

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

P.A.T.H.
Providing Addiction Treatment and Healing
Substance Use Treatment Provider Network
FY 2023 Application Packet

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PROVIDER APPLICATION INSTRUCTIONS

Purpose

The Behavioral Health and Wellness Division is accepting applications to become a City of Albuquerque Substance Use Treatment Provider, to be part of The P.A.T.H., for FY 2023. It is the intent of the City to continue the development of a Substance Use Treatment Provider Network that is able to provide high quality, ethical, comprehensive, and evidence-based substance use treatment. The City desires to develop a full continuum of treatment services and ensure that all agencies are clinically appropriate and culturally relevant to meet the needs of those in treatment.

The Behavioral Health and Wellness Division has an open application process to become a member of the City's Substance Use Treatment Provider Network. Only those applicants scoring 160 points or above will be considered for a contract. Agencies currently contracting with the City to provide substance use treatment who score less than 160 will not be eligible to reapply until the next fiscal year (FY 2023), and will need to submit a plan of action to their assigned program specialist detailing how current clients will be transitioned to other voucher agencies to continue their treatment beyond June 30, 2022. **Agencies that score less than 160 and are not currently contracting with the City may resubmit an application before January 31 of Fiscal Year 2023 to be reconsidered for funding.** The Department reserves the right to refuse to proceed with the development of a contract at any time if it is in the best interest or convenience of the City.

Please Note:

Applications that received a score of 180 or above in FY 2022 and have had acceptable monitoring visits, at the discretion of the City, need only complete the re-application packet for FY 2023. The re-application packet will be emailed to you by your program specialist.

The City will not issue a contract for FY 2023 to any agency with outstanding debt(s) to the City.

Application Forms and Instructions

There is one application for both adult and adolescent substance use treatment services. Please mark the appropriate box on the application. In developing your application, be sure to answer **all** questions with **complete** and **thorough** responses.

Applications must be in 12-point font. Each narrative response should be concise, complete, and must not exceed **three (3) single-sided pages** in length. Do not delete questions from the application. Provide your answers below the question. Appendices or non-required attachments including letters of endorsement, agency brochures, or news clips may be included if copied onto 8 1/2" x 11" paper.

Applications will be submitted electronically, via email.

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Application Review

Applications will be reviewed by the Behavioral Health and Wellness Division based on the criteria in the table below. A Technical Review will be conducted prior to scoring: Incomplete applications or applications missing documentation may be deemed nonresponsive. A minimum score of 160 is required to be eligible to receive a contract for FY 2023.

Criteria	Maximum Score: Current Providers	Maximum Score: New Providers
Past Performance	20	N/A
Clinical Supervision/Staff Credentials	20	25
Case Management	25	25
Mental Health Services	10	10
Vouchered Services	15	15
Discharge Planning	10	10
After-Care	10	10
ASAM Criteria	20	20
Service Mix	25	25
Treatment Offered and Recovery Philosophy	45	60

Provider Application Guides

Please refer to the *Albuquerque Minimum Standards for Substance Abuse Treatment*, the *Administrative Requirements for Contracts Awarded under the City of Albuquerque*, and the additional information contained within this FY 2023 Application Packet prior to developing your Applications’ responses.

Submitting Your Application

Submit one complete original application, including all required attachments, via email to Jeanné Padilla, Program Specialist, at jcpadilla@cabq.gov. Label the submission as **Substance Use Treatment Provider Network Application – FY 2023**. Please number and collate. Applications must be submitted to the Behavioral Health and Wellness Division and received no later than **4:00 p.m., Thursday, January 31, 2023**. (Earlier submissions are highly recommended). Applications received after that date and time will not be accepted for Fiscal Year 2023. Earlier submissions are highly encouraged to allow for adequate time for review, and contract execution. Email Application Package to Jeanné Padilla, Program Specialist at jcpadilla@cabq.gov.

Applications may be posted on the Behavioral Health and Wellness Division website after contracts have been awarded.

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ASAM PATIENT PLACEMENT CRITERIA

LEVEL 0.5 – EARLY INTERVENTION

Early Intervention is an organized service designed to explore and address problems that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use. This level is appropriate for individuals who demonstrate problems and risk factors that appear to be related to substance use but do not meet the diagnostic criteria for Substance-Related Disorder as defined in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Length of Service

Length of Service at Level 0.5 varies according to: (a) an individual’s ability to understand the information provided and use of that information to make behavior changes and avoid problems related to substance use or (b) the appearance of new problems arise that require treatment at another level of care.

Required Support Systems

Level 0.5 requires the following Support Systems:

1. Referral for ongoing treatment of substance use or dependence;
2. Referral for medical, psychological or psychiatric services, including assessment; or,
3. Provide case management and/or referral to other social service agencies.

Staff

Level 0.5 staff are trained and knowledgeable about biopsychosocial dimensions of substance use and dependence, the recognition of substance related disorders, alcohol and other drug education, motivational counseling, and the legal and personal consequences of inappropriate substance use.

Interventions

Interventions at this level can include individual, group or family counseling, as well as planned educational experiences that focus on helping the individual to avoid harmful or inappropriate substance use.

LEVEL I – OUTPATIENT TREATMENT

Level I encompasses organized outpatient treatment services in which Substance Use Treatment professionals, including addiction-licensed physicians, provide professionally directed evaluation, treatment, and recovery services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine (9) contact hours a week in accordance with the City’s required Service Mix. The services follow a defined set of policies and procedures or clinical protocols.

Level I services are tailored to each client’s level of clinical severity and are designed to help the client achieve changes in substance use behaviors. Treatment must address major lifestyle, beliefs, and behavior patterns that have the potential to undermine the goals of treatment or to impair the individual’s ability to cope with major life tasks without the non-medical use of substances.

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Level I services are appropriate in several different situations:

- Level I may be the initial level of care for a client whose severity of illness warrants this intensity of treatment. Such a client should be able to complete professionally directed addiction treatment at this level. Level of treatment may change based on (a) an unanticipated event causes a change in his or her level of functioning, leading to a reassessment of the appropriateness of this level of care, or (b) there is recurring evidence of the client's inability to use this level of care (such as repeated episodes of drinking or non-medical drug use even after the treatment plan has been reviewed and revised).
- Level I may represent a "step down" from a more intensive level of care for a client whose progress warrants such a transfer, assuming that he or she meets Level I placement criteria.
- Level I may be used for a client who is in the early stages of change and who is not yet ready to commit to full recovery (Dimension 4 issues). For such a client, placement in a more intensive level of care is apt to lead to increased conflict, passive compliance or even leaving treatment.

The relationship between the severity of illness and the intensity of treatment is more clearly seen in Dimensions 1, 2, and 3. On the other hand, increasing the intensity of services solely because of Dimension 4 issues may be counterproductive. An alternative approach is to use Level I services to engage the resistant individual in treatment. If this approach proves successful, the client may no longer require a higher intensity of service, or may be able to better use such services.

Co-Occurring Mental and Substance Related Disorders

Level I services are appropriate for clients with co-occurring disorders if:

1. The clients' disorders are of *moderate severity* (Dimension 3 is very stable or the client is receiving concurrent mental health monitoring) and clients have responded to more intensive treatment services. The co-occurring disorders have been managed to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.
2. The clients' disorders are of *high severity* (Dimension 4 indicates a high resistance to change, but client is stable in the other Dimensions) and persist but have stabilized to such an extent that integrated mental health and substance use treatment services are assessed and may be beneficial. Clients who have severe and persistent mental illness may not have been able to achieve sobriety or to maintain abstinence for a significant period of time (months); however, they are appropriately placed at Level I because they need engagement strategies and intensive Case Management Services.

Length of Service

Duration of treatment varies with the severity of an individual's substance use and response to treatment.

Required Support Systems

Level I clients require the following support systems:

1. Referral, consultation, or onsite medical, psychiatric, psychological, laboratory, and toxicology services. Medical and psychiatric consultation should be available in a time frame appropriate to the severity and urgency of the situation;

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2. Direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management, and
3. Emergency services available by telephone 24 hours a day, 7 days a week.

Staff

Level I treatment providers are staffed by appropriately licensed treatment professionals, who assess and treat substance-related disorders. Staff are able to obtain and interpret information regarding the client's biopsychosocial needs, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, including assessment of the client's stage of readiness to change. Staff are capable of monitoring stabilized mental health problems and recognizing any instability of clients with co-occurring mental health problems.

Interventions

Interventions at this level involve appropriate treatment services, which may include individual and group counseling, motivational enhancement, Medication Assisted Treatment (MAT), family counseling, educational groups, occupational and recreational therapy, or psychotherapy. If a client has a co-occurring disorder, the use psychotropic medication and mental health treatment and the relationship to substance use are addressed as appropriate.

LEVEL II.I - INTENSIVE OUTPATIENT TREATMENT

Intensive outpatient agencies (IOPs) generally provide nine (9) or more hours of structured programming per week, consisting primarily of counseling and education about substance related and mental health problems. The provider facilitates education and treatment services and encourages clients to utilize acquired skills. Providers have the capacity to arrange for medical and psychiatric consultation, psycho-pharmacological consultation, medication management, and 24-hour crisis services. In addition, providers must have the ability to provide case management and/or refer clients to a higher level of care. If the client is stable and requires only monitoring, psychiatric and medical services are addressed through consultation and referral arrangements. Services provided outside the primary agency must be tightly coordinated.

Beyond the essential services, agencies provide psycho-pharmacological assessment and treatment and have the capacity to effectively treat clients who have complex co-occurring disorders.

Co-Occurring Mental and Substance Related Disorders

Level II.I treatment services are appropriate for clients with co-occurring disorders if:

1. The mental health and addiction treatment services are integrated into the intensive outpatient agency.
2. Clients require active mental health services, which should be delivered through Level II.I Dual Diagnosis Capable or Dual Diagnosis Enhanced Programs.

Length of Service

Duration of treatment varies with the severity of the client's illness and his or her response to treatment.

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Required Support Systems

Level II.I requires the following support systems:

1. Referral, consultation, or onsite medical, psychiatric, psychological, laboratory and toxicology services. Medical and psychiatric consultation should be available in a time frame appropriate to the severity and urgency of the situation;
2. Direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management;
3. Emergency services available by telephone 24 hours a day, 7 days a week; and
4. Agencies offering Level II.I services must be staffed to treat clients with co-occurring disorders. Minimum staff licensure requirements are LMHC, LMSW or the equivalent, with the appropriate clinical supervision.

Staff

Level II.I treatment providers are staffed by appropriately licensed treatment professionals, who assess and treat substance related disorders. Staff are able to obtain and interpret information regarding the client's biopsychosocial needs, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, including assessment of the client's stage of readiness to change. Staff are capable of and trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions with substance related disorders.

Interventions

Interventions at this level involve appropriate treatment services, which may include individual and group counseling, motivational enhancement, Medication Assisted Treatment (MAT), family counseling, educational groups, occupational and recreational therapy, or psychotherapy. If a client has a co-occurring disorder, the use of psychotropic medication, mental health treatment, and the relationship to substance use are addressed.

REQUIRED SERVICE MIX

EARLY INTERVENTION (LEVEL .5)

Early Intervention/Education level of care is to explore and address problems or risk factors that are related to substance use and to help the client recognize the harmful consequences of inappropriate substance use. Each agency that offers Early Intervention/Education needs to use an established and recognized curriculum. Services are intended to run at least 90 days in length for the average client. Each agency serving clients appropriate for Level .5 should, *at a minimum*, adhere to the following:

1. **Initial Service Plan.** Each client shall have an initial service plan created at the time of intake. The service plan shall be reviewed, signed, and dated by the client, counselor and clinical supervisor. The client must be provided with an Initial Service Plan within 30 calendar days of intake and updated as clinically indicated.

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2. **Early Intervention Session.** Each client shall participate in a minimum of one education group per week, but services are not limited to education groups. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client's record.
3. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, and Initial Service Plan. If a client needs Case Management, as evidenced by the ASA and Initial Service Plan, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from Early Intervention Services.

OUTPATIENT TREATMENT (LEVEL I)

Provide individual, group and/or family counseling for an average period of 90 to 120 days that addresses major lifestyle, beliefs, and behavioral patterns that have the potential to result in addiction or substance use or to impair the individual's ability to cope with major life tasks without the non-medical use of substances. Services are provided in regularly scheduled sessions of usually fewer than nine (9) contact hours per week, but not less than once a week. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client's record. Each agency serving clients appropriate for Level I should, *at a minimum*, adhere to the following:

1. **Treatment Plan.** An individualized Treatment Plan shall be developed within 30 calendar days of intake. The Treatment Plan shall be reviewed and signed by the client, counselor, and clinical supervisor. The Treatment Plan shall be reviewed, updated and signed by client, counselor, and clinical supervisor not less than quarterly.
2. **Counseling Session.** Each client shall participate in a minimum of one individual, group or family counseling session not less than once a week, with a minimum of two individual sessions per month. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client's record.
3. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education and vocational, health, and social services as indicated through the ASA, Individualized Treatment Plan, and case management assessment and/or service plan. If a client needs case management, the agency must provide the non-counseling services on site or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.

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5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from treatment.

INTENSIVE OUTPATIENT TREATMENT AGENCIES (LEVEL II.I)

Provide individual, group and/or family counseling and education about substance-related and mental health problems, with an intensity of nine (9) or more hours of structured programming being offered per week and the client receiving six (6) or more hours of services per week, and a frequency of not less than three (3) times per week for an average of 60 days; once the client reaches the point that Level II.I services are no longer appropriate, the change in service level must be documented in the client's record. Level II.I services have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. The client's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the client is stable and requires only maintenance monitoring. Level II.I agencies must have licensed mental health clinicians on staff or contract to see Level II.I clients. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client record.

1. **Staffing.** Agencies offering Level II.1 services must be staffed to treat clients with co-occurring disorders. Minimum staff licensure requirements are LMHC, LMSW or the equivalent, with the appropriate clinical supervision.
2. **Treatment Plan.** An individualized Treatment Plan shall be developed within 30 calendar days of admission. For Level II.1 clients, the treatment plan shall be reviewed and signed by the client, counselor, and clinical supervisor. The Treatment Plan shall be reviewed, updated, and signed by the counselor, client, and clinical supervisor not less than quarterly.
3. **Counseling Session.** Each client shall participate in a minimum of one individual, group or family Counseling Session three times per week, with a minimum of one (1) individual session per week, and two (2) group sessions per week. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client record.
4. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, Individualized Treatment Plan, and Case Management assessment and/or service plan. If a client needs case management, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
5. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
6. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from treatment.

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APPLICATION CHECKLIST

Agency Name: _____

Submit this completed checklist with the Application. If you are not submitting all items on this checklist, indicate "N/A" on the line next to the number. **All lines must be completed.**

- ____ 1. Signed Application Summary and Certification Form.
- ____ 2. One original Application and applicable appendix.
- ____ 3. Insurance Waiver if applicable.
- ____ 4. Registration Certificate from the New Mexico Taxation and Revenue Department or, proof of an exemption from payment of Federal Income Tax pursuant to the Internal Revenue Code of 1954 [26 U.S.C. Section 501(c)(3)] must be included in the Application.
- ____ 5. Copies of all applicable business licenses including, but not limited to, current City of Albuquerque Business Registration license, etc. (non-profits are not required to submit a City business license)
- ____ 6. Verification of Substance Use licensure for all current clinical staff/contractors in compliance with the State of New Mexico Substance Use Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9A of the New Mexico Counseling and Therapy Practice Act: section 61-9A-14.2 Substance Use Intern, requirements for licensure; 61-9A-14.3 Alcohol and drug use counselor, requirements for licensure; and 61-9A-16 Temporary licensure.
- ____ 7. A letter of assurance regarding current compliance with all applicable rules and regulations of the Americans with Disabilities Act of 1990, PL 101-336 (42 U.S.C. Section 12101, et seq.) See <http://www.ada.gov> and <http://www.access-board.gov> and Section 504 of the Rehabilitation Act (29 U.S.C. Section 794) <https://www.hhs.gov/sites/default/files/knowyourrights504adafactsheet.pdf> for additional information.
- ____ 8. Certification of Non-Profit Incorporation from IRS, if applicable.
- ____ 9. Articles of Incorporation.
- ____ 10. Current By-laws.
- ____ 11. List of Current Board Members (Non-profit and government agencies only).

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- ___ 12. Organization Chart.
- ___ 13. Accounting Policies and Procedures. Clearly identify agency's billing and filing procedures.
- ___ 14. Personnel Policies and Procedures.
- ___ 15. Operating Standards/Program Policies and Procedures.
- ___ 16. Conflict of Interest Statement (Non-Profit Only).
- ___ 17. Certificate of Good Standing, as applicable.
- ___ 18. HIPAA Compliant Confidentiality Policies.
- ___ 19. Completed W-9. See <http://www.cabq.gov/dfa/onlineservices/modified-w9-supplier-form>.
- ___ 20. Drug-Free Workplace Statement. Attached.
- ___ 21. Copies of clinical supervisor's workshop attendance as required by State Regulations. See 16.27.19.9(B) at <http://www.rld.state.nm.us/uploads/files/Counseling%20Rules%20and%20Statutes.pdf> for additional information.
- ___ 22. Copy of Clinical Supervision Policy.
- ___ 23. Signed copy of Certification of Receipt of *Minimum Standards and Administrative Requirements*. Attached.
- ___ 24. Copy of Group Schedule offered at agency.
- ___ 25. Provide evidence of additional funding sources to support Question 12 of the Application.
- ___ 26. Copy of sliding fee schedule if applicable.
- ___ 27. Copy of telehealth policies.
- ___ 28. Disclosure of Lobbying Activities. Attached.
- ___ 29. Completed Application Checklist.

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City of Albuquerque Substitute W-9

City of Albuquerque Substitute W-9 and instructions are online at:

<https://www.cabq.gov/dfa/onlineservices/modified-w9-supplier-form>

Please be sure to include an email address to receive invoicing communications such purchase orders.

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DRUG FREE WORKPLACE REQUIREMENT CERTIFICATION FORM

The agency certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the agency's workplace, and specifying the actions that will be taken against employees for violation of such prohibition;
2. Establishing a drug-free awareness program to inform employees of:
 - a. The dangers of drug abuse in the workplace;
 - b. The agency's policy of maintaining a drug-free workplace;
 - c. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
3. Making it a requirement that each employee to be engaged in the performance of an agreement with the City be given a copy of the agency's drug-free workplace statement.
4. Notifying each employer that as a condition of employment under the City's agreement, that employee will:
 - a. Abide by the terms of the agency's drug-free workplace statement, and
 - b. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace, no later than five (5) days after such conviction.
5. Notifying the City of Albuquerque, Department of Family and Community Services within ten (10) days after receiving an employee notice or otherwise receiving actual notice of an employee drug statute conviction for a violation occurring in the workplace.
6. Taking one of the following actions within thirty (30) days of receiving notice of an employee's drug statute conviction for a violation occurring in the workplace:
 - a. Taking appropriate personnel action against such an employee, up to and including termination;
 - b. or requiring such employee to participate satisfactorily at a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
7. Making a good faith effort to continue to maintain a drug-free workplace through the implementation of the above requirements.

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8. The agency also certifies that the agency's drug-free workplace requirements will apply to all locations where services are offered under the agreement with the City of Albuquerque. Such locations are identified as follows:

Street Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Typed Name of Authorized Board Official: _____

Title: _____

Signature of Authorized Board Official: _____

Date: _____

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ACORD™ CERTIFICATE OF LIABILITY INSURANCE		Cert ID 30000
		DATE (MM/DD/YYYY) 1/1/2009
PRODUCER Hudson & Mann, Inc. 4600 Coolidge Highway Royal Oak MI 48072 (248) 549-3519	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
INSURED Sample Film Producer 1111 Thomas Ave Berkeley CA 94999	INSURERS AFFORDING COVERAGE INSURER A: Sample Insurance Company INSURER B: Sample Insurance Company INSURER C: INSURER D: INSURER E:	NAIC #

COVERAGES
 THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR NO./LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
B	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY CLAIMS MADE <input checked="" type="checkbox"/> OCCUR	121456789	1/01/2005	1/01/2010	EACH OCCURRENCE \$ 1,000,000
	GENL. AGGREGATE LIMIT APPLIES PER: POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/>				DAMAGE TO RENTED PREMISES (EA occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	23456789	1/01/2005	1/01/2010	COMBINED SINGLE LIMIT (EA accident) \$ 1,000,000
					BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTOONLY - EA ACCIDENT \$ OTHER THAN AUTOONLY: EA ACC \$ AGG \$
	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE \$ RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	34567891	1/01/2005	1/01/2010	<input checked="" type="checkbox"/> MC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000
B	OTHER PROPERTY	456789123	1/01/2005	1/01/2010	(see DESCRIPTION if coverage applies to this certificate.)

SAMPLE

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 Sample Certificate Holder is named as Additional Insured and Loss Payee as their interests may appear....

CERTIFICATE HOLDER Sample Certificate Holder 1234 Main Street Royal Oak MI 48072	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>30</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE
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INSURANCE COVERAGE INSTRUCTIONS

The Contractor shall procure and maintain at its expense until final payment by the City for Services covered by the Agreement insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Agreement, whether performed by it or its agents. Before commencing the Services, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the city showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days written notice be given to Director, Risk Management Department, City of Albuquerque, PO Box 1293, Albuquerque, New Mexico 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. **The City shall be named as an additional insured under the Commercial General Liability (CGL) policy.**

In order for any of these coverages to be waived, Contractor will need to sign and return the Insurance Waiver Request form enclosed in this packet. Your Program Specialist will consult with the City Risk Management Department regarding approving the waiver.

If you have any questions, please contact your assigned Program Specialist.

BASIC INSURANCE REQUIREMENTS

For all City contracts for goods and/or services, it is required that all vendors/contractors maintain the following basic insurance coverages (and limits):

A. Commercial General Liability Insurance (“CGL”): A CGL insurance policy with combined limits of liability for bodily injury or property damage as follows:

\$ 2,000,000	Per Occurrence
\$ 2,000,000	Policy Aggregate
\$ 1,000,000	Products Liability/Completed Operations
\$ 1,000,000	Personal and Advertising Injury
\$ 5,000	Medical Payments

The CGL insurance policy must include coverage for all operations performed for the City by the Contractor, and the contractual liability coverage shall specifically insure the hold harmless provisions of the City’s contract with the Contractor. The City shall also be listed as an “additional insured” by endorsement onto the CGL policy. Proof of this additional insured relationship shall be evidenced on the Certificate of Insurance (COI) and on the insurance endorsement.

B. Commercial Automobile Liability Insurance (“CAL”): A CAL policy with not less than a \$1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. The CAL policy must include coverage for the use of all owned, non-owned, and hired automobiles, vehicles and other

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equipment both on and off work. This CAL policy cannot be a personal automobile liability insurance policy as most personal automobile liability policies exclude coverage for work-related losses.

C. Workers' Compensation Insurance: Workers' Compensation Insurance for the Contractor's employees when required by, and in accordance with, the provisions of the Workers' Compensation Act of the State of New Mexico ("Act"). The Contractor must have three (3) or more employees to trigger the Act's workers' compensation insurance requirement. Per the Act, this number includes the owner of the business. If the Contractor is not required to carry Workers' Compensation coverage; the Contractor will need to sign and return the Worker's Comp Statement enclosed in this packet.

ADDITIONAL INSURANCE COVERAGES

The following coverages should be considered based on the course and scope of the individual contract:

D. Professional Liability (Errors and Omissions) Insurance: Professional liability (errors and omissions) insurance in an amount not less than \$1,000,000 combined single limit of liability per occurrence with a general aggregate of \$1,000,000.

Professional liability insurance cannot be waived for medical directors, psychologists, psychiatrists, mental health counselors, or laboratories.

E. Sexual Abuse Molestation Coverage: Sexual abuse molestation insurance in an amount not less than \$1,000,000 combined single limit of liability per occurrence with a general aggregate of \$1,000,000. This coverage should be required, unless specific circumstances that eliminate potential risks indicate otherwise, if the vendor/contractor will be working with, or in physical or virtual contact with, children under the age of 18 or a compromised client base (deaf and hard of hearing, blind, senior and older adults, persons with mental disabilities, intellectual disabilities, and/or have a developmental disability).

F. Cyber Liability Coverage: Cyber liability insurance in an amount not less than \$2,000,000 combined single limit of liability per occurrence with a general aggregate of \$2,000,000. This coverage should be required, unless specific circumstances that eliminate potential risks indicate otherwise, if the vendor/contractor may have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems.

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INSURANCE WAIVER REQUEST

Agency/Organization: _____

Typed Name of Authorized Official of the Agency: _____

Title: _____

Signature: _____ Date: _____

Contractor requests the following insurance be waived. Please check **all** that apply and sign associated certifications.

A. Commercial General Liability Insurance (“CGL”)

Please provide an explanation for why you believe this insurance should be waived for your agency:

Signature: _____ Date: _____

B. Commercial Automobile Liability Insurance (“CAL”)

I hereby certify that neither I, nor employees or contractors employed by this agency, use vehicles in other than a commuting capacity. I further certify that should I, or any employees or contractors employed by this agency, use vehicles in any manner other than a commuting capacity, the agency will comply with the City of Albuquerque’s Automobile Insurance requirements.

Signature: _____ Date: _____

C. Workers' Compensation Insurance

I hereby certify that I employ fewer than three employees and am, therefore, not subject to the provisions of the Workers’ Compensation Act of the State of New Mexico. I further certify that should I employ three or more persons during the term of my contract with the City, I will comply with the provisions of the New Mexico Workers’ Compensation Act and provide proof of such compliance to the City of Albuquerque.

Signature: _____ Date: _____

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D. Professional Liability (Errors and Omissions) Insurance

Please provide an explanation for why you believe this insurance should be waived for your agency:

E. Sexual Abuse Molestation Coverage:

I hereby certify that neither I, nor employees or contractors employed by this agency, will have unsupervised or one-on-one contact with children or compromised adults. I further certify that should I, or any employees or contractors employed by this agency, have unsupervised or one-on-one contact with children or compromised adults, the agency will comply with the City of Albuquerque's Sexual Abuse Molestation Coverage Insurance requirements.

Signature: _____ Date: _____

F. Cyber Liability Coverage

I hereby certify that neither I, nor employees or contractors employed by this agency, will have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems. I further certify that should I, or any employees or contractors employed by this agency, have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems, the agency will comply with the City of Albuquerque's Cyber Liability Coverage Insurance requirements.

Signature: _____ Date: _____

For City of Albuquerque Use Only:

Insurance Waiver Approved:

By: _____

Title: _____

Date: _____

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REPRESENTATIONS AND CERTIFICATIONS

The undersigned HEREBY GIVE ASSURANCE THAT:

The applicant agency named below will comply and act in accordance with all Federal laws and Executive Orders relating to the enforcement of civil rights, including but not limited to, Federal Code, Title 5, USCA 7142, Sub-Chapter 11, Anti-discrimination in Employment, and Executive Order number 11246, Equal Opportunity in Employment; and

That the applicant agency named below will comply with all New Mexico State Statutes and City Ordinances regarding enforcement of civil rights; and

That no funds awarded as a result of this request will be used for sectarian religious purposes, specifically that (a) there shall be no religious test for admission for services; (b) there shall be no requirement for attendance of religious services; (c) there shall be no inquiry as to a client's religious preference or affiliations; (d) there shall be no proselytizing; and (e) services provided shall be essentially secular, however, eligible activities, as determined by the fund source, and inherently religious activities may occur in the same structure so long as the religious activity is voluntarily and separated in time and/or location.

Agency Name _____

Typed Name of Authorized Board Official: _____

Title: _____

Signature of Authorized Board Official: _____

Date: _____

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DEBARMENT, SUSPENSION, INELIGIBILITY AND EXCLUSION CERTIFICATION

I certify that the agency has not been debarred, suspended, or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government.

I further certify that should any notice of debarment, suspension, ineligibility, or exclusion be received by the agency, the City of Albuquerque, Department of Family and Community Services will be notified immediately.

Agency: _____

Typed Name of Authorized Board Official: _____

Title: _____

Signature of Authorized Board Official: _____

Date: _____

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CERTIFICATION OF RECEIPT OF
MINIMUM STANDARDS AND ADMINISTRATIVE REQUIREMENTS

The undersigned HEREBY CERTIFY THAT:

1. The agency/organization has been made aware that the ***Albuquerque Minimum Standards for Substance Abuse Treatment and Prevention Services***, Department of Family and Community Services, Division of Health & Human Services, revised January 2009, can be viewed at:
<https://www.cabq.gov/family/documents/minimumstandardsfy09final.pdf/view>.
2. The agency named below will adhere to the *Minimum Standards* in its operation of City-funded programs.
3. The agency/organization has been made aware that the ***Administrative Requirements for Contracts Awarded Under the City of Albuquerque***, Department of Family and Community Services, issued July 2019, can be viewed and downloaded at:
<https://www.cabq.gov/family/documents/administrative-requirements-coa-family-and-community-services-july-2019-nosp.pdf>.
4. The agency/organization named below will adhere to the *Administrative Requirements* in its operation of City-funded programs.

Name of Agency: _____

Typed Name of Authorized Board Official: _____

Title: _____

Signature of Authorized Board Official: _____

Date: _____

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Disclosure of Lobbying Activities

Disclosure of Lobbying Activities form and instructions are online at:

Form: <https://www.gsa.gov/Forms/TrackForm/33144>

Instructions: https://apply07.grants.gov/apply/forms/instructions/SFLLL_1_2-V1.2-Instructions.pdf

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Albuquerque Pay Equity Initiative Instructions

Information about the Albuquerque Pay Equity Initiative

All businesses submitting bids or proposals (to the City, County, or Water Authority) must include a valid Pay Equity Reporting Form or Certificate with their bid or proposal. The required form and additional details about the initiative can be found at the following link:

<https://www.cabq.gov/gender-pay-equity-initiative>

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APPLICATION SUMMARY AND CERTIFICATION FORM

1. Agency Name:

2. Mailing Address (Include City, State, & Zip Code)	3. Agency Contact & Telephone Number
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4. City Program Name: P.A.T.H Substance Use Treatment Provider Network

5. Due Date: Tuesday, January 31, 2023 before 4pm (earlier submissions are highly recommended)	6. Date Submitted:
--	--------------------

7. Title of Applicant's Project and Brief Description:
--

8. Certification: It is understood and agreed by the undersigned that: 1) Any funds awarded as a result of this request are to be expended for the purposes set forth herein and in accordance with all applicable Federal, State, and City regulations and restrictions; and 2) the undersigned hereby gives assurances that this proposal has been prepared according to the policies and procedures of the above named Agency, obtained all necessary approvals by its governing body prior to submission, the material presented is factual and accurate to the best of her/his knowledge, and that s/he has been duly authorized by action of the governing body to bind the organization. The undersigned also hereby gives assurances that the agency will adhere to the Minimum Standards and the Administrative Requirements in its operation of City funded programs.

a. Typed Name of Authorized Official of the Agency:	b. Title	c. Telephone Number
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d. Signature of Authorized Official of the Agency:	e. Date Signed:
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NOTE: INCLUDE THIS COMPLETED FORM AS PAGE 1 OF THE APPLICATION.
FY 2023 PATH PROVIDER APPLICATION

Complete the Application below, providing concise and complete responses. Questions should be directed to Jeanné Padilla, Program Specialist, Behavioral Health and Wellness Division at jcpadilla@cabq.gov.

Type of Application: Adult
 Adolescent

Levels of Care: Level .5
 Level I
 Level II

1. Agency Information

Agency Name: _____

Number of Years Established as an Agency: _____

Administrator: _____

Address: _____

Telephone #: _____ Fax #: _____

E-Mail Address: _____ Website Address: _____

Contact for Billing: _____ Telephone #: _____

2. Languages in which therapeutic services can be provided: (Check all that apply.)

_____ English _____ Spanish _____ ASL _____ Other languages (Specify): _____

3. Is your agency authorized to accept Medicaid?

4. Describe your processes to ensure eligible clients are enrolled in Medicaid in order to maximize access to services.

5. Please indicate the days of the week and the hours that you provide services:

Hours of Operation	Hours You Admit Clients
Monday ___ a.m. ___ p.m.	Monday ___ a.m. ___ p.m.
Tuesday ___ a.m. ___ p.m.	Tuesday ___ a.m. ___ p.m.

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Wednesday ____ a.m. ____ p.m.	Wednesday ____ a.m. ____ p.m.
Thursday ____ a.m. ____ p.m.	Thursday ____ a.m. ____ p.m.
Friday ____ a.m. ____ p.m.	Friday ____ a.m. ____ p.m.
Saturday ____ a.m. ____ p.m.	Saturday ____ a.m. ____ p.m.
Sunday ____ a.m. ____ p.m.	Sunday ____ a.m. ____ p.m.

6. Substance Use Treatment Program

- a. Describe your Substance Use Treatment program as you would describe it to a new client, including the agency’s philosophy toward substance use treatment.
- b. Are there any substances for which your agency DOES NOT provide treatment?
- c. Describe Recovery Support Services either provided at or through an MOU with your agency.

7. Clinical Staffing

- a. Identify Clinical Supervisors in your organization. Complete table below.

Name	Licensure Level	Years of Experience at this Level

- b. Explain the process you use to adhere to the *Minimum Standards* regarding clinical supervision activities. Include a copy of your clinical supervision workshops and a copy of the agency’s clinical supervision policy if applicable.
- c. List all staff that provide services including substance use treatment, case manager, and mental health in the table below. Add additional lines in the table as necessary.

Staff	Title	Licensure	Years At This Licensure Level	Substance Use Training	Other Certifications

- d. List all interns that provide services including substance use treatment, case manager, and mental health in the table below. Add additional lines in the table as necessary.

Staff	Title	Licensure	Years At This Licensure Level	Substance Use Training	Other Certifications

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8. Populations Served

- a. Specify any population your agency prefers to work with and is staffed and specifically trained to treat.
- b. Specify any populations that your agency prefers not to work with or is not staffed/trained to treat.
- c. Describe how your agency provides specific treatment for any special populations and describe what training your staff has received to work with this specific population.
- d. For Applications to serve an adolescent population only: What qualifies your agency to provide treatment to adolescents?

9. Case Management

- a. Describe how your agency determines whether a client needs case management services.
- b. Describe the case management services that are provided on site.
- c. Describe in detail how your case managers assist clients in accessing services.

10. Mental Health Services

- a. Does your agency provide mental health services with licensed and qualified mental health practitioners?
Yes No If Yes, please complete 10b & 10c. If No, go to 11.
- b. Please check all mental health services that your agency provides to clients.
 Mental Health Assessment/Diagnosis Mental Health Therapy (Not substance use Tx.)
 Psychotropic Medication Evaluation Psychological Testing Services
- c. For each item checked above, please provide a description of how the services are provided.

11. Children and Adolescent Safety (only applicable for Applications to serve an adolescent population)

- a. Please describe how your agency provides for adolescent safety if both adults and adolescents are treated at the same site.

12. Vouchered Services

- a. Since City voucher funds may not cover an entire course of treatment, the City is looking for evidence that agencies are able to leverage funds to sustain clients in treatment. Please list specifically what measures your agency takes to continue treatment for clients once the voucher funds have been expended.

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13. Discharge Planning and Aftercare

- a. Describe your agency's discharge planning procedures to ensure successful discharge of clients. Include a copy of the agency's discharge planning policy.

- b. Does your agency provide aftercare services on site? If yes, describe how you ensure the client is engaged in aftercare (groups, life skills, peer support, etc.). If not, describe how you ensure the client is engaged in aftercare at other entities.

14. Include the Proposal Summary and Certification Form (page 24 of this Application packet) as the first page to this Application with all appropriate signatures. Applications without this form will not be accepted.

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APPENDIX A

ASAM CRITERIA AND REQUIRED SERVICE MIX

Provide a **SEPARATE** Appendix A for Type of Application and each Level of Treatment for which you are applying.

1. Type of Application

(check ONE only—use another Appendix A if applying for both):

- Adult
- Adolescent

2. Identify Level of Treatment

(check ONE only—use a separate Appendix A for each level applying for):

- Level .5
- Level I
- Level II.I

3. Please review pages 4–7 in this Application Packet. Based on the ASAM Criteria detailed on pages 4–7, and at www.ASAM.org; describe how your agency meets or exceeds that ASAM Criteria for the level of care marked above.

4. Please review pages 7–9 in this Application Packet. Based on the required Service Mix detailed on pages 7–9, describe how your agency meets or exceeds the required Service Mix for the level of care marked above.

5. FOR ADOLESCENT APPLICATIONS ONLY: How does your treatment methodology differ between your adolescent and adult substance use treatment programs, for the specific level of care addressed on this Appendix?