

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	May 1st 2018
Full Name of Individual Treatment Provider/ Program	Ho'opi'i Ola Pono (Striving for good health) Tobacco Program
Organizational / Institutional Sponsor (if applicable)	Ko'olauloa Health Center
Street Address	56-119 Pualalea Street
City, State, Zip	Kahuku, HI, 96731
Website URL	https://koolauloachc.org/
ATTUD Member Contact Name(s)	Helen P. Hudson LMFT, Thomas Robertson LCSW
Telephone	808 293 9231
Fax	
Email Address	HHudson@koolauloachc.org
Sources of Funding (check all that apply)	<input checked="" type="checkbox"/> Federal grants <input checked="" type="checkbox"/> State grants / appropriations / tobacco control programs <input checked="" type="checkbox"/> Fee for services <input type="checkbox"/> Other in-house funding <input type="checkbox"/> Pharmaceutical industry contracts <input type="checkbox"/> Foundation funding <input type="checkbox"/> Other, please describe:
Years treatment program has been in existence	Enter year program was started: 2016 Total years in operation: 2

Number of tobacco users receiving treatment per year	60+
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: Treating Tobacco Use And Dependence (2008). US Dept of Health <input type="checkbox"/> No, please explain:
Is there a cost for treatment? (Please indicate whether pharmacotherapy is covered in the cost)	<input checked="" type="checkbox"/> YES, please specify: Participants may be responsible for co-pay + <input type="checkbox"/> NO What is covered by this cost? (check all that apply) <input checked="" type="checkbox"/> Counseling <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Web Access <input checked="" type="checkbox"/> Printed Materials
How many counseling sessions are provided and how long is each session?	Describe: Sessions usually run 30 to 45 minutes. A minimum of 4 is recommended.
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:
Is alternative treatment part of your approach? Alternative treatment approaches are described as: <ul style="list-style-type: none"> • Hypnotherapy • Acupuncture • Laser Therapy • Anti-cholinergic Shot Therapy • Herbal Therapy 	<input checked="" type="checkbox"/> Yes (Please describe): Emotional Freedom Techniques (EFT). Otherwise known as Acu-tap or tapping. <input 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): Medical provides to prescribe <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 checked="" type="checkbox"/> Nurse <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychologist <input checked="" type="checkbox"/> Mental Health Counselor <input checked="" 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 checked="" type="checkbox"/> Other (please list): Licensed Marriage and Family

TREATMENT FORMAT(S)

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
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TREATMENT DIVERSITY

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) Family based treatment, members of L <input type="checkbox"/> No (please explain)

ADMINISTRATIVE ASSURANCE

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)
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ASSURANCE STATEMENT

Name of Treatment Individual / Program:

Ho'opi 'i Ola Pono (Striving toward Good Health) Tobacco 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

Helen P. Hudson

Tobacco Treatment Provider/Program Director

05 / 21 / 2018 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
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