***If submitting multiple projects, complete and submit a complete application with all Appendixes for each project.***

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| **TRANSMITTAL LETTER** |
| **Solicitation ID Number** | RGA-2023-DBH-01-OPIOI |
| **Applicant Organization Name** |  |
| **Applicant Address** |  |
| **Date of Submission** |  |
| **Project Title** |  |

To whom it may concern:

We hereby submit this response to the Solicitation referenced above, in complete accordance with all conditions and specifications set forth in the Solicitation.

We attest to the fact that:

1. The Applicant has read and fully understands this Solicitation and agrees to be bound by its terms, conditions, and requirements.
2. The Applicant has read and fully understands Appendix A - Grant Agreement, Form G-1, and Appendix C - Standard Exhibits.
3. The Applicant’s Grant Application is effective for a period of 180 days from the Grant Application Due Date or until the Effective Date of any resulting Grant Award, whichever is later.
4. The prices, terms and conditions, and services in the Applicant’s Grant Application have been established without collusion with other Applicants.
5. This document is signed by a person who is authorized to legally obligate the responding Applicant.

Further, in accordance with RSA 21-I:11-c, the undersigned Applicant certifies that neither the Applicant nor any of its subsidiaries, affiliates or principal officers is currently debarred from performing work on any project of the federal government or the government of any state.

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| **Authorized Signature**  |  |
| **Authorized Signature (printed)** |  |
| **Title** |  |
| **Telephone** |  |
| **Email** |  |

1. **Applicant Eligible Entity Type**

Please select your organization’s entity type:

[ ]  **Governmental entities, including school districts, towns, cities, and counties within the state of New Hampshire (NH);**

[ ]  **New Hampshire State agencies, boards, or commissions; or**

[ ]  **Non-profit or charitable organizations registered and in good standing with the New Hampshire attorney general’s charitable trusts unit.**

1. **Proposed Project Criteria**

Please select which of the following criteria that your project addresses (select all that apply):

[ ]  **Reimburse the State or any political subdivision within the state for any portion of the cost incurred beginning July 1, 2020 related to outpatient and residential opioid use disorder (OUD) and any co-occurring substance use disorder or mental health (SUD/MH) treatment services, including, but not limited to:**

* **Services provided to incarcerated individuals;**
* **Medication assisted treatment (MAT);**
* **Abstinence-based treatment; or**
* **Treatment, recovery or other services provided by states, subdivisions, community health centers, or not-for-profit providers.**

[ ]  **Reimburse the State or any political subdivision for costs incurred beginning July 1, 2020 related to emergency response services related to OUD and any co-occurring SUD/MH issues provided by law enforcement and first responders.**

[ ]  **Support mobile intervention, treatment, and recovery services, offered by qualified professionals, for individuals with OUD and any co-occurring SUD/MH issues or individuals who have experienced an opioid overdose.**

[ ]  **Support detoxification services for individuals with OUD and any co-occurring SUD/MH issues, including medical detoxification, referral to treatment or connections to other services.**

[ ]  **Reimburse the State and any political subdivision within the state for any portion of the cost of administering naloxone incurred beginning July 1, 2020.**

[ ]  **Provide access to housing for individuals with OUD and any co-occurring SUD/MH issues, including supportive housing, recovery housing, or housing assistance programs.**

[ ]  **Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH issues;**

[ ]  **Provide employment training or educational services for individuals in treatment for or in recovery from OUD and any co-occurring SUD/MH;**

[ ]  **Create or support centralized call centers that provide information and connections to appropriate services and supports for individuals with OUD and any co-occurring SUD/MH issues;**

[ ]  **Improve oversight of opioid treatment programs (OTPs) to assure evidence-based, evidence-informed practices;**

[ ]  **Provide scholarships and supports for certified addiction counselors and other mental and behavioral health providers involved in addressing OUD and any co-occurring SUD/MH issues, including, but not limited to:**

[ ]  **Training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas of the state.**

[ ]  **Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based, evidence-informed programs or strategies;**

[ ]  **Support enhancements or improvements consistent with state law to the prescription drug monitoring program; or**

[ ]  **Support the education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.**

[ ]  **Support evidence-based prevention programs and services, including efforts to promote healthy, drug-free lifestyles, reduce isolation, build skills and confidence, and facilitate community-based prevention efforts.**

[ ]  **Support for public and non-public school programs and services for students with OUD and any co-occurring SUD/MH issues or who have been affected by OUD and any co-occurring SUD/MH issues within their family.**

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| 1. **Applicant Contact Information**
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| **Primary Point of Contact***Individual who will serve as the Applicant’s primary contact for all other matters relating to the RGA.* | **Name** |  |
| **Title** |  |
| **Email** |  |
| **Telephone** |  |
| **Fiscal Contact** *Individual who will serve as the Applicant’s primary contact for fiscal matters.* | **Name** |  |
| **Title** |  |
| **Email** |  |
| **Telephone** |  |

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| 1. **Affiliations – Conflict of Interest**
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| Does your organization have any affiliations that might result in a conflict of interest in relation to this Solicitation? | Choose an item. |
| * + 1. If **YES**, explain the relationship(s) and how the affiliation(s) would not represent a conflict of interest.
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