PROJECT APPLICATION FORM

This form is required to be completed in its entirety. **All fields are mandatory**. If not appropriate or applicable, place N/A. Any failure to respond to any question, may result in disqualification. Do not add or delete from this Application Form.

A. Organization Type. Define the primary Applicant's organization type as registered with the State of Nevada Secretary of State Office. *Note: Different funding sources have limits on type of organizations that may receive funding.* If unsure, refer to your business license. **You must check one.**

☐ Public Agency ☐ 501(c)(3) Nonprofit ☐ Private ☐ Higher Education ☐ Tribal

☐ Other, specify _____

B. Geographic Area of Service

COUNTY, STATEWIDE OR BY ZIP CODE. SELECT ONLY ONE AND DESCRIBE IN BOX ADJACENT.	
☐ **CITY, OR ZIP CODE**	
☐ **COUNTY**	
☐ **REGION**	
☐ **STATEWIDE**	

C. Applicant Organization

ALL SECTIONS OF THE APPLICANT ORGANIZATION ARE MANDATORY AND N/A IS NOT ACCEPTABLE. APPLICANTS THAT DO NOT PROVIDE A FEDERAL TAX IDENTIFICATION NUMBER AND A UNIQUE ENTITY IDENTIFIER (UEI) NUMBER WILL BE DISQUALIFIED.		
ORGANIZATION NAME		
MAILING ADDRESS		
PHYSICAL ADDRESS		
CITY		**NV**
ZIP (9-DIGIT ZIP REQUIRED)		
FEDERAL TAX ID #		
UNIQUE ENTITY IDENTIFIER (UEI) NUMBER		

D. Program Manager, Point of Contact

PROGRAM CONTACT IS THE INDIVIDUAL WHO WILL BE RESPONSIBLE FOR THE ACTIVITIES OF THE GRANT (I.E. MEETING SCOPE OF WORK DELIVERABLES).		
NAME		
TITLE		
PHONE		
E-MAIL		
SAME MAILING ADDRESS AS SECTION C? ☐ **YES** ☐ **NO, USE BELOW ADDRESS INFORMATION**		
ADDRESS		
CITY		**NV**
ZIP (9-DIGIT ZIP REQUIRED)		

E. Fiscal Officer

FISCAL CONTACT IS INDIVIDUAL RESPONSIBLE FOR THE BUDGET AND SUBMISSION OF REIMBURSEMENT REQUESTS.		
NAME		
TITLE		
PHONE		
EMAIL		
SAME MAILING ADDRESS AS SECTION C? ☐ **YES** ☐ **NO, USE BELOW ADDRESS INFORMATION**		
ADDRESS		
CITY		**NV**
ZIP (9-DIGIT ZIP REQUIRED)		

F. Key Personnel

KEY PERSONNEL ARE DIRECTLY RESPONSIBLE FOR PROJECT DELIVERABLES. Key personnel are employees, consultants, subcontractors, or volunteers who have the required qualifications and professional licenses to provide the proposed services. The GPRA Coordinator is required.

NAME	TITLE	LICENSED?
	Program Manager (Mandatory Field) If licensed, License Type: License Number:	☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

G. Third Party (e.g. Medicaid) Payer Identification

A RESPONSE OF YES MEANS YOU ARE CURRENTLY ENROLLED AS A PROVIDER AND NOT THAT YOU ARE IN THE PROCESS.	
Are you currently a registered provider with the Division of Health Care Finance and Policy (DHCFP) – Nevada Medicaid?	☐ Yes ☐ No
Are you currently registered as a provider with the Health Plan of Nevada?	☐ Yes ☐ No
Are you currently registered as a provider with United Health Care?	☐ Yes ☐ No
Are you currently registered as a provider with Anthem Blue Cross and Blue Shield?	☐ Yes ☐ No
Are you currently registered as a provider with Silver Summit?	☐ Yes ☐ No
Please identify any other third-party payors billed (e.g., insurance companies) your organization is registered with as a provider type for billing purposes.	

Current provider types (PT) for third-party payors:	
PT 11 Hospital, Inpatient	☐ Yes ☐ No
PT 12 Hospital, Outpatient	☐ Yes ☐ No
PT 13 Psychiatric Hospital	☐ Yes ☐ No
PT 14 Behavioral Health Outpatient	☐ Yes ☐ No
PT 17 Specialty Clinic (e.g. CCBHC, FQHC)	☐ Yes ☐ No
PT 20 Physician	☐ Yes ☐ No
PT 26 Psychologist	☐ Yes ☐ No
PT 32 Community Paramedicine	☐ Yes ☐ No
PT 47 Indian Health Programs and Tribal Clinics	☐ Yes ☐ No
PT 54 Targeted Case Management	☐ Yes ☐ No
PT 60 School Based	☐ Yes ☐ No
PT 63 Residential Treatment Center (RTC)	☐ Yes ☐ No
PT 82 Behavioral Health Rehabilitative Treatment	☐ Yes ☐ No
Other, Please Define:	

H. Certification of Provider

ANSWERS ARE SPECIFIC TO THE ORGANIZATION CERTIFICATION AT THE TIME OF THE SUBMITTAL AND NOT ANY TEAM MEMBER CERTIFICATIONS.	
Are you JCAHO (Joint Commission) Certified?	☐ Yes ☐ No
Are you SAPTA Certified under Nevada Revised Statute (NRS) 458, and Nevada Administrative Code (NAC) 458 *and* do you have a minimum of two (2) years providing substance use disorder treatment?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
OR, are you able to provide memorandums of understanding (MOU)s with community partners who will provide treatment and are able to provide proof of SAPTA certification in good standing?	☐ Yes ☐ No
Please identify any additional certifications your organization (not individuals) holds:	

I. Current Funding (Federal, State, and Private Funding)

FEDERAL, STATE AND PRIVATE FUNDING. PRIVATE FUNDING MAY BE IDENTIFIED AS TOTAL. ANY FEDERAL OR STATE FUNDS MUST BE DETAILED OUT. ADD ROWS AS REQUIRED. THIS INCLUDES ALL FEDERAL OR STATE GRANTS. State grants are not private funding.

Funding	Type	Project Period End Date	Current or Previous Amount Awarded ($)
Example: State Opioid Response Grant	*Grant*	*9/2023*	*$100,000*