SAMPLE HANDBOOK

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Policies and Procedures

[Your organization's name]

Written from 42 U.S.C. 300x-21 to 300x-66 and 45 CFR Part 96, Subpart L, checked November 10, 2026.

How to use this sample

Replace the bracketed name with your organization's. Change the job titles to the ones you use. Have the people who do the work read each section and correct anything that does not match how you operate. Then have your director or board approve it and sign the last page.

This is a sample, not legal advice. It follows the federal regulation. Your grant agreement and your funder's manual can add or tighten requirements, and they control where they differ.

Introduction

This handbook explains the policies and procedures our organization uses to manage money from the Substance Use Prevention, Treatment, and Recovery Services Block Grant. SAMHSA, the federal Substance Abuse and Mental Health Services Administration, shortens the name to SUPTRS BG or SUBG, and we use SUBG. Many people still call it by its old name, the Substance Abuse Prevention and Treatment Block Grant (SABG), and the federal regulation still uses that name. SAMHSA awards the grant to each state. We receive our share as a subrecipient under a contract or subaward with the state substance use agency or with a county or managed-care organization acting for it. In this handbook we call that funder the state agency. Most of the federal rules are duties of the state, which passes them to us through our contract, and each section says who a rule binds. Each section states our policy, lists the steps our staff follow, and names the laws and regulations it rests on. Where the state agency sets a number, a form or a deadline, we follow our contract. If this handbook and our contract ever differ, the contract and the regulation control. Sections that do not fit our services, such as treatment rules for a prevention-only provider, do not apply to us. The executive director reviews this handbook each year and whenever the rules or our contract change.

What the program expects in writing

- Formal written policies and procedures that protect paper and electronic patient records (42 CFR 2.16(a))
- A patient notice of privacy practices, a consent form with the required elements, and the notice that goes with each disclosure (42 CFR 2.22; 42 CFR 2.31; 42 CFR 2.32)
- A written admission preference order that puts pregnant women and people who inject drugs first (45 CFR 96.131(a))
- A procedure for telling the state within 7 days when the program reaches 90 percent of its capacity (45 CFR 96.126(a))
- A waiting list with a unique identifier for each person and a way to stay in contact with people on it (45 CFR 96.126(c))
- A procedure for offering interim services within 48 hours when a person cannot be admitted (45 CFR 96.121; 45 CFR 96.126(b) to (d); 45 CFR 96.131(d))
- A written outreach approach for people who inject drugs (45 CFR 96.126(e))
- Tuberculosis services and infection control procedures that follow the state agency's procedures (45 CFR 96.127(a))
- A system for checking eligibility for other coverage, billing other payers and collecting client fees (45 CFR 96.137)
- A list of costs the grant cannot pay for, and accounting records that trace each grant dollar (45 CFR 96.135(a); 45 CFR 96.30(a))
- A continuing education provision for staff who deliver prevention or treatment services (45 CFR 96.132(b))
- For religious organizations: a notice of the right to an alternative provider and a referral procedure (42 CFR 54.8)

1. What block grant funds may and may not pay for

OUR POLICY

We spend SUBG funds only on the prevention, treatment and recovery support services named in our contract. The regulation lists things the state may not spend the grant on, and the state passes those limits to us: inpatient hospital services (with a narrow exception), cash payments to the people who receive services, buying or improving land, buying, building or permanently improving a building (minor remodeling is allowed), buying major medical equipment, meeting another federal program's requirement to spend non-federal money, and financial assistance to any organization that is not public or nonprofit. Grant funds also may not be used to give people needles or syringes for illegal drug use, except as federal law and the state agency allow. The state may spend no more than 5 percent of the grant on administration, so the amount we may charge for administration is whatever our contract sets. Congress also limits pay: under the fiscal year 2026 HHS appropriations act, no salary may be charged to an HHS grant at a rate above Level II of the federal Executive Schedule, and that limit is set year by year.

WHAT WE DO

1. The program director keeps a chart that matches each budget line in our contract to the service it pays for and to the spending limits in 45 CFR 96.135.
2. The finance manager checks each cost against that chart before charging it to the grant and charges anything on the restricted list to other funds.
3. The finance manager does not pay cash to clients from grant funds and pays for client supports that our contract allows, such as transportation or child care, straight to the vendor.
4. The executive director asks the state agency in writing before any grant spending on building work or medical equipment, because the regulation does not define minor remodeling or major medical equipment and only HHS can waive the construction limit, at the state's request.
5. The clinical director charges inpatient hospital care to the grant only if our contract allows it and a physician has determined that the person's primary diagnosis is a substance use disorder, that the person cannot be treated safely in a community-based residential program, that the service can reasonably be expected to improve the person's condition, and that the hospital program follows national standards of practice.
6. The finance manager limits any inpatient hospital charge to the days that are medically necessary and to a daily rate no higher than the comparable rate for community-based residential treatment.
7. The finance manager compares each salary charged to the grant with the current Executive Schedule Level II rate at the start of each contract year, confirms the limit with the state agency, and charges any pay above it to other funds.
8. The program director asks the state agency in writing before starting any service that is not in our contract or passing grant funds to another organization, since the grant cannot give financial assistance to a for-profit entity.

Rules this covers: 45 CFR 96.135(a); 45 CFR 96.135(b); 45 CFR 96.135(c); 45 CFR 96.135(d); 42 U.S.C. 300x-21(b); 42 U.S.C. 300x-31; 42 U.S.C. 300ee-5; Pub. L. 119-75, Division B, section 202; Pub. L. 119-75, Division B, section 525

2. Admission priority, capacity reporting, waiting list and interim services

OUR POLICY

Any program of ours that serves women gives pregnant women preference in admission. If our program serves people who inject drugs, we give preference in this order: pregnant women who inject drugs, other pregnant women with a substance use disorder, other people who inject drugs, then everyone else. The regulation tells the state to make sure a person who asks for and needs treatment for injection drug use is admitted within 14 days of the request, or within 120 days if no program has room and interim services are offered within 48 hours. Interim services are services that reduce health risks and the spread of disease while a person waits for admission. The state meets these duties through its providers, so we follow these time limits and use the capacity and waiting list system the state agency runs. The regulation uses older terms such as intravenous substance abusers, and we say people who inject drugs.

WHAT WE DO

1. The intake worker asks every person who requests treatment whether they are pregnant and whether they inject drugs, and records the date and time of the request.
2. The intake worker offers openings in the preference order in this policy whenever more people are waiting than we can admit.
3. The clinical director admits a person who needs treatment for injection drug use within 14 days of the request whenever we have room.
4. The intake worker, when we cannot admit that person within 14 days, checks the state's capacity system for another program with an opening, offers interim services within 48 hours of the request, and adds the person to our waiting list.
5. The intake worker refers a pregnant woman we cannot admit to the state agency right away, in the way the state agency directs, so that she can be placed with another program or offered interim services within 48 hours of seeking treatment.
6. The counselor who provides interim services covers at least counseling and education about HIV and tuberculosis, the risks of sharing needles, the risks of passing disease to sexual partners and infants, and steps to prevent transmission, refers the person for HIV or tuberculosis treatment if needed, and for a pregnant woman adds counseling on the effects of alcohol and drug use on the fetus and a referral for prenatal care.
7. The intake worker keeps a waiting list with a unique identifier for each person who injects drugs and is waiting for treatment, stays in contact with each person, and takes a person off the list only when they cannot be located or refuse treatment, while the clinical director reviews the list on a regular schedule so that each person is admitted within 120 days of the request.
8. The clinical director notifies the state agency within 7 days each time the program reaches 90 percent of its capacity to admit people, using the reporting method the state agency sets.

Rules this covers: 45 CFR 96.121; 45 CFR 96.126(a); 45 CFR 96.126(b); 45 CFR 96.126(c); 45 CFR 96.126(d); 45 CFR 96.131; 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-27

3. Services for pregnant women and women with dependent children

OUR POLICY

The state has to spend a set amount of the grant on treatment services designed for pregnant women and women with dependent children. If our contract includes that funding, we treat the family as a unit and admit both women and their children into treatment when that is appropriate. We provide, or arrange through other providers, the five kinds of services listed in 45 CFR 96.124(e). These services are also for women who are trying to regain custody of their children. We spend this funding on people who have no other way to pay for the services.

WHAT WE DO

1. The clinical director keeps a list showing how each of the five required services is delivered, either by our own staff or by a named partner organization.
2. The counselor assesses the needs of each woman and her children at admission and writes the services they will receive into the treatment plan.
3. The case manager arranges primary medical care for each woman, including a referral for prenatal care, and child care while she receives that care.
4. The case manager arranges primary pediatric care, including immunizations, for the children.
5. The clinical director provides gender-specific substance use treatment and other therapeutic services for women, which may address relationships, sexual and physical abuse and parenting, with child care while the women are in those services.
6. The clinical director arranges therapeutic services for children in the custody of women in treatment, which may address developmental needs, sexual and physical abuse, and neglect.
7. The case manager provides enough case management and transportation for women and their children to reach each of these services.
8. The finance manager tracks spending on these services under its own budget line so the state agency can report it, and bills other payers first as described in the payment of last resort section.

Rules this covers: 45 CFR 96.124(c); 45 CFR 96.124(e); 45 CFR 96.131; 45 CFR 96.137; 42 U.S.C. 300x-22(b)

4. Outreach to people who inject drugs, tuberculosis services and HIV early intervention

OUR POLICY

If we receive grant funds to treat people who inject drugs, we carry out outreach that encourages people who need treatment to enter it. Every treatment program we run with grant funds makes tuberculosis (TB) services routinely available to each person in treatment, either directly or through arrangements with other public or nonprofit providers, and follows the TB procedures written by the state agency. HIV early intervention services under this grant are required only in a designated state, which is a state with 10 or more AIDS cases per 100,000 people, and only at the project sites the state chooses. If we are one of those sites, the services are voluntary, are given with the person's informed consent, and are never a condition of receiving treatment or any other service.

WHAT WE DO

1. The clinical director chooses an outreach model that is scientifically sound or, if no such model fits our area, an approach that can reasonably be expected to work, and writes down the reason for the choice.
2. The clinical director selects, trains and supervises the outreach workers.
3. The outreach worker contacts and follows up with people at high risk, their associates and neighborhood residents within the confidentiality rules, explains the link between injecting drugs and diseases such as HIV, recommends steps to prevent HIV transmission, and encourages people to enter treatment.
4. The clinical director makes sure each person in treatment is offered TB services, which are counseling about TB, testing for TB infection, and medical evaluation and treatment, provided by us or by referral, for anyone who is infected.
5. The intake worker refers a person who needs treatment but is turned away because we lack capacity to another provider of TB services.
6. The clinical director follows the state's TB infection control procedures, which include screening patients, identifying people at high risk of infection, meeting state reporting requirements within the confidentiality rules, and case management so that people receive the services.
7. The clinical director, if we are an HIV early intervention site, offers pretest counseling, testing, post-test counseling and the related therapeutic measures at the treatment site, gets informed consent first, and keeps working links with other health and social service organizations.
8. The finance manager bills other payers first for TB and HIV services and charges the grant only for costs that no other payer has paid or can reasonably be expected to pay.

Rules this covers: 45 CFR 96.121; 45 CFR 96.126(e); 45 CFR 96.127; 45 CFR 96.128; 45 CFR 96.137; 42 U.S.C. 300x-23(b); 42 U.S.C. 300x-24

5. Primary prevention services

OUR POLICY

Primary prevention programs are for people who have not been found to need treatment. The state has to spend at least 20 percent of the grant on primary prevention and has to build a statewide program that uses a mix of strategies, including the six the regulation names: information dissemination, education, alternatives, problem identification and referral, community-based process, and environmental strategies. Those duties belong to the state. Our part is the prevention work in our contract, which we plan, deliver and document by strategy and by the group of people served.

WHAT WE DO

1. The program director labels each prevention activity in our work plan with the strategy it falls under and the group it serves, either the general population or a group at higher risk.
2. The program director follows the priorities the state agency sets for groups at risk of developing a substance use problem.
3. The prevention specialist keeps a log for each activity showing the date, the place, the strategy and the number of people reached.
4. The prevention specialist does not assess whether a person needs treatment as part of problem identification and referral, and refers anyone who may need treatment to a treatment provider.

5 The finance manager charges prevention costs only to the prevention budget lines in our contract and does not use prevention funds to pay for treatment services.
6 The program director sends prevention data to the state agency in the form and on the schedule the state agency sets.

Rules this covers: 45 CFR 96.121; 45 CFR 96.124(b); 45 CFR 96.125; 42 U.S.C. 300x-22(a)

6. Confidentiality of patient records

OUR POLICY

Our treatment records are protected by the federal substance use disorder confidentiality rules in 42 CFR Part 2. Those rules bind us directly because we are a federally assisted program that provides substance use disorder diagnosis, treatment or referral for treatment. We use or disclose information that identifies a patient only with a written consent that meets Part 2 or under a specific exception in Part 2, and we share only what the purpose requires. If we send health information electronically for transactions HIPAA covers, such as claims to a health plan, we are also a HIPAA covered entity and follow the HIPAA privacy, security and breach rules. We notify affected patients of a breach of unsecured records without unreasonable delay and no later than 60 calendar days after we discover it. Separately, the state has to keep a system that protects patient records at funded providers, including staff education on confidentiality and on the fact that improper disclosure can lead to discipline.

WHAT WE DO

1 The privacy officer, who is the staff member the executive director names to oversee confidentiality, keeps formal written policies for protecting paper and electronic records, covering how records are stored, accessed, moved, removed and destroyed.
2 The intake worker tells each patient at admission that federal law protects the confidentiality of their records and gives them our written notice of privacy practices.
3 The counselor gets a written consent before any disclosure that needs one, on a form that names the patient, who may disclose, what information, who receives it and for what purpose, and that states the right to revoke, an expiration date or event, and the patient's signature and date.
4 The staff member who makes a disclosure with consent limits it to the information needed for the purpose and sends with it the required notice that 42 CFR Part 2 prohibits unauthorized use or disclosure, plus a copy of the consent or a clear explanation of its scope.
5 The front desk worker answers any request for information that we cannot lawfully give in a way that does not reveal whether a person has ever been our patient.
6 The privacy officer signs a qualified service organization agreement with an outside vendor, such as a billing or data processing company, before sharing patient records with it, and has auditors and monitors agree in writing to the Part 2 limits before they review records.
7 The clinical director writes into the patient's record, right after any disclosure to medical personnel in a medical emergency, who received the information, who disclosed it, the date and time, and the nature of the emergency.
8 The privacy officer trains every employee on these rules at hire and at least once a year, tells them that improper disclosure can lead to discipline, and keeps the attendance records.

Rules this covers: 42 CFR 2.11; 42 CFR 2.12; 42 CFR 2.13; 42 CFR 2.16; 42 CFR 2.22; 42 CFR 2.31; 42 CFR 2.32; 42 CFR 2.51; 42 CFR 2.53; 45 CFR 96.132(e); 42 U.S.C. 300x-53(b); 45 CFR 160.103; 45 CFR 164.404; 45 CFR 164.530

7. Nondiscrimination and charitable choice

OUR POLICY

Federal law treats programs funded by this grant as receiving federal financial assistance for the civil rights laws on age, disability, sex, and race, color and national origin. It adds its own rule: no one may be excluded from, denied the benefits of, or discriminated against in a grant-funded program because of sex, including pregnancy, or religion. The charitable choice rules in 42 CFR Part 54 cover religious organizations that provide grant-funded services. If our organization is religious, we do not spend grant funds on worship, religious instruction or proselytization, we keep any such activities separate in time or place from grant-funded services and voluntary, and we refer a person who objects to our religious character to another provider. If our organization is not religious, the notice and referral steps below apply to us only if the state agency asks every provider to follow them, and we may be the alternative provider that receives a referral.

WHAT WE DO

1. The executive director posts our nondiscrimination statement, puts it in the client handbook, and applies it to admission, services and discharge.
2. The program director handles any discrimination complaint under our written complaint procedure and tells the client how to contact the state agency.
3. The intake worker at a religious organization gives each client and applicant a written notice of the right to services from an alternative provider, using the model notice in the appendix to 42 CFR Part 54a or the state agency's version.
4. The clinical director at a religious organization, when a client objects to our religious character, refers the client within a reasonable time to an alternative provider, using any provider list the state agency supplies.
5. The clinical director makes each such referral in line with the confidentiality rules in 42 CFR Part 2, notifies the state agency of the referral, and confirms that the client made contact with the alternative provider.
6. The program director at a religious organization schedules any worship, religious instruction or similar activity at a separate time or place from grant-funded services and makes sure clients know taking part is voluntary.
7. The finance manager at a religious organization keeps federal funds in an account separate from non-federal funds and charges no religious activity to the grant.
8. The executive director trains staff that no client is treated differently because of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively take part in a religious practice.

Rules this covers: 42 U.S.C. 300x-57; 42 U.S.C. 300x-65; 42 CFR 54.4; 42 CFR 54.5; 42 CFR 54.7; 42 CFR 54.8; 42 CFR 54.10; 45 CFR 96.123(a)(17); 45 CFR 96.123(a)(18)

8. Payment of last resort and collecting from other payers

OUR POLICY

The block grant is the payment of last resort for the services the regulation lists: the set-aside services for pregnant women and women with dependent children, tuberculosis services, and HIV early intervention services. For those services we make every reasonable effort to collect from Medicare, Medicaid, private insurance and any other program that covers the person, and to collect payment from clients according to their ability to pay. The regulation says that effort includes systems for eligibility determination, billing and collection. Our contract may apply the same rule to every grant-funded service, and where it does we follow the contract.

WHAT WE DO

1. The intake worker asks each client at admission about Medicaid, Medicare, private insurance and other benefits, and records and verifies the answers.
2. The intake worker helps a client who appears eligible for Medicaid or another benefit program to apply.
3. The finance manager bills the other payer first and charges the grant only for the cost that payer does not cover.
4. The finance manager sets client fees from our written fee schedule, which is based on ability to pay, or from the schedule the state agency sets.
5. The finance manager does not charge the grant for a TB or HIV service when payment has been made, or can reasonably be expected to be made, by an insurance policy, a federal or state health benefits program, a state compensation program or a prepaid health plan.
6. The finance manager records insurance payments and client fees collected for grant-funded services and handles them as our contract directs.
7. The finance manager tests a sample of services billed to the grant on a regular schedule to confirm no other payer was available and corrects any errors found.

Rules this covers: 45 CFR 96.137; 45 CFR 96.124(e); 45 CFR 96.128(e); 42 U.S.C. 300x-24(c)

9. Financial management and timekeeping

OUR POLICY

The federal block grant rule says a state spends and accounts for block grant funds under the laws and procedures it uses for its own money, and that its fiscal controls have to trace the funds well enough to show they were not spent on anything the statute forbids. HHS now follows the government-wide Uniform Guidance at 2 CFR Part 200, which it adopted at 2 CFR Part 300 in place of its former rules at 45 CFR Part 75. The Uniform Guidance says most of its administrative and cost rules (subparts C, D and E) do not apply to the block grants authorized by the 1981 budget law, while its rules for monitoring subrecipients and its audit rules still apply. The state agency, not our organization, decides how that exception applies to this grant, so the fiscal rules that bind us are mainly the ones in our contract. Where our contract adopts the Uniform Guidance cost and timekeeping standards we follow them, and where it is silent we use them as our working standard. We track SUBG funds apart from all other money and can trace every charge to a source document.

WHAT WE DO

1. The finance manager sets up a separate fund or cost center for each SUBG contract, with accounts that match the budget lines in the contract.
2. The finance manager reads the fiscal terms of each new contract, writes down which cost, timekeeping, indirect cost and procurement rules it applies, and asks the state agency in writing about anything the contract leaves unclear.
3. The finance manager confirms before charging a cost to the grant that it is necessary, reasonable, documented, and treated the same way we treat similar costs paid from other funds.
4. The supervisor approves a timesheet for each employee paid in part with grant funds that shows all hours worked, split by program and activity.
5. The finance manager charges salaries to the grant from approved time records and corrects any charges that were first booked from budget estimates.
6. The finance manager splits shared costs such as rent, phones and insurance using the method in our written cost allocation plan.
7. The finance manager charges indirect costs (overhead that cannot be tied to one program) only as our contract allows and at the rate it names, noting that the Uniform Guidance rate for organizations with no negotiated rate is up to 15 percent of modified total direct costs where the contract applies it.
8. The finance manager compares actual spending with the budget each month, prepares each invoice on the schedule in our contract with the supporting records, and has the executive director review and sign it within the contract's spending period.

Rules this covers: 45 CFR 96.30(a); 42 U.S.C. 300x-62; 2 CFR 200.101(e); 2 CFR 200.302; 2 CFR 200.303; 2 CFR 200.403; 2 CFR 200.414(f); 2 CFR 200.430(g); 2 CFR 300.106

10. Procurement and conflicts of interest

OUR POLICY

We buy goods and services with grant funds through fair, documented steps and follow the procurement terms in our contract. Where the contract applies the Uniform Guidance procurement standards, or is silent, we use those standards: written procedures, competition that fits the size of the purchase, and a record of each purchase. No employee, officer, board member or agent takes part in choosing or managing a contract when they have a real or apparent conflict of interest. We disclose potential conflicts of interest to the state agency in writing, and we report credible evidence of fraud, bribery or similar violations that involve the grant.

WHAT WE DO

1. The finance manager follows our written procurement procedures, which set the method for each purchase size: micro-purchases, small purchases with price quotes, and sealed bids or proposals for large purchases.
2. The finance manager uses the dollar thresholds in our procurement policy, which we set no higher than our contract and the Uniform Guidance allow.
3. The program director gets price or rate quotes from an adequate number of qualified sources for purchases above our micro-purchase threshold and keeps the quotes.
4. The finance manager keeps a file for each purchase that shows why the method was chosen, the type of contract, why the vendor was selected or rejected, and the basis for the price.

5 The finance manager confirms before a contract is signed that the vendor is not suspended or debarred from federal work, for example by checking SAM.gov.
6 The executive director has each employee and board member sign our conflict of interest policy and report any possible conflict in writing as soon as it comes up.
7 The executive director discloses any potential conflict of interest that involves the grant to the state agency in writing.
8 The executive director promptly reports in writing to the state agency, SAMHSA and the HHS Office of Inspector General any credible evidence of fraud, bribery, gratuity or conflict of interest crimes or of false claims connected to the grant.

Rules this covers: 45 CFR 96.30(a); 45 CFR 96.33; 42 U.S.C. 300x-56; 2 CFR 200.112; 2 CFR 200.113; 2 CFR 200.214; 2 CFR 200.318; 2 CFR 200.320

11. Staff training, peer review, data reporting, records and audits

OUR POLICY

Several quality and reporting rules bind the state and reach us through our contract. The state has to see that continuing education is available to employees who deliver grant-funded prevention or treatment services, and it puts a continuing education provision in each provider's agreement. The state also arranges independent peer review of treatment services each year, covering at least 5 percent of the entities that provide services under the grant, so our program may be chosen. The state reports client data to SAMHSA, including admissions and discharges for the Treatment Episode Data Set (TEDS), and we supply our part in the form and on the schedule the state agency sets. The block grant regulation does not set a retention period for provider records. The Uniform Guidance period is three years from the final financial report, but that rule sits in a subpart that does not apply on its own to the 1981 block grants, so we keep records for the period in our contract. We give auditors and monitors access to our records, and we get a single audit for any fiscal year in which we spend $1,000,000 or more in federal awards.

WHAT WE DO

1 The clinical director keeps a written training plan that gives each employee who delivers prevention or treatment services continuing education each year, in the amount our contract or state licensing rules set, and keeps the attendance records.
2 The clinical director cooperates with independent peer reviewers by giving them the sample of client records they ask for, which they use to look at admission and intake, assessments, treatment planning, documentation of services, discharge and continuing care planning, and treatment outcomes.
3 The clinical director writes a plan to act on any peer review or monitoring finding and sends it to the state agency by its deadline.
4 The program director enters admission, discharge and other client data in the state's data system on the schedule the state agency sets and checks the data for missing or wrong entries each month.
5 The program director sends the performance and financial reports listed in our contract on the schedule it sets.

6 The finance manager keeps a retention schedule that holds grant records for the period in our contract and holds anything tied to an open audit, claim or lawsuit until it is resolved.

7 The executive director gives the state agency, HHS, the Comptroller General and independent auditors access to our books, documents and records on reasonable request, with patient records shared only as 42 CFR Part 2 allows.

8 The finance manager arranges a single audit for any fiscal year in which our organization spends $1,000,000 or more in federal awards from all sources and sends the report to the state agency as our contract requires.

Rules this covers: 45 CFR 96.31; 45 CFR 96.132(b); 45 CFR 96.136; 42 U.S.C. 300x-28(b); 42 U.S.C. 300x-52; 42 U.S.C. 300x-53(a); 42 U.S.C. 300x-55(g); 42 CFR 2.53; 2 CFR 200.101(e); 2 CFR 200.332; 2 CFR 200.334; 2 CFR 200.501(a)

Adoption

This handbook was reviewed and adopted by our organization on the date below. We review it once a year and whenever the grant agreement or the regulation changes.

Adopted by: _____ Title: _____

Signature: _____ Date: _____

Sources

- 45 CFR Part 96: The HHS block grant regulation. Subpart L (96.120 to 96.137) covers the substance use block grant, and Subpart C (96.30 to 96.33) covers fiscal rules and audits. https://www.ecfr.gov/current/title-45/part-96
- 42 U.S.C. 300x-21 to 300x-35: The statute for the block grant, titled Block Grants for Substance Use Prevention, Treatment, and Recovery Services (Public Health Service Act, Title XIX, Part B, Subpart II). https://uscode.house.gov/us/usc/t42/chapter6A-subchapterXVII-partB-subpartii-front.html
- 42 U.S.C. 300x-51 to 300x-66: The general provisions that apply to the block grant, including reports and audits, peer review, patient records, access to records, false statements, nondiscrimination and charitable choice (Subpart III). https://uscode.house.gov/us/usc/t42/chapter6A-subchapterXVII-partB-subpartiii-front.html
- 42 CFR Part 2: The federal rules on confidentiality of substance use disorder patient records. https://www.ecfr.gov/current/title-42/part-2
- 42 CFR Part 54: The charitable choice rules for religious organizations that provide block grant services. The model notice to clients is in the appendix to 42 CFR Part 54a. https://www.ecfr.gov/current/title-42/part-54
- 45 CFR Parts 160 and 164: The HIPAA rules, including who is a covered entity (160.103), breach notification (164.404) and written privacy policies and training (164.530). https://www.ecfr.gov/current/title-45/part-164
- 2 CFR Part 200: The federal Uniform Guidance. Section 200.101(e) lists the parts that do not apply to the 1981 block grants, and Subpart F sets the single audit rules. https://www.ecfr.gov/current/title-2/part-200
- 2 CFR Part 300: The HHS rule that adopts 2 CFR Part 200 (section 300.106). It took the place of 45 CFR Part 75, which was removed from the Code of Federal Regulations on October 1, 2025. https://www.ecfr.gov/current/title-2/part-300
- Consolidated Appropriations Act, 2026 (Pub. L. 119-75): The fiscal year 2026 HHS appropriations act. Division B, section 202 holds the Executive Level II salary limit and section 525 holds the limit on buying needles and syringes. https://www.govinfo.gov/content/pkg/PLAW-119publ75/html/PLAW-119publ75.htm

- SAMHSA: Substance Use Prevention, Treatment, and Recovery Services Block Grant: SAMHSA's page for the grant, with its current name and short names, the populations it targets and the primary prevention strategies. https://www.samhsa.gov/grants/block-grants/subg
- SAMHSA: Block Grants Laws and Regulations: SAMHSA's list of the laws and regulations that govern the block grants and affect subrecipients. https://www.samhsa.gov/grants/block-grants/laws-regulations
- SAMHSA: FY 2026-2027 Block Grant Application: The application and plan each state completes, which shows how SAMHSA asks states about priority admissions, charitable choice and data. https://www.samhsa.gov/sites/default/files/fy26-27-block-grant-application.pdf
- SAMHSA: Treatment Episode Data Set (TEDS): SAMHSA's page for the national data set on admissions to and discharges from substance use treatment, reported by state agencies. https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set