



# **Application for Ohio SBIRT Participating Providers Year 2**

**Program Year: August 1, 2014 to July 31, 2015**

**Implementation Period: August 1, 2014 to June 30, 2015**

**John R. Kasich, Governor**

**Tracy J. Plouck, Director**

## **OHIO SBIRT PROGRAM**

### **Introduction**

OhioMHAS has been awarded a 5-year, \$10 million cooperative agreement from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) for a statewide Screening, Brief Intervention and Referral for Treatment (SBIRT) program referred to as "Ohio SBIRT." The program is designed to expand/enhance the state continuum of care for substance misuse services and to: ▪ Reduce alcohol and drug consumption and its negative health impact; ▪ Increase abstinence and reduce costly health care utilization; and ▪ Promote sustainability of SBIRT services through the use of health information technology (HIT). Ohio SBIRT program is also designed to facilitate and ensure sustainability after the SAMHSA\CSAT funding is terminated.

### **Purpose and Goals**

The purpose of Ohio SBIRT is to implement universal screening for adults in primary care and community health settings and offer brief interventions or referral for treatment to those individuals at risk for substance misuse and substance use disorders (SUDs). Ohio SBIRT goals are to:

- 1) Expand the use of SBIRT in hospital and primary health care settings;
- 2) Support clinically appropriate services for people at-risk for or diagnosed with a substance abused disorder;
- 3) Enhance and expand use of current technological strategies to embed SBIRT as a clinical and business practice;
- 4) Identify and implement systems and policy changes to increase access to treatment in generalist and specialist settings; and
- 5) Expand the use of the Ohio Board of Pharmacy Prescription Management Program (OARRS, or Ohio Automated Rx Reporting System) in conjunction with SBIRT to facilitate identification of potential misuse of prescription drugs.

### **Performance Targets**

The program performance targets include: ▪ Reducing alcohol and other drug use by patients receiving SBIRT services; ▪ Increasing the number of clients who present with asymptomatic, risky use or SUD that receive treatment in primary care and community health settings; ▪ Increasing the number of primary care and community health settings where SBIRT services are provided; and ▪ Providing treatment services within approved cost parameters for each treatment modality.

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**Availability of Funds**

Funding will depend on the availability of federal funds for State Fiscal Year (SFY) 2015. Should funding be reduced below the estimated level, the amount of funds available for Ohio SBIRT may be reduced or terminated per written notice to the applicant by OhioMHAS. Future notices of funding awards will be contingent upon program expansion and data collection reimbursement levels.

**Eligible Applicants**

Applications will be accepted only from 501 (c) 3 non-profit organizations that are a primary care or other community health setting such as a hospital or health center.

**OHIO SBIRT SERVICES**

Services are to be delivered face-to-face. Computer tablets, may be used to administer the prescreen tool and full screening tools. The screening for the presence of a co-occurring mental health and substance use disorder is to be completed. The screening information is to be used to develop appropriate treatment approaches. The presence of depression is being used as an indicator of a co-occurring disorder. Services shall be culturally and linguistically appropriate for the population served.

Screening

The prescreen tool consists of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) single question for alcohol, modified National Institute of Drug Abuse (NIDA) Quick Screen V1.0. for other drugs (the alcohol and tobacco questions have been deleted) and Physician Health Questionnaire-2 (PHQ-2) for depression. Patients will complete applicable full screens for positive prescreens. All patients who complete a full screen will also complete the tobacco product use screen. The full screen tools consist of the Alcohol Use Disorders Identification Test (AUDIT) for alcohol, Drug Abuse Screening Test (DAST) 10 for other drugs; and the Patient Health Questionnaire-9 for depression (PHQ-9). Table 1 outlines service recommendations based on full screening scores.

Table 1. Service recommendations based on screening scores.

<b>Risk Level</b>	<b>Service Recommendation</b>	<b>AUDIT*</b>	<b>DAST</b>	<b>PHQ-9**</b>
Low Risk	Education and Reinforcement	0-7	0	0-4
Moderate Risk (Hazardous)	Brief Intervention	8-15	1-2	5-9
Moderate High Risk (Harmful)	Brief Treatment	16-19	3-5	10-14
High Risk (Severe/Dependency)	Referral to Treatment	20+	6+	15+

\*Cut-off points are gender and age sensitive.

\*\*Other than scoring within the low risk category, PHQ-9 scores indicate the severity of depression and services are to be based on the degree of severity.

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### **Brief Interventions**

Brief intervention involves one to five sessions for patients whose screening score indicates hazardous alcohol and/or other drug use. Motivational interviewing technique is to be used for brief intervention, which is a client centered, non-judgmental approach to changing behavior by providing feedback to patients about their use and enhancing patients' motivation to change.

### **Referral to Treatment**

Referral to treatment includes Brief Treatment and Referral to Treatment. Brief treatment involves up to 12 sessions to help patients identify and develop needed skills and resources to change and should be offered to patients whose screening score indicates harmful use. Brief Treatment can be based on motivational and cognitive approaches and can include a standardized assessment. Patient-centered goal setting and strategies focused on change that can be accomplished quickly are paramount to brief treatment. Patients can be referred to an alcohol and other drug provider for this service, or the SUB-AWARDEE can provide this service at its own expense if the facility and/or staff meet State of Ohio qualifications. Patients referred to brief treatment may also receive brief intervention as a means of engagement, to help with resistance issues or for care coordination purposes.

Patients whose screening score indicate high risk, i.e. severe or dependency are to be referred to the patients' local publicly funded or private specialty treatment, i.e. alcohol and other drug treatment system, or the SUB-AWARDEE can provide this service at its own expense if the facility and/or staff meet State of Ohio qualifications. Patients referred to specialty treatment may also receive brief intervention and/or brief treatment as a means of engagement, to help with resistance issues or for care coordination purposes. The SUB-AWARDEE must refer patients to specialty treatment if they may qualify for a diagnosis of substance use disorder and they are non-responsive to an initial Brief Intervention or Brief Treatment.

NOTE: The Consumer Advocacy Model (CAM) offered through the Substance Abuse Resources and Disability Issues (SARDI) program at Wright State University is the identified specialty treatment for Ohio SBIRT and will provide telehealth services, when appropriate.

### **Patients Using Tobacco Products**

The SUB-AWARDEE must promote abstinence from all tobacco products. For patients currently using tobacco products the SUB-AWARDEE will encourage patients to quit and provide information or resources to patients who would like help quitting, including, but not limited to access to a local tobacco cessation program if available. The SUB-AWARDEE will set annual targets for the reduction of past month (30-day) tobacco use (measured by the screening tool) among patients who complete a full screen.

### **DATA COLLECTION AND REPORTING**

As authorized in Ohio Revised Code Section 5119.61, OhioMHAS will collect information and data from SUB-AWARDEEs. This information and data are outlined in the Reporting Requirements, which will be distributed with all the Notice of Sub-Awards. These Reporting

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Requirements will be available on the OhioMHAS website. Reporting requirements, such as expenditure reports and quarterly program summary reports, will be reviewed by OhioMHAS staff. Failure to comply with reporting requirements shall result in further action by OhioMHAS.

### **Health Information Technology**

SAMHSA/CSAT SBIRT program is currently being driven by health information technology (HIT). HIT includes embedding screening tools into EHR/EMR at the medical facilities to improve care coordination, support evidence-based practices, improve workflow, reduce provider burden and/or improve coordination of billing and reimbursement with a focus on developing sustainable practices. In addition EHR/EMR upgrades support consent management and the exchange of health records that are subject to 42 CFR Part 2 using the health information exchange system, CliniSync, managed by the Ohio Health Information Partnership.

The SUB-AWARDEE may be issued computer equipment to use for patient screenings. The OhioMHAS issued computer equipment will include the screening tools and will be configured to imbed the questions and responses directly into the SUB-AWARDEE's current electronic health/medical record (EHR/EMR), in a manner consistent with current industry-standard methods, i.e. encryption, to facilitate security and protection of patient data. The SUB-AWARDEE is responsible for securing and maintaining the computer equipment in working order. The Department will not replace damaged, lost or stolen computer equipment. The SUB-AWARDEE must replace any damaged, lost or stolen computer equipment at the SUB-AWARDEE's cost. The computer equipment remains the property of the Department, and will be returned to the Department at the conclusion of the award period.

The SUB-AWARDEE shall have a contingency plan as a back-up for administering screenings, as well as scoring, and making recommendations for services, collecting and reporting GPRA data, and documenting services for cost reimbursement purposes in the event of malfunction of the EHR/EMR system.

### **Government Performance and Results Act (GPRA)**

The Government Performance and Results Act (GPRA) data collection and reporting is required for all patients. The GPRA interviews are to be conducted face-to-face or in person. Telephone GPRA interviews can be conducted on a case-by-case, as needed basis. GPRA interviews cannot be conducted through mail or email. The SUB-AWARDEE will be trained at no cost on data collection and reporting. Table 2 outlines what GPRA data are to be collected and when.

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Table 2: GPR requirements for SBIRT services.

	<b>INTAKE/ BASELINE</b>	<b>DISCHARGE</b>	<b>6-MONTH FOLLOW-UP*</b>
<b>SBIRT Service</b>	<b>GPR Section</b>	<b>GPR Section</b>	<b>GPR Section</b>
Pre/Screening Only or Patient Refuses Services (BI, BT or RT)	A	None	None
Brief Intervention 8 days	A, B	A, J, K+	A, B, I
Brief Treatment ≥ 8 days	A, B, C, D, E, F, G (A-G)	A, B, C, D, E, F, G, J, K** (A-G and J, K)	A, B, C, D, E, F, G, I (A-G and I)
Referral to Treatment	A, B, C, D, E, F, G (A-G)	A, B, C, D, E, F, G, J, K**++ (A-G and J, K)	A, B, C, D, E, F, G, I (A-G and I)

\*Complete Sections A and I when a follow-up interview is not conducted.

\*\*Complete only Sections A, J and K when a discharge interview is not conducted.

+No face-to-face discharge interview is required.

++No face-to-face discharge interview is required after a patient/client failed to show up for 30 days.

This information will be used to report on the GPR performance measures: ▪ Abstinence from use; ▪ Housing status; ▪ Employment status; ▪ Criminal justice system involvement; ▪ Access to services; ▪ Retention in services; and ▪ Social connectedness. The GPR tool for discretionary services can be viewed at: <http://www.samhsa.gov/grants/CSAT-GPR/services.aspx>.

Only patients who have a positive full screen and receive brief intervention, brief treatment or referral to treatment can be in the 6-month follow-up sample pool. Ten (10 percent) of patients will be randomly sampled, i.e. everyone has an equal chance of being selected, for the 6-month follow-up interview. Eighty (80) percent of the 6-month follow-up interviews must be completed, or the SAMHSA/CSAT funding for SBIRT services is subject to forfeit. “Care Coordinators” assigned by the SUB-AWARDEE must maintain contact with patients with GPR client identification numbers that begin with the number three (3). The “Locator Form” completed by patients is to be used to assist in locating patients for the follow-up interview.

**Additional Data Collection**

Additional data collection and reporting, to assist with the preparation of the semi-annual reports to maintain funding and for performance management purposes, including the core outcome data: Number served (unduplicated) and percent of service recipients who: ▪ Have no past month substance abuse use; ▪ Have no or reduced alcohol or illegal drug consequences; ▪ Are permanently housed in community/living in stable housing environment; ▪ Are employed/in school; ▪ Have no or reduced criminal justice involvement; ▪ Have increased social connectedness; and ▪ Have good or improved health and mental health status.

Other data needed includes: Number of: ▪ Prescreens completed; ▪ Brief Intervention sessions (and length of sessions); ▪ Brief Treatment sessions (and length of sessions); and ▪ Referral to Treatment by admitting level of care. Data will be reported by race; ethnicity; gender; and by other subpopulations as applicable: ▪ Older adults (65 or older); ▪ Pregnant women; ▪ Lesbian, gay, bisexual and transgender (LGBT) status; ▪ and Military status (service member or veteran).

**Patient Satisfaction Survey**

The SUB-AWARDEE will have a procedure for surveying patients' satisfaction related to SBIRT services and will submit to the Department, as part of the quarterly report, key learning's or results from the patient satisfaction survey that may serve as a basis to improve SBIRT services. SUB-AWARDEE will submit its proposed patient satisfaction survey and reporting plan to the Department for approval.

**Performance Assessment**

The SUB-AWARDEE is expected to participate in a performance assessment as needed. The Performance assessment is used to assist in determining if program goals, objectives and outcomes are being achieved and whether adjustments or improvements need to be made. Barriers encountered and efforts to overcome these barriers are also to be part of the performance assessment as well as policy and system change, funding and access, training and TA barriers and the expansion of the continuum of care for patients with a SUD. Unidentified information from patient satisfaction surveys may be used.

**PROGRAM REQUIREMENTS**

**Program Service Responsibilities**

The SUB-AWARDEE will administer prescreens to all adult patients, i.e. 18 years old or older, receiving services delivered by the SUB-AWARDEE through July 31 , 2015. Patients will complete the applicable full screen when there is a positive prescreen and the tobacco screen. For patients who score positive on an alcohol and/or other drug full screen, SUB-AWARDEE will provide care coordination for a minimum of six (6) months, and complete the applicable SAMHSA/CSAT GPRA interviews. For subsequent years of funding, the SUB-AWARDEE will administer prescreens and, as appropriate, full screens and intervention and referral services, to all adult patients on an annual basis. Care coordination for a minimum of six (6) months for patients who score positive on an alcohol and/or other drug full screen and completion of the applicable GPRA interviews will be provided only for new adult patients.

Services for patients who are unable to communicate, e.g. in a coma, are to be offered services when they regain their ability to communicate should this occur before their discharge. Patients who are not able to participate because of their inability to communicate shall be documented and reported to the Department as non-participants. Information to be reported includes day, date, medical service or chief complaint and reason for non-participation.

Patients who refuse to participate shall be documented and reported to the Department. Information to be reported includes day, date, time of day, age, gender, race, ethnicity, and reason for refusal (if known) to assist in determining training or technical assistance needs.

The SUB-AWARDEE shall refer patients in need of Brief Treatment or Referral to (Specialty) Treatment through the patients' local publicly funded behavioral health system, private specialty providers, as appropriate, or SUB-AWARDEE may provide the services within the SUB-

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AWARDEE system, if appropriately qualified and credentialed to provide the services in the state of Ohio. The local publicly funded system or private practitioners may make the referrals, as appropriate, to the Consumer Advocacy Model (CAM) for telehealth services under this project. If the SUB-AWARDEE is providing outpatient services for patients referred to specialty treatment, the SUB-AWARDEE may make the referral to CAM for telehealth services, as appropriate.

The SUB-AWARDEE will ensure patients receive appropriate SBIRT services based on the screening scores, including development of a treatment plan for mental health services and provision of mental health services, or referral for mental health services, as needed.

The SUB-AWARDEE shall not be abstinence based, but shall work towards having patients limit alcohol consumption to the established low-risk level, except for patients under the age of 21 and those who may have or have been diagnosed as having or have a SUD. The SUB-AWARDEE will work towards abstinence for these patients.

The SUB-AWARDEE will have a policy for the identification of and referral for patients in need of detoxification.

For patients who are misusing prescription drugs, the SUB-AWARDEE shall work towards having patients use prescription drugs as prescribed. For patients who are using illegal drugs, the SUB-AWARDEE shall work towards having patients abstain from using illegal drugs.

For patients who indicate they use tobacco products, the SUB-AWARDEE will encourage patients to quit and provide information and resources to patients who would like help quitting, including, but not limited access to a local tobacco cessation program if available.

### **Program Operations and Management**

Any use of funds for equipment (including electronic devices such as computers, tablets and cell phones), furniture or computer software must be justified in terms of the relationship of the equipment, furniture or computer software to the program or activity. Justification to purchase equipment, furniture, computer software must be submitted to OhioMHAS for prior approval and include consideration of how the equipment, furniture or computer software will be used, why the purchase is necessary, what alternatives were considered, how the cost was determined and why the program considers the cost reasonable. Funds cannot be expended for equipment, furniture or computer software until approved by the Department.

Equipment, furniture or computer software purchased under a grant is the property of OhioMHAS. A list of equipment, furniture and computer software, including serial numbers must be submitted to the Community Funding unit. See Item #10 in the general assurances and agreements in the event of termination or non-renewal.

The SUB-AWARDEE will ensure that the patient or legal guardian completes the appropriate consent forms and the locator form relating to SBIRT services, collection and reporting of GPRA

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data, and exchange of information.

The SUB-AWARDEE will maintain a workflow for SBIRT services consistent with that submitted with the Application and approved by OhioMHAS.

The SUB-AWARDEE shall provide to the Department, by August 1, 2014, documentation of a formal agreement with each referral entity, and shall keep the Department informed of changes with referral entities.

### **APPLICATION REQUIREMENTS**

#### **Submission Requirements**

The following documents must be submitted with this Application (see attached):

- 1) OhioMHAS Face Sheet, signed and dated by an authorized person;
- 2) Budget Expenditure Form
- 3) Budget Narrative Template
- 4) Equipment/Furniture/Computer Software/Hardware Itemization Form (as applicable)
- 5) Copy of 501 (c) 3 Documentation
- 6) New Vendor Information Form
- 7) W-9 Form
- 8) Ohio SBIRT Services Plan (requirements are described below)
- 9) General Agreement and Assurances
- 10) Specific Program Agreement and Assurances

Electronic bids must be sent to [OhioMHASBidOpportunity@mha.ohio.gov](mailto:OhioMHASBidOpportunity@mha.ohio.gov)

Questions regarding this grant must be sent via the State of Ohio Procurement Website [www.procure.ohio.gov](http://www.procure.ohio.gov) under the Request for Proposal "Submit Inquiry" link.

### **OHIO SBIRT SERVICES PLAN**

Please provide the following information in six (6) pages or less using a 12-point font. Please use the following headings.

#### Abstract

Provide a concise summary how SBIRT services will be implemented that includes a brief description of the program, the need for the services, population of focus, expected outcomes, sustainability strategy(ies) and total amount of program funding (including OhioMHAS and other sources).

#### Population of Focus

Provide a description of the population to be served. Note: All patients 18 years of age or older are to be offered SBIRT services, except for hospital applicants. Hospital applicants may limit

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the offer of SBIRT services to patients admitted to specific medical services or admissions as demonstrated by need. Emergency Departments are considered their own community health settings and must be their own applicant. Include information about gender, race, ethnicity, cultural and linguistic and literacy factors, including but not limited to LGBT status. Provide an estimated number of patients to be served by payer source.

### **Organizational Capacity Workflow**

Describe the staffing for SBIRT services and the organization's capacity to provide the services. Include a workflow in narrative and/or flowchart format that describes/illustrates who will be doing what and when. Include entities patients will be referred to such as tobacco cessation program, brief treatment and specialty treatment. Flowcharts do not count towards page limit.

### **Sustainability Plan**

Describe how the program will be sustained after funding. Include spread and diffusion plans for the program.

## **AGREEMENT AND ASSURANCES**

The Agreement and Assurances include federal and/or state requirements that must be adhered to by the applicant. The Agreement and Assurances must be signed and submitted with the Application. SUB-AWARDEE agrees to comply with the terms therein, including all attachments.

SBIRT/PR/JRK/TPP/SHO/Year 2 provider application FINALv1.docx  
03/14/14



# VENDOR INFORMATION FORM

All parts of the form must be completed by the vendor. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at [www.ohiosharedservices.ohio.gov](http://www.ohiosharedservices.ohio.gov).

## SECTION 1 – PLEASE SPECIFY TYPE OF ACTION (MUST BE COMPLETED)

- NEW (**W-9 OR W-8ECI FORM ATTACHED**)     CHANGE OF CONTACT PERSON/INFORMATON
- ADDITIONAL ADDRESS – (**A COPY OF AN INVOICE OR A LETTER INCLUDING THE ADDRESS IS REQUIRED**)
- CHANGE OF ADDRESS – (**PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER**)
 

ADDRESS TO BE REPLACED:
- CHANGE OF TIN (**W-9 & A CHANGE OF TIN FORM OR A LETTER OF EXPLANATION FOR THIS CHANGE, WHICH MUST INCLUDE THE NEW & OLD TIN**)
- CHANGE OF NAME (**W-9 & A CHANGE OF NAME FORM OR A LETTER OF EXPLANATION FOR THIS CHANGE, WHICH MUST INCLUDE THE NEW & OLD NAME**)
- CHANGE OF PAY TERMS     CHANGE OF PO DISPATCH METHOD     OTHER \_\_\_\_\_

## SECTION 2 – PLEASE PROVIDE VENDOR INFORMATION (MUST BE COMPLETED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-8ECI FORM)

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BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

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FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN):

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## SECTION 3 – REMIT TO ADDRESS REQUIRED (MUST BE COMPLETED)

ADDRESS:	COUNTY:	
ADDRESS (CONT.):		
CITY:	STATE:	ZIP CODE:

## SECTION 4 – ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS:	COUNTY:	
ADDRESS (CONT.):		
CITY:	STATE:	ZIP CODE:

**SECTION 5 – CONTACT INFORMATION OR PERSON TO RECEIVE PURCHASE ORDER**

NAME:

WEBSITE:

PHONE:

FAX:

EMAIL:

**SECTION 6 – CONTACT PERSON TO RECEIVE EMAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE EMAIL ADDRESS BELOW – (BUSINESSES ONLY)**

NAME:

EMAIL:

TO ADD AN ADDITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

 ADDITIONAL STRATEGIC SOURCING CONTACT REPLACE SS CONTACT **(WILL BE MARKED INACTIVE)**

NAME:

EMAIL:

**SECTION 7 – PAYMENT TERMS (PLEASE CHECK ONE – IF NONE IS SELECTED THEN NET 30 WILL APPLY)** 2/10 NET 30 NET 30 NET 45 NET 60 NET 90**SECTION 8 – PURCHASE ORDER DISTRIBUTION—OTHER THAN USPS MAIL (ONLY APPLICABLE TO THOSE RECEIVING POs)**EMAIL OR FAX:**SECTION 9 – PLEASE SIGN & DATE (MUST BE COMPLETED)**

PRINT NAME:

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED)

DATE:

**SECTION 10 – STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)**

AGENCY CONTACT NAME/EMAIL/PHONE:

COMMENTS:

**Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.****SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:****Email:** [vendor@ohio.gov](mailto:vendor@ohio.gov)**Fax:** 1 (614) 485-1052**Mail:** Ohio Shared Services  
Attn: Vendor Maintenance  
P.O. Box 182880 Cols., OH 43218-2880**QUESTIONS? PLEASE CONTACT:****Phone:** 1 (877) OHIO - SS1 (1-877-644-6771)

1 (614) 338-4781

**Website:** [www.ohiosharedservices.ohio.gov/](http://www.ohiosharedservices.ohio.gov/)**Email:** [vendor@ohio.gov](mailto:vendor@ohio.gov)

# Request for Taxpayer Identification Number and Certification

**Give Form to the  
 requester. Do not  
 send to the IRS.**

Print or type  
 See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name/disregarded entity name, if different from above	
Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate  <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____  <input type="checkbox"/> Other (see instructions) ▶ _____	Exemptions (see instructions):  Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number									

Employer identification number									

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** The IRS has created a page on IRS.gov for information about Form W-9, at [www.irs.gov/w9](http://www.irs.gov/w9). Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the

withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

**Note.** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

**Directions for Completion of Agreement and Assurances by Applicant for Sub-Award:**

1. Type into or select the appropriate box that is **highlighted blue** and **gray**.
2. Please note that paragraphs 24-33 only apply to sub-awards funded in whole or part with federal Mental Health Block Grant (MHBG) funds. Paragraphs 34-46 only apply to sub-awards funded in whole or part with federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds.
3. Sign the signature page.
4. Read and Sign Attachment 2: "Certifications," Attachment 3: "Non Construction Programs" for sub-awards funded in whole or part with federal funds and Attachment 4: "Standard Affirmation and Disclosure—Executive Order 2011-12K".
5. IF necessary, add other documents and incorporate into Attachment 5.
6. Mail completed and signed documents to the attention of your Mental Health Block Project Lead.

***NOTE: Changes and/or modifications to the Agreement and Assurance will not be accepted by ODMHAS.***

## **AGREEMENT and ASSURANCES (Attachment 1)**

**In accepting a sub-award from the Ohio Department of Mental Health and Addiction Services, hereinafter DEPARTMENT, ("SUB-AWARDEE"),  
Located at;**

**Agrees and makes the following assurances:**

1. SUB-AWARDEE has applied for a sub-award ("sub-award") from one or more of the following fund sources:
  - Community Mental Health Block Grant (CFDA 93.958)
  - Title IV-B, Part 1 Child and Family Services Grant (CFDA No. 93.645, Federal Award No. 0701OH00FP)
  - Title IV-B Part 2 Family Support Grant (CFDA No. 93-556, Federal Award No. 0701OH1400)
  - 5AU Rotary; ODMHAS Account for Receipt of federal funds
  - Projects for Assistance in Transition from Homelessness (PATH) Grant (CFDA No. 93.150)
  - GRF Allocation Line Item (ALI) Grant
  - Title XX (CFDA No. 93.667)
  - Child Care Quality (CFDA No. 93.713)
  - Other: [include CFDA # for federal funds]
  - Other: [include CFDA # for federal funds]
  - Other: [include CFDA # for federal funds]
  - SAPT Block Grant funds as defined in Public Laws 102-394, and 102-321 administered by the DEPARTMENT for the purpose(s) described in the final approved version of the Application(s) for Funding (APPLICATION). The APPLICATION includes goals, objectives, activities, performance indicators, budget and budget narrative.

2. If applicable, the Notice of Sub-Award (NOSA) or Intrastate Transfer Voucher (ISTV) (included as Attachment 6) is incorporated by reference as an integral part of this agreement.

The NOSA establishes the:

- a) Dollar amount awarded by the DEPARTMENT;
- b) Plan for drawing down funds;
- c) Specific terms and conditions or amendments to this Agreement;
- d) Frequency of required reporting and the persons at the DEPARTMENT to whom those reports should be submitted.

The ISTV establishes:

- a) Dollar amount awarded by the DEPARTMENT;
- b) OAKS Coding
- c) Project Description

All other attachments to this Agreement referenced herein, including those listed in Attachment 5, are hereby incorporated by reference as integral parts of this Agreement.

3. With the signing of this Agreement, the SUB-AWARDEE will begin work to accomplish the goals, objectives, activities and meet the performance indicators (including but not limited to production of deliverables) identified in the APPLICATION.
4. The Application, Interagency Agreement (if applicable) and this Agreement, including all attachments, constitutes the entire agreement between the parties and may be changed or modified only in writing, signed by all the parties hereto or their legal successors.
5. The SUB-AWARDEE assumes full responsibility for implementation of the goals, objectives and activities as described in the APPLICATION, including those performed by any lower tier sub-recipient ("SUB-RECIPIENT") named in the APPLICATION. SUB-AWARDEE is responsible for ensuring that its SUB-RECIPIENT (if any) is responsible for meeting the terms and conditions of this Agreement in accordance with the performance indicators detailed in the APPLICATION. [45 CFR 92.37]
6. This sub-award is subject to the availability of funds from the appropriate fund source, and allocated to the DEPARTMENT by the State of Ohio, Office of Budget and Management [ORC 126.07]. The DEPARTMENT reserves the right to alter the amount of this sub-award without prior notice to the SUB-AWARDEE. If funds designated for this program become unavailable during the term of this Agreement, the DEPARTMENT's obligations under this Agreement expire immediately and SUB-AWARDEE shall be paid for any non-cancelable obligations appropriately related to the sub-award. Upon such notice SUB-AWARDEE shall preserve and provide all work in progress to the DEPARTMENT. Upon satisfactory delivery of those materials and an acceptable final report, the DEPARTMENT will remit any payments due and release the SUB-AWARDEE from its obligations to DEPARTMENT for further performance under this Agreement.
7. SUB-AWARDEES subject to the audit requirements of OMB Circular A-133 are required to submit to the DEPARTMENT a copy of their A-133 audit(s) covering the period of the sub-award. If SUB-AWARDEE is not subject to the audit requirements of OMB Circular A-133, SUB-AWARDEE shall submit to the DEPARTMENT a copy of its annual financial audit(s) covering the period of the sub-award within the earlier of thirty (30) days after receipt of the auditor's report(s) or nine months after the end of the audit period, or such longer period as is agreed to in advance by the DEPARTMENT, unless a waiver of this requirement is approved in advance by the DEPARTMENT.
8. The SUB-AWARDEE shall purchase or maintain liability insurance and shall assure the DEPARTMENT that SUB-AWARDEE has in place adequate insurance and/or bonds all of its board members, officers or employees who are responsible for payments and expenditures from federal funds received from the DEPARTMENT. For SUB-AWARDEES that are ADAMH/CMH/ADAS Boards, this requirement may be met by participation in CORSA (County Risk Sharing Authority), a statement that the Board is self-insured and maintains adequate reserves to cover anticipated liabilities or purchase of insurance/bonds. This paragraph does not apply to Ohio's state agencies.