TRUMBULL COUNTY
Mental Health and Recovery Board

Community Grant Application

Funding Period: State Fiscal Year 2026

July 1, 2025 – June 30, 2026

PURPOSE

The Trumbull County Mental Health & Recovery Board (TCMHRB) is committed to supporting the recovery of Trumbull County residents from mental health & substance use disorders and recognizes that a variety of community programs is required to achieve long term success. The TCMHRB will award grants up to $50,000 to qualifying community organizations that provide mental health and/or substance use disorder services and supports to Trumbull County residents. Grant funds may be used to develop and/or sustain programs or services. Requests for amounts greater than $50,000 should be submitted using the TCMHRB's Funding Application packet at www.trumbullmhrb.org. Any provider that is awarded funding will enter into an Agreement with the TCMHRB prior to receiving any payments. Questions regarding this application should be directed to Lauren Thorp, Associate Director, at (330) 675-2765 ext. 119.

INFORMATION REVIEW PROCESS

The TCMHRB staff will review each grant submission for completeness and accuracy, requesting clarification or revisions, if necessary, from the organization. Consideration of community-wide needs and financial resources will be central to such review. The TCMHRB's staff will visit the program/property prior to grant approval. Final approval is determined by the TCMHRB Executive Director and Board of Directors.

QUALIFIED APPLICANTS

Qualified applicants will:

- Have been in operation at least 12 months and can provide backup documentation of the duration
- Serve residents of Trumbull County
- Not supplant existing funds with TCMHRB funds
- Adhere to reporting and confidentiality requirements of the TCMHRB

The completed Grant 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 18, 2025

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SECTION I

ORGANIZATIONAL 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

Annual Operating Budget $ | Audited? ☐ Yes ☐ No

ORGANIZATIONAL CONTACTS

Chief Executive Officer Name:	
Phone:	
Email:	

Project Director Name:	
Phone:	
Email:	

Chief Financial Officer Name:	
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:	

ORGANIZATIONAL DESCRIPTION

Please provide a brief Organizational History *(new applicants only)*:

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

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 the Ohio Department of Mental Health and Addiction Services (OHIOMHAS) or the Ohio Supreme Court?

☐ YES ☐ NO

If yes, specify which Entity: _____

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 correction

EMPLOYEE DEMOGRAPHIC REPORTING

The demographic makeup of an agency's workforce should ideally mirror the demographics of the community they serve. By having employees with similar backgrounds and characteristics as their clients, agencies can better understand client's needs, challenges, and perspectives.

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

Gender	# of Direct Care Staff	# of Supervision Staff	# of Administrative Staff
Female			
Male			
Staff Prefer not to answer			
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			

ORGANIZATION SPECIFIC INFORMATION

1. **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 SFY2025? ☐ Yes ☐ No

Are there plans to take part in such training in SFY2026? ☐ Yes ☐ No

2. **Trauma-Informed Care** is an approach that explicitly acknowledges the role trauma plays in people's lives. Trauma-Informed Care means that every part of an organization or program understands the impact of trauma on the individuals they serve and adopts a culture that considers and addresses this impact.

   Are you and/or your staff members trained in Trauma-Informed Care? ☐ Yes ☐ No

   If yes, please explain

Are there plans to take part in such training in SFY2026? ☐ Yes ☐ No

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.

FY2024 Client Profile	
Gender	# of Clients
Female	
Male	
Prefer not to answer/ unknown	
Other:	
Ethnicity	# of Clients
Hispanic	
Non-Hispanic	
Prefer not to answer/ unknown	
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	
Prefer not to answer/ unknown	
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	
Prefer not to answer/ unknown	
Total	

4. TCMHRB Priorities

Check the boxes in the right- hand column to show which Board-identified community challenges, gaps in service and access, and population(s) 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	

SECTION II

PROGRAM PROPOSAL

The Program Proposal form must be completed for each program funded by the TCMHRB. Each program should be on a separate page/table. Two tables have been provided. Additional copies should be made as needed.

Form may not be modified.

Program Name: _____

Total Request TCMHRB Funds for Program: _____

PROGRAM LOCATION			
PROGRAM DESCRIPTION			
TARGET POPULATION			
BOARD-ALIGNED PRIORITY AREA(S) SPECIFIC TO THE PROGRAM *(See Page 8)*			
PROJECTED TOTAL # SERVED		**ACTUAL TOTAL # SERVED IN PREVIOUS YEAR** *(If applicable)*	
PROPOSED QUARTERLY OUTCOME INDICATOR	*Ex. Increase in school attendance among the truancy prevention program participants*		
BASELINE	*Ex: Overall school attendance among program participants was 57% at enrollment.*		
TARGET	*Ex: School attendance percentage will increase by at least 10% each quarter.*		

Program Name: _____

Total Request TCMHRB Funds for Program: _____

PROGRAM LOCATION			
PROGRAM DESCRIPTION			
TARGET POPULATION			
BOARD-ALIGNED PRIORITY AREA(S) SPECIFIC TO THE PROGRAM *(See Page 8)*			
PROJECTED TOTAL # SERVED		**ACTUAL TOTAL # SERVED IN PREVIOUS YEAR** *(If applicable)*	
PROPOSED QUARTERLY OUTCOME INDICATOR	*Ex. Increase in school attendance among the truancy prevention program participants*		
BASELINE	*Ex: Overall school attendance among program participants was 57% at enrollment.*		
TARGET	*Ex: School attendance percentage will increase by at least 10% each quarter.*		

SECTION III

GRANT PROJECT BUDGET FORM

Organization Name: _____

Proposal Name: _____

REVENUES:	**Requested Amount**
Trumbull County Mental Health & Recovery Bd.	$

(Amount in this column should equal the sum of all proposed projects)

Other Sources of Revenue:	
Federal Grants	
State Grants	
Local Grants	
Other:	
Other:	
TOTAL REVENUES	$ 0

EXPENDITURES:

	Trumbull County Mental Health & Recovery Board	**All Other Sources**	**Total Project Expense**
Salaries and Wages			0
Fringe Benefits/Payroll Taxes			0
TOTAL PERSONNEL	$ 0	$ 0	$ 0
OTHER EXPENSES:			
Training			0
Travel			0
Consultants and Professional Fees			0
Rent & Utilities			0
Telephone			0
Supplies			0
Printing/ Postage			0
Equipment			0
Program Costs			0
Food			0
Other:			0
Other:			0
Other:			0
Other:			0
TOTAL OTHER EXPENSES	$ 0	$ 0	$ 0

TOTAL EXPENSES	$ 0	$ 0	$ 0

(Amount in this column should match total request from the TCMHRB)

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
	Most recent Financial Audit
	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
	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: