

## ATTUD TREATMENT PROGRAM WEBSITE LISTING: APPLICATION FORM

This form is intended to provide a mechanism by which treatment providers and programs can apply to list their services on the ATTUD web site ([www.attud.org](http://www.attud.org)). Those seeking treatment resources will be able to review the listed treatment programs for suitability.

Please complete the following form describing your Tobacco Dependence Treatment Program. Please answer all questions, providing detailed information (the table will expand to accommodate your responses). Please **do not** send any supplemental materials unless this is specifically requested.

The ATTUD Review Panel will evaluate submissions to determine if all categories have been answered and whether any clarifications are required. Applications will be denied for the following reasons:

1. Gross misrepresentation, false, or misleading claims of the program and its treatment protocols.
2. Primary or substantial use of non-evidence based treatment components.
3. Relationship (financial or otherwise) with the tobacco industry.

If the submission meets ATTUD's standards for listing, the program contact will be so notified. Your program's description will be provided as a viewable and / or downloadable PDF file from ATTUD's website.

**Inclusion on this list does not imply endorsement by ATTUD.** ATTUD reserves the right to exclude programs based on the criteria stated above. A review panel appointed by the ATTUD Board of Directors will perform these reviews. If you have questions, feel to contact the ATTUD Communications Chairperson (contact information can be found at [www.attud.org](http://www.attud.org)).

APPLICATION NUMBER	[APPLICANT, PLEASE LEAVE THIS AREA BLANK]
<b>PROGRAM INFORMATION &amp; OVERVIEW</b>	
Date of this Application	9/26/2017
Full Name of Individual Treatment Provider/ Program	Elizabeth B. Stern / Quit 101
Organizational / Institutional Sponsor (if applicable)	Spectrum Health, Healthier Communities Department
Street Address	665 Seward NW
City, State, Zip	Grand Rapids, MI 49504
Website URL	
ATTUD Member Contact Name(s)	
Telephone	616-486-6503
Fax	616-391-2109
Email Address	elizabeth.stern@spectrumhealth.org
Sources of Funding (check all that apply)	<input type="checkbox"/> Federal grants <input type="checkbox"/> State grants / appropriations / tobacco control programs <input type="checkbox"/> Fee for services <input checked="" type="checkbox"/> Other in-house funding <input type="checkbox"/> Pharmaceutical industry contracts <input checked="" type="checkbox"/> Foundation funding <input type="checkbox"/> Other, please describe:
Years treatment program has been in existence	Enter year program was started: 2008 Total years in operation: 9

Number of tobacco users receiving treatment per year	50-100
Types of tobacco use treated	(Select all that apply) <input checked="" type="checkbox"/> Cigarettes <input checked="" type="checkbox"/> Moist Snuff <input checked="" type="checkbox"/> Cigars <input checked="" type="checkbox"/> Chewing Tobacco <input checked="" type="checkbox"/> Pipes <input checked="" type="checkbox"/> Other: Water pipes; bidis; etc
Are your treatment protocols based upon a set of evidenced-based guidelines?	<input checked="" type="checkbox"/> Yes, cite:                    2008 Clinical Practice Guideline  <input type="checkbox"/> No, please explain:
Is there a cost for treatment? (Please indicate whether pharmacotherapy is covered in the cost)	<input type="checkbox"/> YES, please specify:  <input checked="" type="checkbox"/> NO  What is covered by this cost? (check all that apply) <input type="checkbox"/> Counseling <input type="checkbox"/> Medication <input type="checkbox"/> Web Access <input type="checkbox"/> Printed Materials
How many counseling sessions are provided and how long is each session?	Describe: 4 session cessation group support 1:1 cessation support 4-8 sessions
What treatment medications are provided (directly or indirectly) by the program?	(Check all that apply) <input checked="" type="checkbox"/> Nicotine patch <input checked="" type="checkbox"/> Nicotine gum <input checked="" type="checkbox"/> Nicotine lozenge <input checked="" type="checkbox"/> Nicotine inhaler <input checked="" type="checkbox"/> Nicotine nasal spray <input checked="" type="checkbox"/> Bupropion SR <input checked="" type="checkbox"/> Varenicline (Chantix) <input checked="" type="checkbox"/> Combination of medications  Enter any further descriptions here: All medications are considered and recommendations are made however the medications are not provided by our
Is alternative treatment part of your approach? Alternative treatment approaches are described as: <ul style="list-style-type: none"> <li>• Hypnotherapy</li> <li>• Acupuncture</li> <li>• Laser Therapy</li> <li>• Anti-cholinergic Shot Therapy</li> <li>• Herbal Therapy</li> </ul>	<input type="checkbox"/> Yes (Please describe):  <input checked="" type="checkbox"/> No
Are you/your Treatment Specialists (TTS) trained to ATTUD's Core Competencies?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (please explain)
Are you/your TTS required to be certified? (Note: ATTUD recognizes that at this time there is no national or universally recognized certification standard and that all certifications are local)	<input checked="" type="checkbox"/> Yes  <input type="checkbox"/> No

Do the services provided by your program have oversight by medical staff?	<input checked="" type="checkbox"/> Yes (please describe): Our program department is under the direction of a physician <input type="checkbox"/> No
Types of treatment providers in your program (check all that apply):	<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychologist <input type="checkbox"/> Mental Health Counselor <input type="checkbox"/> Addiction Specialist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Physical/Occupational/Speech Therapist <input type="checkbox"/> Health Educator <input checked="" type="checkbox"/> Social Worker <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Other (please list):
<b>TREATMENT FORMAT(S)</b>	
What treatment formats are provided by your program?	(Check all that apply) <input checked="" type="checkbox"/> Individual <input checked="" type="checkbox"/> Group <input checked="" type="checkbox"/> Phone <input type="checkbox"/> Web-based
<b>TREATMENT DIVERSITY</b>	
Do you provide treatment in languages other than English?	<input type="checkbox"/> Yes (please list) <input checked="" type="checkbox"/> No, English only
Is your treatment program culturally and/or sexually diverse?	<input checked="" type="checkbox"/> Yes (please explain)    It is available to anyone in the community <input type="checkbox"/> No (please explain)
<b>ADMINISTRATIVE ASSURANCE</b>	
Name and title of official who assumes responsibility for completion of this application	<input checked="" type="checkbox"/> By checking this box, I affirm that the information provided herein is accurate to the best of my knowledge.  (Be sure to sign and send the attached Assurance Form)

**APPLICATION TO LIST A TTS TREATMENT PROGRAM ON THE ATTUD WEBSITE**

**[APPLICANT, PLEASE LEAVE THIS AREA BLANK]**

**ASSURANCE STATEMENT**

**Name of Treatment Individual / Program:**

Elizabeth B. Stern, LMSW, CTTS/Spectrum Health, Quit 101

A formal application has been submitted to ATTUD for listing on the ATTUD website. The ID number of that application matches the one listed above. To the best of our knowledge, I/we attest to the following:

1. All information provided is complete and accurate.
2. Our program is currently active.
3. We agree to notify ATTUD with any significant changes to the information provided above.
4. We understand that if approved, our program information will be viewable on the ATTUD website and downloadable as a PDF file.

**Signatures**

Elizabeth B. Stern, LMSW, CTTS

\_\_\_\_\_  
Tobacco Treatment Provider/Program Director

09 / 26 / 2017 Date

\_\_\_\_\_  
Program Official (if needed)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date

Please indicate if either signer is a current ATTUD Member  YES  NO

After signing above, please do one of the following:

1. Complete this form with your electronic signature, save and email to [txproviders@attud.org](mailto:txproviders@attud.org)
2. Sign and scan this form and email to [txproviders@attud.org](mailto:txproviders@attud.org)

Your application will be assigned to the review committee once all materials are received. You will be contacted once that process is complete. Please allow 2 – 4 weeks for processing.

Thank you,

ATTUD Communications Chairperson