Knox County Mental Health Board (KCMHB)
Application for Funding
FY 2019-2020

APPLICATION PROCESS

Effective 03-12-19

- Applications available online and at the Knox County clerk's office after February 25, 2019.

- By April 8, 2019, 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

- Please refer to the KCMHB **Guidelines for Funding** and the KCMHB **Funding Categories** when completing this application.

- The KCMHB will review applications and announce funding awards no later than the Board's June meeting.

- Applicants may or may not be asked to make oral presentations.

- 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 an entire new/different application.

- KCMHB may not grant all funding requests and may not expend all available funds in any year.

- Additional funding may become available during the year.

- Questions may be sent to: knoxcountymentalhealthboard@co.knox.il.us

2019 Board Members

Greg Bacon, President, term ends: 12-31-2019
Steve Watts, Secretary, term ends: 12-31-2022

Kyle Rohweder, County Board Member, term ends: 12-31-2020
Tasha Easley, Board Member, term ends: 12-31-2020

Carol Maloney, Board Member, term ends: 12-31-2020
Luke Raymond, Board Member, term ends: 12-31-2019
John Schlaf, Board Member, term ends: 12-31-2022

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I. CONTACT INFORMATION

Date of Application:
Name of Applying Organization:
Applying Organization Mailing Address:
Office Telephone:

Organization's Authorizing Representative:
Authorizing Representative's Telephone Number/Extension:
Email Address:

Person Completing the Application:
Author's Telephone Number/Extension:
Email Address:

II. DESCRIPTION OF ORGANIZATION

A. STATEMENT OF PURPOSE:

In a brief statement, describe the general purpose of the applying organization in an introductory statement below:

Statement:

B. SERVICES PROVIDED:

In a detailed narrative below, describe the general services provided by the applying organization. Identify individual programs, their relationship to each other and the objectives of the organization.

If the applying organization is a subsidiary of a "parent organization", provide the name of that organization and the relationship between the two as it relates to the "parent organization's" service objectives.

Narrative:

C. LICENSING:

Is the applying organization licensed or registered in the State of Illinois.

Response:

D. GEOGRAPHIC AREA SERVED:

Response:

E. ACCREDITATION:

Is the applying organization accredited and, if so, by which accrediting body (examples include but are not limited to: Joint Commission, CARF, COA).

Response:

F. BOARD MEMBERS:

Please include names and contact information.

(**NOTE:** Applicant may expand/reduce positions as necessary.)

Title:
Contact Information:

Title:
Contact Information:

Title:

Contact Information:

Title:
Contact Information:

G. SENIOR MANAGEMENT STAFF:

Please include names and contact information.

(**NOTE:** Applicant may expand/reduce positions as necessary.)

Chief Executive Officer (CEO):
Contact Information:

Chief Financial Officer (CFO):
Contact Information:

Chief Operational Officer (COO):
Contact Information:

Local Director:
Contact Information:

H. POSITION QUALIFICATIONS:

List the title and required qualifications for the positions responsible for managing and/or supervising the services provided by the program for which funds have been requested.

(**NOTE:** Applicant may expand/reduce positions as necessary.)

Title:
Qualifications:

Title:
Qualifications:

Title:
Qualifications:

Title:
Qualifications:

I. AGREEMENTS:

Does an oral or written collaborative agreement with any other organization(s) exist regarding the program for which funding has been requested. If such agreements exist, please attach copies (See Section J. below) of the written agreement(s). Oral agreements should be described below:

Response:

J. ATTACHMENT(S) REQUESTED:

Attach a copy/copies of any such written agreement(s) described (See Section I.) above:

III. SPECIFY THE FUNDING CATEGORY

A. FUNDING CATEGORY:

Select only one of the two options below to briefly explain which Funding Category (General Funding or Special Funding) will be selected for the organization's use of KCMHB Funds. The response should also identify which specific sub-category or categories will be impacted by the proposed program (For example: within the General Funding Category, the organization may plan to address Comprehensive Screening and Assessment programs. Within the Special Funding Category, the organization may plan to address Staff Development).

Response for the General Funding Category:

Response for Special Funding Category:

B. NEED FOR THE PROGRAM:

In a detailed narrative below, describe the need for the proposed program relative to the seriousness of the problem for Knox County residents who would be served by the program. The need may be substantiated by: needs surveys; requests for service; changes in the service delivery system(s); current utilization of the service(s) by individuals, agencies, referrals, waiting lists and any other data or facts identified by the applicant.

Narrative:

C. SERVICE POPULATION:

In the columns below, verify the number of Unduplicated and Duplicated individuals served by the applying organization:

(**NOTE:** Applicant should remove the "XX" place holders below and replace with relevant numbers.)

(**NOTE:** The unduplicated counts should answer the question: "How many individuals have been served by the organization during a specific reporting period?")

Unduplicated Persons Served	Prev. Year (Actual)	Current Year (Est.)	Next Year (Est.)
Males	XX	XX	XX
Females	XX	XX	XX
Total Persons Served:	XX	XX	XX

Unduplicated Persons Served	Prev. Year (Actual)	Current Year (Est.)	Next Year (Est.)
All persons aged: 0-17 years:	XX	XX	XX
All persons aged: 18-64 years:	XX	XX	XX
All persons aged: 65 and over:	XX	XX	XX

(**NOTE:** The duplicated counts should answer the question: "How many services did individuals receive from the organization during a specific reporting period?")

Duplicated Services	Prev. Year (Actual)	Current Year (Est.)	Next Year (Est.)
Persons with Mental Health Needs:	XX	XX	XX
Persons with Developmental Disability Needs	XX	XX	XX
Persons with Substance Use Disorder Needs:	XX	XX	XX

Total Duplicated Services Provided to persons:	XX	XX	XX

D. PROGRAM DESCRIPTION:

In a detailed narrative below, clearly describe the program for which the organization has requested funds from the KCMHB.

(**NOTE:** The applicant should ensure that the detailed narrative has included the Key Points of: What, When, Where, How and Who, as it relates to the program for which funds have been requested, and should strive to answer: the program's Goals and Objectives, the existence of a fee structure, the amount of any such fees and the manner the fee structure has been determined, the need for follow-up services and/or referrals, the capacity of the program and the estimated number of persons served annually, the hour and days of operation, the number of years the program has been in existence.)

Narrative:

E. LONGEVITY:

In the response below, please state if it is anticipated that the need for the program will exceed one year. In the event that it is anticipated that the program will exist for more than one year, the response should include the three-year Goals for the program.

Response:

IV. BUDGET INFORMATION:

A. FUNDS REQUESTED:

(**NOTE:** Applicant should remove the "XX" place holders below and replace with relevant numbers.)

Total Amount Requested from the KCMHB:	$XXXX.00

B. BUDGET DETAILS:

Respond to the question(s) below regarding regarding Budget Details:

The applicable "Parent Organization" Annual Budget for Knox County:	$XXXX.00
The Annual Budget for the applying Organization:	$XXXX.00
The Total Budget for the program for which funds have been requested:	$XXXX.00

The organization's fiscal year as well as any additional sources of funding:

Response:

C. PARTIAL FUNDING:

In the response below, please state if the organization will accept partial funding for the program outlined:

Response:

D. PREVIOUS FUNDING:

In the response below, please confirm if the organization has previously applied for funds from the KCMHB. In the event that previous funding has been requested and subsequently approved, please confirm if the requested funds were expended as proposed in the original application or if a Change Order was submitted. In the event that a Change Order was submitted also briefly explain the reason(s) for the Change Order.

Response:

E. ATTACHMENT(S) REQUESTED:

Attach a copy of the Program Budget for the Funds Requested. The budget should include all expenses anticipated to operate the program, including but not limited to personnel, office expenses, materials, equipment and miscellaneous supplies.

V. FUND RAISING:

A. PAST FUND RAISING EFFORTS:

In the response below, describe the Fund Raising efforts which have taken place during the previous year:

Response:

B. FUTURE FUND RAISING EFFORTS:

In the response below, describe the Fund Raising efforts which are anticipated for the next year:

Response:

VI. PROGRAM VERIFICATION:

A. EVALUATION:

In the response below, describe the internal evaluation methods used by the organization to measure the impact of the program for which funding has been requested as well as a general overview of the other program(s) which may be presented by the organization:

(**NOTE:** The applicant should ensure that the response includes some reference to the organization's willingness to submit reports regarding the status of any funds which may be awarded and the progress of any funded program within a time frame (quarterly, semi-annually, annually) or as otherwise specified by the KCMHB.)

Response:

B. VERIFICATION:

In the response below, the Organization's Authorizing Representative has certified the application submitted to the KCMHB as follows:

By signing this application, I certify the statement 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 of Provider Authority: _____