

**FY2021 REQUEST FOR INVESTMENT
JULY 1, 2021 TO JUNE 30, 2022**

To be considered for funding, applicants must complete and submit one (1) signed and complete RFI along with Table of Organization to the Trumbull County Mental Health and Recovery Board.

The RFI should be submitted to:
Ilona Roth-Cohn, Associate Director
via email: irothcohn@TrumbullMHRB.org
fax: (330) 675-2772
or mail : 4076 Youngstown Rd SE
#201
Warren, OH 44484

Due by close of business on
April 30, 2021

BOARD PLANNING

The Trumbull County Mental Health and Recovery Board (TCMHRB) serves as the planning agency for mental health and alcohol and other drugs (AoD) treatment and prevention services for Trumbull County residents. As such, the TCMHRB continues to review and gather information regarding treatment and prevention programs and services for the state fiscal year 2022 beginning July 1, 2021.

In accordance with the procedures and guidelines established by the Ohio Department of Mental Health and Addiction Services (OhioMHAS), and the Ohio Revised Code (ORC), the TCMHRB shall:

1. Evaluate and assess community needs for facility services, mental health and addiction services and recovery supports;
2. Set priorities and develop plans for the operation of mental health and addiction services and recovery support programs in cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations;
3. Consider the cost effectiveness of services provided by the program and the program's quality and continuity of care. The Board may review cost elements, including salary costs, of the services provided by the program.

INFORMATION REVIEW PROCESS

It is anticipated that staff will review each RFI packet submitted for completeness and accuracy, requesting clarification or revision if necessary from the provider. Consideration of community-wide needs and financial resources will be central to such review. Staff will then provide summary information for each provider and project to a Committee of the Board at a scheduled meeting for discussion and review. It is anticipated that the Committee will recommend funding to the full Board for consideration no later than the June 2021 Board meeting.

APPLICANT INFORMATION

Organization Information

Applicant Organization:		
Mailing Address:		
City:	State:	Zip:
Telephone:	Fax:	County Served:
Website:		
Executive Director:		Email:
Project Director (<i>if different</i>):		Email:
Title (<i>if different</i>):		Phone:

Tax Status

Tax Status (check one): <input type="checkbox"/> 501(c)(3) <input type="checkbox"/> Church (by definition) <input type="checkbox"/> Agency of Government <input type="checkbox"/> Not a nonprofit organization; we have a fiscal sponsor. <i>Fiscal Sponsor Name:</i>	
Legal Name, per IRS determination:	
Tax ID #:	Date of IRS letter:

(* W9 form must accompany this application if first time applicant or information has changed in past year)

Organization's Mission

Brief statement of organization's objectives and/or activities:	
Annual operating budget:	Audited? <input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION (To be completed for each Program/Service)

Summary of Request

Name of Service/Activity:

Amount requested: \$

a. What services/activities/interventions are you proposing and for what target population(s)? How many people are proposed to be served?

b. What evidence is there of need for these services/activities/interventions?

c. How/why were the proposed services/activities/interventions selected to address the need? Is the proposed activity evidence-based? If so, how will you monitor fidelity to the evidence-based model?

d. The agency will be required to provide quarterly outcome reports to the TCMHRB. How will you monitor and report to the TCMHRB participation in the services/activities/interventions?

e. Does your organization require background checks on employees and volunteers? Yes No
If yes, what kind of background check is conducted?

f. Does the organization have liability and Officer and Directors Insurance? Yes No
(If yes, please include certificate of insurance with application)

Program Budget Form (To be completed for each Program/Service)

Organization Name:

Program Name:

REVENUES:**Program Budget**

Trumbull County Mental Health & Recovery Board	
Other Sources of Revenue:	
TOTAL REVENUES	\$

EXPENDITURES:

	Trumbull County Mental Health & Recovery Board	All Other Sources	Total Program Expense
Salaries and Wages			
Fringe Benefits/Payroll Taxes			
TOTAL PERSONNEL	\$	\$	\$
OTHER EXPENSES:			
Training			
Travel			
Consultants and Professional Fees			
Rent & Utilities			
Telephone			
Supplies			
Printing/ Postage			
Equipment			
Program Costs			
Food			
Other:			
Other:			
Other:			
Other:			
TOTAL OTHER EXPENSES	\$	\$	\$
TOTAL EXPENDITURES	\$	\$	\$

Signature of Executive Director: _____ Date: _____