

Application Substance Use Disorder Treatment Services

Only one application is required per agency, even if applying for multiple areas.

Agency Legal Name: _____

Agency Website: _____ **Phone:** _____

Mailing Address/City/Zip: _____

Location of Services Address/City/Zip: _____

Organization Category:

- Private Not-for-Profit
 - Private For-Profit
 - Public Non-Profit
 - B-Corporation
 - Other: _____
-

Using the checkboxes below, please identify which service categories you are applying to provide. Details of services found in Attachment 1: Service Categories & Program Information:

Service Categories

- 1. Outpatient Drug-Free (ODF) Treatment - ASAM Level 1.0
 - 1.1. General ODF
 - 1.2. Specialty Population: ODF for SUD Court Participants
- 2. Narcotic (Opioid) Treatment Program (NTP) – ASAM Level 1.0
- 3. Adolescent Treatment Program (ATP) – ASAM Levels 1.0 & 2.1
- 4. Intensive Outpatient Treatment (IOT) – ASAM Level 2.1
 - 4.1. Special Population: IOT for SUD Court Participants
 - 4.2. Specialty Program: Perinatal Intensive Outpatient Treatment Program
 - 4.3. General IOT

- 5. Residential Therapeutic Treatment – ASAM Levels 3.1 & 3.5
 - 5.1. General Residential Therapeutic Treatment
 - 5.2. Specialty Program: Perinatal Residential Therapeutic Treatment
 - 5.3. Specialty Population: Mono-lingual Spanish Speaking
 - 5.4. Specialty Population: Adolescents
- 6. Clinically Managed Residential Withdrawal Management – ASAM Level 3.2
- 7. Recovery Residences

Service Provision Details

For any Service Categories selected above, please fill details below.

Service Category	ASAM Levels Served	Population Served	Hours of Operation	Frequency and Duration of Services	Address of Facility
<i>e.g. 5.1 General Residential Therapeutic Treatment</i>	<i>e.g. 3.1 & 3.5</i>	<i>e.g. Men, Women, Youth, Ages 18-24</i>	<i>e.g. 24 Hours, M-F 8AM – 5PM</i>	<i>e.g. Daily 3-5 hours</i>	<i>e.g. 1430 Neotomas Ave, Santa Rosa, CA 95403</i>

Certification Information

As indicated in Attachment 1: Service Categories & Program Information, Proof of Certification is required for all services your agency intends to apply to provide. Please attach copies of appropriate certifications for the services you have indicated in this application.

Contracting Information

Authorized Signer

Name of Person Authorized to sign contracts: _____

Title: _____ Phone: _____

Email: _____

Program Contact

Name of Agency Programmatic Lead: _____

Title: _____ Phone: _____

Email: _____

Contracting/Administration Contact

Name of Agency Contracting Lead: _____

Title: _____ Phone: _____

Email: _____

Fiscal Contact

Name of Agency Fiscal Lead: _____

Title: _____ Phone: _____

Email: _____

Privacy Officer

Name Agency Privacy Officer: _____

Title: _____ Phone: _____

Email: _____

Conditions for Contracting with the County of Sonoma

In order to contract with the County, an individual or agency must meet the following criteria and agree to the criteria by initialing each criteria below.

1. _____ Be legally capable and willing to contract with the County based on Sample Contract.
2. _____ Be able to provide current insurance documents as described.
3. _____ Be willing to attend monthly provider meetings and maintain routine communication with Department Program Contact.

Signature

To the best of my knowledge and belief, all information in this proposal is true and correct. The Respondent and/or Cosigner will comply with all of the requirements of the application process and the subsequent contract with the County.

Signature: _____ Date: _____

Printed Name: _____

Please check to make sure the below are included with your Application:

1. Signed Application (all pages of this document)
2. Copies of Certification/Licensure for any indicated services
3. Completed Supplemental Questions (Attachment 2)
4. Signed Attestation Regarding County Contract (including proposed edits, if any)
5. Signed Acceptance of County Insurance Requirements

Send all materials to:

Subject: SUD Treatment RFA - [Provider Name]

Email: DHS-Procurement@sonoma-county.org