TRUMBULL COUNTY
Mental Health and Recovery Board

# Funding Application

# Funding Period:

## State Fiscal Year 2027

## July 1, 2026 – June 30, 2027

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 24, 2026

**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.

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## 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 2027 beginning July 1, 2026.

In accordance with the procedures and guidelines established by the Ohio Department of Behavioral Health (DBH), 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.
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 2026 Board of Directors meeting. Any provider that is awarded funding for July 1, 2026, through June 30, 2027 , will enter into a contract with the TCMHRB prior to receipt of any payments related to such contract. Providers will be required to submit the DBH Agency Assurances. All decisions of the TCMHRB on the allocation of funds are final and are contingent upon the receipt of allocations from the DBH. 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 Behavioral Health for at least 6 months.
- Treatment agencies hold a National Accreditation from one of the following: CARF, COA, TJC(JCAHO).
- Entity has a local Controlling Board of Authority.
- A provider 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 12 consecutive months.
- A provider 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 in 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 workers' 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 2026 Board meeting.

# Table of Contents

# 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 | | |

**ORGANIZATIONAL CONTACTS**

| | | | |
|---|---|---|---|
| Chief Executive Officer Name: | | Clinical Director Name: | |
| Phone: | | Phone: | |
| Email: | | Email: | |
| Chief Financial Officer Name: | | Quality Improvement Director Name: | |
| Phone: | | Phone: | |
| Email: | | Email: | |
| Chief Operating Officer Name: | | Clients' Rights Officer Name: | |
| Phone: | | Phone: | |
| Email: | | Email: | |
| Human Resource Officer Name: | | Community Relations Director Name: | |
| Phone: | | Phone: | |
| Email: | | Email: | |
| Unusual Incident Reporter Name: | | Person Coordinating Program Audits | |
| Phone: | | Phone: | |
| Email: | | 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 *(for 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? |
|---|---|---|---|---|---|
| | | | | | |
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## TRUMBULL COUNTY CLIENTS BY PRIMARY PAYOR

The number of Trumbull County clients served by Primary Payor Source in SFY2025:

___ Medicaid ___ Private Insurance ___ TCMHRB

___ Medicare ___ Other Payor *(please, specify):*_____

## 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 Behavioral Health (DBH)?

YES NO

If no, please provide explanation: _____

In the past 2 years, have there been any actions against your organization through a national accreditation body (CARF, COA, Joint Commission), DBH 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 (DBH) 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

Check the Medicaid Managed Care Organizations and Private Insurance Companies with whom your organization has contracts:

- ☐ Aetna (Medicaid)
- ☐ Aetna (Private Insurance)
- ☐ Allwell
- ☐ Ambetter- Buckeye Health Plan
- ☐ AmeriHealth Caritas Ohio, Inc.
- ☐ Anthem Blue Cross/Blue Shield (Medicaid)
- ☐ Anthem Blue Cross/Blue Shield (Private Insurance)
- ☐ Aultcare
- ☐ Buckeye/Cenpatico
- ☐ Buckeye Community Health Plan
- ☐ Carelon Behavioral Health
- ☐ CareSource Medicare Advantage
- ☐ CareSource Ohio, Inc (Medicaid)
- ☐ CareSource Ohio, Inc (Private Insurance)
- ☐ Champ VA
- ☐ Cigna
- ☐ Communicare Advantage Plans/Medicare
- ☐ Devoted Health- Magellan Medicare
- ☐ Emerald Health Network
- ☐ Highmark
- ☐ Humana Gold Choice
- ☐ Humana Healthy Horizons in Ohio
- ☐ Humana Military East
- ☐ Magellan Healthcare
- ☐ Medical Mutual
- ☐ Molina Healthcare of Ohio, Inc. (Medicaid)
- ☐ Molina Healthcare of Ohio, Inc. (Private Insurance)
- ☐ Mutual Health
- ☐ Railroad Medicare
- ☐ SummaCare
- ☐ The Health Plan
- ☐ Tricare
- ☐ UnitedHealthcare Community Plan
- ☐ UnitedHealthcare/Optum
- ☐ UPMC Healthcare
- ☐ Wellcare

Other Medicaid Managed Care and Private Insurance Companies not listed above:

## EMPLOYEE DEMOGRAPHICS 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 clients' 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 | | | |
| Unknown | | | |
| **Language** | **# of Direct Care Staff** | **# of Supervision Staff** | **# of Administrative Staff** |
| Multilingual Spanish | | | |
| Multilingual Other | | | |
| Total # of Staff | | | |

## FINANCIAL MONITORING/SUB-RECIPIENT MONITORING

**A. Financial Audit Information** *(For new applicants only. Agencies with a recent audit on file, skip to B)*

**1.** Date Most Recent Audit Conducted: _____ Name of Audit Agency/Firm: _____

Attach a copy of your organization's most recent financial audit report.

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

_____

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

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

**5.** 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. Monitoring**

**1. Complexity:**

a) Does your organization intend to use 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 federal funds? ☐ Yes ☐ No

If yes, does the total amount of Federal awards equal $1,000,000 or more? ☐ Yes ☐ No

c) Does your organization receive any Federal awards directly from a federal awarding agency? ☐ Yes ☐ No

If yes, please list: _____

**2. Organizational/System Changes**

a) Have there been changes in the accounting or computer systems in the past 12 months and/or any anticipated 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.

| |
|---|
| |

**4. Personnel Stability:**

a) What was the average staff turnover rate during CY25? _____

*Formula:*
*# of employees leaving* during a period of 1/1/25 – 12/31/25*
*DIVIDED BY*
*the AVERAGE of (# of employees on 1.1.25 and # of employees on 12.31.25)*
*(See https://www.youtube.com/watch?v=7oY8YmlyIUg for instructions)*
**Includes employees who left for any reason*

Optional: Provide any observations or explanation regarding CY25 turnover:

| |
|---|
| |

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

Direct Care Staff: _____
Supervision Staff: _____
Administrative Staff: _____

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

| |
|---|
| |

## 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?

_____

**Most recent reports are to be submitted with this application.*

## CLIENT RIGHTS AND GRIEVANCE PROCEDURE

*Pursuant to OAC 5122-26-18, each DBH 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 where services are provided, unless the location is not under control of the provider (i.e. school, jail, etc. and/or it's 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 reported/resolved in your Organization during CY25 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 CY25 to address client grievances?

## ORGANIZATION SPECIFIC INFORMATION

**1. Emergencies Occurring During and Outside of Operating Hours**

Describe your organization's provisions for dealing with general psychiatric/medical/substance use 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.

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.

a.) 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.*

b.) Have you provided any cultural competence training in SFY2026? ☐ Yes ☐ No

Cultural Competency Development Activities/Initiatives Planned for SFY2027:

**2. 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.

| **CY2025 Trumbull County Client Profile** | |
|---|---|
| Gender | # of Clients |
| Female | |
| Male | |
| 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 | |
| Unknown | |
| Generation | # of Clients |
| The Silent Generation- born 1925-1945 | |
| Baby Boomers- born 1946-1964 | |
| Generation X- born 1965-1980 | |
| Millennials- born 1981-1996 | |
| Generation Z- born 1997-2010 | |
| Generation Alpha- born 2011-2024 | |
| Total # of clients served (unduplicated count) | |

**3. 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.

**4. TCMHRB Priorities**

Select 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 | Youth Marijuana Use | |
| **II. Mental Health and Addiction Challenges** | | |
| 2A | Adult depresssion | |
| 2B | Adult Substance Use Disorder | |
| 2C | MH and SUD conditions among adults (overall) | |
| **III. Service 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 | |
| | | |
| | | |

**5. Service Priority**

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

# SECTION II

## SFY27 Service Interest

### EXISITING PROVIDER SERVICE INTEREST

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 SFY26 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 SFY26 contract (required by current contract)

**PART 2:**

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

If you have a grant that is ending during the SFY26 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:**

**If you are requesting an increase in program funding, please identify which program or service(s) and provide rationale for requested increase.** If not applicable, check box ☐

Programs or Services: _____

Rationale for increased funding request:

If the increased funding request is not granted, how will the program or service be sustained?

**PART 4:**

**Program Specific Information (Outcomes) Matrix (Excel form) must be completed for all programs funded by the TCMHRB. Tips for Outcomes Reporting have been added to the Matrix Workbook.**

**If proposing school-based prevention programs, the School Services Worksheet is to be completed also.**

*Forms may not be modified.*

**Part 5 - 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: *If not applicable, check box* ☐

Describe plans to complete minor building upgrades and repairs for TCMHRB owned properties:

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

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

# SECTION III

## BUDGET FORMS AND NARRATIVE

The funding "cap" for the total 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 and not on file with the TCMHRB* |
| | DBH Certificate(s) for each site- *new applicants only* |
| | General Liability Insurance- - *if applicable and not on file with the TCMHRB* |
| | 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 |
| | 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 - *new applicants only* |
| | 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:<br><br>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:<br><br>Date: |