Program Year 4 - 6: Renewal

Winnebago County Community Mental Health Board

1. Service, Program or Project Proposal Name

Organization Name:*
Character Limit: 100

Service, Program, or Project Proposal Name:*
Character Limit: 250

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-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.

Please use the links below if you need support.

Collaborator Instructions Word Document
Collaborator Instructions Video

Add Member to Organization Instructions

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 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
Please use the links below if you need support.

Copy Instructions Word Document
Copy Instructions Video

<u>Recommended for those filling out more than one application</u>:

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 PY4-6*

Click on the link to access documents on the WCCMHB Funding Resources page. The following documents can be located here WCCMHB Funding Resources Page :

PY4-6 Renewal Application Evaluation Rubric
Strategic Plan 2.0
Community Support System Primer
WCCMHB PY4-6 Funding Policy

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 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)

2a. Program Contact Information

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

3. 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.

Character Limit: 10000

Program Updated Information*

Please use this area to describe any of the following that you feel the reviewers need to know about the program as it will run in PY4-PY6.

- How it fits the updated PY4-6 Renewal Application Evaluation Rubric:
- Changes to your program due to lessons learned from previous funding cycles. 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 previously submitted outcomes when looking at your application.

Character Limit: 10000

OPTIONAL: Additional Supporting Documents

If necessary, please upload any supporting documents such as Memorandums of Understanding (MOU), letters of support, etc.

Do not include any client identifying information or documents.

File Size Limit: 20 MB

4. 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 enter 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

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.*

Please only update this section if the relevant accreditation has change, lapsed, or if you have additional accreditations.

Include accreditations from: Commission on Accrediatation 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. If it is easier, you may attach only the accreditation that is relevant to your proposed program.

Character Limit: 10000 | File Size Limit: 1 MB

File Size Limit: 1 MB

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

Choices

Yes
No

5. Proposal Budget

All AGENCY FUNDING APPLICATION BUDGET INFORMATION

Download and save the PY4-6 Budget Worksheet Template to your computer from the WCCMHB website. The PY4-6 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 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.

Budget PY4-PY6*

Please upload the completed PY4-PY6 Budget Template (found on the WCCMHB website).

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 PY4-PY6*

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 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: 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"). You will need to upload your organization capitalization policy below as well.

Examples:

- Duplex supported housing unit
- Vehicles

Character Limit: 10000

Capitalization policy

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

File Size Limit: 4 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)

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

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.
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.
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.
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

6. 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?*
See the *WCCMHB Risk Management Summary* for information on what constitutes a Risk Management Plan.

Choices
Yes
No

6a. Risk Management Plan - Yes

Attach the agency's Risk Management Plan or Policy*
NOTE: If your agency has changed your Risk Management Plan, please provide an updated file copy here.

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

File Size Limit: 2 MB

6b. Risk Management Plan - No

Provide an explanation for not having a Risk Management Plan or Policy*
Character Limit: 10000

4a. 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

5a. 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

This concludes the Winnebago County Community Mental Health Board PY4-6 Renewal 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. 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