VERMONT
DEPARTMENT OF HEALTH

Substance Abuse Treatment New Program Application

Title of Project

Applicant Information:

Facility/Entity Name:

Facility/Entity Address:

Facility/Entity Administrator

Name:

Address:

Telephone:

Title:

Email:

DRAFT

Principal Contact Person

Name:

Address:

Telephone:

Title:

Email:

Ownership Information

Type of Ownership: ◯ For profit ◯ Not for profit

Names of owners

Accreditations

VERMONT
DEPARTMENT OF HEALTH

Proposed Project Information*
Include in your description the following items, if applicable:

- ☐ Project description;
- ☐ The need for the project (with supporting data);
- ☐ Detailed description of programming and evidence-based practices to be implemented;
- ☐ Services to be expanded, added, replaced, or reduced, identifying the proposed location of each;
- ☐ Objective to be achieved by implementation of the proposed services and expected outcomes;
- ☐ Population to be served;
- ☐ Location(s) of the proposed project, facility or service, including primary, satellite, and mobile locations;
- ☐ Description of the proposed service area;
- ☐ Organizational capacity to carry out proposed program;
- ☐ How staffing and training of staff will be implemented and conducted;
- ☐ Implementation timeline for first two years;
- ☐ Data and outcome reporting capacity;
- ☐ Budget and budget narrative for proposed services;
- ☐ How the project will be financed and description of organization's ability to take financial risk;
- ☐ Anticipated impact on health care costs, access and quality.

DRAFT

*Additional information may be requested and required based on the above documents.

Certification of Accuracy
I certify that the information contained in this application, and all documents that have been submitted with this application, are accurate and complete to the best of my knowledge. I understand that any false statements or failure to disclose information may be sufficient grounds to deny approval.

Name:		Title:	
Signature:		Date:	

Submit Application by Email