

**Mental Health Services Award**

**2021-2022**

**Application Form**

**Award Description**The Mental Health Improvement Award is available to critical access hospitals in Illinois. The intent of this award is to provide funding to assist CAHs to initiate and/or expand local mental health services within their communities. Funds can be used to develop of expand the use of local behavioral health services and/or creation or expansion of coalitions with established mental health providers. Due to the nature of the funding for this project, only critical access hospitals can apply.

**Award Project Suggestions:**

Creation of a community based program to address a specific mental health need

Creation of a Mental Health advocacy program

Community outreach program to improve the mental health of a specific age population

Increase mental health screenings and establish best practice referral protocols

Collaborative effort with Community Resources to increase access to Behavioral Health Care

**Project Period: September 1, 2021–June 30, 2022**

**Amount: $8,000 maximum for each recipient. There are approximately 6 awards available.**

**Application Deadline: End of business on Friday, November 12th, 2021**

**Contact:**

**Laura S. Fischer, Flex Grant Project Manager**

 **Illinois Critical Access Hospital Network**

**Lfischer@icahn.org**



**Mental Health Services Award**

**2021-2022**

**Application Form**

*Due back to the Illinois Critical Access Hospital Network by November 12th, 2021*

|  |  |
| --- | --- |
| ***Hospital Name*** | ***Date*** |
| ***Address*** | ***Contact Person*** |
| ***Phone Number*** | ***Email Address*** |
| ***FEIN (Federal Employee Identification Number)*** | ***IDHR # (Illinois Department of Human Rights)*** |

*\*Blank fields may result in application being considered non-responsive.*

***Hospital Ownership (please mark one):***

[ ] For Profit; [ ] Not for Profit; [ ] Government

 **Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Application Instructions**

All application fields/sections must be completed. Applications with blank fields/sections will be considered non-responsive and will not be considered for award. Applicants must be in compliance with all previous awards in order to be eligible. Only one application per hospital per category will be accepted.

Please send completed application to Laura Fischer lfischer@icahn.org. Applications are to be submitted as a Word document or PDF. **Handwritten applications are not accepted**. Fields may be expanded to suit the space requirements of the response; however, all fields must be included, i.e., do not delete any fields or fail to respond to information sought in each field

**PROGRAM NARRATIVE**

|  |
| --- |
| Please respond to each question. Question fields left blank will result in application being considered non-responsive. Each question area should be expanded so sufficient detail can be provided.  |

**What do you plan to use the funds for? Please check one (1) or more areas this award program or project will address:**

 [ ]  Creation of a program to address a specific mental health need

[ ]  Collaborative effort with Community Based Mental Health Providers to increase engagement

[ ]  Collaborative effort with Community Resources to increase access to Behavioral Health Care

[ ]  Creation of a Mental Health advocacy program

[ ]  Community outreach program to improve the mental health of a specific age population

[ ]  Increase mental health screenings and establish best practice referral protocols

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Describe the proposed program/project. Describe how this project will initiate and/or expand local mental health services, develop new providers, new collaborations, or new approaches to providing behavioral health services in the service area.**
2. **Describe the need for this project and how it relates to the overall goal of improving mental health services in the service area. Use data to support the need for this project.**
3. **Describe your hospital’s current efforts in the identified program/project and any challenges or successes the hospital has had in its efforts.**
4. **If the project involves the local community, detail local involvement, evidence of community support and any costs to the community.**
5. **If this award is to support an ongoing project, please detail the plans for sustaining the service beyond the scope of the project award.**
6. Project Goals—Creation of **SMART** Goals

 **List 2 goals for your project. Be as SPECIFIC as possible.**

 **How will you MEASURE if each of the goals listed above is achieved? What are the metrics and milestones that need to be met for this project to be a success?**

 **What other resources will you need to ACHIEVE your goals and for this project to be a success? These may include such things as: additional funding support from the hospital, or if outside expert consultants are needed—describe their qualifications and experience.**

 **If key hospital personnel will be needed to manage the project and ACHIEVE your goals—describe their qualifications, experience, and the amount of time they will be able to dedicate to the project.**

 **How are the proposed project goals RELEVANT to strengthening the mental/behavioral health services or the creation of mental health coalitions in the service area?**

 **Detail the major steps in your work plan. What is needed for project completion and the projected TIMELINE for the proposed project. (Included major steps from planning to implementation to final measurement)**

|  |
| --- |
| **2021-2022 Proposed Award Budget—$8,000** |
| **Category** | **Award Funds** | **Hospital/Community Matching Funds** | **Total Funds** |
| Consultant’s Fees |  |  |  |
| Contracted Services  |   |   |   |
| Communications/Marketing |   |   |   |
| Education/Training |   |   |   |
| Equipment/Supplies |   |   |   |
| Hardware/Software |   |   |   |
| Employee Salaries |  |  |  |
| **Total** |  |  |  |

**Budget Narrative** Provide detail of the amounts listed in budget section above**.** You may include additional materials to further support this Award Application. If documentation is not provided to explain expenses listed in each category your application will not be eligible for an award. Only include allowable expenses as identified in the state cost principles as part of uniform guidance (No direct patient care, purchase of vehicles, purchase food or use of funds to purchase or improve real property).

Consultant’s Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software

Employee Salaries

**Review Criteria—Application Hints**

This Award Application will be reviewed by outside award reviewers and assigned awarding scores based on the following criteria:

1. Was all hospital information completed (including Federal Employee Identification Number, Illinois Department of Human Rights Number, and Hospital Ownership)?

2. How well did the applicant explain the problem/issue and how they were planning on addressing it?

3. Is the program/project clearly described?

4. Is information provided which supports the idea that the program/project will meet the identified outcomes?

5. Is the method of evaluating the effectiveness of the program/project reasonable?

6. Does the applicant provide enough budgetary detail to assess the likely success of the program/project?

7. Is the budget reasonable for this type of program/project?

8. Is there an indication that this program/project will continue in the future?

9. Does the program/project make sense? Is it valuable to the community? Does it improve the hospital? Is there community involvement?