

Program Years 7 - 9: Renewal

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>

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 owner of the request can use the Copy Feature, but it is only available 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.

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.

Copy Feature Tutorials:

- <https://support.foundant.com/hc/en-us/articles/4523861991575-Applicant-Tutorial-Copy-Request-Responses>

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

Acknowledgement PY7-9:

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 Renewal Application Rubric

This is a **Continued Funding/Renewal Application**. This is for **PY4-6 Core programs** who wish to apply for continued funding into the PY7-9 cycle. In order to be eligible for continued funding, the program must be the same one as the one previously funded in the PY4-6 cycle with:

- The same lead agency that was previously funded
- Has up to a 10% larger funding ask than the previous cycle
- Minimal to no changes in program structure, programming, or staffing

Acknowledgement*

Choices

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

Agency Name & Proposal Name:

Agency/Organization Name*

Character Limit: 250

Project Name*

Character Limit: 250

Proposal Description:

Elevator Pitch*

Please provide a brief elevator pitch of the program

Character Limit: 4000

Updated Information:

**Please use the text areas below to describe any and all updates to the program for
Program Years 7 - 9**

Lessons Learned:*

Please describe any and all updates to the program based on lessons learned from the previous cycles. *This can include outcomes, communications, finances, etc.*

Character Limit: 4000

Personnel PY7-9*

Please list:

- 1. the positions or titles of personnel who will be funded by the WCCMHB*
- 2. their FTE*
- 3. their qualifications*

This includes anyone who will be directly working on the program. Exclude anyone whose costs you will report in indirect costs (financial officers, etc.).

Character Limit: 4000

Partnerships/Collaboration:

Please list any and all organizations your program/agency partners with for referrals, systems coordination, or other functions:

Character Limit: 3000

Supporting Documents:

Please upload any supporting documents, such as Memorandums of Understanding (MOUs), letters of support, etc.

File Size Limit: 20 MB

Please explain how your agency and program is systems-oriented.*

Character Limit: 3000

Strategic Plan 3.0 Alignment:

Of the seven pillars pictured in the CCBHC framework, which one(s) does your agency best fit into?*

For the framework, please refer to Strategic Plan 3.0

Choices

Behavioral Health Provider
Crisis Response
Community-Based Services
Federally-Qualified Health Center (FQHC)
Educational Institutions
Hospital
Justice System

Please explain how the program fits into Strategic Plan 3.0, including the new framework:*

Please include how your agency & program incorporate the 'structural conditions' and 'community conditions'

Character Limit: 4000

How will your proposal/program integrate within the CCBHC model?*

Character Limit: 4000

What is the referral and intake pathway for your program?*

If one does not exist yet, please choose the pathway you expect to establish

Choices

Pathway 1: Intake done at CCBHC, CCBHC refers out (one way)
Pathway 2: Intake done at CCBHC, CCBHC and other Provider refers (both ways)
Pathway 3: Provider does intake and refers out (one way)
Pathway 4: Provider does intake, both CCBHC and other Provider can refer (both ways)
Other (please explain)

Other

If 'Other' was chosen above, please explain. Otherwise, please put 'N/A'

Character Limit: 250

Service Breakdown:

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

Choices

Crisis Response
Clinical Treatment
Case Management

Supportive Housing
 Client Identification & 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 Effort:
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	

Budget & Finances:

Amount Requested from the WCCMHB:

Please put the full three-year cycle amount

Character Limit: 20

Please upload your PY7-9 budget below:*

Please ensure that each program year in the 'revenue' tab is filled out and totals to the requested amount inputted above.

If your program is expected to see revenue beyond WCCMHB funding, please enter the amount and type of revenue your program is expected to generate (such as Medicaid, state grants, federal grants, etc.)

Please ensure your indirect rate is at or below the 15% threshold.

File Size Limit: 20 MB

PY4-6 Budget Utilization:*

If your program has expended ***less than 85% of the total PY4 & 5 award amount***, please use the text area below to describe how you will improve spending in the coming cycle.

Additionally, if your program is requesting an ***increase*** in award amount and ***has spent less than 85% of the total PY4 & 5 awarded amount***, please describe why your program is requesting

additional funds and how you will improve on spending.

Please reach out should you need the most up-to-date numbers on your spending. For PY4 and PY5 budget totals, please add the totals from cells C40 and D40 on the Revenue tab of your budget.

Character Limit: 4000

Budget Narrative:*

Please include a brief description of what each line item will be used for

Character Limit: 3000

Will funds from WCCMHB replace any funding your organization currently receives?*

Choices

Yes, the funds will replace current funding

No, the funds will not replace current funding

Capital Expenses:*

Please list out any capital expenses that will appear on your budget. This applies to items that are over your agency's capitalization level and will be in use beyond a year.

As a reminder, per budget instructions, you will need to list these items as 'Direct Equipment' in your budget (NOT 'Commodities').

Character Limit: 4000

Capitalization Policy:

Please upload your capitalization policy below:

File Size Limit: 4 MB

Agency Finances, Accreditation, and Insurance:

What type of agency is your organization?*

Choices

Not-for-Profit

Hospital or Healthcare Organization

Government Entity

Audit Upload*

Attached the 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: 20 MB

Accreditation*

Have your agency's accreditations changed, lapsed, or has your agency obtained additional accreditations since the PY4-6 application cycle?

Choices

Yes

No

Updated Accreditations:

If 'yes' is chosen above, please upload your agency's current/updated accreditations

File Size Limit: 10 MB

Insurance:*

Does this agency currently bill Medicaid/Medicare or commercial insurance?

Choices

Yes

No

AI Disclosure:

Prompt List*

If Artificial Intelligence (AI) was used in any capacity to develop and/or write your application, please provide the list of prompts used below:

If you did not use AI, please write 'N/A'

Character Limit: 4000

Type of AI (research only):*

In the text area below, please specify what AI was used to assist in application development (ChatGPT, Gemini, CoPilot, Grammarly, etc.) and why it was utilized:

If you did not use AI, please write 'N/A'

Character Limit: 4000

Acknowledgement:*

By checking the box below, I acknowledge and understand that concision, authenticity, and originality are evaluation criteria in the WCCMHB PY7-9 Cycle, and that WCCMHB reserves the right to deny an application based on these criteria.

Choices

I acknowledge that I have read and understand the above disclosure

Thank You

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