River Forest Township Mental Health Committee

APPLICATION FOR FUNDING OVERVIEW

River Forest Township Mental Health Committee will be using this application for the FY 2019 funding process for new agencies and/or new 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 15, 2017 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

COVER & AUTHORIZATION

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, 2018 to June 30, 2019) 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.

III. Agency Revenues	**Current FY 2018**	**Projected FY 2019**
Total Agency Revenue (all programs/sources)		
RFMHC Revenue (all programs)		
River Forest as % of Total		

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 2017**	**Current FY 2018**	**Projected Next FY 2019**
A. PERSONNEL EXPENSES: **Administrative & Support** Staff Salaries & Fringes			
Direct Service Staff Salaries & Fringes			
B. TTL CONTRACTUAL SERVICE	**$**	**$**	**$**
C. TOTAL OTHER EXPENSES	**$**	**$**	**$**
GRAND TOTAL (A-C) **PRGRM OPERATING BUDGET**	**$**	**$**	**$**

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

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.

FUNDING SOURCE	AMOUNT	PENDING / RECEIVED

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: _____

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

BOARD OF DIRECTORS (COMPLETE OR ATTACH A LIST)

AGENCY NAME_____ **DATE OF BOARD ELECTION** _____

President of Board: **Vice President:** **Other:**		**Secretary:** **Treasurer:** **Other:**	

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)			