WORKSPACE FORM

1-800-518-4726
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This Workspace form is one of the forms you need to complete prior to submitting your Application Package. This form can be completed in its entirety offline using Adobe Reader. You can save your form by clicking the "Save" button and see any errors by clicking the “Check For Errors” button. In-progress and completed forms can be uploaded at any time to Grants.gov using the Workspace feature.

When you open a form, required fields are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message. Additional instructions and FAQs about the Application Package can be found in the Grants.gov Applicants tab.

OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	SM-24-006
Opportunity Title:	Assisted Outpatient Treatment Program for Individuals with Serious Mental Illness
Opportunity Package ID:	PKG00285063
CFDA Number:	93.997
CFDA Description:	Assisted Outpatient Treatment
Competition ID:	SM-24-006
Competition Title:	AOT
Opening Date:	02/26/2024
Closing Date:	04/26/2024
Agency:	Substance Abuse and Mental Health Services Adminis
Contact Information:	Cassandra Henry Center for Mental Health Services Substance Abuse and Mental Health Services Administration 240-276-2256 AOT@samhsa.hhs.gov

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS01272346
Application Filing Name:	Behavioral Wellness Mental Health AOT
UEI:	PM14B6H7PEK7
Organization:	BEHAVIORAL WELLNESS
Form Name:	Application for Federal Assistance (SF-424)
Form Version:	4.0
Requirement:	Mandatory
Download Date/Time:	Apr 15, 2024 04:11:03 PM EDT
Form State:	No Errors

FORM ACTIONS:

OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier: KATIECOHEN

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: County of Santa Barbara

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6002833

* c. UEI: PM14B6H7PEK7

d. Address:

* Street1: 315 Camino del Remedio
Street2:
* City: Santa Barbara
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 93110-1332

e. Organizational Unit:

Department Name: Behavioral Wellness

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Katie
Middle Name:
* Last Name: Cohen
Suffix:

Title: Branch Chief of Clinical Outpatient Operation

Organizational Affiliation:

* Telephone Number: 805-448-0851
Fax Number: 805-692-5262

* Email: kcohen@sbcbwell.org

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Substance Abuse and Mental Health Services Adminis

11. Catalog of Federal Domestic Assistance Number:

93.997

CFDA Title:

Assisted Outpatient Treatment

*** 12. Funding Opportunity Number:**

SM-24-006

* Title:

Assisted Outpatient Treatment Program for Individuals with Serious Mental Illness

13. Competition Identification Number:

SM-24-006

Title:

AOT

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

SBC Behavioral Wellness AOT Program Expansion

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CA: 24

* b. Program/Project: CA: 24

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 07/31/2024

* b. End Date: 06/30/2028

18. Estimated Funding ($):

* a. Federal	1,999,964.40
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,999,964.40

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☒ a. This application was made available to the State under the Executive Order 12372 Process for review on 07/25/2024.

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:

* First Name: Antonette

Middle Name:

* Last Name: Navarro

Suffix:

* Title: Director

* Telephone Number: 805-681-5233

Fax Number: 805-681-5445

* Email: anavarro@sbcbwell.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission.

* Date Signed: Completed by Grants.gov upon submission.