

PY23 CONTINUED FUNDING Winnebago County Community Mental Health Board

Winnebago County Community Mental Health Board

Optional checklists - new questions, update questions, file uploads

Note: These will not automatically update. You may use them if it is helpful to keep track of changes needed due to using the Copy feature.

Optional checklist: Questions that need to be answered for PY23 application

You can use this checklist to keep track of the questions that will need new inputs in this application. This will not influence your score in any way.

Choices

- Program contact (section 1)
- Independent financial audit (file upload, section 2)
- Program elevator pitch (may be copied from website) (section 6)
- Narrative about the continued program as necessary (section 6)
- New budget (file upload, section 7)
- Personnel list (section 7)
- Capital expense list (section 7)
- Estimates of Priority Area funding (section 7)

Optional checklist: Questions that may need to be updated for PY23 application

You can use this checklist to keep track of the questions you may need to update in this application. This will not influence your score in any way.

Choices

- Accreditation as needed (file upload; section 2)
- Insurance as needed (file upload; section 2)
- Cultural humility and trauma informed care as needed (section 3)
- Consumer satisfaction collected as needed (section 3)
- Risk management plan as needed (file upload; section 3)
- Outcomes as needed (section 5)
- Collaboration LOS/MOU as needed (file upload; section 5)
- Additional data as needed (potential file upload; section 6)
- Hours of operation as needed (section 6)
- Clients served numbers as needed (section 6)

1. Instructions, Acknowledgement, and Program Contact

Instruction for the Collaborate Feature

The Collaborate feature (the lightbulb at the top right of the page) can be used to invite other people to work on this request.

- From the Collaborate popup, enter the email address of the person you wish to collaborate with
- Set Permission to either View (the collaborator can only view forms in the request), Edit (the collaborator can view and edit the request), or Submit (the collaborator can view, edit, and submit the request)
- Include a message about what you are asking your collaborator to do for you and select "Invite"
- You can revoke this permission at any time

An email will be sent to the collaborator containing your message, their username, and a link to the log-on page. After clicking this link, they will be brought to the log-in page. If this is their first time logging onto the system, they will be asked to create a password. Once in the system, the collaborator will be able to see the request under the Collaboration Requests tab of their Applicant Dashboard, where they can select Edit Application to complete your request.

Note: adding a member to your organization using the Collaborate tool is easier than having them make a new profile from the login page.

[Written Collaborator Tutorial](#)

[Video Collaborator Tutorial](#)

[Add Member to Organization](#)

Instructions for the Copy Feature

To copy responses that correspond to identical questions on additional applications, click the blue "Copy Previous Answers" button at the top right of any subsequent applications you complete.

The Copy Feature can only be used if the same applicant submitted the previous application as is submitting this one. The owner is the person who receives the follow-up forms automatically, which some organizations have changed over the course of the grant. This does not include those permitted as collaborators, only the person who owns the request.

Each of our applications has similar or identical questions. To save you time, you can use the Copy Answers tool on subsequent applications.

To use the Copy Feature:

1. **Start the new application in the account of the person who owns the request you wish to copy.**
2. **Click the Copy Previous Answers button on the top right of the screen.**
3. **Select the request you would like to copy answers from, and this will copy all answers into identical questions on the new application.**
4. **Add collaborators as needed.**

Please let Kristen (khayden@r1planning.org) know if there are any issues with this or if you need to know who your request owner is.

<https://docs.google.com/document/d/1UMwxxKW8fBe68Mo1V8QZ2KNikIfdwVBH8RiBGi9-sl8/edit>

Written Copy Tutorial

Video Copy Tutorial

Recommended for those filling out more than one application:

1. If you have an application you can copy from, use the copy feature for either a CONTINUED FUNDING or NEW application for this year. Reminder, this can only be done if the requests are from the same account.
2. Update agency information as you fill out the first application.
3. Start any other applications you may be submitting this year, but don't fill out any of the agency/logistic information.
4. Use the Copy Feature to copy updated information into the other applications. The Copy Feature will NOT replace any information you added to those applications.

Acknowledgement PY23*

Click on the link to access documents. Most documents are also available on the WCCMHB webpage in the "Funding Resources" section.

Application Rubric for PY23 (Part E now applies to previously funded organizations)

Strategic Plan (updated November 3, 2021)

Community Support System Primer

Funding Policy PY23

This is a CONTINUED FUNDING Application. This is for projects with the following characteristics:

- Proposed by a lead organization that was previously funded, with a proposal that
 - is the same as the one funded previously
 - has up to a 5% larger funding ask than last year

Choices

I acknowledge that I have read and understand the documents and instructions above

Program contact*

Who is the best person to contact with questions about this application including the narrative and the budget?

Choices

Same person as applicant

Someone else (you will be asked to input their information)

1a. Program Contact Information

Program contact*

Please indicate if this person is already in the Foundant system. If they are not, please input their name and contact information (name, title, and email and/or phone). If they are, please type their name.

Character Limit: 1000

2. Agency Finances, Accreditation, and Insurance

Agency type*

Choices

Government entity

Not for profit

Hospital or healthcare organization

For profit (including sole proprietor and LLC)

Organization FTE*

Please write the approximate number of FTE in your entire organization. This is to help reviewers understand how the proposed program size compares to your current organization size.

Character Limit: 20

Evidence for Length of Time in Existence*

Please attach evidence that this organization has been in existence for at least 3 years. This could include tax returns, articles of incorporation, or other relevant documents.

File Size Limit: 2 MB

Attach a recent independent financial audit, balance sheet, revenue/expenses & cash flow report PY23*

If the agency is not required to receive an independent financial audit, attach the most recent unaudited balance sheet, revenue/expenses and cash flow report.

File Size Limit: 4 MB

Attach the agency's current accreditation.*

UPDATE ONLY IF RELEVANT ACCREDITATION HAS CHANGED, LAPSED, OR IF YOU HAVE ADDED ADDITIONAL ACCREDITATIONS

Include accreditations from: CARF, Joint Commission, Healthcare Facilities Accreditation Program, Council on Quality Leadership and/or Council on Accreditation.

If not accredited by one of the above accreditation organizations, please provide an explanation. If it is easier, you may attach only the accreditation that is relevant to your proposed program.

Character Limit: 3000 | File Size Limit: 1 MB

File Size Limit: 1 MB

Does the agency currently bill Medicaid/Medicare or commercial insurance?*

Choices

Yes

No

2a. Insurance

Attach Medicaid/Medicare certifications*

File Size Limit: 2 MB

File Size Limit: 2 MB

File Size Limit: 2 MB

Provide a list of billable Insurance Panels the agency is credentialed with.*

Character Limit: 1000

3. Agency Cultural Humility, Trauma-Informed Care, and Risk Management Strategy

Cultural Competency & Trauma Informed*

UPDATE IF NEEDED

Please describe the agency's policy and approach to cultural humility and trauma-informed practice.

Character Limit: 3000

Explain the agency's current process of capturing consumer satisfaction information.*

UPDATE IF NEEDED

Include frequency, method and evaluation. If the agency is not capturing consumer satisfaction information, please explain how it will meet this funding requirement. This could include a plan to work with WCCMHB to develop these processes.

Character Limit: 3000

Does the agency have a Risk Management Plan or Policy?*

Read the *WCCMHB Risk Management Summary* to determine what constitutes a Risk Management Plan.

Choices

Yes

No

3a. Risk Management Plan - Yes

Attach the agency's Risk Management Plan or Policy*

UPDATE IF YOUR RISK MANAGEMENT PLAN OR POLICY HAS CHANGED

If the file is too large, upload an abbreviated version.

File Size Limit: 2 MB

3b. Risk Management Plan - No

Provide an explanation for not having a Risk Management Plan or Policy*

Character Limit: 1000

4. Service, Program or Project Proposal Name

Project Name*

Character Limit: 100

5. Target Population, Project Priority Area, Collaboration

Because this is a Continued Funding application, the Target Population(s) and Priority Area(s) selections should remain the same as last year. Outcomes may change somewhat.

Updated descriptions can be found in the Strategic Plan, which can also be found on the WCCMHB Funding Resources page.

Target Populations: Pages 46-49

Priority Areas: Pages 40-45

Intended Outcomes: Pages 51-55

Which Target Population will this proposal support?

Please select the Target Population(s) this project will support. You may choose more than one.

Choices

- Substance Abuse Disorders (all ages)
- Serious Mental Illness (18+)
- Infant and Early Childhood Mental Health (0-5)
- Severe Emotional Disturbances (children)

Which Priority Area(s) will this proposal serve?

Select the Priority Area(s) this proposal will serve. You may choose more than one.

Choices

- Mental Health Treatment
- Crisis Response Services
- Family and Community Support

Case Management

Please check the outcomes you intend to measure, evaluate, or work towards if your program is funded. You can expand on these outcomes in your narrative section when you describe what this program will accomplish.

As a continued funding application, we expect that your outcomes will be similar to your outcomes from PY22. If they have changed, please add some description for that into the continued funding question.

If chosen for funding, you will define or redefine these outcomes for your reporting including their baselines, evaluation strategy, and target.

System Capacity Outcomes*

Please select which of the following System Capacity Outcomes your proposal will measure. If there are others, please select "Other" and describe them later in the narrative section.

Choices

Accessibility
 Hours of service
 Other (to be specified in narrative description of program proposal)
 Payment options
 Translation services
 Wait time
 Mobile services
 More providers
 Housing
 Coordination
 Awareness

Individual and Family Outcomes*

Please select which of the following Individual and Family Outcomes your proposal will measure. If there are others, please select "Other" and describe them later in the narrative section.

Choices

Persons and families served
 Education/Employment
 Criminal Justice Involvement
 Housing Stability
 Perception of Care
 Other
 Meeting Patient Treatment Goals

Collaboration PY23*

Is this application for a collaboration between two or more organizations?

Choices

Yes

No

5a. Collaboration LOS/MOU

Please use the updated narrative question to describe your collaboration. See part C of the Application Rubric to understand how collaboration will be reviewed in this grant cycle.

MOU*

Organizations involved in collaborations must have an LOS (Letter of Support) or MOU (Memorandum of Understanding). Please upload these documents for each/all of your relationships.

File Size Limit: 1 MB

Additional upload space

File Size Limit: 1 MB

Additional upload space

File Size Limit: 1 MB

6. Proposal Description**Program elevator pitch***

In a few sentences, please describe your program as you would describe it to the public. If funded, you will have the chance to update the description.

If the program description listed on the WCCMHB Funded Programs page is still accurate, you can copy and paste it here.

Character Limit: 3000

Program Updated Information*

Please use this area to describe any of the following that you feel reviewers need to know about the program as it would run in PY23.

- How it fits the updated Application Rubric including:
 - Community Support System

- Agency Compliance
- Updated language
- Changes to your program due to lessons learned from PY22. If these changes are substantial, please consider filling out a New application instead.
- Changes to staffing or capital expenses
- Updated outcomes expectations

As a reminder, reviewers will have your Q1 and Q2 outcomes when looking at your application.

Character Limit: 10000

Provide additional data

UPDATE AS NEEDED

Please upload, list, and/or describe supporting data, research, or community-based information that you feel highlights how this program uses evidence-based practices, best practices, or promising practices. Additional evidence will be used to understand why your particular services match the priorities of the <https://static1.squarespace.com/static/54f7d1eee4b056cf8def292a/t/618428b8f0a3493b28028f54/1636051129479/WCCMHB+Strategic+Plan+22-24+Updated+Version+Nov+21+FINAL.pdf> Strategic Plan and are the best way to serve the community you plan to serve. See page 50 of the <https://static1.squarespace.com/static/54f7d1eee4b056cf8def292a/t/618428b8f0a3493b28028f54/1636051129479/WCCMHB+Strategic+Plan+22-24+Updated+Version+Nov+21+FINAL.pdf> Strategic Plan for more information about definitions for these terms.

Character Limit: 3000

Upload additional data as needed

File Size Limit: 3 MB

Define the proposed service, program, project to be supported or delivered by requested funds.

DO NOT UPDATE

As a Continued Funding applicant, you will not update this section. Please indicate any program changes in the previous questions. Your answer is here to provide reference for you and for reviewers.

Character Limit: 10000

Please list Evidence-Based Practices proposed

DO NOT UPDATE

Include how the agency will maintain fidelity to these practices.

Character Limit: 5000

Winnebago County*

DO NOT UPDATE

The MHB grants can only be used for programs serving Winnebago County residents. How will you ensure this proposal will serve this population?

Character Limit: 5000

Please provide logistic information below

Hours of Program Operation*

Please specify the hours of operation and describe why these are appropriate for the services and target populations in the proposal.

Character Limit: 200

Please provide estimate of individuals served for each of the following Target Populations

Updated descriptions can be found in the Strategic Plan, which can also be found on the WCCMHB Funding Resources page.

This is unique individuals in each target area your program will serve. The total value may be lower than the sum of clients in each of the Target Areas since some clients may fall into more than one category.

Target Populations: Pages 46-49

Clients Served - Infant and Early Childhood Mental Health*

Estimate the number of clients served in this population with the MHB funds. Enter 0 if this proposal does not serve clients in this area.

Character Limit: 10

Clients Served - Severe Emotional Disturbances*

Estimate the number of clients served in this population with the MHB funds. Enter 0 if this proposal does not serve clients in this area.

Character Limit: 10

Clients Served - Serious Mental Illness*

Estimate the number of clients served in this population with the MHB funds. Enter 0 if this proposal does not serve clients in this area.

Character Limit: 10

Clients Served - Substance Abuse*

Estimate the number of clients served in this population with the MHB funds. Enter 0 if this proposal does not serve clients in this area.

Character Limit: 10

Clients Served - Total

Since some clients may fall into more than one category (for example, Substance Use and Serious Mental Illness), please estimate the total unique patients your program will serve throughout the year.

Character Limit: 10

7. Proposal Budget

All AGENCY FUNDING APPLICATION BUDGET INFORMATION

<https://docs.google.com/spreadsheets/d/1OYxCNO0K3fTrXm3e8BPspQafzYcVzQZ5/edit?usp=s haring&ouid=111598488396924586957&rtpof=true&sd=true>

Link to Budget Template

Download and save the PY23 Budget Worksheet Template to your computer. The PY23 Budget Worksheet Template is required to be filled out and uploaded as part of this application.

IMPORTANT: If you intend to fund a program distinct from the rest of your organizations (i.e. the staff you intend to hire will be able to bill their time directly to this program and the program will not receive funding the rest of your organization does), you will **ONLY** need to include revenue/expenses for that program. **This is preferred.** If you intend to incorporate this program into your overall budget, you must submit ALL organization revenue and expenses. This will also be true for reimbursement/advance payments.

NEW SINCE LAST YEAR

To make reporting simpler, we are no longer asking you to split your budget into sections by Priority Area. However, as we still need to determine how much funding is going to each Priority Area for reporting purposes, we will still need an estimate of amount for each Priority Area. See following questions for more information.

Budget PY23*

Please upload the completed PY23 Budget Template

File Size Limit: 1 MB

Total Amount Requested*

Character Limit: 20

Fund replacement*

Will funds from the WCCMHB **replace** any funding your organization currently receives? This may include funding for positions, space, or aspects of the proposal.

Choices

Yes, the funds will replace current funding

No, the funds will not replace any current funding

Personnel PY23*

If this does not apply to your program, write N/A

Please list 1) the position titles of personnel who would be funded by the WCCMHB, 2) their %FTE, and 3) their qualifications. This includes anyone who will directly be working on the program. Exclude anyone whose costs you will report in indirect costs (e.g. financial officers, etc). You may copy and paste from workplans or amendments as applicable.

Examples

Position 1: Therapists, 250% FTE, Bachelor's degree and experience working with families

Position 2: Program assistant, 50% FTE, Education or experience in direct mental health care. Experience with customer service.

Character Limit: 3000

Capital Expenses*

If this does not apply to your program, write N/A

Please list any capital expenses that will appear on your budget. This applies to items that are over your agency capitalization level and will be in use beyond a year. As a reminder, per the budget instructions, you will need to list these items as "Direct Equipment" in your budget (not "Commodities"). You will need to upload your organization capitalization policy below as well.

Examples

1 duplex supported housing unit

3 vehicles

Character Limit: 3000

Capitalization policy

If you intend to make capital purchases, upload your capitalization policy here.

File Size Limit: 4 MB

Priority Area Reporting

This year, you may either report using **amounts toward each Priority Area (as in last year's application)** or report **estimated percentages of overall budget** going towards each.

Rather than reporting the amounts in each expense request, you will be asked to update the numbers at the end of the year to reflect a better estimate of what you actually spent in each area.

Percentage Example:

- Clinicians are anticipated to respond to crisis calls 1/2 of their time and provide mental health care, including to families, 1/2 of their time
- Office space will be used for mental health care and family support services (not crisis response) and the purchase of the building is the only major capital expense this year
- Office cost is equal to cost for clinician salaries and the other costs (supplies, etc) are low

Percentage to Crisis Response: 25%

Percentage to Mental Health Care: 37.5%

Percentage to Family and Community Services: 37.5%

Round to the nearest 0.1% if necessary

Updated descriptions can be found in the Strategic Plan, which can also be found on the WCCMHB Funding Resources page.

Priority Areas: Pages 40-45

Report Priority Area Funding by Percentage or Amount*

Please choose which method you will use to report amounts going towards each Priority Area.

Choices

Report by percentage

Report by amount (some values will copy from previous application)

7a. Non-supplanting funds

Non-supplanting funds*

The WCCMHB is not able to disburse funds that supplant other sources of funding. Please describe the current funding for these activities and how you will prevent the WCCMHB funds from supplanting them.

Character Limit: 10000

7b. Report by Percentage

Write the number value of the percentage of funds you intend to spend on each Priority Area. If you are not planning to put funding towards a Priority Area, write 0.0

Percentage of funds to Mental Health Treatment*

The format for this answer is 000.0. You will need to add a .0 to any whole number. Example: 25.0, 0.0

Character Limit: 20

Percentage of funds to Case Management*

The format for this answer is 000.0. You will need to add a .0 to any whole number. Example: 25.0, 0.0

Character Limit: 20

Percentage of funds to Crisis Response Services*

The format for this answer is 000.0. You will need to add a .0 to any whole number. Example: 25.0, 0.0

Character Limit: 20

Percentage of funds to Family and Community Support*

The format for this answer is 000.0. You will need to add a .0 to any whole number. Example: 25.0, 0.0

Character Limit: 20

7c. Report by Amount

Write the amount you intend to spend for each Priority Area. If you do not intend to spend any amount on a Priority Area, write 0.

Amount Requested - Mental Health Treatment*

Character Limit: 20

Amount Requested - Case Management*

Character Limit: 20

Amount Requested - Crisis Response Services*

Character Limit: 20

Amount Requested - Family and Community Support*

Character Limit: 20

This concludes the Winnebago County Community Mental Health Board PY21 Annual Funding application.

Please review the responses carefully before submitting the application. Once submitted you will receive an email verification that the Mental Health Board has received the Agency's application. We may contact you with further questions if necessary. If the application is selected for funding, we will also be reaching out for further information.

Thank you for the submission and interest in serving the residents of Winnebago County.

The following three questions are to understand how to improve the application itself. They are all optional so you may answer any of them you choose. No answers you put will affect your funding or the review process in any way. You may also send comments to info@mentalhealth.wincoil.us.

Application survey #1

This application was...

Choices

Too long for the amount of money I requested

Appropriate for the amount of money I requested

Application survey #2

This application was...

Choices

Confusing or difficult to fill out
Easy to fill out

Application survey #3

If you have further comments to leave about the application or application process we would love to hear them!

Character Limit: 10000

Staff Rated Agency Compliance

Select this radio button if you determine this application to be non-compliant with requirements of the WCCMHB. This will highlight to board members issues with the application.

Choices

Non-compliant

If non-compliant, explain rationale

Character Limit: 3000