

3.2 APPLICATION FORM

Note: A completed Application Form is mandatory. If the Application Form is not completed in full the application may be rejected or for minor deficiencies may receive a 5-point reduction in the scoring total.

Instructions: Complete each item. Add extra rows if more space is needed to provide complete response.

A. Type(s) of Proposed Gambling Treatment Service Outpatient Residential

B. Organization Type For-Profit 501(c)(3) Nonprofit Government Agency

C. Geographic Area of Service (list all locations where in-person services will be provided)

Address(es)	
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D. Applicant Organization

Name		
Mailing Address		
Physical Address		
City & State		Zip (9-digit)
Federal Tax ID #		
State Vender ID #		
Unique Entity ID#		

E. Program Point of Contact

Name		
Title		
Phone		
Email		
Same mailing address as section B? <input type="checkbox"/> Yes <input type="checkbox"/> No, use below address information		
Address		
City		Zip (9-digit)

F. Fiscal Officer

Name & Title	
Phone & Email	

G. Subcontracting of Services

Does your organization subcontract its services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subcontractor	
Mailing Address	
Physical Address	
City	Zip (9-digit)
Federal Tax ID #	

H. Key Personnel

Name	Title	Licensed/Certified? <i>If yes, include copy of licenses/certifications in application</i>
		<input type="checkbox"/> Yes, CGAC or CGAC-I <input type="checkbox"/> Yes, other <input type="checkbox"/> No
		<input type="checkbox"/> Yes, CGAC or CGAC-I <input type="checkbox"/> Yes, other <input type="checkbox"/> No
		<input type="checkbox"/> Yes, CGAC or CGAC-I <input type="checkbox"/> Yes, other <input type="checkbox"/> No
		<input type="checkbox"/> Yes, CGAC or CGAC-I <input type="checkbox"/> Yes, other <input type="checkbox"/> No
		<input type="checkbox"/> Yes, CGAC or CGAC-I <input type="checkbox"/> Yes, other <input type="checkbox"/> No
		<input type="checkbox"/> Yes, CGAC or CGAC-I <input type="checkbox"/> Yes, other <input type="checkbox"/> No

I. Medicaid Payers of Services

Does your organization or its subcontractors bill Medicaid for services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List the names of Nevada Medicaid Enrolled Providers employed or contracted by your organization that would be eligible to bill Medicaid for gambling treatment services.	
If "No" is marked above, do you plan to be able to bill Medicaid for services within the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

J. Third-Party Payers of Services

Does your organization or its subcontractors bill any third-party payers (e.g., insurance companies) for services? <input type="checkbox"/> Yes, specified below <input type="checkbox"/> No			
Third-Party Payers	Period	Billables Received (\$)	Percentage of Operating Income (%)

K. Current Funding

Funding	Type	Project Period End Date	Amount Awarded (\$)

L. Certification by Authorized Official

As the authorized official for the applying agency, I certify that the proposed project and activities described in this application meets all requirements detailed within the Problem Gambling Treatment Services Provider Manual and of the legislation governing the grant as indicated by DHWP and the certifications in the Application Instructions; that all the information contained in the application is correct; that the appropriate coordination with affected agencies and organizations, including subcontractors, took place; that this agency agrees to comply with all provisions of the applicable grant program and all other applicable federal and state laws, current or future rules, and regulations. I understand and agree that any award received as a result of this application is subject to the conditions set forth in the Notice of Subaward and accompanying documents.

Name (type/print)

Phone

Title

Email

Signature

Date

3.3 PROPOSAL NARRATIVE

Instructions: Content defined in this section must be submitted by each applicant. Applicants applying for both outpatient and residential services are required to submit separate proposal narratives for each service category. The outpatient service category encompasses all outpatient gambling treatment services modeling American Society for Addiction Medicine (ASAM) Level 0.5 through Level 2.1. The residential gambling service category is specific to modeling ASAM Level 3.5. The applicant is limited to a total of 20 pages to address the below six proposal narrative sections. Pages must be formatted to use 1.0” margins and 11-point Arial font. The page limits exclude the Application Form (3.2), and attachments required under section 3.1.

Refer to the Nevada Problem Gambling Treatment Services Provider Manual for details about provider standards and expectations. Note only those treatment services with a code and rate within Exhibit 4 of the Provider Manual are eligible for reimbursement with these funds then answer the following questions.

I: Executive Summary (0 points)

Provide an overview of the proposed program or project.

II: Services Provided (40 points)

(a) Describe the services you will provide that fit within the “Nevada Problem Gambling Services Continuum of Care” (as described within the Strategic Plan).

(b) Describe the proposed program’s treatment models and processes from the first point of contact with potential clients through discharge and continued recovery support. (i) Include details about your use of evidence-based practices.

(ii) Describe specific recovery support services, tools, and collateral used within your proposed program.

(iii) Describe measures to assure screening, assessment, and treatment or referral for possible co-occurring substance use disorders, mental health disorders, or physical health issues.

(iv) For individuals receiving assistance from sources outside your program, describe how your program will coordinate care.

(c) If you plan to provide multiple levels of care, estimate the percentage of your clients whose primary course of problem gambling treatment will consist of ASAM Level 1 outpatient care, ASAM Level 2.1 intensive outpatient care, and ASAM Level 3.5 residential treatment.

(d) For Residential Gambling Treatment Applicants Only: Prior experience with Residential Gambling Treatment in Nevada suggests three core program challenges: 1. Difficulty maintaining sufficient staffing levels to support a dedicated and specific gambling treatment track or program; 2. Maintaining a daily client census large enough to hold therapy groups with individuals with a Gambling Disorder primary diagnosis; and 3. Relying on within agency transfers from Residential Substance Use Disorder Treatment into Residential Gambling Disorder Treatment to maintain the program. (a) Describe how your proposed Residential Gambling Treatment Program will address these challenges to create a sustainable service for those in need of residential gambling treatment at an ASAM Level 3.5, and (b) provide details on how your proposed program will meet the Eligibility criteria described on page 6.

III: Population to be Served (15 points)

(a) What geographical area will you serve? Provide service location addresses and indicate whether you will be providing statewide services and if so, explain how. Describe your primary treatment catchment area (Where do you expect most of your clients will come from?), include information about this area such as demographics of the area. As the Las Vegas Metro area is large and populous, if your program is based in the Las Vegas area describe what regions within the metro area you anticipate will form your client base.

(b) Provide a statement of need for the catchment area you propose to serve including current gambling treatment availability and any gaps you propose to fill within the proposed program's catchment area.

(c) Do you plan to target any special populations (e.g., veterans, seniors, traditionally underserved ethnic populations, persons with disabilities, youth)? If so, describe the populations and specific efforts and resources/partners that suggest those efforts will be successful. What led you to target your services in this manner?

IV: Organization and Staff (20 points)

(a) Provide an overview of your organization. How long have you been in business? How has the organization grown through the years? Is there a business plan in place?

(b) Provide a list of key staff members including the executive director, program manager, fiscal manager and program staff. For counselors, indicate whether they are a Certified Problem Gambling Counselor, Certified Problem Gambling Counselor Intern (CPGC-I), or hold other certifications, licensures, credentials, or experience that demonstrates their ability to succeed as a treating clinician for individuals with gambling disorders. If you intend to utilize peer recovery support services, describe your vision for how peer recovery support services will be

incorporated into your program. For all staff, indicate the length of time they have worked in the problem gambling field and for the organization.

(c) To what extent will you use CPGC-I(s) in the provision of service to State subsidized clients? If you will use CPGC-I(s), describe the supervision they will receive.

(d) Does your organization hold any certifications, licenses, or letters of approval as a treatment agency? If so, please provide details. Has your organization ever had disciplinary or legal action taken against it for ethical, legal, or contract violations? If so, please explain.

(e) Provide any additional details about your organization that you believe adds to its credibility as a viable candidate to provide state support gambling treatment services.

V: Support of DHHS Problem Gambling Services FY2024 - FY2027 Strategic Plan’s Treatment System Goals and Enhancement Activities (15 points)

The Strategic Plan includes sections on Nevada’s Problem Gambling Services Framework (Section III) and “Priorities, Goals, Tactics” (Section IV). Describe how the proposed gambling treatment program will contribute to advancing Nevada’s Problem Gambling Service System’s stated goals described under the Section IV headings: advance equity, expand service, engage partners, foster excellence, and promote sustainability.

VI: Funding Request (10 points)

(a) For Current Grantees: Funding for treatment will be allocated based on a formula developed by the BBHWP staff and used in previous years (See Appendix B of the RFA.) Apply this allocation formula by completing the table below for your agency. If you do not have the data available, request the information from your DHHS grant administrator.

Draws from July 2023 through June 2024*	Performance Rating Adjustment** (7/7 performance standards = 10% increase, 6/7 = 5% increase, 5/7 = 0%, 4/7 = (-10%), 3/7= (-20%)	Projected Need for FY26 Award***

*SFY2024 encounter claims data will be utilized in the funding formula for FY2026.

**Performance rating adjustment based on SFY2024 findings as reported in the UNLV International Gaming Institute, Nevada Problem Gambling Study, Annual Report, Fiscal Year 2024.

***This formula will be used as a basis to provide beginning of the year allocations. Recognizing significant program changes may have occurred in SFY2025, other considerations may be factored in

during the post-award budget negotiation period. At least one adjustment each fiscal year will be made to best match available funding with updated grantee claims data. Allocation adjustments may increase or decrease award amounts over the course of the grant period based on grantee claim totals, systemwide claim totals, and available funding.

(a) For New Applicants / Applicants who are Not a Current Grantee: Sharing principles with the funding formula for current grantees, new applicants must base their funding requests on two primary factors; projected number of clients to be served and average cost per problem gambler treatment episode. To calculate funding request, complete the below table:

Funding Request Formula: Applicants who were not gambling treatment grantees in SFY2025

Enrollment Category	Projected Number of Enrollments in SFY 2026	Average Case Cost	Total
Outpatient Gambling Treatment		\$1,596	
Outpatient Concerned Other		\$1,270	
Residential Gambling Treatment		\$2,033	
Total Funds Requested			

Note: Average case cost based on actual data from SFY2024 and were calculated from all enrollments including those who left treatment early against staff advice and successful completers.

Provide a detailed justification for the projected number of clients to be served and how that projection was formulated including assumptions. Cite any applicable historical data, research, or other supporting information.

(b) All Applicants: Grantees are encouraged to support their problem gambling treatment services from multiple funding streams including Medicaid, private insurance, charitable fund raising, corporate sponsorship, etc. List sources of income, financial support, donated services, or any collaborative projects your organization is engaged in, that will help sustain and grow services for problem gamblers and their concerned others should funding from this RFA’s resulting grants be insufficient to meet treatment demand or other identified needs.

APPENDIX A: PROBLEM GAMBLING TREATMENT SERVICES SCORING MATRIX

Accepted proposals will be evaluated based on the following criteria:

- A. All parts of each section are included and addressed.
- B. Descriptions and details are clear, organized and understandable.
- C. Descriptions are responsive to the intent of the RFA objectives.
- D. The overall ability of the applicant, as judged by the evaluation committee, to successfully provide services in accordance with the Problem Gambling Prevention Guidelines.
- E. Proposals with an average reviewer score lower than 70 may be excluded from further consideration. Proposal with an average reviewer score lower than 60 will be deemed unqualified for any rewards resulting from this RFA.

Points will be assigned for each item listed as follows:

- 80% - 100% of Maximum Points:** Applicant’s proposal or capability is superior and exceeds expectations for this criterion.
- 70% - 79% of Maximum Points:** Applicant’s proposal or capability is satisfactory and meets expectations for this criterion.
- 60% - 69% of Maximum Points:** Applicant’s proposal or capability is unsatisfactory and contains numerous deficiencies for this criterion.
- 0 – 59% of Maximum Points:** Applicant’s proposal or capability is not acceptable or applicable for this criterion.

The maximum points to be awarded for each proposal section are as follows:

Proposal Component	Potential Maximum Score
I. Executive Summary	Not Scored
II. Services Proposed/ Program Description	40
III. Population to be Served	15
IV. Organization and Program Staff	20
V. Support of DHHS Problem Gambling Services 2024 & 2027 Strategic Plan’s Treatment System Goals and Enhancement Activities	15
VI. Funding Request	10
Total*	100

**A completed Application Form (Section 3.2) is mandatory. If the Application Form is not completed in full the application may be rejected or for minor deficiencies may receive a 5-point reduction in the scoring total.*

APPENDIX B: FUNDING FORMULA FOR CURRENT GRANTEES

Problem Gambling Treatment Funding Awards for SFY2026 Based on Draws in SFY24

Draws from July 2023 through June 2024*	Performance Rating Adjustment** (7/7 performance standards = 10% increase, 6/7 = 5%, 5/7 = 0%, 4/7 = (-10%), 3/7= (-20%)	Projected Need for FY26 Award***

BBHWP Problem Gambling Treatment Grantee Performance Standards

Access: The amount of time between a problem gambling affected individual’s request for outpatient services and the first offered service appointment must be five business days or less for at least 90% of all individuals receiving services funded through this Agreement.

Retention: The percent of problem gambling affected individuals receiving services funded through this Agreement who actively engage in problem gambling treatment for at least 10 clinical contact sessions must not be less than 50%.

Successful Completion: The percent of all individuals receiving services funded through this Agreement who successfully complete treatment must not be less than 50%. A successful problem gambling treatment completion is defined as the individual’s: (a) achievement of at least 75% of short-term treatment goals, (b) completion of a continued wellness plan (i.e., relapse prevention plan), and (c) lack of engagement in problem gambling behaviors for at least 30 days prior to discharge from services.

Client Satisfaction: The percent of problem gambling affected individuals receiving services funded through this Agreement who complete a problem gambling client satisfaction survey would positively recommend the Provider to others must not be less than 85%.

Long-term Outcome: The percent of problem gambling affected individuals receiving services funded through this Agreement who successfully complete treatment whose responses to a problem gambling follow-up survey suggest maintained improvement at twelve months after intake must not be less than 50%.

Consent for Follow-Up Evaluation: The percentage of problem gambling affected individuals receiving services funded through this Agreement at each clinic consenting for follow-up evaluation should be no less than 80% of the average percentage of clients consenting system wide.

Documentation Accuracy: A comparison of documented clinical services provided within client files and client sign-in sheets with encounters entered the UNLV Problem Gambling Treatment Data Management System must have a correspondence rate of 95% or greater for any period of 28 consecutive calendar days or longer.

APPENDIX C: APPLICATION CHECKLIST

Complete this checklist prior to scanning/submitting.

Section I: Application Form

- All boxes are checked to indicate the correct answer.
- All fields are completed according to instructions.
- Certification is signed.

Section II: Narrative

- Section 3.3-I: Executive Summary*
- Section 3.3-II: Services Proposed/ Program Description*
- Section 3.3-III: Population to be Served*
- Section 3.3-IV: Organization and Program Staff*
- Section 3.3-VI: Support of DHHS Problem Gambling Services 2022 & 2023 Strategic Plan's Treatment System Goals and Enhancement Activities*
- Section 3.3-VI: Funding Request*
- Page limits have not been exceeded.
- Arial 11-point font has been retained.
- One-inch margins have been retained.

Application Submission

Include copies of the following:

- Proof of agency liability insurance
- Proof of workers' compensation insurance
- Most recent Single Audit and Management Letter (if agency receives more than \$1,000,000 annually in federal funds) OR most recent year-end financial statements (if federal audit is not applicable.)
- Copy of treatment clinician(s) licenses, certifications, and resumes
- As applicable, copy of agency's IRS 501(c)(3) Letter of Determination
- As applicable, Letters of Agreement or Memorandums of Understanding
- As applicable, Draft Agreements with Sub-awardees
- As applicable, Board of Directors or Other Governing Board Roster, including member affiliations and terms of office
- As applicable, copy of agency licenses and certifications
- A PDF will be emailed to K.GARCIA@HEALTH.NV.GOV with all required documentation no later than March 26, 2025, by 5pm.