

Knox County Mental Health Board (KCMHB)

Application for Funding

FY 2018-2019

APPLICATION PROCESS

- Applications available online and at the Knox County clerk's office after **February 14, 2018**.
- By **April 1, 2018**, submit a completed & signed original application, plus seven (7) copies to:
Knox County Mental Health Board
Attn: Knox County Clerk, Scott Erickson
200 South Cherry Street
Galesburg, IL 61401
- The KCMHB will review applications and announce its decisions no later than its June meeting.
- Applicants may or may not be asked to make oral presentations.
- Questions may be sent to:
- In completing this application please refer to and use the KCMHB Guidelines for Funding and the KCMHB Funding Categories
- If applying for funding for multiple programs, please complete **Sections 3, 4, 5 and 6** for each program.
- If applying for Special Funding or Contingency Funding outside of the application period set forth above please complete a new application.
- KCMHB may not grant all funding requests and in any year may not expend all available funds.
- **Upon application additional funding may** be available during the year.

1. CONTACT INFORMATION

Name of Applicant:	
Applicant Mailing Address:	
Phone:	
Contact Person:	
Contact's Phone Number / Extension:	
Email Address:	
Date of Application:	

2. DESCRIPTION OF ORGANIZATION

a. Purpose of organization.

b. Briefly describe all services provided by your organization, identifying individual programs and their relationship to each other and the objectives of the organization. (If you are a subsidiary of a “parent organization”, give the name of the “parent organization” and the relationship of your subsidiary in the total picture of the “parent organization’s” services.).

c. Is your organization licensed or registered in the State of Illinois?

d. Geographic area served.

e. Is your agency accredited? If yes, by which accrediting body (ex: Joint Commission, CARF, COA)?

f. Board members (include names and contact information, please identify officers by title.).

g. Management staff.

Name	Contact information
CEO	
CFO	
COO	
Local director	

h. List the title and required qualifications for persons managing and/or supervising the services provided by the funded program.

Title	Professional Qualifications (Degrees, licensure, certification, etc.)

i. Do you have oral or written collaborative agreements with any other organizations regarding the program for which you are requesting funding? If yes, please attach all written agreements. Do you have any oral working agreements? If so, please provide a written description.

3. REQUESTED FUNDS

If requesting funds for more than one program, copy and complete Section 3 for each.

a. Please indicate which categories of funding will be supported through your organization's use of KCMHB funds (**Use the KCMHB General Funding/Special Funding** categories). **Note:** Part f. Unduplicated and Duplicated Service Populations may not apply for some Special Funding categories. In such circumstances, applicants should complete section e., in detail, and include comments regarding the impact and benefit the Special Category Funds would provide for the population served by the applying Organization. Part f. may remain blank with reference to Part e.

General Funding Category:

Special Funding Category:

b. Amount of KCMHB funding requested for this program. Please include funding requested for equipment, materials, supplies, etc.

c. Will you accept partial funding?

d. Need for Service. Describe the need for the program relative to the seriousness of the problem for Knox County residents. Need may be substantiated by: needs surveys; requests for service; changes in the service delivery system; utilization of service by individuals, agencies, referrals, and/or waiting lists.

e. Identify program objectives.

g. Describe in **detail** the program for which your organization requests funds. If the request is for a Special Funding Category, the explanation should specifically describe the reasons Special Funding is required. For both General Funding and Special Funding please answer the basic questions in separate bulleted paragraphs: what; when; where; how; who

h. In addition to your detailed Program Description, please provide answers to the following:

1. Does your program charge a fee? If yes, please indicate how the fee is determined and the dollar amount charged. Please attach a sliding fee schedule if applicable.

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2. Describe the follow-up services, if any, which will be required. If, intra or inter-agency referral will be necessary, please describe.

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3. What is the capacity of the program? How many persons will be served annually?

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4. What days and hours will the program operate?

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5. Number of years the program has been in existence.

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i. Do you anticipate a need for this program for more than one year? If yes, what are your three-year goals and objectives for this program?

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4. BUDGET DATA

Funds Requested	
4a. Total amount of request from KCMHB.	
Total program budget (program for which funds are requested) for year of funding request.	
Organization budget for funding year in Knox County.	
Give total “ parent organization ” budget for funding year in Knox County:	

General Budget Information
4b. Organization Fiscal Year (ex: July- June, October – September, Calendar Year)
List of other sources of funding for this program.

Has the organization had an independent financial audit for the most recent completed fiscal year? If so, please submit a copy of the auditor's Letter of Governance and Internal Control Letter. The KCMHB reserves the right to request and receive a complete copy of the most recent audit prior to or during any funding period.

Please attach a completed budget on the KCMHB on line provided form.

5. FUNDRAISING

Describe efforts and results of fund-raising your organization has done during this past year.

Identify plans for fundraising in the next fiscal year.

6. PROGRAM EVALUATION

Describe the evaluation methods used by your organization to assess the effectiveness of the service(s) offered in your program.

For Providers

By signing this application, I certify to the statements contained in the list of certifications, and that the statements herein are true, complete and accurate to the best of my knowledge. I have provided the required documentation and agree to adhere to the services as presented in the application, and I will comply with any resulting terms when an award is accepted. I am aware that any false, fictitious or fraudulent statements of claims may subject me to criminal, civil or administrative penalties. I understand that the funding disbursement is contingent on the availability of tax revenues collected by Knox County.

This application has been reviewed and approved by:

Signature of Provider Authority:	
Date:	
Printed Name and Title of Provider Authority:	

For Knox County Community Mental Health Board Use Only:

Funding for provider: Full Funding Approved Partial Funding Approved Not Funded

Total amount of funding approved: \$ _____

Comments:

Approved on ____/____/2017:

Greg Bacon, President: _____

Steve Watts, Secretary; Dick Conklin, County Board Member; Carol Maloney, Board Member; Tasha Easley, Board Member John Schlaf, Board Member; Luke Raymond, Board Member.