TRUMBULL COUNTY
Mental Health and Recovery Board

Funding Application

Funding Period

July 1, 2024 – June 30, 2025

The completed Funding Application should be sent in an electronic format to Lauren Thorp at the following email address:

LThorp@TrumbullMHRB.org

By close of business on
April 26, 2024

The *required* electronic forms are listed in the Table of Contents.

All questions regarding this application should be directed to Lauren Thorp at (330) 675-2765 ext. 119 or LThorp@TrumbullMHRB.org.

BOARD PLANNING

The Trumbull County Mental Health and Recovery Board (TCMHRB) serves as the planning agency for mental health and substance use disorder 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 2025 beginning July 1, 2024.

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.

PURPOSE FOR REQUESTING INFORMATION

Provider responses to this Request for Investment (RFI) will assist the Board in its required duties as noted above and identified in the ORC, Chapter 340.
This Request for Investment is not a formal contract proposal. It is anticipated that final decisions for the allocation of the TCMHRB funds shall be made by resolution of the TCMHRB no later than the June 2024 Board of Directors meeting. Any provider that is awarded funding for July 1, 2024, through June 30, 2025, will enter into a contract with the TCMHRB prior to receipt of any payments related to such contract. Providers will be required to submit OhioMHAS Agency Assurances. All decisions of the TCMHRB on the allocation of funds are final and are contingent upon the receipt of allocations from OhioMHAS. The TCMHRB reserves the right to qualify allocation decisions based on acceptable performance target outcomes.

ELIGIBLE APPLICANTS

Eligible Applicants must be able to meet the following contract requirements:

- Treatment and Prevention agencies are certified by the Ohio Department of Mental Health and Addiction Services for at least 6 months.
- Treatment agencies holds a National Accreditation from one of the following: CARF, COA, TJC(JACHO)
- Entity has a local Controlling Board of Authority
- A treatment agency operates an office located in Trumbull County that offers on-site clinical hours 5 days per week and has operated this office for a minimum of 6 consecutive months
- A treatment agency is certified to provide Medicaid funded services and has done so for a minimum of one year with no fiscal citation, disciplinary action, or suspension
- Entity is able to provide an unqualified audit to the TCMHRB
- Entity is able to show or demonstrate that they are providing trauma informed services
- Entity is a member of good standing in the community. This is demonstrated in various ways including, but not limited to, reports from other counties in which the agency has a presence, consumers' and families' statements about the quality of service and care they've received, and review of online comments/reviews by patients/clients.
- Have proof of the following insurance coverage with the TCMHRB named as an additional insured:
    - General liability insurance in an amount of at least $1,000,000 per occurrence with an annual aggregate limit of at least $3,000,000
    - Professional liability insurance providing single limit coverage in an amount of at least $1,000,000 per occurrence with an annual aggregate limit of at least $3,000,000
    - Employers' liability insurance in a minimum amount of $500,000
    - Automobile liability insurance for passenger vehicles for all such vehicles used to transport clients, whether such vehicles are owned by the Provider or its agents or employees in an amount at least equal to Ohio minimum requirements
    - Proper worker's compensation coverage
    - Coverage against employee dishonesty, in the amount of at least $150,000 per occurrence
    - Directors and Officers Insurance in an amount of at least $2,000,000 per occurrence with an annual aggregate limit of at least $2,000,000
- Site visit completed by TCMHRB staff.

INFORMATION REVIEW PROCESS

The TCMHRB staff will review each RFI packet submitted for completeness and accuracy, requesting clarification or revision, if necessary, from the applicant. If the RFI packet is incomplete, it will be returned to the applicant to complete. Consideration of community-wide needs and financial resources will be central to such review. Staff will then provide summary information for each applicant and present to the Budget and Finance Committee of the Board of Directors for discussion and review. It is anticipated that the Committee will recommend funding to the full Board of Directors for consideration no later than the June 2024 Board meeting.

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SECTION I

ORGANIZATION INFORMATION

Organization Name

Administrative Office Address

Administrative Office Phone Number | Date of Incorporation

Organization Structure: (Non-Profit, For Profit, LLC, Other)

Federal Tax ID # | DUNS Number | SAM.gov Unique Entity ID#

Minority Business Enterprise (MBE) ☐ Yes ☐ No

Encouraging Diversity, Growth and Equity (EDGE) Business Enterprise ☐ Yes ☐ No

ORGANIZATIONAL CONTACTS

Chief Executive Officer Name:	
Phone:	
Email:	

Clinical Director Name:	
Phone:	
Email:	

Chief Financial Officer Name:	
Phone:	
Email:	

Quality Improvement Director Name:	
Phone:	
Email:	

Chief Operating Officer Name:	
Phone:	
Email:	

Clients' Rights Officer Name:	
Phone:	
Email:	

Human Resource Officer Name:	
Phone:	
Email:	

Community Relations Director Name:	
Phone:	
Email:	

Unusual Incident Reporter Name:	
Phone:	
Email:	

Person Coordinating Program Audits	
Phone:	
Email:	

Board of Directors:

Chairperson Name:	
Chairperson Phone:	
Chairperson Email:	
Member Name:	
Member Name:	
Member Name:	
Member Name:	
Member Name:	

Member Name:	
Member Name:	
Member Name:	
Member Name:	
Member Name:	
Member Name:	
Member Name:	
Member Name:	

ORGANIZATIONAL DESCRIPTION

Please provide a brief Organizational History:

Please include your Organization's Mission Statement in the box provided below:

List of Organization's Office sites/addresses where services are/would be provided to Trumbull County Residents:

Address	Phone #	Fax #	Services	Days of Operation	Hours of Operation	Arrangements available for appts outside these hours?

TRUMBULL COUNTY CLIENTS BY PRIMARY PAYOR

All Applicants complete the current number of Trumbull County clients served by Primary Payor Source:

Medicaid Private Insurance TCMHRB

Medicare Other Payor

ACCREDITATION/CERTIFICATION INFORMATION

Does your organization have National Accreditation? ☐ YES ☐ NO

If yes, specify Entity (i.e., CARF, COA, Joint Commission): _____

Is your organization certified by Ohio Department of Mental Health and Addiction Services (OHIOMHAS)?

☐ YES ☐ NO

If no, please describe your organization _____

In the past 2 years, have there been any actions against your organization through a national accreditation body (CARF, COA, Joint Commission), OHIOMHAS, or any other state licensing body requiring a corrective action plan or a temporary license/certification revocation?

☐ YES ☐ NO

If yes, provide corrective action plan and outcome of the corrections

In the past 10 years, has a national accrediting body (CARF, COA, Joint Commission), governmental entity (Medicare, Medicaid), or a state licensing authority (OHIOMHAS) revoked or terminated their relationship with your organization resulting in loss of ability to bill for services or loss of programs?

☐ YES ☐ NO

If yes, provide corrective action plan and outcome of the corrections

Medicaid Managed Care Organizations that your organization has current contracts with:

Aetna	☐ Yes	☐ No	☐ Applied but Pending
AmeriHealth Caritas Ohio, Inc.	☐ Yes	☐ No	☐ Applied but Pending
Anthem Blue Cross and Blue Shield	☐ Yes	☐ No	☐ Applied but Pending
Buckeye Community Health Plan	☐ Yes	☐ No	☐ Applied but Pending
CareSource Ohio, Inc	☐ Yes	☐ No	☐ Applied but Pending
Humana Healthy Horizons in Ohio	☐ Yes	☐ No	☐ Applied but Pending
Molina Healthcare of Ohio, Inc.	☐ Yes	☐ No	☐ Applied but Pending
UnitedHealthcare Community Plan	☐ Yes	☐ No	☐ Applied but Pending

List of Private Insurance Companies with which organization is paneled:

STAFFING AND AFFIRMATIVE ACTION REPORTING

Please complete the following table regarding current Employee Demographics at your Organization dedicated to Trumbull County clients/services:

Staff Demographics:

Gender Identity	# of Direct Care Staff	# of Supervision Staff	# of Administrative Staff
Female			
Male			
Transgender			
Non-binary			
Staff Prefer not to answer			
Other:			
Sexual Orientation	**# of Direct Care Staff**	**# of Supervision Staff**	**# of Administrative Staff**
Identify as part of the LGBTQ+ Community			
Straight/heterosexual			
Staff Prefer not to answer			
Unknown			
Other:			
Ethnicity	**# of Direct Care Staff**	**# of Supervision Staff**	**# of Administrative Staff**
Hispanic			
Non-Hispanic			
Race (Based on the following US Census race categories)	**# of Direct Care Staff**	**# of Supervision Staff**	**# of Administrative Staff**
Caucasian			
African American			
Asian			
Native Hawaiian or Other Pacific Islander			
American Indian or Alaskan Native			
Multiracial			
Other Race			
Language	**# of Direct Care Staff**	**# of Supervision Staff**	**# of Administrative Staff**
Multi lingual Spanish			
Multi lingual Other			
Total			

INSURANCE INFORMATION

Claims-Made Policies:

Does your organization have a Claims-made policy? ☐ Yes ☐ No

If yes, extended reporting period ("tail") coverage or continuous coverage from date of first contact with the TCMHRB is required.

FINANCIAL MONITORING/SUB-RECIPIENT MONITORING

A. Financial Audit Information

1. Most Recent Audit Conducted (date): _____ Name of Audit Agency/Firm: _____
   Name of the Lead Partner on the Audit Engagement: _____
   How many years have they been Lead Partner on organization's audit? _____

2. Attach a copy of your organization's most recent financial audit report. If already provided to the TCMHRB, Specify date submitted: _____

3. Does your organization receive federal funds? ☐ Yes ☐ No
   If yes, what were the results of previous audits including whether a Single Audit was performed in accordance with the Uniform Guidance, and the extent to which the same or similar sub-awards were audited as a major program.

B. Accounting System/Controls

1. Identify the method(s) used for financial reporting on your Organizational Level Reports and your Financial Statements during Audit (i.e., Cash, Accrual, etc.) _____

2. How often do you report your financial statements to your board of directors?
   ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other, please explain_____

3. What financial software package does the Organization utilize (i.e., Excel. QuickBooks, etc.)?
   _____

4. What EHR software/program is being utilized by the Organization? _____

5. Does your accounting system identify the receipt and expenditure of program funds separately for each grant?
   ☐ Yes ☐ No ☐ Not Sure

6. Does your accounting system provide for the recording of expenditures for each grant/contract by budget cost categories shown in the approved budget?
   ☐ Yes ☐ No ☐ Not Sure

7. Are time distribution records maintained for each employee that specifically identify effort charged to a grant or cost objective?
   ☐ Yes ☐ No ☐ Not Sure

8. Does your accounting system include budgetary controls to preclude incurring obligations or costs more than total funds available or by budget cost category (i.e., Personnel, Travel, etc.)? ☐ Yes ☐ No ■ Not Sure

C. Property Standards & Procurement Standards

1. Does your property management system(s) provide for maintaining:
   a) a description of the equipment ☐ Yes ☐ No ☐ Not Sure
   b) identification numbers ☐ Yes ☐ No ☐ Not Sure
   c) source of the property, including the award number ☐ Yes ☐ No ☐ Not Sure
   d) where title vests ☐ Yes ☐ No ☐ Not Sure
   e) acquisition date ☐ Yes ☐ No ☐ Not Sure
   f) federal share of property costs ☐ Yes ☐ No ☐ Not Sure
   g) location and condition of the property ☐ Yes ☐ No ☐ Not Sure
   h) acquisition cost ☐ Yes ☐ No ☐ Not Sure
   i) ultimate disposition information ☐ Yes ☐ No ☐ Not Sure

2. Does your organization maintain written procurement procedures that
   a) avoid unnecessary purchases ☐ Yes ☐ No
   b) provide an analysis of lease and purchase alternatives ☐ Yes ☐ No
   c) provide a process for soliciting goods and services ☐ Yes ☐ No

3. Does your procurement system provide for selection on a competitive basis and documentation of cost or price analysis for each procurement action? ☐ Yes ☐ No ☐ Not Sure

D. Monitoring

1. Key Performance Indicators:

Please provide the following Calculations as of the most recent audit dated_____.

Current Assets:			Current Liabilities:	
Total Assets:			Total Liabilities:	
Total Net Assets:			Total Revenue & Support:	
Total Administrative Costs:			Total Expenses	
Total Current Revenue from the TCMHRB:				

Ratios	Best Practice Benchmark	Organization Results	Calculation Instructions
1. Current Ratio	> 1.50		Current Assets divided by Current Liabilities
2. Debt to Equity Ratio	< 1.50		Total Liabilities divided by Total Assets
3. Administrative Costs to Expenses	< 20%		Total Administrative Costs divided by Total Expenses
4. Revenue to Expenses	>1		Total Revenue divided by Total Expenses
5. Net Asset Reserve (# months)	≥ 3		Total Net Assets divided by Total Expenses divided by 12
6. Percent of Funding from the TCMHRB	< 70%		Total Revenue from the TCMHRB divided by Total Revenue

If any of the benchmarks are not met, please provide a brief explanation:

2. Complexity:

a) Does your organization intend on using any funds received from the TCMHRB to meet any of your matching requirements? ☐ Yes ☐ No

If "Yes", please provide details (i.e. – **Funding Source, Amount, etc.**):

b) Does your organization receive any Federal awards directly from a federal awarding agency?

☐ Yes ☐ No

If yes, please list: _____

c) Identify any additional examples of relevant experience with federal awards and compliance with federal awards and compliance with federal award/subaward requirements, if applicable: ☐ N/A

3. Organizational/System Changes

a) Have there been changes in the accounting or computer systems in the past 12 months and/or any participated changes in the foreseeable future? ☐ Yes ☐ No

If yes, describe: _____

b) Have there been changes in the EHR computer system in the past 12 months and/or any anticipated changes in the foreseeable future? ☐ Yes ☐ No

If yes, describe: _____

c) Have there been changes in the management (i.e.-CEO, CFO, etc.) in the past 12 months and/or any anticipated changes in the foreseeable future (i.e. – planned retirements)? ☐ Yes ☐ No

If yes, describe: _____

d) Has the Organization undergone a re-organization, re-structuring or downsizing in the past 12 months and/or any anticipated changes in the foreseeable future? ☐ Yes ☐ No

If yes, describe: _____

e) Identify the major changes in policies or procedures in the past 12 months and/or any anticipated changes in the foreseeable future, (i.e., funding priorities, organization operations) if applicable: ☐ N/A

f) Is there any known potential for a significant reduction of, or a termination of, current funding within your organization or any other issues that may cause concern about program or organization viability? (i.e., grant expiration, potential serious financial loss exposures, bad debt, etc.) ☐ Yes ☐ No

If yes, provide details including corrective actions taken and the effectiveness of those actions.

g) Describe your organization's outreach plan and methodology to both increase access and awareness to your services. Examples of outreach include but are not limited to: in-person advocacy within the community, telehealth capabilities, collaboration with pharmacies, advertisements, and online presence on social media platforms.

4. Management/Personnel Stability:

a) Does the administrative staff (CEO, CFO) have at least three (3) years' experiences in their current position with the organization, or at least five (5) years' experiences in a comparable position in the field? **Please list staff and number of years.**

Name of Staff Person	Position	# of Years

b) What was the average staff turnover rate during CY23? _____

Formula:
# of employees leaving during a period of 1/1/23 – 12/31/23*
DIVIDED BY
the AVERAGE of (# of employees on 1.1.23and # of employees on 12.31.23)
(See https://www.youtube.com/watch?v=7oY8YmlyIUg for instructions)
**Includes employees who left for any reason*

Optional: Provide any observations or explanation regarding CY23 turnover:

c) Number of open positions for the following personnel types:

Direct Line Staff: _____
Supervision Staff: _____
Administrative Staff: _____

d) List the steps to ensure clients in the program or service continue to receive services consistent with contract when staff vacancies occur.

4. Irregularities:

Is the Organization aware of any of the following at the Organization or with its sub-contractors?

1) Fraud ☐ Yes ☐ No
2) Waste ☐ Yes ☐ No
3) Abuse ☐ Yes ☐ No

If so, what are the proposed or actual actions? _____

CONSUMER OUTCOMES AND SATISFACTION (PURSUANT WITH OAC 5122 -28-04)

Pursuant to OAC 5122-28-04, each provider shall use a system to measure consumer outcomes and satisfaction for children, youth and adults. Please consult the OAC rule for requirements.

How often do you collect consumer outcome and satisfaction information?

_____

**2023 reports are to be submitted with this application.*

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

Pursuant to OAC 5122-26-18, each OHIOMHAS certified provider shall have a written policy/procedure for client rights and grievances. The TCMHRB will ensure compliance per OAC 5122:2-1-02.

The Clients Rights Policy and Grievance Procedure is to be posted in each location in which services are provided, unless the location is not under control of the provider (i.e., school, jail, etc. and where is not feasible for provider to do so). The CRO's name, location, hours, and contact information shall be included. Where can the posting(s) be found in the Trumbull County sites (specify by site/location)?

If not posted, specify plans to come into compliance:

List Number of Grievances reports/resolved in your Organization during CY 23 involving Trumbull County Residents:

Types of Grievances by Client Rights Categories	Number of Grievances Received	Number of Grievances Resolved	FOR REFERENCE: Category aligns with the following Client Rights:		
			Community Provider	Residential Class 1 Provider	Residential Class 2/3 Provider
Right to Dignity and Respect			1, 2, 3	5, 6, 7, 8, 20, 21, 29	5, 6, 7, 8, 21, 22, 30
Right to Informed Choice and Treatment			4, 5, 6, 45, 13, 20	14, 18, 19, 22, 30	14, 19, 20, 23, 31
Right to Freedom			7, 8, 9	9, 10,11, 24, 26, 25, 28, 29, 31, 32	9, 10, 11, 25, 26, 28, 29, 32, 33
Right to Personal Liberties			10, 11, 14, 15, 21	12, 13, 15, 16, 17, 23	12, 13, 15, 16, 17, 18, 24
Right to Freely Exercise All Rights			16, 17, 18	1, 2, 3, 4, 27	1, 2, 3, 4, 27
Service Improvement and Environment					
Other: (Housing, Employment, Custody, etc.)					

How many grievances resulted in some sort of Quality Improvement at the Provider Level? _____

Briefly list/describe client rights quality improvement initiatives implemented in CY23 to address client grievances?

ORGANIZATION SPECIFIC INFORMATION

1. Emergencies Occurring During Operating Hours

Describe your organization's provisions for dealing with general psychiatric/medical/intoxication emergencies during and outside of regular operating hours. Include reference to emergency phone requests, provisions for working with other community agencies and staffing arrangements, highlighting any changes from the previous application and rationale for these changes. Agencies may include applicable procedures as an addendum to the application.

2. **Cultural Competence** is a continuous learning process that builds knowledge, awareness, skills, and capacity to identify, understand, and respect the unique beliefs, values, customs, languages, abilities, and traditions of all Ohioans to develop policies to promote effective programs and services.

Describe your efforts to ensure the services provided are culturally competent. *If a plan was created for national accreditation, please attach that in lieu of completing this section.*

Have you provided any cultural competence training in SFY2024? ☐ Yes ☐ No

Are there plans to provide such training in SFY2025? ☐ Yes ☐ No

Cultural Competency Training Plans for SFY2025

Additional Cultural Competency Development Activities/Initiatives Planned for SFY2025

3. Client Demographics

Long-standing systemic social and health inequities have put certain population groups at increased risk for having poorer health outcomes. Programs and services are more likely to succeed when they recognize and reflect the diversity of the community with intention. The TCMHRB is committed to working alongside funded providers to ensure quality services to those in need in our community, which includes establishing or enhancing programs and services to reach marginalized populations.

FY2023 Client Profile	
Gender Identity	# of Clients
Female	
Male	
Transgender	
Non-binary	
Prefer not to answer	
Other:	
Sexual Orientation	# of Clients
Identify as part of the LGBTQ+ Community	
Straight/heterosexual	
Prefer not to answer	
Other:	
Ethnicity	# of Clients
Hispanic	
Non-Hispanic	
Race (Based on the following US Census race categories)	# of Clients
Caucasian	
African American	
Asian	
Native Hawaiian or Other Pacific Islander	
American Indian or Alaskan Native	
Multiracial	
Other Race	
Generation	# of Clients
Traditionalist- born 1925-1945	
Baby Boomers- born 1946-1964	
Generation X- born 1965-1980	
Millennials- born 1981-2000	
Generation Z- born 2001-2020	
Total	

4. Subcontracts

List any subcontracts your organization has in place for which the TCMHRB funding in your contract is passed through to another provider, inclusive of vendor name, services or duties performed, term, and dollar value.

5. TCMHRB Priorities

Check which Board-identified community challenges, gaps in service and access, and population experiencing disparities your proposal will directly address

Priority Area	Description	
I. Children, Youth & Families		
1A	Mental, emotional, and behavioral health conditions in children and youth	
1B	Adverse childhood experiences (ACEs)	
1C	Suicidal Ideation	
II. Mental Health and Addiction Challenges		
2A	Adult suicide deaths	
2B	Drug overdose deaths	
2C	MH and SUD conditions among adults (overall)	
III. Services Gaps		
3A	Crisis services	
3B	Mental Health Workforce (mental health professional shortage areas)	
3C	Substance use disorder treatment workforce	
IV. Gaps in access for children, youth and families		
4A	Lack of follow-up care for children prescribed psychotropic medications	
4B	Unmet need for mental health treatment	
4C	Access to SUD treatment (youth)	
V. Gaps in access for adults		
5A	Low SUD treatment retention	
5B	Lack of follow-up after hospitalization for mental illness challenges	
5C	Lack of follow-up after substance use	
VI. Disproportionately impacted populations		
6A	People with low incomes or low educational attainment	
6B	People with a disability	
6C	Residents of rural areas	
6D	Black residents	
6E	Older adults (ages 65+)	
6F	Veterans	
6G	LGBTQ+	
6H	People who use injection drugs (IDU)	
6I	People involved in the criminal justice system	

6. Service Priority

Describe how your organization operationalizes the practices to align access and services with the TCMHRB priority populations.

SECTION II

SFY25 Service Interest

EXISITING PROVIDER SERVICE INTEREST SECTION II-A

The TCMHRB service priorities have been established in Ohio Revised Code §340, the Community Assessment and Plan (CAP), the National Outcomes Measures (NOMS) and the Community Health Improvement Plan (CHIP). It is expected that these priorities will be addressed in your service descriptions.

PART 1:

Are you proposing alterations in the service array from the SFY24 Plans (adding, discontinuing, or altering programs/services)?

☐ Yes – Please describe in Part 2

☐ No – Proceed to Part 3

NOTE: Any proposed substantial change to amount, scope or ability of a client to access a service requires written notification to the TCMHRB Board no later than 120 days prior to the end of the SFY24 contract (required by current contract)

PART 2:

If you are proposing discontinuing a current service, please identify which program or service(s) and provide rationale for proposed discontinuance. If not applicable, check box ☐

Programs or Services: _____

Rationale for proposed discontinuance:

If you are proposing a new or altered services, please briefly explain what gap in Trumbull County's service delivery system that this will fill and any unique program characteristics:

If you have a grant that is ending during the SFY25 contract period AND you believe that TCMHRB funding is necessary to fill a gap that exists in Trumbull County's service delivery system without the grant funds, please briefly explain (include dollar amount, time period, etc.)

PART 3:

Program Specific Information (Outcomes) Matrix (Excel form) must be completed for all programs funded by the TCMHRB. If proposing school-based prevention programs, the School Services Worksheet is to be completed also.

Forms may not be modified.

Part 4 - TCMHRB Program Specific, One Time Capital Outlays:

Describe plans to purchase significant program supplies and minor equipment used in day-to-day agency operations at TCMHRB owned properties that your agency manages:

Describe plans to complete minor building upgrades and repairs for TCMHRB owned properties managed by your agency:

Sources of funding are available to supplement TCMHRB funding:_____ Amount:$_____

Does your agency set aside funding annually for replacement of equipment? ☐ Yes ☐ No

Does your Board of Directors require designation of funds for equipment and repairs to properties? ☐ Yes ☐ No

SECTION III

BUDGET FORMS AND NARRATIVE

The funding "cap" for the total County of the TCMHRB system is set by the TCMHRB Board of Directors and subject to announced changes in financial conditions.
It is important to carefully consider your agency's funding requests in the context of actual fund utilization.

All organizations are required to develop budgets in accordance with generally accepted accounting principles.

Budgets that are incomplete and/or contain mathematical inaccuracies will be returned to organizations for correction. Forms returned for additional work may delay processing and final approval of your contract.

Deficit budgets will not be accepted.

Complete, organization-wide budget information must be submitted.

All organizations will complete an Excel budget workbook containing these forms:

☐ Form 1: Program Budget Form
☐ Form 2: Personnel Roster
☐ Form 3: Budget Request Summary

SECTION IV

CHECKLIST OF ATTACHMENTS

All attachments should be named according to the checklist below

	National Accreditation Certificate, if applicable
	OHIOMHAS Certificate(s) for each site, if applicable
	General Liability Insurance
	Certificate of Professional Liability Insurance
	Certificate of Employers' Liability Insurance
	Certificate of Automobile Insurance, if applicable
	Certificate of Employee Dishonesty Insurance Coverage, if applicable
	Certificate of Directors and Officers Insurance
	For claims-made insurance policies, extended reporting period (tail) coverage endorsement or evidence of continued coverage from first claims-made policy issued while under contract with the TCMHRB (if applicable)
	Most recent Financial Audit
	Most recent Consumer Satisfaction/Outcomes Report
	Current Client Rights/Grievance Policy/Procedure
	Proof of Annual Fire Inspections (For Board owned properties only)
	National accreditation or state licensing body corrective action plan (Past 2 years if applicable)
	National accreditation, government entity, or state licensing body revocation or termination of relationship corrective action plan (Past 10 years, if applicable)
	Current OBWC Certificate
	Program Specific Information (outcomes) Matrix (Excel)
	Program Budget Package (Excel)
	School Based Service Programs Worksheet (Excel)- *if applicable*

EXECUTIVE DIRECTOR/CEO CERTIFICATION/SIGNATURE

I hereby attest that this document is a true and complete reflection of our organization and the services/project(s) being proposed for funding.

Executive Director/CEO Name:
Executive Director/CEO Signature: Date:

I hereby attest that this document is a true and complete reflection of our organization and the services/project(s) being proposed for funding. I have assembled this packet for submission.

Packet Organizer Name:
Packet Organizer Signature: Date:

Row 4

Row 2	Agency Name
Column A	Program Name
Column B	Program Location
Column C	Program Description
Column D	Program Type
Column E	Services Offered
Column F	Target Population
Column G	Board-Aligned Priority Area(s)
Column H	Evidenced Based Practices
Column I	Projected Served- Total
Column J	Projected Served- TCMHRB Funds
Column K	Actual TOTAL Served in Previous Year
Column L	Actual TCMHRB Clients Served in Previous Year
Column M	Proposed Outcomes

Column N	Baseline Data
Column O	Target
Column P	Changes from Previous Year
Column Q	Implementation Plan for New Programs
Column S	Total Other funds

Row 4 is an EXAMPLE for agencies to use as a reference when completing the document

Insert Agency name on this line

List each separate program, by name, in individual rows. This will be how the program will be referenced in TCMHRB correspondence. If you are requesting funding for 5 programs, you will complete 5 rows for each of those programs. Add additional rows as needed. If your program is a Class 1, 2

Indicate whether the program will take place in an office setting, community or school. Give as much detail about the location as possible including the

Briefly provide a summary of what the program is that you are proposing. This would include additional information that you find pertinent that is not already listed on the program matrix. There is a limit of 1,500 characters

Indicate whether the program is a prevention, treatment or support service. ***You can choose more than one where applicable***

List **ALL** services you plan to render in this program.

Identify **ALL** potential target populations that you propose to serve.

Progams should align with the TCMHRB priorities identified on page 16 of the funding application. The number associated with each priority should be

List **ALL** Evidenced Best Practices you propose to serve within this program. Indicate if utilizing a promising practice and/or best practice.

List the **TOTAL** clients you propose to serve within this program. This is an **UNDUPLICATED** client count and includes all funding streams (i.e. Medicaid,

List the number of **TOTAL TCMHRB FUNDED** client you prose to serve within this program. This is an **UNDUPLICATED** count of individuals not otherwise covered by other funding streams (i.e. Medicaid, commercial insurance, self pay), when applicable

Provide the **TOTAL # served in the previous calendar year**. This would include total number served that includes all funding streams (i.e. Medicaid,

Provide the **TOTAL TCMHRB funded clients count served in the previous calendar year**. This is an UNDUPLICATED count of individuals not otherwise covered by other funding streams (i.e. Medicaid, commercial insurance, self pay), when applicable

List outcomes that you will be required to submit quarterly to the TCMHRB. This should align with the TCMHRB identified priority indicators

Provide baseline data for chosen outcomes including the timeframe of data

Select target goal for outcomes. Targets should be defined in quantitaive terms

List any material changes to the program and reasons from the previous year (i.e. change in population served, changed in #s served, an addition of a

If proposing a new program, explain how you plan to startup your program, including timeline. If it's an exsiting program, explain how you plan to

Provide total of all funding streams (i.e. Medicaid, commercial insurance, self pay, etc.) contributing to the program

SFY25 Funding Application
July 1, 2024 - June 30, 2025

Provider Organization Name _____

	Program Name	School District	School Building	School type	Newly Proposed Program?	Evidence-Based Program (EBP)?	Program Capacity (# of students per program)	Typical Program Duration (i.e # of days, weeks)	# of Times Full Program is Offered	Grades Served *(list each grade)*	
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
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36											

PROGRAM/SERVICES BUDGET FORM

(Complete this Form for Each Proposed Program)

Agency Name: _____

Program/Service Name: _____

REVENUE

Trumbull County MHRB request	$ -

Other Sources of Revenue:

Medicaid	$ -
Commercial insurance	$ -
1st party fees	$ -
Federal grants	$ -
State grants	$ -
Local grant	$ -
Other:	$ -
Other:	$ -
TOTAL REVENUE	**$ -**

EXPENSES

	Trumbull County Mental Health & Recovery Board	All Other Sources	Total Project Expense
Direct Personnel	$ -	$ -	$ -
Support Personnel	$ -	$ -	$ -
Administrative Personnel	$ -	$ -	$ -
TOTAL PERSONNEL COSTS	$ -	$ -	$ -
Other Expenses:			
Training	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Consultants and Professional Fees	$ -	$ -	$ -
Rent & Utilities	$ -	$ -	$ -
Telephone	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Printing / Postage	$ -	$ -	$ -
Equipment	$ -	$ -	$ -
Program Costs	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other:	$ -	$ -	$ -
Other:	$ -	$ -	$ -
Other:	$ -	$ -	$ -
TOTAL OTHER EXPENSES	**$ -**	$ -	$ -