ONE ARIZONA DISTRIBUTION OF OPIOID SETTLEMENT FUNDS AGREEMENT

General Principles

- The people of the State of Arizona and Arizona communities have been harmed by the opioid epidemic, which was caused by entities within the Pharmaceutical Supply Chain.
- The State of Arizona, *ex rel.* Mark Brnovich, Attorney General (the "State"), and certain Participating Local Governments are separately engaged in litigation seeking to hold the Pharmaceutical Supply Chain Participants accountable for the damage they caused.
- The State and the Participating Local Governments share a common desire to abate and alleviate the impacts of the Pharmaceutical Supply Chain Participants' misconduct throughout the State of Arizona.
- The State and the Participating Local Governments previously entered into the One Arizona Opioid Settlement Memorandum of Understanding for the purpose of jointly approaching Settlement negotiations with the Pharmaceutical Supply Chain Participants.
- The State and the Participating Local Governments now enter into this One Arizona Distribution of Opioid Settlement Funds Agreement ("Agreement") to establish binding terms for the distribution and spending of funds from Settlements with the Pharmaceutical Supply Chain Participants.

A. Definitions

As used in this Agreement:

1. "Approved Purpose(s)" shall mean those uses identified in the agreed Opioid Abatement Strategies attached as Exhibit A.

2. "Contingency Fee Fund" shall mean a sub fund established in a Settlement for the purpose of paying contingency fees, such as the Attorney Fee Fund described in Section I.V of the Settlement with the Settling Distributors and the sub fund of the Attorney Fee Fund described in Section II.D of the Settlement with J&J.[1]

3. "J&J" shall mean Johnson & Johnson, Janssen Pharmaceuticals, Inc., OrthoMcNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc.

4. "Litigation" means existing or potential legal claims against Pharmaceutical Supply Chain Participants seeking to hold them accountable for the damage caused by their misfeasance, nonfeasance, and malfeasance relating to the unlawful manufacture, marketing, promotion, distribution, or dispensing of prescription opioids.

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[1] Text of both settlements available at https://nationalopioidsettlement.com.

5. "Opioid Funds" shall mean monetary amounts obtained through a Settlement as defined in this Agreement.

6. "Participating Local Government(s)" shall mean all counties, cities, and towns within the geographic boundaries of the State that have chosen to sign on to this Agreement and each applicable Settlement. The Participating Local Governments may be referred to separately in this Agreement as "Participating Counties" and "Participating Cities and Towns" (or "Participating Cities or Towns," as appropriate).

7. "Parties" shall mean the State and the Participating Local Governments.

8. "Pharmaceutical Supply Chain" shall mean the process and channels through which licit opioids are manufactured, marketed, promoted, distributed, or dispensed.

9. "Pharmaceutical Supply Chain Participant" shall mean any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution, or dispensing of licit opioids.

10. "Settlement" shall mean the negotiated resolution of legal or equitable claims against a Pharmaceutical Supply Chain Participant when that resolution has been jointly entered into by the State and the Participating Local Government and approved as final by a court of competent jurisdiction.

11. "Settling Distributors" shall mean McKesson Corporation, Cardinal Health, Inc., and AmerisourceBergen Corporation.

12. "Trustee" shall mean either (1) an independent trustee who shall be responsible for the ministerial task of releasing the Opioid Funds that are in trust as authorized herein and accounting for all payments into or out of the trust, or (2) a settlement fund administrator, in the event that the Settlement includes a fund administrator. In either case, the Trustee will distribute funds in accordance with this Agreement.

B. Intrastate Regions

1. The State of Arizona will be divided into regions, each of which will be referred to as a "Region" and will consist of: (1) a single Participating County and all of its Participating Cities and Towns; or (2) all of the Participating Cities and Towns within a non-Participating County. If there is only one Participating City or Town within a non-Participating County, that single Participating City or Town will still constitute a Region. Two or more Regions may at their discretion form a group ("Multicounty Region"). Regions that do not choose to form a Multicounty Region will be their own Region. Participating Cities and Towns within a non-Participating County may not form a Region with Participating Cities and Towns in another county.

2. The LG Share funds described in Section C(1) will be distributed to each Region according to the percentages set forth in Exhibit B. The Regional allocation model uses three equally weighted factors: (1) the amount of opioids shipped to the Region; (2) the number of opioid deaths that occurred in that Region; and (3) the number of people who suffer opioid use disorder in that Region. In the event any county does not participate in this Agreement, that

county's percentage share shall be reallocated proportionally amongst the Participating Counties by applying this same methodology to only the Participating Counties.

3. In single-county Regions, that county's health department will serve as the lead agency responsible for distributing the LG Share funds. That health department, acting as the lead agency, shall consult with the cities and towns in the county regarding distribution of the LG Share funds.

4. For each Multicounty Region, an advisory council shall be formed from the Participating Local Governments in the Multicounty Region to distribute the collective LG Share funds. Each advisory council shall include at least three Participating Local Government representatives, not all of whom may reside in the same county. Each advisory council shall consult with the Participating Local Governments in the Multicounty Region regarding distribution of the collective LG Share funds.

5. For each Region consisting of the Participating Cities and Towns within a non-Participating County, an advisory council shall be formed from the Participating Cities and Towns in the Region to distribute the LG Share funds. Each advisory council shall include at least three representatives from the Participating Cities and Towns in the Region, or a representative from each Participating City and Town if the Region consists of fewer than three Participating Cities and Towns. In no event may more than one individual represent the same city or town. To the extent any Participating Cities or Towns in the Region are not represented on the advisory council, the advisory council shall consult with the non-represented Participating Cities and Towns regarding distribution of the collective LG Share funds.

C. Allocation of Settlement Proceeds

1. All Opioid Funds shall be divided with 44% to the State ("State Share") and 56% to the Participating Local Governments ("LG Share").[2]

2. All Opioid Funds, except those allocated to payment of counsel and litigation expenses as set forth in Section E, shall be utilized in a manner consistent with the Approved Purposes definition. Compliance with this requirement shall be verified through reporting, as set out in Section F.

3. Each LG Share will be distributed to each Region or Multicounty Region as set forth in Section B(2). Participating Counties and their constituent Participating Cities and Towns may distribute the funds allocated to the Region or Multicounty Region amongst themselves in any manner they choose. If a county and its cities and towns cannot agree on how to allocate the funds, the default allocation in Exhibit C will apply. The default allocation formula uses historical federal data showing how each county and the cities and towns within it have made opioids-related expenditures in the past. If a county or any cities or towns within a Region or Multicounty Region do not sign on to this Agreement and each

[2] This Agreement assumes that any opioid settlement for Native American Tribes and Third-Party Payors, including municipal insurance pools, will be dealt with separately.

Settlement, and if the Participating Local Governments in the Region or Multicounty Region cannot agree on how to allocate the funds from that Settlement amongst themselves, the funds shall be reallocated proportionally by applying this same methodology to only the Participating Local Governments in the Region or Multicounty Region.

4. If the LG Share for a given Participating Local Government is less than $500, then that amount will instead be distributed to the Region or Multicounty Region in which the Participating Local Government is located to allow practical application of the abatement remedy. If the county did not sign on to the Settlement as defined herein, the funds will be reallocated to the State Share.

5. The State Share shall be paid by check or wire transfer directly to the State through the Trustee, who shall hold the funds in trust, or as otherwise required by a Settlement for the benefit of the State, to be timely distributed as set forth in C(1) herein. The LG Share shall be paid by check or wire transfer directly to the Regions or Multicounty Regions through the Trustee, who shall hold the funds in trust, or as otherwise required by a Settlement for the benefit of the Participating Local Governments, to be timely distributed as set forth in B(2), C(1), C(3), and C(4) herein.

6. The State Share shall be used only for (1) Approved Purposes within the State or (2) grants to organizations for Approved Purposes within the State.

7. The LG Share shall be used only for (1) Approved Purposes by Participating Local Governments within a Region or Multicounty Region or (2) grants to organizations for Approved Purposes within a Region or Multicounty Region.

8. The State will endeavor to prioritize up to 30% of the State Share for opioid education and advertising related to awareness, addiction, or treatment; Department of Corrections and related prison and jail opioid uses; and opioid interdiction and abatement on Arizona's southern border, including grants to assist with the building, remodeling and/or operation of centers for treatment, drug testing, medication-assisted treatment services, probation, job training, and/or counseling services, among other programs.

9. If the federal Center for Medicare and Medicaid Services ("CMS") disallows any federal funding for the State's Medicaid programs pursuant to 42 U.S.C. § 1396b as a consequence of sums received pursuant to resolution of any Litigation with Pharmaceutical Supply Chain Participants, or otherwise seeks to recover sums it regards as the federal share of any Settlement, the amount recovered by CMS shall first be paid from the total amount of Opioid Funds available to the Parties under that Settlement and the distribution to the State and Participating Local Governments shall thereafter be made from the remaining funds.

10. The Parties acknowledge and agree that any Settlement may require Participating Local Governments to release all their claims against the settling Pharmaceutical Supply Chain Participants to receive Opioid Funds. The Parties further acknowledge and agree based on the terms of any such national Settlement, a Participating Local Government will not receive funds through this Agreement until it has complied with all requirements set forth

in that national Settlement to release its claims. This Agreement is not a promise by any Party that any Settlement (including any Settlement resolved through bankruptcy) will be finalized or executed.

D. Participation of Cities and Towns

1. By signing on to the Agreement and any Settlement, a Participating County will receive 60% of its available LG Share for that Settlement when distribution under that Settlement occurs. Any such Participating County will receive up to an additional 40% of its available LG Share for that Settlement by securing the participation of its constituent cities and towns as signatories to this Agreement and that Settlement when distribution under that Settlement occurs. The sliding scale attached as Exhibit D will determine the share of funds available to the Participating County.[3]

2. If a Participating County does not achieve 100% participation of its cities and towns within the period of time required in a Settlement document for subdivision participation, the remaining portions of the LG Share that were otherwise available to the Participating County will be reallocated to (i) the State Share and (ii) the LG Share for the Participating Counties which have achieved 100% participation of their cities and towns in accordance with the percentages described in Sections B(2), C(1), and C(3), and set forth in Exhibits B and C.

E. Payment of Counsel and Litigation Expenses

1. The Parties anticipate that any Settlement will provide for the payment of all or a portion of the fees and litigation expenses of certain state and local governments.

2. If the court in *In Re: National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio) or if a Settlement establishes a common benefit fund or similar device to compensate attorneys for services rendered and expenses incurred that have benefited plaintiffs generally in the litigation (the "Common Benefit Fund"), and requires certain governmental plaintiffs to pay a share of their recoveries from defendants into the Common Benefit Fund as a "tax," then the Participating Local Governments shall first seek to have the settling defendants pay the "tax." If the settling defendants do not agree to pay the "tax," then the "tax" shall be paid from the LG Share prior to allocation and distribution of funds to the Participating Local Governments.[4]

[3] Population allocation of cities and towns within counties will be derived from the population data included in any national Settlement. If such data is not included in the respective national Settlement, then population allocation will be determined from those cities and towns listed in Exhibit C. The data in Exhibit C is derived from the U.S. Census Estimate (July 1, 2019).

[4] This paragraph shall not apply to the Settlement with the Settling Distributors or the Settlement with J&J.

3. Any governmental entity that seeks attorneys' fees and expenses from the Litigation shall seek those fees and expenses first from the national Settlement.[5] In addition, the Parties agree that the Participating Local Governments will create a supplemental attorney's fees and costs fund (the "Backstop Fund").

4. In the event that any Settlement imposes additional limitations or obligations on the payment of counsel and litigation expenses, those limitations and obligations take precedence over this Agreement.

5. The Backstop Fund is to be used to compensate counsel for Participating Local Governments that filed opioid lawsuits by September 1, 2020 ("Litigating Participating Local Governments"). Payments out of the Backstop Fund shall be determined by a committee consisting of one representative from each of the Litigating Participating Local Governments (the "Opioid Fee and Expense Committee").

6. The amount of the Backstop Fund shall be determined as follows: From any national Settlement, the funds in the Backstop Fund shall equal 14.25% of the LG Share for that Settlement. No portion of the State Share shall be used for the Backstop Fund or in any other way to fund any Participating Local Government's attorney's fees and costs. If required to do so by any Settlement, Participating Local Governments must report to the national Settlement Fund Administrator regarding contributions to, or payments from, the Backstop Fund.

7. The maximum percentage of any contingency fee agreement permitted for compensation shall be 25% of the portion of the LG Share attributable to the Litigating Participating Local Government that is a party to the contingency fee agreement, plus expenses attributable to that Litigating Participating Local Government, unless a Settlement or other court order imposes a lower limitation on contingency fees. Under no circumstances may counsel collect more for its work on behalf of a Litigating Participating Local Government than it would under its contingency agreement with that Litigating Participating Local Government.

8. Payments to counsel for Participating Local Governments shall be made from the Backstop Fund in the same percentages and over the same period of time as the national Contingency Fee Fund for each settlement. The Attorneys' Fees and Costs schedule for the Settling Distributors is listed in Exhibit R §(II)(S)(1) of the Settlement with the Settling

[5] The State retained outside counsel in the Purdue litigation and if it is unable to secure payment of attorneys' fees and expenses from the bankruptcy proceedings in an amount sufficient to compensate outside counsel consistent with the terms of the State's contract with that outside counsel, any remaining attorneys' fees and expenses related to the representation of the State will first be paid directly from the total amount of Opioid Funds available to the Parties under that Settlement, up to the agreed amount in the outside counsel contract, and the distribution to the State and Participating Local Governments shall thereafter be made from the remaining funds.

Distributors.[6] The Attorneys' Fees and Costs schedule for J&J is listed in Exhibit R §(II)(A)(1) of the Settlement with J&J.[7] For future Settlements with other defendants in the Pharmaceutical Supply Chain, any necessary payments to counsel for Participating Local Governments shall be made from the Backstop Fund in the same percentages and over the same periods of time as the fee funds for those Settlements, if applicable, subject to the limitations set forth in this Agreement set form in paragraph E(7) above.

9. Any funds remaining in the Backstop Fund in excess of the amounts needed to cover private counsel's representation agreements shall revert to the Participating Local Governments according to the percentages set forth in Exhibits B and C, to be used for Approved Purposes as set forth herein and in Exhibit A.

F. Compliance Reporting and Accountability

1. If the State and Participating Local Governments use a Trustee for purposes of distributing funds pursuant to any Settlement, the Trustee shall be requested to provide timely an up-to-date accounting of payments into or out of any trust established to hold such funds and/or its subaccounts upon written request of the State or a Participating Local Government.

2. The State, Regions, and Participating Local Governments may object to an allocation or expenditure of Opioid Funds solely on the basis that the allocation or expenditure at issue (1) is inconsistent with provision C(1) hereof with respect to the amount of the State Share or LG Share; (2) is inconsistent with an agreed-upon allocation, or the default allocations in Exhibits B and C, as contemplated by Section C(3); or (3) violates the limitations set forth in F(3) with respect to compensation of the Trustee. The objector shall have the right to bring that objection within two years of the date of its discovery to a superior court in Maricopa County, Arizona.

3. In the event that the State and Participating Local Governments use a Trustee, compensation for Trustee's expenses of fund administration may be paid out of the Opioid Funds for reasonable expenses; provided that, reasonable expenses do not exceed the administrative expenses allowed under the terms of the relevant Settlement.

4. The Parties shall maintain, for a period of at least five years, records of abatement expenditures and documents underlying those expenditures, so that it can be verified that funds are being or have been utilized in a manner consistent with the Approved Purposes definition. This requirement supersedes any shorter period of time specified in any applicable document retention or destruction policy.

5. At least annually, by July 31 of each year, each Region or Multicounty Region shall provide to the State a report detailing for the preceding fiscal year (1) the amount of the LG Share received by each Participating Local Government within the Region or Multicounty Region, (2) the allocation of any awards approved (listing the recipient, the amount awarded, the program to be funded, and disbursement terms), and (3) the amounts

[6] Text of settlement available at https://nationalopioidsettlement.com.

[7] Text of settlement available at https://nationalopioidsettlement.com.

disbursed on approved allocations. In order to facilitate this reporting, each Participating Local Government within a Region or Multicounty Region shall provide information necessary to meet these reporting obligations to a delegate(s) selected by the Region or Multicounty Region to provide its annual report to the State. Any Participating Local Government shall also comply with any reporting requirements imposed by any Settlement.

6. No later than September 30 of each year, the State shall publish on its website a report detailing for the preceding fiscal year (1) the amount of the State Share received, (2) the allocation of any awards approved (listing the recipient, the amount awarded, the program to be funded, and disbursement terms), and (3) the amounts disbursed on approved allocations. In addition, the State shall publish on its website the reports described in F(5) above. The State shall also comply with any reporting requirements imposed by any Settlement.

7. If it appears to the State, a Region, or a Multicounty Region that the State or another Region or Multicounty Region is using or has used Settlement funds for non-Approved Purposes, the State, Region, or Multicounty Region may on written request seek and obtain the documentation underlying the report(s) described in F(5) or F(6), as applicable, including documentation described in F(4). The State, Region, or Multicounty Region receiving such request shall have 14 days to provide the requested information. The requesting party and the State, Region, or Multicounty Region receiving such request may extend the time period for compliance with the request only upon mutual agreement.

8. Following a request made pursuant to F(7) and when it appears that LG Share funds are being or have been spent on non-Approved Purposes, the State may seek and obtain in an action in a court of competent jurisdiction in Maricopa County, Arizona an injunction prohibiting the Region or Multicounty Region from spending LG Share funds on non-Approved Purposes and requiring the Region or Multicounty Region to return the monies that it spent on non-Approved Purposes after notice as is required by the rules of civil procedure. So long as the action is pending, distribution of LG Share funds to the Region or Multicounty Region temporarily will be suspended. Once the action is resolved, the suspended payments will resume, less any amounts that were ordered returned but have not been returned by the time the action is resolved.

9. Following a request made pursuant to F(7) and when it appears to at least eight Participating Counties that have signed on to this Agreement and a subsequent Settlement that the State Share funds are being or have been spent on non-Approved Purposes, the Participating Counties may seek and obtain in an action in a superior court of Maricopa County, Arizona an injunction prohibiting the State from spending State Share funds on non-Approved Purposes and requiring the State to return the monies it spent on non-Approved Purposes after notice as is required by the rules of civil procedure. So long as the action is pending, distribution of State Share funds to the State temporarily will be suspended. Once the action is resolved, the suspended payments will resume, less any monies that were ordered returned but have not been returned by the time the action is resolved.

10. In an action brought pursuant to F(8) or F(9), attorney's fees and costs shall not be recoverable.

G. Settlement Negotiations

1. The State and the Participating Local Governments agree to inform each other in advance of any negotiations relating to an Arizona-only settlement with a Pharmaceutical Supply Chain Participant that includes both the State and the Participating Local Governments and shall provide each other the opportunity to participate in all such negotiations.

2. The State and the Participating Local Governments further agree to keep each other reasonably informed of all other global settlement negotiations with Pharmaceutical Supply Chain Participants. Neither this provision, nor any other, shall be construed to state or imply that either the State or the Participating Local Governments (collectively, the "Arizona Parties") are unauthorized to engage in settlement negotiations with Pharmaceutical Supply Chain Participants without prior consent or contemporaneous participation of the other, or that either party is entitled to participate as an active or direct participant in settlement negotiations with the other. Rather, while the State's and the Participating Local Government's efforts to achieve worthwhile settlements are to be collaborative, incremental stages need not be so.

3. The State or any Participating Local Government may withdraw from coordinated Settlement discussions detailed in this Section upon 10 business days' written notice to the other Arizona Parties and counsel for any affected Pharmaceutical Supply Chain Participant. The withdrawal of any Arizona Party releases the remaining Arizona Parties from the restrictions and obligations in this Section.

4. The obligations in this Section shall not affect any Party's right to proceed with trial or, within 30 days of the date upon which a trial involving that Party's claims against a specific Pharmaceutical Supply Chain Participant is scheduled to begin, reach a case-specific resolution with that particular Pharmaceutical Supply Chain Participant.

H. Amendments

1. The Parties agree to make such amendments as necessary to implement the intent of this Agreement.

One Arizona Distribution of Opioid Settlement Funds Agreement ACCEPTED by the undersigned and executed this _____ day of _____, 2021.

ARIZONA ATTORNEY GENERAL

_____
Mark Brnovich

APACHE COUNTY

APACHE COUNTY

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By: _____

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EAGER TOWN

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Exhibit A

O P I O I D A B A T E M E N T S T R A T E G I E S

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions, co-usage, and/or co-addiction through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including but not limited to:

    a. Medication-Assisted Treatment (MAT);

    b. Abstinence-based treatment;

    c. Treatment, recovery, or other services provided by states, subdivisions, community health centers; non-for-profit providers; or for-profit providers;

    d. Treatment by providers that focus on OUD treatment as well as treatment by providers that offer OUD treatment along with treatment for other SUD/MH conditions, co-usage, and/or co-addiction; or

    e. Evidence-informed residential services programs, as noted below.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based, evidence-informed, or promising practices such as adequate methadone dosing.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction and for persons who have experienced an opioid overdose.

6. Support treatment of mental health trauma resulting from the traumatic experiences of the opioid user (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose

or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support detoxification (detox) and withdrawal management services for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including medical detox, referral to treatment, or connections to other services or supports.

8. Support training on MAT for health care providers, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

10. Provide fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

12. Support the dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

13. Support the development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in treatment for and recovery from OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Provide the full continuum of care of recovery services for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including supportive housing, residential treatment, medical detox services, peer support services and counseling, community navigators, case management, and connections to community-based services.

2. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

3. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including supportive housing, recovery housing, housing assistance programs, or training for housing providers.

4. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

5. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

6. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

7. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

8. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to manage the opioid user in the family.

9. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to current and recovering opioid users, including reducing stigma.

10. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or are at risk of developing – OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Support Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Support training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

6. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, or persons who have experienced an opioid overdose, into community treatment or recovery services through a bridge clinic or similar approach.

7. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction or persons that have experienced an opioid overdose.

8. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

9. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction or to persons who have experienced an opioid overdose.

10. Provide funding for peer navigators, recovery coaches, care coordinators, or care managers that offer assistance to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction or to persons who have experienced on opioid overdose.

11. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

12. Develop and support best practices on addressing OUD in the workplace.

13. Support assistance programs for health care providers with OUD.

14. Engage non-profits and the faith community as a system to support outreach for treatment.

15. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

16. Create or support intake and call centers to facilitate education and access to treatment, prevention, and recovery services for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

17. Develop or support a National Treatment Availability Clearinghouse – a multistate/nationally accessible database whereby health care providers can list locations for currently available in-patient and out-patient OUD treatment services that are accessible on a real-time basis by persons who seek treatment.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction who are involved – or are at risk of becoming involved – in the criminal justice system through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or post-arrest diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including established strategies such as:

    a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

    b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

    c. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative;

    f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise and to reduce perceived barriers associated with law enforcement 911 responses; or

    g. County prosecution diversion programs, including diversion officer salary, only for counties with a population of 50,000 or less. Any diversion services in matters involving opioids must include drug testing, monitoring, or treatment.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, but only if these courts provide referrals to evidence-informed treatment, including MAT.

4. Provide evidence-informed treatment, including MAT, recovery support, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, and the needs of their families, including babies with neonatal abstinence syndrome, through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based, evidence-informed, or promising treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Provide training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

3. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

4. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

5. Offer enhanced family supports and home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including but not limited to parent skills training.

6. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

2. Academic counter-detailing to educate prescribers on appropriate opioid prescribing.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

    a. Increase the number of prescribers using PDMPs;

    b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs or by improving the interface that prescribers use to access PDMP data, or both; or

    c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD.

6. Development and implementation of a national PDMP – Fund development of a multistate/national PDMP that permits information sharing while providing appropriate safeguards on sharing of private health information, including but not limited to:

    a. Integration of PDMP data with electronic health records, overdose episodes, and decision support tools for health care providers relating to OUD.

b. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Corrective advertising or affirmative public education campaigns based on evidence.

2. Public education relating to drug disposal.

3. Drug take-back disposal or destruction programs.

4. Fund community anti-drug coalitions that engage in drug prevention efforts.

5. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

6. Engage non-profits and faith-based communities as systems to support prevention.

7. Support evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

8. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

9. Support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

10. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

11. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses or other school staff, to

address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, opioid users, families and friends of opioid users, schools, community navigators and outreach workers, drug offenders upon release from jail/prison, or other members of the general public.

2. Provision by public health entities of free naloxone to anyone in the community, including but not limited to provision of intra-nasal naloxone in settings where other options are not available or allowed.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

10. Support mobile units that offer or provide referrals to treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

11. Provide training in treatment and recovery strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

12. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items C8, D1 through D7, H1, H3, and H8, support the following:

1. Current and future law enforcement expenditures relating to the opioid epidemic.

2. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, and coordination to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Community regional planning to identify goals for reducing harms related to the opioid epidemic, to identify areas and populations with the greatest needs for treatment intervention services, or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A government dashboard to track key opioid-related indicators and supports as identified through collaborative community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to in various items above, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Invest in infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

5. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

6. Research on expanded modalities such as prescription methadone that can expand access to MAT.

Exhibit B

Exhibit B	
Allocation to Arizona Counties/Regions	
County/Region	**Percentage of LG Share**
APACHE	0.690%
COCHISE	1.855%
COCONINO	1.688%
GILA	1.142%
GRAHAM	0.719%
GREENLEE	0.090%
LA PAZ	0.301%
MARICOPA	57.930%
MOHAVE	4.898%
NAVAJO	1.535%
PIMA	18.647%
PINAL	3.836%
SANTA CRUZ	0.370%
YAVAPAI	4.291%
YUMA	2.008%

Exhibit C

Exhibit C					
Government Name	**County Name**	**State Name**	**Government Type**	**Census ID**	**Intra-county Allocation (%) Based on Past Spending**
APACHE COUNTY					
APACHE COUNTY	Apache County	ARIZONA	County	3100100100000	56.63%
EAGAR TOWN	Apache County	ARIZONA	City	3200100100000	20.66%
SPRINGERVILLE TOWN	Apache County	ARIZONA	City	3200100300000	10.73%
ST JOHNS CITY	Apache County	ARIZONA	City	3200100200000	11.98%
COCHISE COUNTY					
COCHISE COUNTY	Cochise County	ARIZONA	County	3100200200000	63.47%
BENSON CITY	Cochise County	ARIZONA	City	3200200100000	3.52%
BISBEE CITY	Cochise County	ARIZONA	City	3200200200000	3.47%
DOUGLAS CITY	Cochise County	ARIZONA	City	3200200300000	8.44%
HUACHUCA CITY TOWN	Cochise County	ARIZONA	City	3200250100000	0.91%
SIERRA VISTA CITY	Cochise County	ARIZONA	City	3200200400000	16.63%
TOMBSTONE CITY	Cochise County	ARIZONA	City	3200200500000	1.16%
WILLCOX CITY	Cochise County	ARIZONA	City	3200200600000	2.39%
COCONINO COUNTY					
COCONINO COUNTY	Coconino County	ARIZONA	County	3100300300000	71.16%
FLAGSTAFF CITY	Coconino County	ARIZONA	City	3200300100000	18.45%
FREDONIA TOWN	Coconino County	ARIZONA	City	3200300300000	0.31%
PAGE CITY	Coconino County	ARIZONA	City	3200390100000	3.41%
SEDONA CITY	Coconino County	ARIZONA	City	3201340200000	4.09%
TUSAYAN TOWN	Coconino County	ARIZONA	City	3200310100000	0.67%
WILLIAMS CITY	Coconino County	ARIZONA	City	3200300200000	1.92%
GILA COUNTY					
GILA COUNTY	Gila County	ARIZONA	County	3100400400000	68.13%
GLOBE CITY	Gila County	ARIZONA	City	3200400100000	10.23%

HAYDEN TOWN	Gila County	ARIZONA	City	3200450100000	2.31%
MIAMI TOWN	Gila County	ARIZONA	City	3200400200000	2.71%
PAYSON TOWN	Gila County	ARIZONA	City	3200490100000	16.17%
STAR VALLEY TOWN	Gila County	ARIZONA	City	3200410100000	0.35%
WINKELMAN TOWN	Gila County	ARIZONA	City	3200400300000	0.10%
GRAHAM COUNTY					
GRAHAM COUNTY	Graham County	ARIZONA	County	3100500500000	62.26%
PIMA TOWN	Graham County	ARIZONA	City	3200500100000	2.22%
SAFFORD CITY	Graham County	ARIZONA	City	3200500200000	26.83%
THATCHER TOWN	Graham County	ARIZONA	City	3200500300000	8.68%
GREENLEE COUNTY					
GREENLEE COUNTY	Greenlee County	ARIZONA	County	3100600600000	88.29%
CLIFTON TOWN	Greenlee County	ARIZONA	City	3200600100000	11.43%
DUNCAN TOWN	Greenlee County	ARIZONA	City	3200600200000	0.28%
LA PAZ COUNTY					
LA PAZ COUNTY	La Paz County	ARIZONA	County	3101501500000	88.71%
PARKER TOWN	La Paz County	ARIZONA	City	3201560100000	5.19%
QUARTZSITE TOWN	La Paz County	ARIZONA	City	3201540100000	6.11%
MARICOPA COUNTY					
MARICOPA COUNTY	Maricopa County	ARIZONA	County	3100700700000	51.53%
APACHE JUNCTION CITY	Maricopa County	ARIZONA	City	3201160100000	0.38%
AVONDALE CITY	Maricopa County	ARIZONA	City	3200700100000	0.98%
BUCKEYE TOWN	Maricopa County	ARIZONA	City	3200700200000	0.46%
CAREFREE TOWN	Maricopa County	ARIZONA	City	3200740100000	0.04%
CAVE CREEK TOWN	Maricopa County	ARIZONA	City	3200740200000	0.06%
CHANDLER CITY	Maricopa County	ARIZONA	City	3200700300000	2.86%
EL MIRAGE CITY	Maricopa County	ARIZONA	City	3200700400000	0.39%
FOUNTAIN HILLS TOWN	Maricopa County	ARIZONA	City	3200740400000	0.17%
GILA BEND TOWN	Maricopa County	ARIZONA	City	3200770100000	0.03%

GILBERT TOWN	Maricopa County	ARIZONA	City	3200700500000	1.71%
GLENDALE CITY	Maricopa County	ARIZONA	City	3200700600000	2.63%
GOODYEAR CITY	Maricopa County	ARIZONA	City	3200700700000	0.76%
GUADALUPE TOWN	Maricopa County	ARIZONA	City	3200790100000	0.00%
LITCHFIELD PARK CITY	Maricopa County	ARIZONA	City	3200740300000	0.04%
MESA CITY	Maricopa County	ARIZONA	City	3200700800000	6.06%
PARADISE VALLEY TOWN	Maricopa County	ARIZONA	City	3200750100000	0.34%
PEORIA CITY	Maricopa County	ARIZONA	City	3200700900000	1.51%
PHOENIX CITY	Maricopa County	ARIZONA	City	3200701000000	21.28%
QUEEN CREEK TOWN	Maricopa County	ARIZONA	City	3200740500000	0.11%
SCOTTSDALE CITY	Maricopa County	ARIZONA	City	3200701100000	3.99%
SURPRISE CITY	Maricopa County	ARIZONA	City	3200750200000	0.98%
TEMPE CITY	Maricopa County	ARIZONA	City	3200701200000	3.27%
TOLLESON CITY	Maricopa County	ARIZONA	City	3200701300000	0.27%
WICKENBURG TOWN	Maricopa County	ARIZONA	City	3200701400000	0.10%
YOUNGTOWN TOWN	Maricopa County	ARIZONA	City	3200750300000	0.05%
MOHAVE COUNTY					
MOHAVE COUNTY	Mohave County	ARIZONA	County	3100800800000	62.51%
BULLHEAD CITY CITY	Mohave County	ARIZONA	City	3200840100000	13.10%
COLORADO CITY TOWN	Mohave County	ARIZONA	City	3200840200000	0.61%
KINGMAN CITY	Mohave County	ARIZONA	City	3200800100000	9.91%
LAKE HAVASU CITY CITY	Mohave County	ARIZONA	City	3200860100000	13.87%
NAVAJO COUNTY					
NAVAJO COUNTY	Navajo County	ARIZONA	County	3100900900000	70.29%
HOLBROOK CITY	Navajo County	ARIZONA	City	3200900100000	3.75%
PINETOP-LAKESIDE TOWN	Navajo County	ARIZONA	City	3200940100000	4.75%
SHOW LOW CITY	Navajo County	ARIZONA	City	3200900200000	9.39%
SNOWFLAKE TOWN	Navajo County	ARIZONA	City	3200900300000	2.94%
TAYLOR TOWN	Navajo County	ARIZONA	City	3200980100000	2.68%

WINSLOW CITY	Navajo County	ARIZONA	City	3200900400000	6.19%
PIMA COUNTY					
PIMA COUNTY	Pima County	ARIZONA	County	3101001000000	72.19%
MARANA TOWN	Pima County	ARIZONA	City	3201090200000	2.06%
ORO VALLEY TOWN	Pima County	ARIZONA	City	3201090100000	1.72%
SAHUARITA TOWN	Pima County	ARIZONA	City	3201020100000	0.81%
SOUTH TUCSON CITY	Pima County	ARIZONA	City	3201000100000	0.31%
TUCSON CITY	Pima County	ARIZONA	City	3201000200000	22.91%
PINAL COUNTY					
PINAL COUNTY	Pinal County	ARIZONA	County	3101101100000	53.01%
CASA GRANDE CITY	Pinal County	ARIZONA	City	3201100100000	5.54%
COOLIDGE CITY	Pinal County	ARIZONA	City	3201100200000	1.68%
ELOY CITY	Pinal County	ARIZONA	City	3201100300000	34.98%
FLORENCE TOWN	Pinal County	ARIZONA	City	3201100400000	1.19%
KEARNY TOWN	Pinal County	ARIZONA	City	3201150100000	0.28%
MAMMOTH TOWN	Pinal County	ARIZONA	City	3201150200000	0.16%
MARICOPA CITY	Pinal County	ARIZONA	City	3201110100000	2.73%
SUPERIOR TOWN	Pinal County	ARIZONA	City	3201190100000	0.44%
SANTA CRUZ COUNTY					
SANTA CRUZ COUNTY	Santa Cruz County	ARIZONA	County	3101201200000	76.78%
NOGALES CITY	Santa Cruz County	ARIZONA	City	3201200100000	22.55%
PATAGONIA TOWN	Santa Cruz County	ARIZONA	City	3201200200000	0.67%
YAVAPAI COUNTY					
YAVAPAI COUNTY	Yavapai County	ARIZONA	County	3101301300000	69.31%
CAMP VERDE TOWN	Yavapai County	ARIZONA	City	3201340100000	0.97%
CHINO VALLEY TOWN	Yavapai County	ARIZONA	City	3201380100000	0.68%
CLARKDALE TOWN	Yavapai County	ARIZONA	City	3201350100000	0.72%
COTTONWOOD CITY	Yavapai County	ARIZONA	City	3201350200000	4.89%

DEWEY-HUMBOLDT TOWN	Yavapai County	ARIZONA	City	3201310100000	1.54%
JEROME TOWN	Yavapai County	ARIZONA	City	3201300100000	0.03%
PRESCOTT CITY	Yavapai County	ARIZONA	City	3201300200000	13.79%
PRESCOTT VALLEY TOWN	Yavapai County	ARIZONA	City	3201360100000	8.09%
YUMA COUNTY					
YUMA COUNTY	Yuma County	ARIZONA	County	3101401400000	66.03%
SAN LUIS CITY	Yuma County	ARIZONA	City	3201460100000	4.80%
SOMERTON CITY	Yuma County	ARIZONA	City	3201400200000	2.24%
WELLTON TOWN	Yuma County	ARIZONA	City	3201480100000	0.61%
YUMA CITY	Yuma County	ARIZONA	City	3201400300000	26.32%

Exhibit D

Exhibit D	
Percent Participation of Cities	**Award**
0	0%
5	2%
10	4%
15	6%
20	8%
25	10%
30	12%
35	14%
40	16%
45	18%
50	20%
55	22%
60	24%
65	26%
70	28%
75	30%
80	32%
85	34%
90	36%
95	38%
100	40%