



**County of Los Angeles – Department of Public Health  
Substance Abuse Prevention and Control**

**Certification Application for the Harm Reduction Syringe Services (SSP) Program**

<b>I. Applicant Organization Information</b>			
Organization Name:		Application Date:	
Proposed SSP Name (if different from above):			
Phone Number:			
Mailing Address:			
City:		State:	Zip Code:
Name of SSP Administrator:			
Title:			
Admin Phone Number:		Admin Email Address:	

<b>II. Materials/Supplies Applicant Will Provide to Persons Who Use Drugs</b>		
<b>Check all applicable boxes</b>	<b>Yes</b>	<b>No</b>
Sterile Needles and Syringes	<input type="checkbox"/>	<input type="checkbox"/>
Safer Smoking Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Personal Sharps Disposal Containers	<input type="checkbox"/>	<input type="checkbox"/>
Naloxone	<input type="checkbox"/>	<input type="checkbox"/>
Condoms and Other Safer Sex Supplies	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl Test Strips	<input type="checkbox"/>	<input type="checkbox"/>
Food and/or Water	<input type="checkbox"/>	<input type="checkbox"/>
Other Safer Drug Use Supplies	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, please describe:		

<b>III. Services Applicant Will Provide to Persons Who Use Drugs</b>		
<b>Check all applicable boxes</b>	<b>Direct</b>	<b>Via Referral</b>
Syringe Distribution/Collection/Disposal	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>
Medications for Addiction Treatment	<input type="checkbox"/>	<input type="checkbox"/>
HIV/Hepatitis C Screening	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infection Screening	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A and B Vaccination	<input type="checkbox"/>	<input type="checkbox"/>
Housing Services	<input type="checkbox"/>	<input type="checkbox"/>
Other Services	<input type="checkbox"/>	<input type="checkbox"/>
• Please describe 'Other Services,' if applicable:		

<b>IV. Required Plans</b>	
<b>Please submit required plans electronically via <a href="mailto:harmreduction@ph.lacounty.gov">harmreduction@ph.lacounty.gov</a> at the time of submission.</b>	<b>Submitted</b>
<i>Please refer to the SAPC Information Notice for additional information regarding required plan components.</i>	
Core Services Delivery Plan	<input type="checkbox"/>
Sterile Syringe Distribution Plan	<input type="checkbox"/>
Syringe Collection and Sharps Waste Disposal Plan  <i>*Applicant must already be or attest to becoming an approved Home-Generated Sharps Consolidation Point through the California Department of Public Health Medical Waste Program within 60 days of obtaining SAPC Harm Reduction Syringe Services (SSP) Program Certification.</i>	<input type="checkbox"/>
Data Collection and Reporting Plan	<input type="checkbox"/>

<b>V. Required Policies &amp; Procedures</b>	
<b>Please submit required policies and procedures electronically via <a href="mailto:harmreduction@ph.lacounty.gov">harmreduction@ph.lacounty.gov</a> at the time of submission.</b>	<b>Submitted</b>
Syringe Distribution	
Syringe Collection and Sharps Waste Disposal	<input type="checkbox"/>
Needle Stick Prevention	<input type="checkbox"/>
Needle Stick Injury Response	<input type="checkbox"/>
Participant Confidentiality in accordance with Title 42 of the Code of Federal Regulations (CFR) Part 2 and the Health Insurance Portability and Accountability Act (HIPAA)	<input type="checkbox"/>

<b>VI. Description and Summary of Proposed SSP</b>			
Estimated Annual Number of Clients Served:			
Estimated Annual Number of Syringes Distributed:			
Estimated Annual Number of Syringes Collected:			
<b>SSP Fixed Site Location(s), Days and Hours of Operation (if applicable).</b>			
<b>Attach table with additional locations, if necessary.</b>			
Location Name	Address	County	Days/Hours of Operation (e.g., Friday's from 12pm-2pm)

<b>SSP Mobile Site Location(s), Days and Hours of Operation (if applicable).</b>					
<b>Attach table with additional locations, if necessary.</b>					
Mobile Service Name	Method		Neighborhood(s)/ Intersection(s)/ Street Boundaries	County	Days/Hours of Operation (e.g., Friday's from 12pm-2pm)
	Vehicle	On-Foot			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Please provide the number of staff, titles of positions, and brief duty descriptions.</b>	
Position Title	Position Description
Overall number of paid and unpaid staff:	

## VII. Applicant Acknowledgement and Attestation

The following SSP services, at a minimum, must be provided to participants by Los Angeles County certified SSPs:

1. Needle and syringe services.
2. Overdose rescue medication (e.g., naloxone, etc.) training and distribution services
3. HIV and viral hepatitis prevention education services; and
4. Safe recovery and disposal of used syringes and sharps waste.

The Applicant attests that upon Certification it will comply with all applicable state laws and regulations.

The Applicant further acknowledges and agrees to the involvement of program participants input into program design, implementation, and evaluation.

Signature:

Date (mm/dd/yyyy):

**IMPORTANT:** Submission of an application does not constitute certification or a contract with the County.

Submit via the 'Submit Form' button at the top. If you experience technical issues completing this form, submissions are also accepted by emailing the completed form to [harmreduction@ph.lacounty.gov](mailto:harmreduction@ph.lacounty.gov).