

Program Years 7 - 9: New PROGRAMMING

Winnebago County Community Mental Health Board

Instructions:

Instructions 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 pop-up, enter the email address of the person with whom you wish to collaborate.
- 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 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 login page. After clicking the link, they will be taken to the login page. If this is their first time logging into the system, they will be asked to create a password.

Collaborator Tutorials:

- <https://support.foundant.com/hc/en-us/articles/4523887747223-Applicant-Tutorial-Collaboration>
- <https://support.foundant.com/hc/en-us/articles/28664505675927-Collaborator-Tutorial>

If you are experiencing issues with the abstract or need assistance identifying the request owner, please contact Alex at amccann@r1planning.org.

Acknowledgement PY7-9:

Acknowledgement:*

Click here to access the WCCMHB Funding Resources Page. The following documents are also linked below:

- Strategic Plan 3.0
- PY7-9 Funding Policy
- PY7-9 NOFO
- PY7-9 New Program Application Rubric

This is a **NEW Programming** application. This is for projects that...

- are entirely new
- PY4-6 programs that have changed structure or function significantly
- PY4-6 programs whose requests **exceed** the 10% increase allotment

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 regarding this abstract?*

Please enter their name, title, and email if they are not the applicant. If the applicant is the best point of contact, please enter N/A.

Character Limit: 250

Organization Name:

Character Limit: 250

Project Name

Character Limit: 100

Requested Amount:*

As a reminder, the minimum request amount is \$300,000.00 (\$100,000.00 per year), with a maximum request amount of \$3 million (\$1 million per year).

Character Limit: 20

Program Overview:

What funding gap will your proposal address?

Choices

Eating Disorder Treatment

Perinatal Mental Health

Harm Reduction

Older Adults (50+) Mental Health and/or Substance Use Treatment

Veterans' Mental Health and/or Substance Use Treatment

Rural Mental Health and/or Substance Use Treatment

Other

Define and describe the service/program to be supported or delivered by the requested funds*

Please describe the program/service you intend to provide. You are welcome to use bullet points or other formatting choices, as desired.

Reviewers will be reading this to understand the following aspects of your program and will consider its alignment with Strategic Plan 3.0. *Final decisions are at the discretion of the WCCMHB.*

Please address the following within the narrative:

- Vision for what your program will accomplish
- The population or community it will serve within Winnebago County, IL
- How this program complements other programs, fills gaps, and/or addresses identified needs
- How this program aligns with Strategic Plan 3.0

*** 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: 5500

What evidence base(s) will your proposed program use?

Choices

Evidence-Based

Best Practice

Promising Practice

Rationale:*

Please upload and/or link any research, publications, or other paperwork that supports your proposal's evidence base.

Character Limit: 2500 | File Size Limit: 20 MB

Service Breakdown:

Please choose the types of DIRECT services your program offers:*

Choices

Crisis Response
 Clinical Treatment
 Case Management
 Supportive Housing
 Client Identification and Outreach
 Peer Support
 Family Support
 Other
 None of the Above

Please choose the types of INDIRECT services your proposal offers:*

Choices

Workforce Development
 Service Coordination
 Community Education
 Other
 None of the Above

Services Breakdown

Please provide an estimated percent breakdown of effort for each service type in your proposal.

The total of the percentages should equal 100%.

Service Type:	Percent Breakdown:
Crisis Response (Direct)	
Clinical Treatment (Direct)	
Case Management (Direct)	
Supportive Housing (Direct)	
Client Identification and Outreach (Direct)	
Peer Support (Direct)	

Family Support (Direct)	
Other (Direct)	
Workforce Development (Indirect)	
Service Coordination (Indirect)	
Community Education (Indirect)	
Other (Indirect)	
SUM	

Organization Overview:

What type of agency is your organization?

Choices

Government Entity

Not For Profit

Hospital or Healthcare Organization

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's size.

Character Limit: 10

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

Please upload any accreditations your agency holds:*File Size Limit: 10 MB***Does the agency currently bill Medicaid/Medicare or commercial insurance?****For mental health and/or substance abuse use services***Choices**

Yes

No

Does your agency have a risk management plan or policy?***Choices**

Yes

No

Insurance: Yes

Attach any Medicaid or Medicare Certifications**File Size Limit: 5 MB***Provide a list of billable Insurance panels****Character Limit: 1000**Risk Management: Yes*

Please upload the agency's risk management plan or policy**If the file is too large, upload an abbreviated version**File Size Limit: 5 MB**Risk Management: No*

Please provide an explanation for not having a risk management or policy**Character Limit: 2500**Budget:*

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 within the budget worksheet.

Please upload the PY7-9 Budget Template:*

File Size Limit: 10 MB

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 PY7-9*

Please list:

- Titles of **DIRECT** personnel who will be funded by the WCCMHB
- Their FTE
- 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: 2500

Capital Expenses:

Please list all expenses that will appear under the 'direct equipment' portion of your budget.

Character Limit: 2500

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

File Size Limit: 5 MB

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: 2500

Winnebago County, IL:**Please enter the location(s) where the proposal will take place***

Please include hours of operation, location, and accessibility information.

Character Limit: 1500

How will you ensure this proposal will serve only the Winnebago County population?*

WCCMHB grants can only be used for programs serving Winnebago County residents.

Character Limit: 1500

Please choose the target population(s) your proposed program will serve**Choices**

Infant and Early Childhood (0-5)
 Serious Emotional Disturbance (3-21)
 Serious Mental Illness (18+)
 Substance Use Disorder (All Ages)
 Co-Occurring (0-17)
 Co-Occurring (18+)

Target Populations:

Please enter this as a breakdown for each Program Year

Target Population:	Number of Individuals
Infant and Early Childhood Mental Health (0-5)	
Serious Emotional Disturbance (3-21)	
Severe Mental Illness (18+)	

Substance Use Disorder (All Ages)	
Co-Occurring (0-17)	
Co-Occurring (18+)	
Total Number of Individuals to be Served	

Collaboration:

Is this proposal a collaboration?*

Choices

Yes

No

LOS/MOU Upload

Organizations involved in collaborations must have a Letter of Support (LOS) or Memorandum of Understanding (MOU). Please upload these documents for all collaborations.

File Size Limit: 5 MB

Cultural Competency & Client Satisfaction:

Describe your agency's policy/approach to cultural competency and trauma-informed practice*

Character Limit: 2500

Please describe how your agency evaluates client satisfaction levels.*

Please 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: 2500

Thank You

This concludes the Winnebago County Community Mental Health Board (WCCMHB) PY7-9 New Programming 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.

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