**Emergency Department Medication for Opioid Use Disorder Initiative**

*Editable Application Copy*

Below is an editable form that you can use to collect your answers prior to completing the official ED MOUD application. Please review [the grant guidelines](https://cfsem.org/initiative/opioid/michigan-opioid-partnership-grants/) before you begin. Email [opioidresponse@cfsem.org](mailto:opioidresponse@cfsem.org) to get the link to submit your official application.

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# Applicant Contact

Please provide the following information for the individual completing this application. This is the person we will reach out to during the application review process if we have any questions.

Contact Information

* Name:
* Prefix (Mr., Ms., Mx., Dr., etc.):
* Email Address:
* Phone Number:

Position Title:

# Organization Information

Please provide the following information for the organization receiving the funds (i.e., the Fiduciary). This is the organization agreeing to the award terms and receiving payments. This is typically the individual hospital, health system, or associated foundation.

When choosing the fiduciary, please keep the following in mind about accepting federally sourced funds:

* The single audit threshold of $750,000
* The source documentation that the organization will be responsible for maintaining and submitting monthly along with program invoices.
* The possibility of federal monitoring virtual site visits

Fiduciary Information

* Legal Name:
* Address:
* Address 2:
* City/Town:
* State/Province:
* ZIP/Postal Code:
* Country:
* Website:
* Phone Number:

Mailing Address: Throughout the award period, all payments will be mailed via paper checks. Please provide the physical address to which checks should be mailed.

* Address:
* Address 2:
* City/Town:
* State/Province:
* ZIP/Postal Code:
* Country:

Tax ID/ EIN:

Unique Entity Identifier Number:

Does the fiduciary qualify as a certified 501(c)(3) nonprofit organization, government entity, or certified religious organization?

* Yes
* No

Has the fiduciary ever received federal funds?

* Yes
* No

Organization Mission:

Brief Background of Organization:

Current Programming of Organization:

Total Number of People Served Each Year by Organization:

If applicable, please indicate on behalf of which health/ hospital system the fiduciary is accepting the award, or to which health/ hospital system the fiduciary belongs.

*Note: this question should only be skipped if the fiduciary is the health/ hospital system.*

If applicable, please indicate on behalf of which hospital(s) the fiduciary is accepting the award.

*Note: this question should only be skipped if the fiduciary is an individual hospital.*

* Hospital 1, Legal Name & Address:
* Hospital 2, Legal Name & Address:
* Hospital 3, Legal Name & Address:
* Hospital 4, Legal Name & Address:
* Hospital 5, Legal Name & Address:
* Hospital 6, Legal Name & Address:
* Hospital 7, Legal Name & Address:
* Hospital 8, Legal Name & Address:
* Hospital 9, Legal Name & Address:
* Hospital 10, Legal Name & Address:

Please provide an outline of the geographies (i.e., neighborhoods, cities, or counties) that will be served by the proposed project:

# Funding Request

Please specify the total amount of funding being requested and provide the project budget. Please keep the following in mind:

* Awards are federally sourced. All expenditures must meet federal standards for allowability under the applicable cost principles and must occur within the award period, ending September 29th, 2023.
* Awards will not exceed $100,000 per hospital or $350,000 per hospital system. (If more funds are anticipated, contact CFSEM to inquire about additional funding).
* Grant funds are limited and are first come first serve.

Total Funding Request:

Please upload the project budget. Utilize the [budget template and FAQ](https://cfsem.org/initiative/opioid/michigan-opioid-partnership-grants/) provided by CFSEM.

# Documents to Upload

Please upload the following documents.

* Current Organizational Budget
* Current Board List with Affiliations
* Most Recent Certified Financial Audit or Review (include management letter if applicable)
* *If applicable*, Most Recent Single Audit (Formerly Known as A-133) (include management letter if applicable).
* Most Recent IRS 990 form
* Most Recent W-9
* Most Recent Approved Indirect Cost Rate Agreement
* Most Recent Internal Revenue Service 501(c)(3) federal tax-exemption letter
* Proof of the ability to serve all patients regardless of income or insurance (e.g., financial assistance policy)
* Proof of commitment to diversity with regard to staff, board, and constituents (*optional*)

# Contacts

Over the next few questions, you'll be asked to designate staff to support the application process, ongoing award management, and programmatic requirements. It is understood that certain individuals may take on more than one role, so please repeat names if needed.

The contact information for these roles can change later on. Please notify CFSEM of any changes throughout the grant period by emailing [opioidresponse@cfsem.org](mailto:opioidresponse@cfsem.org).

## Award Contacts

**Primary Award Contact**

Please provide the following information for the primary award contact. This person will be CFSEM’s main contact for all award needs and is the individual responsible for managing the award and overseeing that all requirements are met.

Contact Information

* Name:
* Prefix (Mr., Ms., Mx., Dr., etc.):
* Email Address:
* Phone Number:

Position Title:

**Finance/ Accounting Contact**

Please provide the following information for the finance/ accounting contact. This person is the individual responsible for overseeing the financial compliance and invoicing needs.

Contact Information

* Name:
* Prefix (Mr., Ms., Mx., Dr., etc.):
* Email Address:
* Phone Number:

Position Title:

**President/ CEO**

Please provide the following information for the president or CEO.

Contact Information

* Name:
* Prefix (Mr., Ms., Mx., Dr., etc.):
* Email Address:
* Phone Number:

Position Title:

**Signatory**

Please provide the following information for the signatory. This person is the individual designated to sign the award terms. If this is the same person as the CEO/President, you can simply type "CEO/President" in the boxes below.

Contact Information

* Name:
* Prefix (Mr., Ms., Mx., Dr., etc.):
* Email Address:
* Phone Number:

Position Title:

**CFO**

Please provide the following information for the CFO.

Contact Information

* Name:
* Prefix (Mr., Ms., Mx., Dr., etc.):
* Email Address:
* Phone Number:

Position Title:

## Program Contacts

**Reporting Contact**

Please provide the following information for the reporting contact. This person is the individual responsible for completing the monthly reports, the pre and post implementation surveys, and all other data collection efforts.

If your organization is the fiduciary on behalf of more than one hospital *and* if this contact differs by hospital, please indicate the reporting contact for each hospital.

Contact Information:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Hospital/ Site Name | Contact Name: | Prefix (Mr., Ms., Mx., Dr., etc.): | Position Title: | Email Address: | Phone Number: |
| Reporting Contact |  |  |  |  |  |  |
| Additional Site-Specific, Reporting Contact (if applicable) |  |  |  |  |  |  |
| Additional Site-Specific, Reporting Contact (if applicable) |  |  |  |  |  |  |
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| Additional Site-Specific, Reporting Contact (if applicable) |  |  |  |  |  |  |
| Additional Site-Specific, Reporting Contact (if applicable) |  |  |  |  |  |  |

**Project Coordinator/ Manager**

Please provide the following information for the Project Coordinator/ Manager. This person is the individual responsible for managing the site-based, programmatic activities and can be a physician, RN, PA, Social Worker, or any role in the ED who is the primary contact for program development.

If your organization is the fiduciary on behalf of more than one hospital *and* if this contact differs by hospital, please indicate the coordinator/ manager for each hospital.

Contact Information:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Hospital/ Site Name | Contact Name: | Prefix (Mr., Ms., Mx., Dr., etc.): | Position Title: | Email Address: | Phone Number: |
| Project Coordinator/Manager |  |  |  |  |  |  |
| Additional Site-Specific, Project Coordinator/Manager (if applicable) |  |  |  |  |  |  |
| Additional Site-Specific, Project Coordinator/Manager (if applicable) |  |  |  |  |  |  |
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| Additional Site-Specific, Project Coordinator/Manager (if applicable) |  |  |  |  |  |  |

**Primary Emergency Department Clinical Champions/ Contacts**

Please provide contact information for at least two clinical champions in the emergency department. These champions may include a physician, registered nurse, nurse practitioner, physician assistant, and/or a pharmacist.

If your organization is the fiduciary on behalf of more than one hospital *and* if these contacts differ by hospital, please indicate the clinical champions for each hospital.

Contact Information:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Hospital/ Site Name | Contact Name: | Prefix (Mr., Ms., Mx., Dr., etc.): | Position Title: | Email Address: | Phone Number: |
| Emergency Department Clinical Champion/Contact (required) |  |  |  |  |  |  |
| Emergency Department Clinical Champion/Contact (required) |  |  |  |  |  |  |
| Additional Site-Specific, Emergency Department Clinical Champion/Contact (if applicable) |  |  |  |  |  |  |
| Additional Site-Specific, Emergency Department Clinical Champion/Contact (if applicable) |  |  |  |  |  |  |
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