NATIONAL COUNCIL for Mental Wellbeing

Building Community Capacity through Rural Community Behavioral Health Organizations Mentorship and Support Program

Request for Applications

The National Council for Mental Wellbeing, with support from the Centers for Disease Control and Prevention (CDC), invites community behavioral health organizations (CBHOs), harm reduction organizations and other community-based organizations serving rural and frontier communities to apply for the upcoming Building Capacity through Rural Community Behavioral Health Organizations Mentorship and Support Program (R-CBHO MSP). Through a competitive application process, National Council staff and project partners will award funding to **up to 18 rural or frontier-serving organizations** to implement strategies to enhance and expand critical services that reduce the risk of overdose by increasing engagement in evidence-based and innovative harm reduction strategies, linkage to care and peer support services. Each selected organization will be paired with a mentor organization and a subject matter expert who will share best practices, resources and insights to strengthen capacity to provide overdose prevention, response and linkage to care services.

Up to $83,500 will be awarded to participate in the six-month R-CBHO MSP that begins February 2025.

Previous recipients of the National Council Building Community Capacity Award (2023–2024) are ineligible to apply as mentees for the R-CBHO MSP.

Applications must be submitted online at https://nationalcouncil.awardsplatform.com/ by Monday, Dec. 16, 2024, 11:59 p.m. ET. Late submissions will not be accepted. Please contact Emma Hayes at EmmaH@TheNationalCouncil.org with any questions.

A. Background

The continuing overdose crisis requires a humane response based on evidence-informed overdose prevention, harm reduction, and linkage to care strategies and services.[1] Most deaths are preceded by at least one potential opportunity to link people to care before the fatal overdose or to implement life-saving actions when the overdose event occurs.[2] Given unprecedented rates of mortality, expanded access to and engagement with overdose prevention and treatment services is needed. Additionally, overdose-related disparities based on race, ethnicity, and other socio-economic factors require a health equity lens in the planning, implementation, and evaluation of overdose prevention and treatment strategies.

[1] Ahmad, F. B., Cisewski, J. A., Rossen, L. M., & Sutton, P. (2022, Oct. 12). *Provisional drug overdose death counts.* National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[2] Centers for Disease Control and Prevention. (2024, Nov. 12). *Overdose Deaths and the Involvement of Illicit Drugs.* https://archive.cdc.gov/#/details?url=https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html

This is especially true in rural areas, where communities face significant challenges that contribute to elevated overdose deaths. Limited access to prevention, harm reduction programs, fewer health care facilities dispersed across large geographic areas and transportation challenges are all barriers that contribute to high overdose mortality in rural and frontier communities.[3]

Linkage to care is a crucial early step in successful overdose prevention and response. It is a coordinated system and practice of actively referring individuals to desired care or services related to problematic opioid or other drug use. Linkage to care initiatives identify people who are at risk for overdose or have recently experienced a non-fatal overdose and link them with harm reduction services, health care, evidence-based substance use treatment, and wraparound supports.[4] The key is that these initiatives are person-centered—helping individuals to access services when they express the desire for them.

Identifying persons who use drugs (PWUD) and persons with substance use disorder (PWSUD) who are at risk of overdose and successfully linking them to care plays a key role in the overall overdose epidemic, by addressing structural inequities related to health, reducing suffering, disease, and death. Effective linkage to care programs are grounded in the following pillars and principles:

- Embrace the inherent value of people.
- Commit to deep community engagement and community building.
- Promote equity, rights, and reparative social justice.
- Offer low barrier access and non-coercive support.
- Focus on any positive change, as defined by the person.
- Assure education, access, and autonomy in service and treatment planning.

However, rural and frontier communities have fewer behavioral health care providers per capita, making it difficult for individuals to access substance use and wraparound services[5]. These resource constraints can lead to delayed or inconsistent care, leaving many individuals without timely support.

Peer work is an essential part of linkage to care initiatives. Emerging evidence shows that peer-recovery models, in which a trained person in recovery or with lived experience of a substance use disorder acts as both a form of social support and a patient navigator, are easily integrated into existing services.[6] Peer workers can provide a range of supports, including:

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[3]Centers for Disease Control and Prevention. (2024, Nov. 12). *Opioid Use Disorder: Rural Policy Brief.* https://www.cdc.gov/rural-health/php/policy-briefs/opioid-overdoses-policy-brief.html

[4] Wraparound supports may include mental health care, transportation to treatment, peer support, infectious disease care, obstetric care, or harm reduction services that can address barriers to care.

[5] Robinson, L., Holbrook, J., Bitsko, R., Hartwig, S., Kaminski, J., Ghandour, R., Peacock, G., Heggs, A., Boyle, C. (2024, Nov. 12). *Differences in Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders Among Children Aged 2–8 Years in Rural and Urban Areas — United States, 2011–2012*. Center for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/66/ss/ss6608a1.htm

[6] Carroll, J.J., Asher, A., Krishnasamy, V., & Dowell, D.(2022, Dec. 21). *Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices.* Centers for Disease Control and Prevention National Center for Injury Prevention and Control. https://www.cdc.gov/drugoverdose/pdf/pubs/linkage-to-care_edited-pdf_508-3-15-2022.pdf

- Service navigation: Peer support workers help with navigating a wide range of health and social welfare service systems, facilitate access to physical and behavioral health care, and support beginning SUD treatment when desired, as well as sustaining engagement in care.
- Informational support: Peer support workers assist individuals to increase their knowledge and awareness of how to reduce the risk of infection and other health issues related to drug use, reduce overdose risk, and co-create wellness goals.
- Emotional support: Peer support workers assist program participants to enhance confidence and motivation to self-defined goals for health and well-being, and to address challenges and barriers to care.

Addressing overdose in underserved rural and frontier communities requires compassionate, evidence-based interventions. Strengthening linkage to care and integrating peer support workers can be vital steps in bridging service gaps, enhancing access to critical health services, and promoting individuals' wellbeing.

B. Goals

With a focus on rural and frontier communities, the goals of the R-CBHO MSP are to:

- Support the implementation and enhancement of evidence-informed, evidence-based and promising practices with some demonstrated successes to prevent and reduce overdose and other drug-related harms.
- Increase the collaboration between CBHOs, harm reduction organizations, and other community-based organizations to link PWUD and PWSUD to harm reduction services, peer support, treatment and recovery support, and other wraparound services.
- Facilitate mentorship, peer learning, and other technical supports to enhance capacity around implementation and effective delivery of critical services to reduce the risk of overdose among PWUD.

Examples of possible projects that are in line with the goals of this mentorship and support opportunity include:

- Community-based overdose or post-overdose response teams, crisis response teams, or rapid response teams that serve rural and frontier communities that are impacted by overdose.
- Partnerships to increase access to services, decrease wait times for appointments, foster low barrier access, and re-engage individuals in care.
- Services that increase access to low barrier treatment with medications for opioid use disorder (MOUD)
    - Bridge clinics (face-to-face and telehealth) in transitional places, such as emergency departments, criminal legal settings, and overdose response programs.
    - MOUD integration within primary care and community health centers.
    - Co-located services (e.g., access to (MOUD) within syringe services programs).
- Health hubs for PWUD.

- Mobile harm reduction services, including clinical wound care, or such care integrated into spaces in which PWUD feel safe.
- Drug checking services.
- Emergency department linkage to care after overdose.
- Re-entry support and linkage to care for individuals returning to a community after incarceration.
- Linkage to care services provided in syringe services programs, naloxone distribution programs, or post overdose outreach.
- Partnerships to increase naloxone distribution and education.

C. Applicant Eligibility

Eligible applicants include CBHOs, harm reduction organizations, and other community-based organizations and/or coalitions in the U.S. that provide services within one or more rural or frontier geographic areas, as defined by the Health Resources and Services Administration (HRSA). Organizations from areas that would be eligible for an HRSA Rural Health Grant are eligible to apply to the R-CBHO MSP. **Applicants must use the Health Resources and Services Administration's Rural Health Grants Eligibility Analyzer to determine their eligibility.**

Previous recipients of the National Council Building Community Capacity Award (2023–2024) are ineligible to apply as mentees for the R-CBHO MSP.

All applicants must:

- **Provide services within one or more geographic areas designated as rural, per HRSA's definition.** This includes:
  - All non-metro counties.
  - All metro census tracts with Rural-Urban Commuting Area (RUCA) codes 4-10.
  - Large area metro census tracts of at least 400 sq. miles in area with population density of 35 or less per sq. mile with RUCA codes 2-3.
  - Census tracts in metro counties that are at least 20 sq. miles, have Road Ruggedness Scores (RRS) of 5 and RUCA codes 2-3.
  - All outlying metro counties with fewer than 50,000 residents.
  - **Applicants must use the Health Resources and Services Administration's Rural Health Grants Eligibility Analyzer to determine their eligibility.**
- **Describe the fatal and non-fatal overdose burden in the rural or frontier areas your organization serves.** Highlight any observable trends, contributing factors, or populations disproportionately impacted by these issues. If applicable, include relevant supporting documentation or data from local, state, or national health departments or agencies to substantiate your description.
- **Possess a Unique Entity ID (UEI) provided by www.SAM.gov.** The Unique Entity ID is a unique twelve-character alphanumeric identification number provided by SAM.gov. It will be used as

the Universal Identifier when applying for federal awards or cooperative agreements. The applicant organization may register for a Unique Entity ID online at www.SAM.gov. SAM.gov is the primary registrant database for the federal government and the repository into which an entity must submit the information required to conduct business as a recipient of federal funds. The UEI will be provided at no charge.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their Unique Entity ID before accepting any funds. If an award is made, the Unique Entity ID must be maintained until a final financial report is submitted or the final payment is received, whichever is later.

- **Have the experience and infrastructure necessary** to begin active implementation within 30 days of the start of the project period.

D. Mentorship and Support Program Expectations and Requirements

Over the 6-month project period, organizations selected for the R-CBHO MSP will be expected to:

- Use funds to support novel and innovative overdose prevention and harm reduction services to support PWUD in rural and frontier communities.
- Use funds to increase the collaborations to link PWUD and PWSUD to harm reduction services, peer support, recovery support and other wraparound services over a project.
- Actively participate in mentorship activities to learn from innovative and experienced organizations and subject matter experts who have demonstrated success in meeting the needs of PWUD in rural and frontier communities.
- Prepare for and participate in at least five monthly mentorship calls and virtual learning sessions with the assigned mentorship team.
- Participate in other cohort learning opportunities, training and technical assistance, such as virtual meetings, webinars or other sessions for sharing tools, resources, and lessons learned.
    - To promote meaningful learning and sustainable implementation, we recommend that organization and coalition members participate together in TTA when possible.
- Participate in project evaluation, including responding to a brief evaluation assessment at the beginning of the project period (baseline), 3 months, and 6 months.
- Provide a brief mid-project report to the National Council that details project activities and lessons learned from the mentorship sessions.

E. Funding Priorities

Priority for selection will be given to organizations that:

- Serve populations highly impacted by drug overdose, including PWUD and PWSUD that are:
    - Black, Indigenous, and people of color (BIPOC)
    - Experiencing homelessness and housing instability
    - Not currently in care
    - Reside in jurisdictions that lack or are underserved by MOUD treatment providers.
    - Justice-involved

    - Overdose survivors
- Use a health equity-focused (or infused) approach in their initiatives.
- Actively collaborate with other organizations that are engaged in overdose prevention and harm reduction activities within their communities.

F. Funding Restrictions

In compliance with federal funding requirements, funds **may not** be used for:

- Prohibited harm reduction supplies, which include naloxone (Narcan), syringes and pipes.
    - However, when injectable naloxone is being used in a program or community, certain activities are allowable, including:
        - Purchasing supplies associated with the use of injectable naloxone (e.g., alcohol pads, antiseptic wipes, personal fitpacks/sharps containers used to carry naloxone and dispose of syringes used with injectable naloxone).
        - Syringe disposal as part of prevention activities.
- Prohibited operational purchases, such as furniture or equipment.
    - Please note that vehicles may be allowable expenses for linkage to care activities.
- Drug disposal, including implementing or expanding drug disposal programs or drug take-back programs, drug drop box, drug disposal bags.
- Provision of medical/clinical care, which includes HIV/HCV or other STD/STI testing.
- Research.
- Direct funding for or expanding SUD treatment.
    - However, activities related to co-location of treatment within existing syringe services programs (SSPs) are allowable; payment for direct services remains unallowable.
- Neonatal abstinence syndrome (NAS) surveillance data collection.
    - Please note that certain activities that cover NAS are allowable, while others are not. In particular, certain NAS-related surveillance and prevention activities may be allowable; however, funding collection of NAS surveillance data is not allowable. Some examples of what would be allowable include:
        - Surveillance of linkage to care during or after pregnancy for mothers who use opioids during pregnancy.
        - Tracking drug use patterns, overdose history and linkage to treatment and harm reduction services for pregnant women.
        - Linking data sources on pregnant women available at the state and local level.
        - Prevention strategies and activities for pregnant women, infants born with NAS and for health care provider/clinician support and education.

Funds **may** be used to support a range of project activities in compliance with the above funding restrictions, including, but not limited to:

- Salaries and wages for staff. **Salaries and wages cannot be used to cover staff time for the distribution of syringes.**
- Fringe benefits

- Consultant costs
- Equipment not listed in the unallowable list
- Supplies
- Travel
- Contractual costs
- Indirect costs

G. Key Dates

Activity	Date
Deadline to submit applications	Monday, Dec. 16, 2024, 11:59 p.m. ET
Funding notifications	Friday, Jan. 10, 2025
Kick-off mentee meeting (Zoom) -- REQUIRED	TBD, week of January 13 or January 20
TA activities, including at least five monthly mentorship calls	Monthly (days and times TBD), March - July
Deadline to submit mid-project report	TBD, late April/early May

H. Application Submissions

Applicants should develop a proposal with project activities spanning six months that would begin in February 2025. All applications are due by **Monday, Dec. 16, 2024, 11:59 p.m. ET** and must be submitted online at **https://nationalcouncil.awardsplatform.com/.**

I. Selection Process

Each application will be reviewed and rated by a panel of subject matter experts. Applications will be scored based on the following criteria:

- Scope of overdose prevention and response, and linkage to care for priority populations (5 points)
- Reasonableness and feasibility of project scope and success (10 points)
- Impact of the proposed project activities on PWUD and on reducing overdose and drug-related harms in rural and frontier communities (10 points)
- Connections to and collaborations with other groups (formal and informal) doing similar work in the community and experience working with the population of focus (5 points)
- Reasonable timeline and ability to begin active implementation within 30 days of the start of the project period (5 points)
- Goals and how success will be measured, including the impact of mentorship on organizational capacity (10 points)
- Appropriateness of proposed budget (5 points)

Additionally, reviewers will consider:

- Commitment and ability to serve highly impacted populations.
- Geographic diversity among selected awardees.

J. Award Process

When organizations have been selected, National Council project staff will contact each applicant to notify them of their application status. Successful applicants will be asked to sign a fixed-price contract detailing roles and responsibilities, project activities and payment schedule. The National Council will distribute funds to awarded organizations in one payment following execution of the contract.

Program decisions are expected to be made, and applicants notified, by January 10, 2025.

Questions about the funding opportunity or application process?
Emma Hayes at EmmaH@TheNationalCouncil.org

This project is supported by the CDC of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $2,250,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. government.

Application for Mentor and Support Program

Application Instructions

Please complete the application in its entirety. **Final application packages should be submitted online at https://nationalcouncil.awardsplatform.com/ by Monday, Dec. 16, 2024, 11:59 p.m. ET.** Application questions are required unless otherwise specified. Word limits are designated for each response. Submit questions related to the application to Emma Hayes at EmmaH@TheNationalCouncil.org

Part I. Contact Information

Field	Response options
1. Contact First and Last Name	
2. Contact Job Title	
3. Contact Email Address	
4. Contact Phone Number	
5. Name and Title of Project Director	
6. Project Director Email Address	
7. Project Director Phone Number	
8. Organization Name	
9. Program Name (if different from above)	
10. Physical Address of Main Office (City, State, ZIP Code)	
11. Federal Employer Identification Number (EIN)	
Please upload a copy of your active sam.gov registration	[File upload]
12. Unique Entity ID (UEI)	
13. Does the organization provide services to one or more geographic areas categorized as rural by the Health Resources & Services Administration (HRSA)? Applicants are required to use the Rural Health Eligibility Analyzer to determine eligibility for this program.	• Yes • No

14. Please upload a screenshot of the results from the Rural Health Eligibility Analyzer. Use your organization address if headquartered in the rural service area; if you provide services to a rural area but are not headquartered in one, use the "by state/county" option to search for the county/counties you operate in.	[File upload]
15. Please list all zip codes for the area(s) that you service.	
16. Website (if applicable)	

Part II. Organizational Overview (5 points)

Field (maximum word count)	Response options
1. Brief description of organization, including overview of services provided, experience working in or with rural geographic location to be served, mission and populations served. (500 words)	
2. Brief description of the fatal and non-fatal overdose burden in the rural or frontier areas served. If applicable, include relevant supporting documentation or data from local, state, or national health departments or agencies **in Part V.** to substantiate your description.	
3. Type of organization (select all)	• Harm reduction • Certified Community Behavioral Health Center • Mental health or substance use treatment organization • Primary care/ health care • Faith-based organization • Community based organization • Recovery community organization • Reentry program • Other (comment box)
If "other", provide the type of organization:	
4. Annual Organizational Budget	
5. Number of individuals served annually	• 1-100 • 101-500

	• 501-1,000 • 1,001-5,000 • 5,001-10,000 • 10,001-15,000 • More than 15,000
6. Populations served (select all)	• People experiencing homelessness and housing instability • BIPOC communities • People with disabilities/differently able • Rural and frontier communities • Tribal communities • People transitioning from correctional settings to the community • LGBTQ+ communities • People transitioning from hospitals/emergency departments back to the community • Jurisdictions with a lack of MOUD treatment providers • PWUD over the age of 55 • PWUD not currently in care • People with co-occurring disorders • Pregnant people • Young adults • Other (comment box)

7. Please select the primary services currently offered for the population(s) to be served with this project. (select all)	• Overdose response
	  ○ Syringe services
	  ○ Naloxone distribution
	  ○ Overdose prevention and reversal training
	  ○ Fentanyl testing strips distribution
	• Peer recovery support services
	• Outreach
	• Mobile services
	• Technology-assisted services (e.g., mobile apps, telehealth, texting)
	• Linkage to SUD treatment
	• Medications for opioid use disorder (MOUD) (e.g., buprenorphine, methadone, naltrexone)
	• Medical care
	  ○ Wound care
	  ○ HIV/HCV testing
	• Re-entry services
	• Case management
	• Housing assistance

	• Employment assistance • Food assistance • Legal assistance • Dental care • Mail services • Other (comment box)
8. Number of staff employed by organization or program	• 1-10 • 11-20 • 21-50 • 51-100 • More than 100
9. Number of volunteers part of the organization or program	• 1-10 • 11-20 • 21-50 • 51-100 • More than 100

Part III. Project Proposal (30 points)

Field (maximum word count)	Short answer response
1. Describe how awarded funds would be used to implement or enhance services to prevent and reduce overdose and other drug-related harms and increase organizational capacity. Describe anticipated outcomes. Include how evidence-informed and innovative harm reduction strategies, linkage to care, and/or peer support services will be integrated. (600 words)	
2. List specific, achievable, related, and timebound (SMART) goals or objectives, and anticipated products and/or deliverables related to use of funds described above. For each goal or objective, describe how you will document and track its achievement. *To better understand what a SMART deliverable may be, please consider the following hypothetical examples.* (1,000 words)	
3. Describe your existing and/or potential key partners/collaborating organizations, the role that each will play for this project, their experience working in the	

geographic location to be served, and their experience working with the population of focus. (500 words)	
4. Provide a brief 6-month project timeline, including key milestones and dates. (300 words)	

Part IV. Mentorship Program (10 points)

Field (maximum word count)	Short answer response
1. Describe what topic areas and types of mentoring and support would be most beneficial to your overdose prevention and response efforts in rural areas. (300 words)	
2. What are your goals for the mentorship? How will achieving these goals improve your organization? How will achieving these goals assist your community in addressing overdose? (400 words)	
3. What challenges, barriers, or obstacles are you facing that mentorship could help address? What training and technical assistance activities would you like to engage in with mentors? (200 words)	
4. Briefly describe how you would measure success for your mentorship. What does "success" look like after six months of mentorship? (200 words)	

Part V. Budget Proposal (5 points)

Field (maximum word count)	Response options
1. Total amount requested (up to $83,500).	$
2. Budget. In a single document, list the expected deliverables or outcomes and the cost of each, using the table format provided. Below the table, provide a budget narrative to support the cost table, describing how the funds will be applied to meet the project goals within the 6-	

month project period. Include how each line item was calculated. Please upload as a single pdf. The budget narrative will be reviewed to ensure proposed spending is in compliance with federal restrictions. Please see Section E of the RFA announcement for a list of unallowable expenses. Budgets should not exceed a total of $83,500. *To better understand how to complete the budget table and budget narrative, please consider the following hypothetical examples.*	

Part VI. Additional Supporting Attachment(s)
Please include the following additional supporting documents:

- Brief biography or resume for the proposed project director (required).
- Materials demonstrating commitment, experience, organizational impact, or current or past overdose prevention and harm reduction programs and services (e.g., brochures, client testimonials, reports) (optional, limit 5 pages).
- Supporting documentation or data from local, state, or national health departments or agencies describing fatal and non-fatal overdose burden in the rural or frontier areas served (optional).

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To better understand what a SMART deliverable may be, please consider the following hypothetical examples.

Example 1: Outcome
By end of project period, increase overdose prevention and response services for people experiencing houselessness by 25 percent, responding to 700 help line calls and distributing 100 emergency kits.

- ***Why this example is SMART**:*
  - *Specific: Increase the reach of overdose prevention and response services*
  - *Measurable: The program will respond to an additional 700 help line calls and distribute 100 emergency kits to population of focus.*
  - *Achievable: Allocate resources to hire staff and equip them with the tools necessary to effectively reach and respond to the target population.*

- *Relevant: Provides resources to prevent and reduce overdose and assist individuals experiencing houselessness.*
- *Timebound: Respond to 700 help line calls and distribute 100 emergency kits within 6 months.*

- ***Documentation**: Review the baseline level of services and track the number of help line calls answered and kits distributed.*

Example 2: Deliverable

By July 2025, pilot test a 10-module training curriculum on key overdose prevention topics for individuals who trade sex.

- ***Why this example is SMART**:*
  - *Specific: Create a training curriculum covering topics like opioid awareness, harm reduction strategies, and naloxone administration.*
  - *Measurable: The curriculum should consist of at least 10 modules and associated training materials; pilot test should involve 25 participants.*
  - *Achievable: Use subject matter experts and resources available within the project scope.*
  - *Relevant: Equips organizations to actively engage in overdose prevention.*
  - *Timebound: Complete and pilot test curriculum within 6 months.*
- ***Documentation**: Review the finalized curriculum, counting the number of modules and assessing their quality and comprehensiveness. Conduct a peer review by experts in the field to ensure the curriculum meets industry standards.*

Example 3: Outcome

***Expected Outcome**: By end of project period, increase community awareness of how individuals can prevent overdose by engaging at least 50 percent of community members in overdose prevention efforts.*

- ***Why this example SMART:***
  - *Specific: Implement a public awareness campaign targeting at least 50% of the community members in the project areas.*
  - *Measurable: Conduct surveys before and after the campaign to assess changes in knowledge and behavior.*
  - *Achievable: Allocate resources for campaign materials and outreach activities.*
  - *Relevant: Empowers the community to actively prevent overdoses.*
  - *Timebound: Achieve the awareness target within 6 months.*

***Documentation**: Compare pre-campaign and post-campaign survey results to measure changes in community awareness. Monitor the distribution of campaign materials and outreach events to ensure they reach the targeted percentage of the community.*

To better understand the required format of the budget table and narrative, please consider the following hypothetical examples.

Project Budget Table

Proposed Deliverables/Outcomes	*Cost per Deliverable/Outcome*
Deliverable/Outcome #1	*$x*
Deliverable/Outcome #2	*$x*
Total cost	*$x*

Example 1

Proposed Deliverables/Outcomes	*Cost per Deliverable/Outcome*
1. Increase overdose prevention and response services for people experiencing houselessness by 30 percent, responding to 1000 help line calls and distributing 300 emergency kits.	*$ 68,500*
2. Pilot test a 10-module training curriculum on key overdose prevention topics for individuals who trade sex.	*$ 15,000*
Total cost	***$ 83,500***

Budget Narrative

Deliverable 1 cost calculations ($68,500):

- *Salary for Peer Engagement Specialist, 0.5 FTE:* ***$20,833.33***
  - *(50,000 x (10/12) x 0.5) where $50,000 is the annual base salary, adjusted for a 10-month project period, budgeted at 0.5 FTE*
- *Fringe @ 25 percent of salary:* ***$5,208.33***
  - *($20,833.33 x 0.25) where $20,833.33 is the allocation for salary (from above) with fringe calculated at 0.25 the salary*
- *Supplies:* ***$33,500***
- *Indirect expense:* ***$8,958.34***

Deliverable 2 cost calculations ($15,000):

- *Salary for Peer Engagement Specialist, 0.25 FTE:* ***$10,416.67***
  - *($50,000 x (10/12) x 0.25) where $50,000 is the annual base salary, adjusted for a 10-month project period, budgeted at 0.25 FTE*
- *Fringe @ 25 percent of salary:* ***$2,604.16***
  - *($10,416.67 x 0.25) where $10,416.67 is the allocation for salary (from above), adjusted for a 10-month project period, with fringe calculated at 0.25 the salary*
- *Supplies:* ***$1,500***
- *Indirect expense:* ***$479.17***

Notes:
*The **Peer Support Specialist** engages community members and assists in linking them to services to support their community stabilization. The Peer Engagement Specialist will connect with individuals and families with mental health needs -- including substance use disorders -- at shelters, homeless encampments, and living room programs, and provide support with therapy and care coordination services until the individuals are linked to long term community providers. The Peer Engagement Specialist will facilitate the training of clinical staff and provision of pre-screening services to clients. Additionally, the Peer Engagement Specialist will facilitate outreach and schedule workshops with libraries and ward offices, as well as assume responsibility for the onboarding, training, and supervision of additional Peer Engagement staff for this program.*

***Fringe** reflects current rate for the agency. Health benefits include health insurance, life insurance, vision, dental, and short-term disability.*

***Supplies** will equip people experiencing homelessness and those at risk for overdose with a variety of materials to support their immediate needs, including but not limited to a dual poncho and blanket, PPE materials to mitigate the spread of COVID-19 and testing strips to promote safe use. Additional supplies include materials to host workshops and outreach events to build community knowledge in harm reduction techniques and improve outreach to at-risk populations and other community members including but not limited to food and drink supplies, laptop computers, and office supplies.*

***Indirect expenses** include technical and administrative costs of the deliverable.*

Example 2

Proposed Deliverables/Outcomes	*Cost per Deliverable/Outcome*
1. Enhance de-escalation and mental health crises services for people experiencing homelessness to prevent and reduce overdose and other drug-related harms by responding to 700 help line calls.	*$65,250*
2. Increase community knowledge of effective harm reduction strategies by hosting a minimum of 10 substance use, harm reduction, and effective alternatives to hospitalization and emergency response workshops.	*$17,000*
3. Improve partnerships with county offices and libraries to increase outreach to at-risk populations and other community members by 35%.	*$1,250*
Total cost	***$83,500***

Budget Narrative
Deliverable 1 cost calculations ($65,250):

- *Salary for Helpline Operator, 1.0 FTE: **$37,500.00***

        - *($45,000 x (10/12)) where $45,000 is the annual base salary, adjusted for a 10-month project period*
    - *Fringe @ 25 percent of salary:* ***$9,375.00***
        - *($37,500.00 x 0.25) where $37,500.00 is the allocation for salary (from above), adjusted for a 10-month project period, with fringe calculated at 0.25 the salary*
    - *Supplies:* ***$10,000***
    - *Indirect expense: $8,375.00*

Deliverable 2 cost calculations ($17,000):

- *Salary for Outreach Coordinator, 0.4 FTE:* ***$11,666.67***
    - *($35,000 x (10/12) x 0.4) where $35,000 is the annual base salary, adjusted for a 10-month project period*
- *Fringe @ 25 percent of salary:* ***$2,916.67***
    - *($11,666.67 x 0.25) where $11,666.67 is the allocation for salary (from above) with fringe calculated at 0.25 the salary*
- *Supplies:* ***$1,000.00***
- *Indirect expense:* ***$1,416.66***

Deliverable 3 cost calculations ($1,250):

- *Travel:* ***$1,250***

Notes:
The ***Helpline Operator*** *answers calls to the help line for people experiencing homelessness who use drugs. The operator will be trained in de-escalation techniques and mental health crisis service provision. The goal of the operator's role is to prevent and reduce overdoses and other drug-related harms for people experiencing homelessness. We estimate the operator will respond to approximately 700 calls over the ten-month timeline of this project.*

The ***Outreach Coordinator*** *plans, coordinates, and delivers activities to educate and train key community stakeholders on specific harm reduction strategies as well as raise overall public awareness about the topic of harm reduction. Over the project timeframe, the coordinator will plan and deliver a minimum of 10 workshops in the community covering substance use, harm reduction, effective alternatives to hospitalization and emergency response strategies. In addition, the coordinator will focus on improving partnerships with county social service offices and public libraries to better reach at-risk populations. The coordinator will provide training for staff at the county offices and public libraries on harm reduction strategies and resources available in their community. The goal of these partnerships will be to increase the number of community members who receive harm reduction information and/or services by 35%.*

Fringe *reflects current rate for the agency. Health benefits include health insurance, life insurance, vision, dental, and short-term disability.*

Supplies *include the phone, laptop computers, call center software, office supplies, etc. needed to establish a help line operator. In addition, this line includes the cost of supplies for hosting workshops, outreach events, and trainings (food and drink, laptop computers, office supplies, etc.) to build*

community knowledge in harm reduction techniques and improve outreach to at-risk populations and other community members.

***Travel** includes the costs of traveling to and from meetings and events required for job duties. Examples of these costs include mileage/gas reimbursement, meals, airfare, car rentals, lodging, etc.*

***Indirect expenses** include technical and administrative costs of the deliverable.*