographic area to be served, by Region and County(ies).
- Discuss the relationship of the target population to the overall population in the proposed geographic area to be served citing relevant data. Identify the source of all data referenced.
- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e. current prevalence rates or incidence data) for the target population based on data. Identify the source of all data referenced. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for data that could be used are key informant interviews, newspaper article, focus groups, local epidemiologic data, state data, and/or national data.
- Identify health disparities among the target population relating to access, use, and outcomes of the proposed service citing relevant data. Identify the source of all data referenced.
- Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective substance use and co-occurring substance use and mental health recovery services in the proposed geographic area to be served that is consistent with purpose of the AFA.
- Describe the existing stakeholders and resources in the proposed geographic area to be served which can help implement the needed infrastructure development.
- Include a Reference/Work Cited page for all data referenced within proposal in **Attachment 1**.

B. Proposed Evidence-Based Service/Practice: (20 Points)

- Describe the purpose of the proposed service.
- Clearly state the goals, objectives and strategies for the service. These must relate to

the purpose of the AFA and each of the performance measures identified in Section E: Data Collection and Performance Measurement.

- Describe all evidence-based practice(s) (EBP) that will be used and justify use for the target population, the proposed service, and the purpose of this AFA. To verify/review EBPs visit SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/>
- If an EBP does not exist/apply for the target population and/or service, fully describe practice(s) to be implemented, explain why it is appropriate for the target population, and justify its use compared to an appropriate, existing EBP.
- Describe how the proposed practice(s) will address the following issues in the target population, while retaining fidelity to the chosen practice: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability.
- Identify any screening tools that will be used and basis for selection. Screening tools do not include clinical assessments, admission criteria, or intake data collection instruments. For more information visit SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) 'Screening Tools' website: <http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs>
- Describe how identified behavioral health disparities will be addressed and suggested strategies to decrease the differences in access, service use, and outcomes among the target population. One strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which can be found at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.
- Describe how the applicant organization will ensure cultural competence in service implementation. All BBHFF grantees are required to receive cultural competence training and to ensure that no one will be discriminated against due to race, ethnicity, religion, gender, age, geography or socioeconomic status. All materials associated with awarded funding must be developed at low literacy levels for further understanding and comprehension in WV communities.
- Describe how privacy and confidentiality will be ensured throughout the entirety of the service, including collection and dissemination of data, consumer feedback, etc.

C. Proposed Implementation Approach: (50 Points)

- Provide a one (1) year/twelve (12) month chart or graph depicting a realistic timeline of the service. The timeline must include the key activities and staff(s)/partners responsible for action through all phases including but not restricted to planning/development, implementation, training/consultation, intervention(s)

milestones (EBPs), data collection/reporting, quality assurance, etc. Be sure to show that the project can be implemented and delivery of the service can begin as soon as possible, and no later than six (6) months post award. Note: The timeline should be part of the Proposal Narrative. It should not be placed in an attachment.

- Describe how achievement of the proposed goals, objectives, and strategies identified for the service will produce meaningful and relevant results in the community (e.g. increase access, availability, prevention, outreach, pre-services, treatment and/or recovery) and demonstrate the purpose of the AFA.
- Describe the proposed service activities and how they relate to the goals, objectives and strategies, how they meet the identified infrastructure needs, how they fit within or support the development of the statewide continuum of care.
- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project with a letter of support and/or Memorandum of Understanding (MOU). Include letters of support and MOUs from community organizations and/or partners supporting the project in **Attachment 2**.
- Describe how you will work across systems to ensure that services provided to the target population are coordinated and considered by multiple levels and systems.
- Clearly state the unduplicated number of individuals to be served (annually) with grant funds, including the types and numbers of services to be provided.
- Describe additional training to be sought and utilized in the development of the service, identifying key training components (by title) and their relevance.
- Describe how you will screen and/or assess clients for the presence of co-occurring mental health and substance use disorders and use the information obtained from the screening and/or assessment to facilitate appropriate referral to treatment for the persons identified as having such co-occurring disorders.
- Describe how you will ensure the input of the target population in planning, implementing, and assessing the proposed service. Describe the feedback loop between the target population, the applicant organization, partners/key stakeholders, and the BBHMF in all implementation stages of the project.
- Describe how you will facilitate the health insurance application and enrollment process for eligible uninsured individuals receiving the proposed service. Also describe how you will ensure the utilization of other revenue realized from the provision of substance use treatment and recovery services to the fullest extent possible, using BBHMF grant funds only to serve individuals for whom coverage has been formally determined to be unaffordable; or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of the BBHMF grant funds).

- Identify the potential barriers to successful conduct of the proposed service and describe strategies to overcome them.
- Describe your plan to continue the proposed service after the funding period ends. Also, describe how service 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 the facility(ies) to be utilized, if any, for the service. This includes an existing facility already owned and operated by the applicant organization, or a facility for which the applicant organization has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHMF is available to discuss what options may exist for securing a building or other location in the event that a location is not readily available. If the applicant organization chooses to speak to the BBHMF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any architectural plans or diagrams that may exist may be included in **Attachment 1**

D. Staff and Organization Experience: (10 Points)

- Discuss the capability and experience of the applicant organization. Demonstrate that the applicant organization has linkages to the target population and ties to grassroots/community-based organizations that are rooted in the culture of the target population.
- Provide a complete list of staff positions for the service, including the Project Officer and other key personnel, showing the role of each, their level of effort/involvement and qualifications.
- Discuss how the key personnel have demonstrated experience, are qualified to serve the target population and are familiar with the applicable culture.
- Discuss the applicant organization's current level of participation in the Governor's Regional Substance Abuse Task Force Meetings in the proposed region and document your ability to attend future meetings.

E. Data Collection and Performance Measurement: (10 Points)

- Describe the plan for data collection, management, analysis, and reporting on the required performance measures, as specified in Section Six: Expected Outcomes / Products of this AFA. Specify and justify any additional measures or instruments to be used.
- Describe the data-driven, quality improvement process by which target population disparities in access, use, and outcomes will be tracked, assessed, and reduced.
- Describe how data will be used to manage the service at a systems level to ensure that the goals, objectives, and strategies are tracked and achieved.

- Describe how information related to process and outcomes will be routinely communicated to the target population, staff, governing and advisory bodies, and stakeholders.

Supporting Documentation:

F. Budget Form and Budget Narrative: *All requirements set forth in Section F must be included in **Attachment 3***

- Include a proposed Target Funding Budget (TFB) with details by line item, including sources of other funds where indicated on the TFB form.
 - Include expenses for attending BBHMF-required meetings and trainings.
- Include a Budget Narrative word document with specific details on how funds are to be expended.
 - The Budget Narrative clarifies and supports the TFB. The Budget Narrative should clearly/specify the intent of and justify each line item in the TFB.
- Describe any potential for other funds or in kind support. Please include a description of such funds as a supplement to the Budget Narrative word document.
- Prepare and submit a separate TFB form for any capital or start-up expenses and attach this separate TFB form to the coordinating Budget Narrative word document.
- Additional financial information and requirements are located in **Appendix C**

All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHMF web-site at: <http://www.dhhr.wv.gov/bhhf/forms/Pages/FinancialForms.aspx>
 Targeted Funding Budget (TFB) Instructions available at:
<http://www.dhhr.wv.gov/bhhf/forms/Documents/FY%202014%20BBHMF%20TFB%20Instructions.pdf>

G. Attachments 1 through 3:

- **Attachment 1:** Reference/Work Cited Page (to include all proposal data citations); Facility/site diagrams (if applicable/available)
- **Attachment 2:** Letters of Support / Memorandum's of Understanding (MOU)
- **Attachment 3:** Targeted Funding Budget(s) and Budget Narrative(s)

Section Six: **EXPECTED OUTCOMES / PERFORMANCE MEASURES**

Expected Outcomes:

1. Develop and provide access to customized, community based services and supports for the target population;
2. Reduce recidivism of the individuals who are engaged in services; as well as,
3. Develop and maintain an effective, statewide continuum of care to address the unique treatment and recovery needs of the target population.

Performance Measures:

Submit all data as related to the Expected Outcomes/Performance Measures within 25 calendar days of the end of each month in accordance with applicable BBHf Data Reporting located at <http://www.dhhr.wv.gov/bhhf/Sections/administration/DAT/Pages/measures.aspx>.

Section Seven: TECHNICAL ASSISTANCE

The **Bureau for Behavioral Health and Health Facilities (BBHFF)** in partnership with the **Division of Justice and Community Service (DJCS)** will provide technical assistance to all applicants through a scheduled technical assistance meeting and/or conference call as indicated on Page 1 of this document.

Technical assistance needs may also be submitted via email to: DHHRBHHFAnnouncement@wv.gov. All emailed technical assistance inquiries will be addressed by the BBHFF and posted to a Frequently Asked Questions (FAQ) document on the BBHFF website available at <http://www.dhhr.wv.gov/bhhf/AFA/Pages/default.aspx>.

1. Additional data resources are available at the BBHFF website. Explore 'Links' to all Division Teams, including 'Prevention' with a sample of Substance-Specific Presentations:
<http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Pages/default.aspx>
2. **WV Behavioral Health Profile** (also accessible by clicking 'Resources' on DADA webpage): Contains Statewide data pertaining to behavioral health issues:
http://www.dhhr.wv.gov/bhhf/resources/Documents/2013_State_Profile.pdf
3. **WV County Profiles:** Contains county-level data pertaining to behavioral health issues, uses convenient 'at a glance' format:
<http://www.dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Pages/2014-County-Profiles.aspx>

Appendix A
Service Definitions and Credential Requirements

Outpatient and Intensive Support Services

Why provide Outpatient and Intensive Support Services? Outpatient Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual with mental, substance and other disorders. Intensive Support Services is the use of structured and well planned intentional interventions in the health, behavior, personal and/or family life of an individual with substance use and mental health disorders that require the same daily level of care as residential treatment but the individual has a safe environment to reside during treatment.

What are Outpatient and Intensive Support Services? The Outpatient Services will consist of individualized, evidence-based treatment interventions for the target population. They include the following interventions: individual/family/group therapy, individual/group supportive counseling, service/treatment planning and targeted case management. These interventions can be offered in a one-on-one (individual), group or family group setting. Intensive Support Services (IS) are the provision of outpatient services in a more frequent and structured environment. IS programming is typically 8-12 weeks in length, an upwards of 12 hours of services provided each week. IS programming is intended to offer open/revolving enrollment and include evidence-based programming that accommodates this structure. All services rendered must comply with the WV Bureau for Medical Services (WVBMS) Medicaid Provider Manual for Behavioral Health Clinic and Rehabilitation services. Prior to offering Intensive Support Services (IS) applicants must complete the necessary enrollment and approval process with WVBMS. In addition to clinical services, the provider organization will be responsible for enrolling eligible uninsured individuals for health benefits and seeking reimbursement for treatment services rendered through the appropriate funding sources (WV Medicaid, private insurance). Note: Engagement Services (Assessment) and Medication services are also regularly offered in conjunction with Outpatient and Intensive Support Services.

What Outpatient and Intensive Support Services are not? These services are not peer-to-peer services or community engagement services. Outpatient and Intensive Support Services are strictly treatment services.

Credentials: Individual/group supportive counseling, service/treatment planning and targeted case management require, at minimum, a Bachelor degree in social work, counseling or psychology. Therapeutic services (individual/family/group) require, at minimum, a Master's degree in social work, counseling or psychology.

Community Engagement Services

Why provide Community Engagement Services? Outreach and integrated community supports are necessary for individuals to achieve and sustain recovery in the community. By establishing social networks, income and integrated resources, an individual can live a meaningful life in a community of their choice, striving to achieve their full potential.

What are Community Engagement Services? The Community Engagement Specialist (CES) will work in the community to assist individuals with, substance use and/or co-occurring disorders that are at risk of reoffending and recidivism. Any individual at risk who resides in the grantee's area will be eligible for assistance from the JRI-CES. The JRI-CES will use all available community resources to help improve community integration and promote recovery by addressing the complex needs of eligible individuals. Specifically, the organization/ specialist will:

1. Develop a network of community resources with key stakeholders in order to share and gain knowledge of available resources, identify gaps, and promote development of resources, such as assistance with obtaining medications, housing, employment, benefits, groceries, utilities, official documents, etc.
2. Provide supportive and preventative services, so that the individual can live securely in the community of their choice
3. Facilitate successful transitions for individuals between correctional facilities and communities
4. Ensure, through intensive follow up and support, that individuals are surrounded by community resources that will strengthen their recovery and resilience in the community

What Community Engagement Services are not? The JRI-CES has a separate and distinct role from crisis services, targeted case management, outpatient therapy, and peer/recovery support specialist. The JRI-CES will not be performing billable activities and will not be providing staff coverage in other programs such as those listed above. The JRI-CES is expected to carry a caseload of 20-30 individuals.

Credentials: Require, at minimum, a high school degree or recognized equivalent

Recovery Residences

Why provide Recovery Residences? Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice, while striving to achieve their full potential. Peer support, community meetings, such as AA/NA and safe and sober living environments, are effective components of the process.

What is a Recovery Residence? Recovery Residences are considered “Non-Treatment”, and are sometimes referred to as “Transitional Living”, “Oxford Houses” and “Recovery Homes or Facilities”. These facilities provide safe housing for adults (aged 18+) who are in/seeking recovery from substance use and/or co-occurring disorders. Residency often follows and/or is provided simultaneously with treatment services and is intended to assist individuals until it is determined they are able to safely transition into a less restrictive environment. Residences are categorized into specific levels of care. All residences must:

1. Provide residents with knowledge of and access to substance use and co-occurring services that are available to aid with their recovery
2. Integrate health, wellness and resiliency into other existing services
3. Increase the numbers of residents served that are gainfully employed and or participating in self-directed employment and educational endeavors
4. Increase the numbers of residents served who transition from the program into the community with safe and stable housing
5. Increase the numbers of residents served that attend recovery support meetings, behavioral health services, volunteer activity, drug/alcohol abstinence and participation with all conditions of community placement
6. Establish culturally and linguistically appropriate integrated models of care

What is the difference between a Level II and Level III Recovery Residence?

Key components of a Level II Recovery Residence include but are not restricted to: House rules provide structure, Peer run groups, Drug Screening, House meetings, and Involvement in self-help and/or treatment services. These facilities are primarily single family residences, possibly apartments or other dwelling types. **Staff positions** for a Level II Recovery Residence include but are not restricted to a House manager or senior resident; staff must have no active or pending legal involvement.

Key components of a Level III Recovery Residence include but are not restricted to: drug screening, house/resident meetings, mutual aid/self-help meetings, structured house/resident rules, peer-run groups, life skill development emphasis, and clinical treatment services accessed and utilized within the community. **Staff positions** for a Level III Recovery Residence include but are not restricted to a Facility Manager, Peer (Recovery) Coach, Case Manager(s), and other Certified Peer staff; staff must have no active or pending legal involvement.

Peer (Recovery) Coaching

Why provide Peer (Recovery) Coaching? Peer (Recovery) Coaching is strength-based supports for persons in or seeking recovery from behavioral health issues. Peer Coaching is a partnership where the person in or seeking recovery self directs his/her recovery while, the coach provides expertise in supporting successful change. Peer Coaching focuses on achieving any goals important to the individual. The coach asks questions and offers suggestions to help the person begin to take the lead in addressing their recovery needs. Peer Coaching focuses on honoring values and making principle-based decisions, creating a clear plan of action, and using current strengths to reach future goals. The coach serves as an accountability partner by helping the person sustain his or her recovery.

What is a Peer (Recovery) Coach? A Peer (Recovery) Coach is a person with lived experience who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovering community, and serves as a navigator and mentor in the management of personal and family recovery. More specifically the coach will:

1. Help to initiate and sustain an individual/family in their recovery from substance use and/or co-occurring disorders
2. Promote recovery by removing barriers and obstacles to recovery
3. Serve as a personal guide and mentor for people seeking, or already in recovery
4. Help an individual find resources for harm reduction, detox, treatment, family support and education, local or online support groups; or help someone create a change plan to recover on their own
5. Help individuals find ways to stop using (abstinence), or reduce the harm associated with addictive behaviors

What Peer (Recovery) Coaches are not? Peer Coaches do not address the past, do not address trauma and there is little emphasis on feelings. Peer Coaches are unlike licensed addiction counselors in that coaches are non-clinical and do not diagnose or treat addiction or any mental health issues, but coaches may assist the individual to access clinical services.

Credentials: Require, at minimum, a high school degree or recognized equivalent; lived experience with substance use challenges (history of criminal justice involvement preferred); involved with a personal support and/or recovery system; reside in stable, recovery-oriented housing the last six (6) months; have no legal involvement within the last six (6) months and/or pending legal issues; no intensive behavioral health treatment involvement within the last six (6) months, including intensive services, crisis stabilization/detoxification services, residential treatment services and/or psychiatric hospitalization.

Appendix B
Required Level II and III Recovery Residence Standards

The West Virginia Bureau for Behavioral Health and Health Facilities (BBHFF), in order to better assure that recovering individuals have safe, recovery-oriented, habitual housing requires adherence to the following Substance Use Recovery Residence Standards for its grantees. All Recovery Residences must be managed in an ethical, honest, and reasonable fashion.

The process of establishing and monitoring minimum standards is an evolving one, intended to elevate the quality of Recovery Residences. There are six major components of the standards which broadly include (1) Organizational/Administrative, (2) Fiscal Management, (3) Operational, (4) Recovery Support, (5) Property and (6) Good Neighbor Standards.

The following are the **Level II Recovery Residence** standards:

1. Organizational/Administrative Standards
1.1 The Recovery Residence is a legal business entity, as evidenced by a business license or incorporation documents;
1.2 The Recovery Residence has a written mission statement and vision statement;
1.3 The Recovery Residence has a written code of ethics;
1.4 The Recovery Residence property owners/operators carry general liability insurance;
1.5 The Recovery Residence complies with State and Federal requirements, including licensure or certification;
1.6 The Recovery Residence clearly identifies the responsible person(s) in charge of the Recovery Residence to all residents;
1.7 The Recovery Residence clearly states the minimum qualifications, duties, and responsibilities of the responsible person(s) in a written job description and/or contract;
1.8 The Recovery Residence provides a drug and alcohol free environment;
1.9 The Recovery Residence collects and reports accurate process and outcome data for continuous quality improvement;
1.10 The Recovery Residence has written permission from the owner of record to operate a Recovery Residence on their property;
2. Fiscal Management Standards
2.1 The Recovery Residence maintains an accounting system that fully documents all resident financial transactions, such as fees, payments and deposits;
3. Operation Standards
3.1 The Recovery Residence posts emergency procedures (including evacuation maps, emergency numbers) and staff emergency contact information in conspicuous locations;
4. Recovery Support Standards
4.1 The Recovery Residence maintains a staffing plan;
4.2 The Recovery Residence use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery;
4.3 The Recovery Residence adheres to all applicable confidentiality laws;
4.4 The Recovery Residence keeps resident records secure, with access limited to authorized staff only;

4.5 The Recovery Residence has a posted grievance policy and procedure for residents;
4.6 The Recovery Residence creates a safe, structured, and recovery supportive environment through written and enforced residents' rights and requirements;
4.7 The Recovery Residence has an orientation process that clearly communicates residents' rights and requirements prior to them signing any agreements; collects demographic and emergency contact information and provides a new resident with written instructions on emergency procedures and staff contact information;
4.8 The Recovery Residence fosters mutual supportive and recovery-oriented relationships between residents and/or staff through peer-based interactions, events, and/or other social activities;
4.9 The Recovery Residence fosters recovery-supportive, alcohol and drug-free environments through written and enforced policies and procedures that address: residents who return to alcohol and/or drug use; hazardous item searches; drug-screening and/or toxicology protocols; and prescription and non-prescription medication usage and storage;
4.10 The Recovery Residence encourages each resident to develop and participate in their own personalized recovery plan;
4.11 The Recovery Residence informs residents of the wide range of local treatment and recovery support services available to them, including: 12-step or other mutual support groups, recovery community centers, recovery ministries, recovery-focused leisure activities and recovery advocacy opportunities;
4.12 The Recovery Residence provides nonclinical, recovery support and related services;
4.13 The Recovery Residence encourages residents to attend mutual supportive, self-help groups and/or outside professional services;
4.14 The Recovery Residence provides access to scheduled and structured peer-based services, such as didactic presentations;
4.15 The Recovery Residence provides access to 3 rd party clinical services in accordance with State laws;
5. Property Standards
5.1 The Recovery Residence abides by all local building and fire safety codes;
5.2 The Recovery Residence provides each resident with food and personal item storage;
5.3 The Recovery Residence places functioning fire extinguishers in plain sight and/or in clearly marked locations;
5.4 The Recovery Residence has functioning smoke detectors installed. If the residence has gas appliances, functioning carbon monoxide detectors are also installed;
5.5 The Recovery Residence provides a non-smoking living environment;
5.6 The Recovery Residence has a community room large enough to accommodate house meetings and sleeping rooms that adhere to Local and State square footage requirements;
5.7 The Recovery Residence has at least one sink, toilet, and shower per six residents or adhere to Local and State requirements;
5.8 The Recovery Residence has laundry services that are accessible to all residents;
5.9 The Recovery Residence maintains the interior and exterior of the property in a functional, safe and clean manner, that is compatible with the neighborhood;
5.10 The Recovery Residence has a meeting space that accommodates all residents;
5.11 The Recovery Residence has appliances that are in working order and furniture that is in good condition;
5.12 The Recovery Residence addresses routine and emergency repairs in a timely fashion;
6. Good Neighbor Standards
6.1 The Recovery Residence provides neighbors with the responsible person(s) contact information upon request. The responsible person(s) responds to neighbor's complaints, even if it is not possible to resolve the issue. All neighbor complaints and responsible person(s) response and actions must be documented;
6.2 The Recovery Residence has rules regarding noise, smoking, loitering, and parking that are responsive to

neighbor's reasonable complaints;

6.3 The Recovery Residence has and enforces a parking courtesy rule in areas where street parking is scarce;

The following are the **Level III Recovery Residence** standards:

1. Organizational/Administrative Standards
1.1 The Recovery Residence is a legal business entity, as evidenced by business license or incorporation documents;
1.2 The Recovery Residence has a written mission statement and vision statement;
1.3 The Recovery Residence has a written code of ethics;
1.4 The Recovery Residence property owners/operators carry general liability insurance;
1.5 The Recovery Residence complies with State and Federal requirements, including licensure or certification;
1.6 The Recovery Residence clearly identifies the responsible person(s) in charge of the Recovery Residence to all residents;
1.7 The Recovery Residence clearly states the minimum qualifications, duties, and responsibilities of the responsible person(s) in a written job description and/or contract;
1.8 The Recovery Residence provides a drug and alcohol free environment;
1.9 The Recovery Residence collects and reports accurate process and outcome data for continuous quality improvement;
1.10 The Recovery Residence has written permission from the owner of record to operate a Recovery Residence on their property;
2. Fiscal Management Standards
2.1 The Recovery Residence maintains an accounting system that fully documents all resident financial transactions, such as fees, payments and deposits;
3. Operation Standards
3.1 The Recovery Residence posts emergency procedures (including evacuation maps, emergency numbers) and staff emergency contact information in conspicuous locations;
4. Recovery Support Standards
4.1 The Recovery Residence maintains a staffing plan;
4.2 The Recovery Residence use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery;
4.3 The Recovery Residence adheres to applicable confidentiality laws;
4.4 The Recovery Residence keeps resident records secure with access limited to authorized staff only;
4.5 The Recovery Residence has a grievance policy and procedure for residents;
4.6 The Recovery Residence creates a safe, structured, and recovery supportive environment as documented by written and enforced residents' rights and requirements;
4.7 The Recovery Residence has an orientation process that clearly communicates residents' rights and responsibilities prior to them signing any agreements; collects demographic and emergency contact information; and, provides each new resident with written instructions on emergency procedures and staff contact information;
4.8 The Recovery Residence fosters mutually supportive and recovery-oriented relationships between residents and/or staff through peer-based interactions, events, and/or other social activities;
4.9 The Recovery Residence fosters recovery-supportive, alcohol and drug-free environments through written and enforced policies and procedures that address: residents who return to alcohol and/or drug use; hazardous item searches; drug-screening and/or toxicology protocols; and, prescription and non-prescription medication usage and storage;

4.10 The Recovery Residence encourages each resident to develop and participate in their own personalized recovery plan;
4.11 The Recovery Residence informs residents on the wide range of local treatment and recovery support services available to them, including: 12-step or other mutual support groups, recovery community centers, recovery ministries, recovery-focused leisure activities and recovery advocacy opportunities;
4.12 The Recovery Residence provides nonclinical, recovery support and related services;
4.13 The Recovery Residence encourages residents to attend mutually supportive, self-help groups and/or outside professional services;
4.14 The Recovery Residence provides access to scheduled and structured peer-based services, such as didactic presentations;
4.15 The Recovery Residence provides access to 3 rd party clinical services in accordance with State laws;
4.16 The Recovery Residence offers life skills development services;
5. Property Standards
5.1 The Recovery Residence abides by all local building and fire safety codes;
5.2 The Recovery Residence provides each resident with food and personal item storage;
5.3 The Recovery Residence places functioning fire extinguishers in plain sight and/or in clearly marked locations;
5.4 The Recovery Residence has functioning smoke detectors installed. If the residence has gas appliances, functioning carbon monoxide detectors are installed;
5.5 The Recovery Residence provides a non-smoking living environment;
5.6 The Recovery Residence has a community room large enough to accommodate house meetings and sleeping rooms that adhere to Local and State square footage requirements;
5.7 The Recovery Residence has one sink, toilet, and shower per six residents or adhere to Local and State requirements;
5.8 The Recovery Residence has laundry services that are accessible to all residents;
5.9 The Recovery Residence maintains the interior and exterior of the property in a functional, safe and clean manner, that is compatible with the neighborhood;
5.10 The Recovery Residence has a meeting space that accommodates all residents;
5.11 The Recovery Residence has appliances that are in working order and furniture that is in good condition;
5.12 The Recovery Residence addresses routine and emergency repairs in a timely fashion;
6. Good Neighbor Standards
6.1 The Recovery Residence provides neighbors with the responsible person(s) contact information upon request. The responsible person(s) responds to neighbor's complaints, even if it is not possible to resolve the issue. All neighbor complaints and responsible person(s) response and actions must be documented;
6.2 The Recovery Residence has rules regarding noise, smoking, loitering, and parking that are responsive to neighbor's reasonable complaints;
6.3 The Recovery Residence has and enforces a parking courtesy rule where street parking is scarce.

Appendix C
Other Financial Information

Allowable Costs:

Please note that Departmental Policies are predicated on requirements and authoritative guidance related to Federal grants management and administrative rules and regulations, Grantees shall be required to adhere to those same requirements when administering other DHHR grants or assistance programs, the source of which is non-Federal funds (e.g. state-appropriated general revenue and appropriated or non-appropriated special revenue funds) unless specifically provided direction to the contrary.

Cost Principles:

For each kind of grantee organization, there is a set of Federal cost principles for determining allowable costs. Allowable costs are determined in accordance with the cost principles applicable to the organization incurring the costs. The following chart lists the kinds of organizations and the applicable cost principles. The Grantee agrees to comply with the applicable cost principles as set forth below.

If the Grantee is a:	OMB Circulars Codified at:
State, local or Indian tribal government use the cost principles in OMB Circular A-87 .	DHS codified at 45 C.F.R. § 92 and 45 C.F.R. § 95 USDA codified at 7 C.F.R. § 3016 ; EDUC codified at 34 C.F.R. § 80 ; EPA codified at 40 C.F.R. § 31 .
Private nonprofit organization other than an (1) institution of higher education, (2) hospital, or (3) organization named in OMB Circular A-122 as not subject to that circular use the cost principles in OMB Circular A-122 .	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ; EDUC codified at 34 C.F.R. § 74 ; EPA codified at 40 C.F.R. § 30 .
Educational Institution use the cost principles in OMB Circular A-21 .	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ; EDUC codified at 34 C.F.R. § 74 ; EPA codified at 40 C.F.R. § 30 .
Hospital use the cost principles in Appendix E of 45 C.F.R. § 74 .	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ; EDUC codified at 34 C.F.R. § 74 ; EPA codified at 40 C.F.R. § 30 .

For-profit organization other than a hospital and an organization named in OMB Circular A-122 as not subject to that circular use the cost principles in 48 C.F.R. pt. 31 Contract Cost Principles and Procedures.	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ; EDUC codified at 34 C.F.R. § 74 ; EPA codified at 40 C.F.R. § 30 .
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Grantee Uniform Administrative Regulations:

For each kind of grantee organization, there is a set of Federal uniform administrative regulations. The following chart lists the kinds of organizations and the applicable uniform administrative regulations for each listed type of grantee.

If the Grantee is a:	OMB Circulars Codified at:
State, local or Indian tribal government use the uniform administrative requirements in OMB Circular A-102 .	Department of Health and Human Services (DHS) codified at 45 C.F.R. § 92 and 45 C.F.R. § 95 ; Department of Agriculture (USDA) codified at 7 C.F.R. § 3016 ; Department of Education (EDUC) codified at 34 C.F.R. § 80 ; Environmental Protection Agency (EPA) codified at 40 C.F.R. § 31 .
Private nonprofit organization, institutions of higher education, or a hospital use the uniform administrative requirements in OMB Circular A-110 .	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ; EDUC codified at 34 C.F.R. § 74 ; EPA codified at 40 C.F.R. § 30 .
For-profit organization use the uniform administrative requirements in OMB Circular A-110 .	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ; EDUC codified at 34 C.F.R. § 74 ; EPA codified at 40 C.F.R. § 30 .