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

ESTABLISHED FIELD-BASED SERVICES LOCATION APPLICATION FORM

To apply for an Established Field-Based Services (FBS) Location, email the completed application to: SAPC-SOC@ph.lacounty.gov with the subject "FBS Application".

NETWORK PROVIDER AGENCY INFORMATION

1. SAPC Network Provider Agency Name:

2. Home DMC-Certified Facility Address:

3. Network Provider Agency Contact Information:

Point of Contact Name: _____

Phone Number: _____

Email Address: _____

Name(s) and email of staff serving at FBS location:

PROPOSED POPULATIONS TO BE SERVED

4. Please share the populations you plan to serve: (Check all that apply)

- ❑ Youth (age 17 and under)
- ❑ Transition-aged youth (18-25)
- ❑ Adult (21-59) population
- ❑ Older adult (60+) population
- ❑ Harm reduction / non-abstinent
- ❑ People who are gang-involved
- ❑ People convicted of arson
- ❑ People who are registered sex offenders
- ❑ Residents of rural areas
- ❑ People who are unstably housed, people experiencing homelessness and chronic homelessness
- ❑ People who are medically fragile
- ❑ People with co-occurring mental or physical conditions
- ❑ People who are pregnant and postpartum
- ❑ LGBTQI+ adults (over 18)
- ❑ LGBTQI+ youth (age 17 and under)
- ❑ Youth involved in the foster care system
- ❑ Youth involved in the juvenile justice system
- ❑ Youth at traditional school sites
- ❑ Youth at alternative school sites
- ❑ Other: _____

PROPOSED SPA(S) TO BE SERVED

5. What Service Planning Area (SPA) does the program propose to serve? (Check all that apply)

❑ SPA 1 ❑ SPA 2 ❑ SPA 3 ❑ SPA 4 ❑ SPA 5 ❑ SPA 6 ❑ SPA 7 ❑ SPA 8

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SERVICE COMPONENTS

6. What FBS service components will you be providing? (Check all that apply)

- ❑ Screening
- ❑ Assessment/Intake
- ❑ Individual Counseling
- ❑ Group Counseling
- ❑ Care Coordination
- ❑ Problem List/Treatment Planning
- ❑ Discharge Planning
- ❑ Crisis Intervention
- ❑ Patient Education
- ❑ Family Therapy
- ❑ Collateral Services
- ❑ Addiction Medication Services (also known as Medications for Addiction Treatment [MAT] Services)
- ❑ Behavioral Health Prevention Education Services (Peer Support Services)
- ❑ Self-Help/Peer Services (Peer Support Services)

AMERICAN SOCIETY OF ADDICTION MEDICINE LEVELS OF CARE

7. Which ASAM Levels of Care (LOC) will be provided?

- ❑ ASAM 0.5 (Early Intervention)
- ❑ ASAM 1.0 (Outpatient)
- ❑ ASAM 2.1 (Intensive Outpatient)
- ❑ Recovery Services

ESTABLISHED FBS LOCATION

Provide information for the proposed Established FBS Location. If you are applying for multiple FBS locations, please complete a separate form for each location.

8. FBS Location Name: _____

9. Address: _____

10. Schedule (days/hours of operation): _____

11. Point of Contact Name and Email:_____

12. FBS Location Type (Select one):

- ❑ Schools (e.g., high schools, alternative schools, school districts, private schools, charter schools)
- ❑ Permanent Housing Sites (e.g., permanent supportive housing, public housing, etc.)
- ❑ Interim Housing (e.g., transitional housing)
- ❑ Homeless Shelter
- ❑ Board and Care / Group Home/ STRTP
- ❑ Community / Drop-In / Day Centers
- ❑ Federally Qualified Health Centers
- ❑ Department of Children and Family Services
- ❑ Department of Public Social Services
- ❑ Park, Recreation Center, Outdoor Recreation Area
- ❑ Department of Mental Health
- ❑ Department of Health Services
- ❑ Department of Probation Area Office
- ❑ Harm Reduction Co-location
- ❑ Other: _____

13. Proposed Place of Service Code:_____

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REQUIRED SUPPLEMENTAL DOCUMENTS

14. A complete FBS application must include all required supplemental documents. Please confirm that you reviewed the FBS Application Instructions (Attachment II) and included the following:

- ❑ FBS application narrative (required)
- ❑ Formal agreement or memorandum of understanding

ATTESTATIONS

15. FBS Standards and Practices

- ❑ I attest that I have reviewed the FBS Standards and Practices, and my agency will fully comply with all requirements, including Allowable Service and Service Expectations (page 5), Documentation (page 9), and monitoring (page 12).

16. Documentation

- ❑ I attest that my agency and all applicable staff will document all FBS in progress notes and claims in accordance with the FBS Standards and Practices and the current SAPC Provider Manual.

SIGNATURE OF AGENCY AUTHORIZED INDIVIDUAL

By signing below, you certify that the information provided in this application and all supplemental materials is complete and accurate to the best of your knowledge.

Name: _____ Email_____

Signature: _____ Date: _____

If submitting a printed and scanned version of this form (instead of using an e-signature), please include BOTH the signed application AND the original fillable form to ensure proper processing.

COUNTY USE ONLY:

- ☐ Application approved by DPH-SAPC SOC _____
- ☐ Other SAPC Section Review: _____
- ☐ Facility review completed on and approved: _____
- ☐ Date of approval for FBS implementation: _____
- ☐ Denied by DPH-SAPC. Reason for denial: _____

FBS Number_____