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). 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).

APPLICATION NUMBER	[APPLICANT, PLEASE LEAVE THIS AREA BLANK]
PROGRAM INFORMATION & OVERVIEW	
Date of this Application	6/17/2021
Full Name of Individual Treatment Provider/ Program	Tobacco Cessation Program
Organizational / Institutional Sponsor (if applicable)	UCHealth Memorial Hospital
Street Address	525 Bob Peters Grove # 0816
City, State, Zip	Colorado Springs, Co 80909
Website URL	www.UCHealth.org
ATTTUD Member Contact Name(s)	Smita Bhattarai
Telephone	719-365-7511
Fax	719-365-9520
Email Address	Smita.Bhattarai@uchealth.org
Sources of Funding (check all that apply)	☐ Federal grants ☐ State grants / appropriations / tobacco control programs ☐ Fee for services ☐ Other in-house funding ☐ Pharmaceutical industry contracts ☐ Foundation funding ☒ Other, please describe: Cost Free
Years treatment program has been in existence	Enter year program was started: 06/01/2020 Total years in operation: 1

Number of tobacco users receiving treatment per year	TBD
Types of tobacco use treated	(Select all that apply) ☒ Cigarettes ☒ Moist Snuff ☒ Cigars ☒ Chewing Tobacco ☐ Pipes ☒ Other: Water pipes; bidis; etc ENDS
Are your treatment protocols based upon a set of evidenced-based guidelines?	☒ Yes, cite: NCCN, ASCO and USPSTF clinical Practice guidelines ☐ No, please explain:
Is there a cost for treatment? (Please indicate whether pharmacotherapy is covered in the cost)	YES, please specify: ☒ NO What is covered by this cost? (check all that apply) ☐ Counseling ☐ Medication ☐ Web Access ☐ Printed Materials
How many counseling sessions are provided and how long is each session?	Describe: As many as patient wants/needs for as long as patient wants/needs
What treatment medications are provided (directly or indirectly) by the program?	(Check all that apply) ☒ Nicotine patch ☒ Nicotine gum ☒ Nicotine lozenge ☒ Nicotine inhaler ☒ Nicotine nasal spray ☒ Bupropion SR ☒ Varenicline (Chantix) ☒ Combination of medications Enter any further descriptions here:
Is alternative treatment part of your approach? Alternative treatment approaches are described as: • Hypnotherapy • Acupuncture • Laser Therapy • Anti-cholinergic Shot Therapy • Herbal Therapy	☐ Yes (Please describe): ☒ No
Are you/your Treatment Specialists (TTS) trained to ATTUD's Core Competencies?	☒ Yes ☐ 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)	☒ Yes ☐ No

Do the services provided by your program have oversight by medical staff?	☒ Yes (please describe): MDs, PAs, NPs, RNs, Oncologists, Radiologist, Surgons ☐ No
Types of treatment providers in your program (check all that apply):	☒ Physician ☒ Physician Assistant ☒ Nurse ☒ Nurse Practitioner ☐ Psychologist ☐ Mental Health Counselor ☐ Addiction Specialist ☒ Pharmacist ☐ Respiratory Therapist ☐ Physical/Occupational/Speech Therapist ☐ Health Educator Social Worker Dentist ☐ Dental Hygienist Other (please list):
TREATMENT FORMAT(S)	
What treatment formats are provided by your program?	(Check all that apply) ☒ Individual ☐ Group ☒ Phone ☐ Web-based
TREATMENT DIVERSITY	
Do you provide treatment in languages other than English?	☒ Yes (please list) we use interpreter services ☐ No, English only
Is your treatment program culturally and/or sexually diverse?	☒ Yes (please explain) As per health system policies ☐ No (please explain)
ADMINISTRATIVE ASSURANCE	
Name and title of official who assumes responsibility for completion of this application	☒ 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:

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

_____ 06 / 17 / 2021 Date

Tobacco Treatment Provider/Program Director

_____ ____/____/____ Date

Program Official (if needed)

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
2. Sign and scan this form and email to 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