Program Year 4-6: New

Winnebago County Community Mental Health Board

1. Service, Program or Project Proposal Name

Proposal Name:*
Character Limit: 100

2. 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 with whom 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-on 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 copy questions to applications created by the owner of the original application. 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 Nicole (nbennett@r1planning.org) know if there are any issues with this or if you need help identifying the request owner.
https://docs.google.com/document/d/1UMwxxKW8fBe68Mo1V8QZ2KNIklfdwVBH8RiBGl9-sI8/edit
Copy Instructions
Copy Instructions Video

Recommended for those filling out more than one application:

1. If you have an application you can copy from, use the copy feature to copy information into 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 PY4-6*

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

Evaluation Rubric

Strategic Plan 2.0 (updated November 1, 2023)
Community Support System Primer
WCCMHB PY4-6 Funding Policy

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

- Proposed by a lead organization that was NOT previously funded

OR

- Proposed by a lead organization that was previously funded, with a proposal that
  - is entirely new
  - has a >5% larger funding ask than last year
  - changed/added Target Population(s) and/or Community Support System Components
  - changed structure or function significantly

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

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)

3. Program Contact

Program Contact*
If the program contact already has their information in the Foundant system, please enter their name below.

If the program contact does not have their information in the Foundant system, please enter their name, title, email and phone number.

Character Limit: 1000

4. Proposal Description

Proposal Description:
Character Limit: 2200

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.

Character Limit: 10000

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

Please describe the program you intend to provide. **You are welcome to use bullet points or other formatting choices as desired.** This question supports rich text formatting.

Board reviewers will be reading to understand the following things about your program and will consider its alignment to the Strategic Plan 2.0 and the Community Support System Model. Reviewers will use the Evaluation Rubric to determine scores for applications - Please review these documents to ensure a strong application. Final decisions are at the discretion of the Board.

Include:

- vision for what your program will accomplish including reference to the outcomes you marked above
- population or community it will serve in Winnebago County
- hours of operation, location, and accessibility information as applicable
- what evidence-based, best practice, or promising practice services the program will provide. You can choose to upload supporting information for your services in the following question
- information about collaborations that support this program as applicable
- how this program complements other programs, fills gaps, and/or addresses identified needs as part of the Community Support System model
- how this program aligns with the Strategic Plan

** Note about proportionate detail: The amount of detail for an application only needs to match the complexity of the program and/or amount of funding requested. The character limits are a requirement of the Foundant system but no applicant is required to use the whole space. For instance, a request for $30,000 to fund a single position could be described concisely while a $1 million grant with multiple positions would be expected to have a more detailed application.

Character Limit: 10000

(OPTIONAL) Additional Data

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.pdfStrategic Plan 2.0 and are the best way to serve the community you plan to serve.

Character Limit: 10000 | File Size Limit: 6 MB

Winnebago County*

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

Character Limit: 10000

Please provide estimates of individuals served for each of the following Target Populations:

Updated descriptions can be found in the Strategic Plan 2.0, 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 14-16

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 - Serious 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 Use*

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

5. Target Population, Community Support System Component, Collaboration

In the following sections, select the Target Population(s) and Community Support System Component(s) that best match your proposal.

Updated descriptions can be found in the Strategic Plan 2.0, which can also be found on the WCCMHB Funding Resources page.

Which Target Population will this proposal support?*

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

Choices

Infant and Early Childhood Mental Health (0-5 yrs)
Serious Emotional Disturbances (3-21 yrs)
Serious Mental Illness (18+)
Substance Use Disorders (all ages)

Which Community Support System Component(s) will this proposal serve?*

Select the Community Support System Component(s) this proposal will serve. You may choose more than one.

Choices

Mental Health Treatment
Crisis Response Services
Family and Community Support
Case Management
Client Identification and Outreach
Housing

Other

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.

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 the 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*

Is this application for a collaboration?

Choices

Yes
No

6. Collaboration LOS/MOU

See Evaluation 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 partnerships.

File Size Limit: 6 MB

Additional Upload Space

File Size Limit: 6 MB

Additional Upload Space

File Size Limit: 6 MB

7. Agency Finances, Accreditation, and Insurance

What type of agency is your organization?*

Choices

Government Entity
Not for Profit
Hospital or Healthcare Organization
For Profit (including Sole Proprietor and LLC)

Organization Full Time Equivalent (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 most recent independent financial audit, balance sheet, revenue/expenses & cash flow report*

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: 10 MB

Attach the agency's current accreditation*

Include accreditations from: Commission on Accreditation of Rehabilitation Facilities (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.

Character Limit: 10000 | File Size Limit: 1 MB

File Size Limit: 1 MB

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

For mental health or substance abuse use services.

Choices

Yes
No

9. Proposal Budget

All AGENCY FUNDING APPLICATION BUDGET INFORMATION

PY4-6 Budget Template

Download and save the PY4 Budget Worksheet Template to your computer. The PY4 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 organization (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 other organizational funding), 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.

PY4-6 Budget*

Please upload the completed PY4-6 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 current funding

Personnel PY4-6*
If this does not apply to your program, write N/A.

Please list 1) the position titles of personnel who will be funded by the WCCMHB, 2) their FTE, and 3) their qualifications. This includes anyone who will directly work on the program. Exclude anyone whose costs you will report in indirect costs (e.g. financial officers, etc).

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: 10000

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"). If you plan to purchase capital investments, 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: 3 MB

Community Support System Component(s) Reporting

Report the percentage of funds you estimate you will spend in each area. If you are not putting funds towards a Community Support System Component, write 0. In your year-end report, you will be asked to update the numbers to reflect a better estimate of what you actually spent in each area.

Example:

- Clinicians are expected 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 the 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.)

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

Character Limit: 20

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.<br id="isPasted">Example: 25.0

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

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.<br id="isPasted">Example: 25.0

Character Limit: 20

Percentage of Funds to Client Outreach and Identification*

The format for this answer is 000.0. You will need to add a .0 to any whole number.<br id="isPasted">Example: 25.0

Character Limit: 20

Percentage of Funds to Housing*

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

Character Limit: 20

Percentage of Funds to Other*
The format for this answer is 000.0. You will need to add a .0 to any whole number.
Example: 25.0

Character Limit: 20

Additional Funding*
If you were given funding above and beyond your requested amount, what will you do with it? Please provide an estimated amount for reference.

Character Limit: 250

8. Insurance

Attach Medicaid/Medicare certifications:*
File Size Limit: 2 MB

File Size Limit: 2 MB

File Size Limit: 2 MB

Provide a list of agency's billable Insurance Panels.*
Character Limit: 10000

10. 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

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

Cultural Competency & Trauma-Informed*
Please describe the agency's policy and approach to cultural competency and trauma-informed practice.

Character Limit: 10000

Client Satisfaction*

Please describe how the agency evaluates the level of client satisfaction.

Include frequency, method, and evaluation.

If the agency is not capturing client satisfaction information, please explain how the agency will meet this funding requirement. This could include a plan to work with WCCMHB to develop these processes.

Character Limit: 10000

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

If you are not familiar with risk management strategies, please read the WCCMHB Risk Management Summary for reference.

Choices

Yes
No

12. Risk Management Plan - Yes

Attach the agency's Risk Management Plan or Policy.*

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

File Size Limit: 2 MB

13. Risk Management Plan - No

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

Character Limit: 10000

14. This concludes the Winnebago County Community Mental Health Board PY4 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 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. These answers will not 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