



Community Grant Application

Funding Period: State Fiscal Year 2027

July 1, 2026 – June 30, 2027

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 \$40,000 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 \$40,000 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. Final approval is determined by the TCMHRB Executive Director and Board of Directors.

QUALIFIED APPLICANTS

Qualified applicants will:

- Have been in operation in Trumbull County 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 17, 2026

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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:		Project Director Name:	
Phone:		Phone:	
Email:		Email:	

Chief Financial Officer Name:	
Phone:	
Email:	

Board of Directors:

Chairperson Name:		Member Name:	
Chairperson Phone:		Member Name:	
Chairperson Email:		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*):

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:

	# of Direct Care Staff	# of Supervision Staff	# of Administrative Staff
Gender Identity			
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

- 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 SFY2026? Yes No

Are there plans to take part in such training in SFY2027? 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 SFY2027? Yes No

3. Client Demographics

Programs and services are more likely to succeed when they recognize and reflect the make-up of the community. 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.

FY2025 Client Profile	
Total # of clients served (unduplicated count)	
Gender Identity	# 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
Silent Generation- born 1928-1945	
Baby Boomers- born 1946-1964	
Generation X- born 1965-1980	
Millennials- born 1981-1996	
Generation Z- born 1997-2012	
Generation Alpha – born 2013-2025	
Prefer not to answer/ unknown	

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	Youth Marijuana Use	
II. Mental Health and Addiction Challenges		
2A	Adult depression	
2B	Adult Substance Use Disorder	
2C	MD and SUD conditions among adults (overall)	
III. Services Gaps		
3A	Crisis services	
3B	Mental Health treatment services	
3C	Criminal Justice	
IV. Gaps in access for children, youth and families		
4A	Unmet need for substance-use/addiction treatment	
4B	Unmet need for mental health treatment	
4C	Uninsured children	
V. Gaps in access for adults		
5A	Low SUD treatment retention	
5B	Lack of follow-up after ED visit for mental health	
5C	Unmet need for mental health treatment	
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	Transition-aged adults (ages 18-24)	
6F	LGBTQ+	
6G	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 <i>(See Page 8)</i>			
PROJECTED TOTAL # SERVED		ACTUAL TOTAL # SERVED IN PREVIOUS YEAR <i>(If applicable)</i>	
PROPOSED QUARTERLY OUTCOME INDICATOR	<i>Ex. Increase in school attendance among the truancy prevention program participants</i>		
BASELINE	<i>Ex: Overall school attendance among program participants was 57% at enrollment.</i>		
TARGET	<i>Ex: School attendance percentage will increase by at least 10% each quarter.</i>		

Program Name: _____

Total Request TCMHRB Funds for Program: _____

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

SECTION III

GRANT PROJECT BUDGET FORM

Organization Name: _____

Proposal Name: _____

REVENUES:

Requested Amount

Trumbull County Mental Health & Recovery Bd.	\$
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(Amount in this column should equal the sum of all proposed projects)

Other Sources of Revenue:	Projected Amount
Federal Grants	
State Grants	
Local Grants	
Other:	
Other:	
TOTAL REVENUES	\$

EXPENDITURES:

	Trumbull County Mental Health & Recovery Board	All Other Sources	Total Project 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:			
TOTAL OTHER EXPENSES	\$	\$	\$

TOTAL EXPENSES	\$	\$	\$
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(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
	ODBH 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)- <i>if applicable</i>

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: