Application: Section III

3.1 APPLICATION INSTRUCTIONS

A. Completed application are due no later than **Wednesday, April 28, 2021**, **by 5:00 PM**. Application must be submitted online by emailing all required documents in a single email to k.garcia@health.nv.gov In the subject line of the email place the RFA title, "Problem Gambling Treatment RFA Response from [name of applicant]".

If a single email is too large to be accepted for transmittal or delivery by an email system used in the transmittal of the application then more than one email may be sent by indicating in the email subject line that the application has been emailed in parts (e.g., "Part 1 of 3").

If you do not receive an acknowledgement of application receipt with 72 hours, please contact Kim Garcia via e-mail at k.garcia@health.nv.gov or via telephone at (775) 443-8106.

B. A complete application will require the following list of items to be included in the proposal. **Convert all items into PDF document format**:

- ☐ Application Form / Description of Applicant Organization
- ☐ Service Description / Proposal Narrative *(15-page max for outpatient, 17-page max for combined outpatient and residential treatment, 1.0" margins, 11-pt Arial font)*
- ☐ Completed Scope of Work Form located in Appendix D
- ☐ Subrecipient Questionnaire
- ☐ Proof of agency liability insurance
- ☐ Proof of workers' compensation insurance
- ☐ Most recent Single Audit and Management Letter (if agency receives more than $750,000 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

C. There is no option to attach unsolicited materials to the online application. Any unsolicited materials mailed, delivered, or e-mailed to BHWP will **not** be accepted. This includes support letters, cover pages, cover letters, brochures, newspaper clippings, photographs, media materials, etc.

D. Complete the Application Checklist located in Appendix C prior to scanning/submitting. The Application Checklist is for the benefit of the applicants and is not required to be included in the submission packet.

E. Once the application is submitted, no corrections or adjustments may be made prior to the negotiation period.

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

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

☐ Address(es)	

C. Applicant Organization

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

D. Program Point of Contact

Name		
Title		
Phone		
Email		
Same mailing address as section B? ☐ Yes ☐ No, use below address information		
Address		
City		Zip (9-digit)

E. Fiscal Officer

Name & Title	
Phone & Email	

F. Subcontracting of Services

Does your organization subcontract its services? ☐ Yes ☐ No		
Subcontractor		
Mailing Address		
Physical Address		
City		Zip (9-digit)
Federal Tax ID #		

G. Key Personnel

Name	**Title**	**Licensed/Certified?** *If yes, include copy of licenses/certifications in application*
		☐ Yes, CGAC or CGAC-I ☐ Yes, other ☐ No
		☐ Yes, CGAC or CGAC-I ☐ Yes, other ☐ No
		☐ Yes, CGAC or CGAC-I ☐ Yes, other ☐ No
		☐ Yes, CGAC or CGAC-I ☐ Yes, other ☐ No

H. Medicaid Payers of Services

Does your organization or its subcontractors bill Medicaid for services? ☐ Yes ☐ 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? ☐ Yes ☐ No	

I. Third-Party Payers of Services

Does your organization or its subcontractors bill any third-party payers (e.g., insurance companies) for services? ☐ Yes, specified below ☐ No			
Third-Party Payers	**Period**	**Billables Received ($)**	**Percentage of Operating Income (%)**

J. Current Funding

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

K. 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. The applicant is limited to a total of 15 pages for applicants proposing outpatient gambling treatment services and 17 pages for applicants proposing both outpatient and residential gambling treatment services. 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 "Treatment" and "Recovery" components of the Behavioral Health Continuum of Care (described on pages 14-15 of the Strategic Plan). Describe specific recovery support services and care coordination elements within your proposed program.

(b) Describe your treatment models and methods. Include details about how you develop a treatment plan.

(c) Describe how your proposed models and methods correspond or differ with the Strategic Plan's Guiding Principles (Section III.B.).

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

(e) 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 I outpatient care, ASAM Level II intensive outpatient care, and ASAM Level III residential treatment. For residential treatment applicants, estimate the percentage of your clients who will receive a combination of inpatient and outpatient treatment at your facility. For more information on ASAM levels of care see: https://www.asam.org/asam-criteria/about

(f) Complete Appendix D, Scope of Work, and attach to the application.

Note, successful applicants will have the opportunity to revise the proposed Scope of Work if (a) there are discrepancies between funding requested and funding awarded or (b) at the request of DHHS or (c) at the request of the grantee with DHHS approval.

(g) For Residential Treatment Providers Only: If funding constraints allow for only one residential treatment program through this Request for Applications, and your organization is that program, how will you market your services, how will you facilitate transportation to and from your program, and what measures will you take to facilitate a smooth step-down transition from residential treatment to the client's local treatment or support resources?

III: Population to be Served *(15 points)*

(a) What geographical area will you serve? Provide the address of all the locations where your program will be staffed by a CPGC or CPGC-I. 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 under-served 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 2022 & 2023 Strategic Plan's Treatment System Goals and Enhancement Activities *(15 points)*

The Strategic Plan includes a section on "Goals, Activities, Enhancements" (Section IV) including a section under the heading "Treatment System" (p. 26). The following questions reflect upon these system goals.

(a) What steps would you take to increase problem gambling treatment enrollments by no less than 10% each year?

(b) What steps will you take to meet defined performance standards within the Provider Manual (refer to Page 6 of the Provider Manual for a description of the gambling treatment provider performance standards)? Provide any data or information that supports your ability to meet these standards.

(c) Describe how you will incorporate the "Add-on" procedure codes and rates listed under Exhibit 4 of the Provider Manual (page 29-30).

VI: Funding Request *(10 points)*

(a) For Current Grantees: Funding for treatment will be allocated based on a formula developed by the BHWP 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 2019 through June 2020*	**Performance Rating Adjustment** (7/7 performance standards = 10% increase, 6/7 = 5%, 5/7 = 0%, 4/7 = (-10%), 3/7= (-20%)**	**Projected Need for FY22 Award*****

**SFY2020 encounter claims data will be utilized in the funding formula for FY2022 as funding level and environmental conditions in SFY2020 are believed to more closely approximate FY2022 conditions than utilizing FY2021 data.*

***Performance rating adjustment based on SFY2020 findings as reported in the UNLV International Gaming Institute, Nevada Problem Gambling Study, Annual Report, Fiscal Year 2020.*

****This formula will be used to provide beginning of the year allocations. 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 SFY2021

Enrollment Category	Projected Number of Enrollments in SFY 2022	Average Case Cost	Total
Outpatient Gambling Treatment		$1,297	
Outpatient Concerned Other		$840	
Residential Gambling Treatment		$2,826	
		Total Funds Requested	

Note: Average case cost based on actual data from SFY2020 and were calculated from all enrollments including those who left treatment 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.