**ATTACHMENT A – Application**

**Marin County Department of Health and Human Services**

**Division of Behavioral Health and Recovery Services**

**Outpatient Substance Use Treatment – Telehealth (RFP-HHS-2023-13)**

* + - 1. **Applicant Information**

|  |  |
| --- | --- |
| Legal Entity Name |  |
| Applicant Contact Name |  |
| Address |  |
| Telephone |  |
| E-mail |  |
| DMC Certification Number |  |
| 6-Digit DHCS Provider ID |  |
| Federal Tax ID |  |
|  | |
| **Certification:** The applicant certifies to the best of their knowledge and belief that the data in this application is true and correct and that filing of the application has been duly authorized by the governing body of the applicant and that applicant will comply with the assurances required of applicant if the application is approved and a contract is awarded. The applicant also attests that the costs of the project can be carried by the applicant for at least 60 days at any point during the term of the contract. | |
| Signature |  |
| Printed Name |  |
| Title |  |
| Date |  |

* + - 1. **Applicant Narrative**

1. Please check all of the applicable fields your organization is applying to provide as part of this RFP.

|  |  |  |
| --- | --- | --- |
| *Check All That Apply* | **Adolescent (12-17 years)** | **Adult (18+ years)** |
| **ASAM Level of Care** |  |  |
| General Outpatient |  |  |
| Intensive Outpatient |  |  |
| Recovery Services |  |  |
| **MAT for OUD** |  |  |
| Provide Directly |  |  |
| Provide Via Referral |  |  |
| **MAT for AUD** |  |  |
| Provide Directly |  |  |
| Provide Via Referral |  |  |
| **Linguistic Capabilities** |  |  |
| Spanish-Speaking Treatment Staff |  |  |
| **Co-Occurring Capacity** |  |  |
| Serve Clients with Mild/Moderate Mental Health |  |  |
| Serve Clients with Serious Emotional Disturbance/Serious Mental Illness |  |  |
| **Other Specialty Services/Populations Served** |  |  |
| Gender-Responsive (e.g. Women's/Perinatal): Describe |  |  |
| LGBTQ+ |  |  |
| Criminal Justice Involved |  |  |
| Other: Describe |  |  |
| Other: Describe |  |  |

1. Please describe your agency's experience providing the services being proposed as part of this RFP. In your response, include:
   1. Number of years providing the applicable services
   2. Number of years holding DMC certification
   3. Overview of programming/curricula, including Evidence-Based Practices used
   4. Strategies to provide culturally and linguistically responsive services
   5. Summary of key performance measures and outcomes
   6. Number of California counties currently contracted to Provide DMC-ODS services, if any
2. Please describe your approach to collaborating with community-based providers for the purpose of coordinating care transitions and/or coordinating with primary care, mental health and/or other care team members.
3. Please list the projected Practitioner types expected to provide services if awarded a contract.