

# River Forest Township Mental Health Committee

## APPLICATION FOR FUNDING OVERVIEW

River Forest Township Mental Health Committee will be using this application for the FY 2018 funding process for new agencies and/or programs only. Completion of the following forms is required:

**A. Cover and Authorization Sheet (one page)**

**NOTE: Written notification is expected if an agency makes changes during the grant period either in services, programs and location of services and/or administrative office.**

**B. Attachments (one page) – NOTE: ONLY 1 COPY IS EXPECTED**

**C. Individual Program Form (three pages)**

**NOTE: The Individual Program Form must be completed for each of the programs for which funds are being requested. For example, an agency requesting funds for three programs must complete 3 sets of the form. **Non-compliance with this requirement will result in rejection of the application.****

**D. Individual Program Narrative Form (three pages)**

**E. Agency Staff Positions Form (one page)**

**F. Community Board Form (agency form may be substituted as long as requested information is included) (one page)**

The application should be collated in the order specified above. Each Individual Program Form for each of the programs for which funds are being requested should precede each Narrative section. Agency Staff Positions and Community Board Form are to be attached at the end of the complete application. Formatting requirements: typed with a font size between 10 and 12 pt.

Please include the following number of copies of the completed applications:

**River Forest Mental Health Committee**

**14 copies**

Specific instructions for completing the application follow. If you have any questions concerning the application, please call.

This set of applications is due by **December 14, 2016 BY 4 P.M** and should be returned to:

**Avis Rudner  
River Forest Township Mental Health Committee  
8020 Madison  
River Forest, IL 60305  
708-771-6159 x 270**

**I. This application packet is for:**  
 \_\_\_\_\_ **River Forest Township Mental Health Committee (RFMHC)**

**Legal Name of Agency:** \_\_\_\_\_

**Address of Administrative Office:** \_\_\_\_\_

**Address of Service Provision Office for RF residents:** \_\_\_\_\_

**Executive:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ **Website:** \_\_\_\_\_

**For Fiscal Year 2018 (July 1, 2017 to June 30, 2018) Indicate agency fiscal year**  
 if other than above \_\_\_\_\_

**II. (a) Name of Programs for Which Agency is Requesting Funds**

1.

2.

3.

4.

5.

6.

| <b>III. Agency Revenues</b>                        | <b>Current FY 2017</b> | <b>Projected FY 2018</b> |
|--|------------------------|--------------------------|
| <b>Total Agency Revenue</b> (all programs/sources) |                        |                          |
| <b>RFMHC Revenue</b> (all programs)                |                        |                          |
| <b>River Forest as % of Total</b>                  |                        |                          |

**UNITED WAY FUNDED:** \_\_\_\_\_

**FEIN NUMBER (or equivalent):** \_\_\_\_\_

**IV. Agency Authorization Signature** \_\_\_\_\_

**Title** \_\_\_\_\_ **Date Sent to Funder** \_\_\_\_\_

**V. Required Attachments - Please provide in the following order.****A. Finances**

- \_\_\_\_\_ Audited financial statements for the last fiscal year, if available, or Form 990.  
If neither document is available at the time of this application, include un-audited financial statement.
- \_\_\_\_\_ Current year agency total operating budget to include both projected expenses and revenues.  
Categorize expenses under program, general and administrative, and fundraising.
- \_\_\_\_\_ A list of foundations, corporations, or governmental agencies which funded the Organization in the last fiscal year, including amounts contributed (\$1,000 and above).
- \_\_\_\_\_ Itemized breakdown of use of requested funds for each program.

**B. Other Supporting Materials**

- \_\_\_\_\_ Mission Statement
- \_\_\_\_\_ Verification of the organization's tax-exempt status under Section 501 (c) 3 of the IRS Code. If using a fiscal agent, please include a Letter of Authorization. *(If requested by the Mental Health Authority).*
- \_\_\_\_\_ Current annual report or a summary of the organization's prior year's activities.
- \_\_\_\_\_ Current board list with related employment affiliation (see example form).
- \_\_\_\_\_ Qualifications of professional program staff (see example form).
- \_\_\_\_\_ If the project for which funding is sought is a collaboration with other agencies, include
- \_\_\_\_\_ Letters of agreement from the collaborating agencies.
- \_\_\_\_\_ Organizational Chart.
- \_\_\_\_\_ Insurance Coverage w/ indemnity clause of the Mental Health Authorities.
- \_\_\_\_\_ Non-discrimination and Conflict of Interest Statements.
- \_\_\_\_\_ Job Descriptions *(If requested by the Mental Health Authority).*

**C. Please check if the following documents or information is available on request by the Mental Health Authorities.**

- \_\_\_\_\_ Billing System (collecting of 3rd party payment, fee schedule, etc).
- \_\_\_\_\_ Evidence that facility is accessible to handicapped.
- \_\_\_\_\_ Board of Directors Meeting Minutes.
- \_\_\_\_\_ Personnel Policies
- \_\_\_\_\_ Strategic/Service Plan
- \_\_\_\_\_ QA & Client Surveys/Reports

**Note:** Additional information not listed may be requested in order to assist the mental health authorities with their funding decisions and monitoring responsibilities.

Funding is requested for: \_\_\_\_\_ River Forest Township Mental Health Committee (RFMHC)

Agency Name: \_\_\_\_\_

Program Name: \_\_\_\_\_

Type of program: (check all that apply):

- Mental Health     Developmental Disabilities     Substance Abuse
- Treatment     Prevention     Improved Community Functioning     Recovery
- Resilience     Education     Workforce Development     Supportive Services
- Social/Recreational     Employment/Vocational
- In-home/Natural Environment Support

| I. SERVICE STATISTICS                        |               | Last Compl'd FY '16 | Current FY '17 | Projected FY '18 |
|--|---------------|---------------------|----------------|------------------|
| AVERAGE # NUMBER OF CLIENTS SERVED PER MONTH | River Forest  |                     |                |                  |
|  | All Others    |                     |                |                  |
|  | PROGRAM TOTAL |                     |                |                  |

Check One: Client Hours  Other (specify) \_\_\_\_\_

| AVERAGE # OF UNITS OF SERVICE PER MONTH |               |  |  |  |
|---|---------------|--|--|--|
|   | River Forest  |  |  |  |
|   | All Others    |  |  |  |
|   | PROGRAM TOTAL |  |  |  |

| C. AVG. # OF CONTACTS PER CLIENT/ PER MO | PROGRAM TOTAL |  |  |  |
|--|---------------|--|--|--|
|  |               |  |  |  |

| D. COST PER UNIT       |  |  |  |
|------------------------|--|--|--|
| Total Cost Per Unit    |  |  |  |
|                        |  |  |  |
| RFMHC Subsidy Per Unit |  |  |  |

| II. PROGRAM OPERATING BUDGET                         | Last Completed FY 2016 | Current FY 2017 | Projected Next FY 2018 |
|--|------------------------|-----------------|------------------------|
| <b>A. PERSONNEL EXPENSES:</b>                        |                        |                 |                        |
| Administrative & Support<br>Staff Salaries & Fringes |                        |                 |                        |
| Direct Service<br>Staff Salaries & Fringes           |                        |                 |                        |
| <b>B. TTL CONTRACTUAL SERVICE</b>                    | \$                     | \$              | \$                     |
| <b>C. TOTAL OTHER EXPENSES</b>                       | \$                     | \$              | \$                     |
| <b>GRAND TOTAL (A-C)<br/>PRGRM OPERATING BUDGET</b>  | \$                     | \$              | \$                     |

| III. SOURCES OF INCOME                        |    |    |    |
|---|----|----|----|
| a1. United Way/Community Chest                |    |    |    |
| a2. Contributions/from Individuals            |    |    |    |
| a3. Foundation(s)                             |    |    |    |
| a4. Other (specify)                           |    |    |    |
| <b>A. TTL FUNDRAISING SUPPORT<br/>(a1-a4)</b> | \$ | \$ | \$ |
| b1. Patient Fees                              |    |    |    |
| b2. Private Insurance                         |    |    |    |
| b3. Medicaid                                  |    |    |    |
| b4. Medicare                                  |    |    |    |
| b5. Other (specify)                           |    |    |    |
| <b>B. TTL FEES/CONTRACTS (b1 - b5)</b>        | \$ | \$ | \$ |
| c1. CMHB of OP                                |    |    |    |
| c2. RF MHC                                    |    |    |    |
| C3. Other Tax Funds (specify)                 |    |    |    |
| <b>C. TTL LOCAL FUNDS (c1 – c3)</b>           | \$ | \$ | \$ |
| <b>D. TTL FEDERAL FUNDS</b>                   | \$ | \$ | \$ |
| <b>E. TTL NON-DHS/STATE FUNDS</b>             | \$ | \$ | \$ |
| <b>F. TTL OMH/ORS/OASA/HFS FUNDS</b>          | \$ | \$ | \$ |
| <b>GRAND TTL (A-F)<br/>SOURCES OF INCOME</b>  | \$ | \$ | \$ |

**Note:** If you receive other private and/or public funds for this program please detail source, amount and if funding is pending or received for your current fiscal year. Use the form on the next page.



**IV. DETAILED PROGRAM DESCRIPTION AND RATIONALE**

**A) Describe the program.**

**1) Program mission statement:**

**2) Summarize the purpose of your request and the services/activities to be supported. (5 sentences or fewer)**

**3) What do you expect to change as a result of these services/activities and what results do you expect to see? (Program goals)**

**4) Are these services/activities modeled after best practices in the field or based on successes your agency has had in the past?**

**5) List each specific type of activity or service you are requesting to purchase with this funding request. (Definition of unit of service, unit rate, eligibility parameters, and documentation requirements will be further specifics in the funding parameters.)**

**6) Intended duration & intensity of services:**

**7) Specify the hours/days/month of operation of the program:**

**8) Where are services provided:**

**C) Identify and describe the proposed target population of the program. (List basic demographics)**

**1) Geographic service area:**

- Oak Park**
- River Forest**
- City of Chicago**
- County** (specify)
- Suburbs** (specify)
- Regional/national**
- Northwest Indiana**
- Other** (specify)

**4) Program Exclusions (if any):**

**V. WAITING LIST RATIONALE** (required only for programs which maintain a waiting list).

**A) Reason for the waiting list (be specific):**

**B) How long are clients on the waiting list:**

**C) How many clients are on the waiting list:**

**Oak Park** \_\_\_\_\_

**River Forest** \_\_\_\_\_

**Other** \_\_\_\_\_

**TOTAL** \_\_\_\_\_



D) What is being done to eliminate the waiting list?

**NEW OR REVISED PROGRAMS ONLY:**

- 1) Describe your agency's qualifications for delivery of the services as described in IV-A:
  
- 2) Document community need and/or special target population demand as identified through media, reports, surveys, current utilization, etc.:
  
- 3) Identify any existing or related services as well as alternatives to the program which you considered. Present a rationale as to why the program is the best among these alternatives.
  
- 4) List the new program start up timetable:

**BLANK SHEET**

AGENCY NAME: \_\_\_\_\_

| <p>(a)<br/>POSITION TITLE<br/>&amp;<br/>CREDENTIALS/DEGREE</p> <p>%Time Alloc'd to Program</p> | <p>(b)<br/>ANNUAL<br/>SALARY</p> | <p>(c)<br/>HOURS/MONTH</p> <p>Administrative/Direct<br/>Service</p> |
|--|----------------------------------|---|
| 1)   |                                  |   |
| 2)   |                                  |   |
| 3)   |                                  |   |
| 4)   |                                  |   |
| 5)   |                                  |   |
| 6)   |                                  |   |
| 7)   |                                  |   |
| 8)   |                                  |   |
| 9)   |                                  |   |
| 10)  |                                  |   |
| 11)  |                                  |   |
| 12)  |                                  |   |
| 13)  |                                  |   |
| 14)  |                                  |   |
| 15)  |                                  |   |
| 16)  |                                  |   |
| 17)  |                                  |   |
| <p><b>TOTAL FULL TIME EQUIVALENT EMPLOYEES:</b></p>  |                                  |   |

## BOARD OF DIRECTORS (COMPLETE OR ATTACH A LIST)

**AGENCY NAME** \_\_\_\_\_ **DATE OF BOARD ELECTION** \_\_\_\_\_

|   |  |   |  |
|---|--|---|--|
| <b>President of Board:</b><br><b>Vice President:</b><br><b>Other:</b> |  | <b>Secretary:</b><br><b>Treasurer:</b><br><b>Other:</b> |  |
|---|--|---|--|

**TOTAL BOARD MEMBERS AUTHORIZED BY BYLAWS:** \_\_\_\_\_

| NAME (include persons above) | Home Address (Street/City) | Occupation and Employment | Term Expires (MO/YR) |
|------------------------------|----------------------------|---------------------------|----------------------|
| 1)                           |                            |                           |                      |
| 2)                           |                            |                           |                      |
| 3)                           |                            |                           |                      |
| 4)                           |                            |                           |                      |
| 5)                           |                            |                           |                      |
| 6)                           |                            |                           |                      |
| 7)                           |                            |                           |                      |
| 8)                           |                            |                           |                      |
| 9)                           |                            |                           |                      |
| 10)                          |                            |                           |                      |
| 11)                          |                            |                           |                      |
| 12)                          |                            |                           |                      |
| 13)                          |                            |                           |                      |
| 14)                          |                            |                           |                      |
| 15)                          |                            |                           |                      |