

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	4/15/13
Full Name of Individual Treatment Provider/ Program	Live Well...Tobacco Free! Program
Organizational / Institutional Sponsor (if applicable)	Castle Medical Center
Street Address	642 Ulukahiki Street, Suite 105
City, State, Zip	Kailua, Hawaii, 96734
Website URL	http://castlemed.org/cgi-bin/quit-smoking.cgi
ATTUD Member Contact Name(s)	Kanani N. Kilbey
Telephone	808-263-5050 (front desk) or 263-5057 (direct)
Fax	808-263-5054
Email Address	KilbeyKN@ah.org or CMCWellness @ah.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 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: 2012 Total years in operation: 15

Number of tobacco users receiving treatment per year	600
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 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: Based on U.S. Department of Health Clinical Practice Guidelines <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: At least 4 sessions, usually 30-40 minutes per individualized coaching session.
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 type="checkbox"/> Nicotine inhaler <input type="checkbox"/> Nicotine nasal spray <input type="checkbox"/> Bupropion SR <input type="checkbox"/> Varenicline (Chantix) <input checked="" type="checkbox"/> Combination of medications Enter any further descriptions here: We facilitate patients in receiving medications covered by their insurance provider, and contact their doctor.
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 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Do the services provided by your program have oversight by medical staff?	<input type="checkbox"/> Yes (please describe): <input checked="" 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 type="checkbox"/> Social Worker <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist <input checked="" type="checkbox"/> Other (please list): (2) Tobacco Treatment Specialists

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) Many are from diverse backgrounds. <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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