DEPARTMENT OF PUBLIC HEALTH
Bureau of Substance Abuse Prevention and Control
FIELD-BASED SERVICES FORM

To apply for Field Based Services (FBS), email the completed application and all supplemental documents to: SAPCMonitoring@ph.lacounty.gov with the subject "Field Based Service Application".

NETWORK PROVIDER AGENCY INFORMATION

1. SAPC Network Provider Agency Name:

2. Home DMC-Certified Facility Address:

3. Network Provider Agency Contact Information:

Name: _____

Phone Number: _____

Email Address: _____

PROPOSED POPULATIONS TO BE SERVED

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

- ❑ General youth (12-17) population
- ❑ General young adult (18-20) population
- ❑ General adult (21-59) population
- ❑ General older adult (60+) population
- ❑ Reaching the 95% of people who need but do not seek or want treatment at traditional sites
- ❑ 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 condition
- ❑ People who are pregnant and postpartum
- ❑ LGBTQI+ adults (21+)
- ❑ LGBTQI+ youth and young adults (12-20)
- ❑ 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 LEVEL(S) OF CARE

5. What Field-Based Level(s) of Care does the program propose to provide? (Check all that apply)

- ❑ Early Intervention for Youth/Young Adults
- ❑ Outpatient
- ❑ Intensive Outpatient
- ❑ Recovery Supports

PROPOSED SPA(S) TO BE SERVED

6. 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

Service Components

7. 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
- ❑ Medication 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

Which ASAM levels of Care will be provided?

❑ ASAM 0.5 ❑ ASAM 1.0 ❑ ASAM 2.1 ❑ Recovery Services

APPLICATION TYPE

8. Please indicate the type of FBS delivery requested as part of this application. Please complete the appropriate sections of the application corresponding to the selections made here.

Check all that apply: ☐ Community FBS Site Approval ☐ New In-Home FBS Approval

FBS TYPE #1: COMMUNITY FBS

For each proposed site, please provide the facility name, address, site schedule/days/hours of operation, and site type. If seeking approval for more than one site, you may include the site list with all relevant information as a separate attachment. SAPC requires that a formal agreement be in place for all requested sites. For each site requested, please include formal agreement documentation (see instructions in Attachment II).

10. Proposed FBS Facility Name: _____

11. Proposed FBS Facility Address: _____

12. Proposed site schedule/day/hours of operation: _____

13. Site Type:

- ❑ Federally Qualified Health Centers (FQHC)
- ❑ Department of Mental Health (DMH)
- ❑ Department of Health Services (DHS)
- ❑ Department of Probation Area Office
- ❑ Department of Children and Family Services (DCFS)
- ❑ Department of Public Social Services (DPSS)
- ❑ Public Unified School District (e.g., LAUSD)
- ❑ LA County Office of Education (LACOE)
- ❑ Charter School
- ❑ Recreation Center
- ❑ Outdoor Recreation Area / Park
- ❑ Harm Reduction Co-location
- ❑ Community / Drop-In / Day Centers
- ❑ Board and Care / Group Home
- ❑ Homeless Encampment
- ❑ Homeless Shelter
- ❑ Interim Housing Sites (e.g., transitional housing, etc.)
- ❑ Permanent Housing Sites (e.g., permanent supportive housing, public housing, etc.)
- ❑ Other: _____

REQUIRED SUPPLEMENTAL DOCUMENTS

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

- ❑ FBS Application Narrative
- ❑ Formal Agreement(s) (e.g., memorandum of understanding)
- ❑ Confidentiality Protocol
- ❑ Safety Plan

ATTESTATIONS

15. SAPC-Facilitated FBS Partnerships: By submitting an FBS application, network provider agencies agree to be placed on a list of FBS providers that will be contacted to provide FBS at SAPC-identified locations upon request. SAPC will proactively reach out to provider agencies based on region, populations served, and other factors to facilitate partnerships with sites requesting SUD services. SAPC strongly encourages all provider agencies to actively participate in SAPC-facilitated site partnerships to enable the SAPC provider network to efficiently connect with clients that can benefit from SUD services.

❑ I attest that my agency agrees to be placed on a list of agencies available to participate in SAPC-identified FBS site partnerships on an as-needed basis.

16. FBS Standards and Practices

❑ I attest to reviewing FBS Standards and Practices and my agency will adhere to its requirements.

17. Documentation: By submitting a FBS application, network provider agencies agree to properly document all FBS per the FBS Standards and Practices and the Provider Manual.

❑ I attest that my agency and all relevant staff will properly document Field Based Services.

SIGNATURE OF AGENCY AUTHORIZED INDIVIDUAL

Please sign to indicate that this application and all supplemental materials provide complete and accurate information.

Name: _____ Email: _____

Signature: _____ Date_____

If you are printing and scanning this form to add your signatures (NOT using an e-signature), please submit BOTH the signed application AND fillable form for application processing.

COUNTY USE ONLY:

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