



**SUBSTANCE ABUSE PREVENTION AND CONTROL
FIELD-BASED SERVICES WORK PLAN**

SUBMIT THE WORK PLAN FORM TO:

Website:

PROVIDER AGENCY INFORMATION			
1. Program/Facility Name:			
2. DMC Certified Facility Address:		3. City/State/Zip:	
PROPOSED POPULATIONS TO BE SERVED			
<p>4. Check all that apply: (must attach a brief narrative of agency experience in treating the proposed population)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Arsonists <input type="checkbox"/> Registered Sex Offenders <input type="checkbox"/> Homeless <input type="checkbox"/> Chronically Homeless <input type="checkbox"/> Co-Occurring Disorder (Mental or Physical Health Condition) <input type="checkbox"/> Medically Fragile <input type="checkbox"/> Other: _____ </div> <div style="width: 45%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Residents of Rural Areas <input type="checkbox"/> Juvenile Justice involved Youth <input type="checkbox"/> Foster Care Youth <input type="checkbox"/> Pregnant and Postpartum Women <input type="checkbox"/> School-Based Youth <input type="checkbox"/> Youth in Alternative School Placements </div> </div>			
PROPOSED FBS SETTINGS			
<p>5a. ADULT POPULATIONS</p> <p>Check all that apply: (must attach a list of proposed site addresses and copies of MOUs)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Board and care settings <input type="checkbox"/> Federal Qualified Health Centers <input type="checkbox"/> Community Centers <input type="checkbox"/> Mental Health Treatment Sites <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Recovery Bridge Housing <input type="checkbox"/> Other: _____ 		<p>5b. YOUTH POPULATIONS</p> <p>Check all that apply: (must attach a list of proposed site addresses)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Youth homeless shelters <input type="checkbox"/> Group homes <input type="checkbox"/> Community facility centers <input type="checkbox"/> Schools <input type="checkbox"/> Recreational centers <input type="checkbox"/> Other: _____ 	
PROPOSED FBS SERVICES			
<p>6. What Field Based Services does the program propose to provide? (must attach brief narrative on how agency proposed to adhere confidentiality rules and regulations in non-clinical settings)</p>			
<ul style="list-style-type: none"> <input type="checkbox"/> Clinical Assessments <input type="checkbox"/> Individual Counseling Sessions <input type="checkbox"/> Group Counseling Sessions <input type="checkbox"/> Case Management <input type="checkbox"/> Patient Education Sessions <input type="checkbox"/> Family Therapy 		<ul style="list-style-type: none"> <input type="checkbox"/> Collateral Services <input type="checkbox"/> Crisis Intervention Services <input type="checkbox"/> Recovery Support Services <input type="checkbox"/> Other: _____ 	
STAFFING			
7. Please list program staff who will conduct field based services:			
Name	Title	License or Certification/Registration	Number of years of experience providing SUD treatment services
<p>I CERTIFY THAT I HAVE READ AND UNDERSTAND THE OPERATION OF THE PROGRAM FOR WHICH I AM APPLYING. I UNDERSTAND THE INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS</p>		<p>Authorized Individual: _____ Title: _____</p> <p>Signature: _____ Date: _____</p>	
<p>Internal SAPC Use Only:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Initial work plan approved by DPH-SAPC <input type="checkbox"/> Revised work plan approved by DPH-SAPC <input type="checkbox"/> Denied by DPH-SAPC. Reason for denial: _____ 		<p>Authorized Individual: _____ Title: _____</p> <p>Signature: _____ Date: _____</p>	

FIELD BASED SERVICES FORM INSTRUCTIONS

Providers are not permitted to initiate field based services until receiving initial approval from DPH-SAPC. To request approval, providers must complete The field based services request form and provide a supporting narratives no longer than two (2) pages for review. Upon approval of submitted work plan, providers may only bill for field based services as outlined in this form and attached narrative. Providers may submit revised work plans for review and approval as needed. Reasons for denial may include but are not limited to: incomplete forms or missing narratives; lack of demonstrated experience with target populations proposed or inappropriate proposed settings that will prevent adherence to confidentiality rules and regulations.

PROVIDER AGENCY INFORMATION

1. Enter the SAPC contracted program/facility name.
2. Enter the SAPC contracted program/facility address.
3. Enter the SAPC contracted program/facility city, state and postal zip code.

PROPOSED POPULATIONS TO BE SERVED

4. Check use population provider proposes to serve via field based services and include an attached narrative explaining provider's experience in providing services to this population and why field based services are needed to serve this population.

PROPOSED FBS SETTINGS

- 5a. Check all proposed field based service settings provider will utilize for adult populations. Must attach list of proposed site addresses.
- 5b. Check all proposed field based service settings provider will utilize for youth populations. Must attach list of proposed site addresses.

PROPOSED FBS SERVICES

6. Check what Field Based Services does the program proposes to provide. Must attach brief narrative on how agency proposed to adhere confidentiality rules and regulations in non-clinical settings.

STAFFING

7. Please list program staff approved to conduct field based services including name, title, license or certification/registration and years of experience providing substance use disorder services.

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