**REQUEST FOR RENEWAL OF FUNDING PROPOSAL--FY 2017**

**January 1, 2017—December 31, 2017**

**Lincoln County Resource Board**

**For assistance with this application or for further information, please contact:**

**Cheri Winchester, Executive Director**

[**director@lincolncountykids.org**](mailto:director@lincolncountykids.org)

**Phone: 636-528-2490**

**RENEWAL APPLICATION DEADLINE IS FRIDAY, AUGUST 26, 2016 AT 2:00 P.M. Renewal applications should be mailed or delivered to Lincoln County Resource Board, 101 West College, Suite 1B, Troy, MO (Delivery Site Phone Number: 636-528-2490).** . Please submit **eight (8**)copies of this application **and email one copy** to [director@lincolncountykids.org](mailto:director@lincolncountykids.org).

**TYPE OF SERVICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| |  |  |  |  | | --- | --- | --- | --- | | **AREAS OF SERVICE** | | | | |  | Temporary Shelter Services |  | Crisis Intervention Services | |  | Respite Care Services |  | School-based Prevention Services | |  | Services to Unwed Mothers & Teen Parents |  | Transitional Living Programs | |  | Outpatient Substance Abuse Treatment Services |  | Home & Community-Based Intervention Services | |  | Outpatient Psychiatric Services |  | Individual, Group & Family Counseling Services | |
|  |

The Lincoln County Resource Board will accept **renewal** applications for agencies seeking one of the following categories. Please check the appropriate category.

1. 🞎 Request for funding with changes only with project budget or cost summary.

Provide a brief narrative of these changes and your rationale of why LCRB

should fund the requested increase in Part V.

1. 🞎 Request for funding with changes noted in program methodology, outcomes, verifications of targets, and/or cost summary/project budget. Provide a brief narrative of these changes and your rationale of why LCRB should fund the requested increase in Part II, Item 4 and Part V.

|  |  |
| --- | --- |
| **AGENCY PROFILE** | |
| Agency Name: |  |
| Agency Address: Street |  |
| City, State, ZIP CODE |  |
| Agency Phone Number: |  |
| Agency Fax Number: |  |
| Agency Web Site: |  |
| Primary Contact: Name |  |
| Primary Contact: Title |  |
| Email Address: |  |
| Contact Phone Number & Ext. |  |
| Contact Cell Phone Number: |  |
| Additional Contact Numbers: |  |

*Please note the list of documents that need to be submitted annually. If changes have been made to any of the other permanent documents, please forward that information to the LCRB office at 101 West College Street, Suite 1B, Troy, MO 63379.* ***Only one (1) copy of the supplemental information is required per application.***

|  |  |  |
| --- | --- | --- |
| **Permanent Documents** | **Document Date (currently on file)** | **Revision Being Sent (write date of revision)** |
|
| Agency By-Laws |  |  |
| Statement of Confidentiality |  |  |
| Policy on Non-Discrimination in Hiring Practices |  |  |
| Policy Statement for Screening of Staff for Past Child Abuse & Neglect |  |  |
| Agency Accreditations |  |  |
| Strategic Plan |  |  |
| **Permanent Documents to Submit Annually** |  | **Revision Being Sent (write date of revision)** |
| Copy of Most Recent 990 tax return |  |  |
| Board of Directors Roster |  |  |
| Certificate of Corporate Good Standing |  |  |
| Most recent Agency Independent Audit |  |  |
| Agency Assurance See Appendix A |  |  |
| Board of Directors Resolution See Appendix B |  |  |

**EXECUTIVE SUMMARY (complete this last)**

Agency Name:

Program Type:

Program Name:

Amount Requested for 2017: $

Number of Youth to be Served in 2017 (estimate):

Unit Cost Requested for 2017: $ # of Units Requested for 2017:

Amount Received for this Program in 2016: $

Number of Youth you Project to Serve in 2016 (projections for 2016 using mid-year actuals):

Unit Cost Requested for 2016: $ # of Units Requested for 2016:

Provide Brief Program Synopsis (Limit to 175 words):

LCRB Executive Director’s Notes (leave blank):

**PROGRAM NARRATIVE**

Provide a succinct narrative for each question in this grant application. If you feel the need to repeat content in multiple sections, please note “see response in Part X, item 1.”

**PART I: DEMONSTRATION OF HUMAN NEED**

1. Describe the target population (with projected age ranges) to be served. If your target population or the problem/unmet need within the community has or is significantly changing, then cite **local** statistical data and relevant **community** information to explain this change.

**PART II: PROGRAM METHODOLOGY & DELIVERY**

1. Describe in detail how program activities will be delivered and/or the flow of services your agency will provide to the target population. For example, if a board member were to shadow the provider on a “typical” day, what would the board member see, experience, etc. Explain how a client typically experiences the program and/or receives services. Prepare a diagram showing the flow of services/program deliverables (See example).
2. Is your program using an evidence-based practice(s)? If yes, name the best practice(s). Demonstrate how this practice is effective with serving Lincoln County youth. Describe the therapeutic methods or curricula that will be used in providing these services. Explain how often you update your therapeutic methods and/or curricula; and the circumstances that prompt your agency to make therapeutic or curricula changes.
3. List the external agencies you collaborate with to better serve your families/clients.
4. Is there anyone currently on your waitlist? Yes No
   1. If yes, how many are currently on your waitlist?
   2. What is a client’s average length of stay on the waitlist?
   3. What (if any) support services do waitlist clients receive?
5. Is your program methodology changing for 2017? Yes No

If no, skip to the next section. If yes, please describe any changes to the methods your program will use to serve the target population? Include the project timeline for instituting these changes, in addition to information on the hiring, training, and any development time needed before actual funded services will be provided.

**PART III: PROJECT OUTCOMES**

A minimum of three (3) clinical goals with anticipated outcomes that are measurable and time specific must be tied to your LCRB-funded program.

Provide copies of your evaluation tools that you will be using to verify client outcomes **if they are different from previous years, or if you have not previously submitted the tools to LCRB**.

1. Describe your program evaluation methodology for measuring/assessing each outcome.
2. Are the clinical outcomes for this program changing in 2017 (not outputs)? Yes No

If not, continue to the Pat IV. If yes, provide your revised list of clinical outcomes (noting or highlighting those that have changed), with a brief rationale for these changes.

Goal 1:

Outcomes:

Goal 2:

Outcomes:

Goal 3:

Outcomes:

**PART IV: PROJECT MANAGEMENT AND STAFF**

1. Who will be responsible for the overall management of the program and who will be the designated key project staff (use job titles and staff members’ names if available)? For each separate job title, please provide a brief narrative of the essential functions as it relates to the funded program request, and the necessary qualifications/experience level.
2. What is your staff turnover for the program in the last three years?
3. Indicate what potential threats, if any, to program continuity that may exist.

**PART V: BUDGET INFORMATION/OUTPUTS NARRATIVE**

1. Review **Appendix C:** **LCRB 2017 Funding Guidelines**, with instructions on how to complete the **Agency-Wide Financial Form, Salary Analysis Form and Project Budget Sheets.**
2. Provide a brief narrative of your project budget or cost summary changes, and your rationale for why LCRB should fund the requested increase.
3. Provide a breakdown of direct and indirect budgeted project expenses to be requested by LCRB, with the total project expenses. Review Appendix D: Direct and Indirect Budget Project Expense Justifications for clarification. Insert the total amount of your request per line item, and cost information and justification. Direct budget expenses are expenses directly related to serving the client and do not include indirect or administrative costs. Expenses within this category are provided below.

**Total Direct Budgeted Project Expenses = $**

Direct Clinical Staff Salaries - $

Immediate Supervisors’ Salaries - $

Staff Fringe Benefits – $

Rent for Direct Client Service Areas - $

Utilities for Direct Client Service Areas - $

Telephone/Cell phones/Internet - $

Consumable Supplies - $

Non-Consumables - $

Printing: $

Mileage: $

Client-Support Living Expenses: $

**Total Indirect Budgeted Project Expenses = $**

These are expenses related to the administrative and/or overhead costs associated with the LCRB-funded program. Expenses related to this section are listed below. Indirect expenses may not exceed 18%.

Administration Salaries:$

Administrative Fringe Benefits:$

Accounting and Fiscal Management: $

Rent and/or Utilities: $

Other Office Supplies/Printing/Postage: $

Staff Training: $

Professional Liability Insurance: $

Advertising: $

Accreditation Expenses: $

**Grant Total Funding Request: $**

1. Provide any additional information or comments relating to the Excel “Agency-Wide Financial Form, Salary Analysis Form and Project Budget Sheets”:

For assistance with this application or for further information, please contact:

Cheri Winchester, Executive Director

[director@lincolncountykids.org](mailto:director@lincolncountykids.org)

Phone: 636-528-2490

**Appendix A**

**Agency Assurance for 2017**

I, the undersigned, certify that the statements in this request for funding proposal application are true and complete to the best of my knowledge, and accept, as to any funds awarded, the obligations to comply with any of the conditions of the *Lincoln County Resource Board* conditions specified in the funding award and contract.

I, the undersigned, certify that in addition to the conditions mentioned above, will maintain accepted accounting procedures to provide for accurate and timely recording or receipt of funds, expenditures and of unexpended balances. I will establish controls, which are adequate to ensure that expenditures used to determine unit cost for allowable purposes, and that documentation will be readily available to verify their accuracy and validity.

Agency President/CEO Printed Name:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Agency Board Chair Printed Name:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

**Appendix B**

**Lincoln County Resource Board  
2017 Application for Funds  
Board of Directors Resolution**

At the Board meeting on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the Board of Directors of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_approved submitting this application form for the purposes of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Project Name Requested Amount

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Project Name Requested Amount

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Project Name Requested Amount

Note: Exact dollars requested are not required. Amounts requested should be submitted as not-to-exceed figures.

The authorized individual(s) to enter into contractual arrangements with the Lincoln County Resource Board is (are):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name Title

We, the undersigned, hereby certify that the statements made in this application are correct to the best of our knowledge and belief, and we are authorized to sign this application on behalf of the applicant, and we shall comply with the LCRB guidelines, monitoring procedures, and formal contract provisions if our request for funding is approved.

Respectfully submitted,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Print Name Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Board of Directors

Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date Phone

**Appendix C: LCRB 2017 Funding Guidelines:**

The board will refer to the following guidelines in making the 2017 funding decisions:

1. Indirect administrative costs will be capped at 18%.
2. Expenses such as rent, utilities, staff training and/or professional liability may only be included as indirect administrative costs. The only exception is programs that actually shelter children in a facility as part of direct care (face-to-face contact), then you may include rent and utilities for that space.
3. “Bundled” costs will not be accepted. Providers will be required to separate the different services offered within the program into appropriate unit costs. For instance, individual counseling services would have a different unit cost than case management services.
4. The Lincoln County Resource Board will look at salary efficiencies and the costs of doing business in regards to setting appropriate unit costs and in awarding 2017 funding.

**Agency-Wide Financial Form, Salary Analysis Form and Project Budget Sheets:**

The 2017 LCRB funding application has a three-part Excel financial section that includes:

1. An **Agency-Wide Financial** Excel form for your overall 2017 agency budget, your 2016 and 2015 actual audited financial information and the budget for the program service for which you are applying.
2. A **Salary Analysis** form on which to list all direct staff assigned to requested projects. Direct clinical supervisors may be included in the analysis. Allocate all salary dollars and billable hours to the specific units of service and identify the specific project number and unit number. The sum of the salary dollars for a project unit of service must match the specific total in the project budget. The Efficiency Standard Percentage by staff indicates percent of billable time vs. total time the staff is budgeted for the agency.
3. Following the Salary Analysis form, you will find a **unit of service project section** that must be completed. Each project budget sheet will support four different units of service calculations per project. All project totals are automatically carried forward to the Agency-Wide Data report to demonstrate the impact of LCRB dollars on your total agency.

**Please note:**

* Each unit of service awarded will require specific tracking and reporting throughout the contract period. We suggest expanding into separate units of service, only if it provides operational value or a significant cost difference.
* The unit of service cost requested on the form is the cost per unit. The total dollars requested for the entire project is filled in at the top of the project budget worksheet: “LCRB Requested Funds”.

For each project budget, select the appropriate service area and provide the required Information.

**UNDER MONTHS OF SERVICE, PLEASE CHECK “12 Months” unless your program specifically will run for less than the full contract period.**

Description of additional awards of income or reductions in income can be included in summary form in the budget justification section. Indicate whether funds are restricted or unrestricted. The blue fields designate input areas. Hover-over comments are embedded throughout the worksheets and appear as small red triangles in the corner of the description. Each comment further describes the information requested or the calculation used. Upon completion, a hard copy of the printout should be included with your application along with an electronic copy of this worksheet. Since an agency may be submitting for multiple projects, please re-name your completed worksheet with your agency name and project in the following format: 2017-Agency Name.xls

**Appendix D: Direct and Indirect Budget Project Expense Justifications**

**Direct Budgeted Project Expenses:**

Direct Clinical Staff Salaries: Include the total number of full-time equivalents (FTEs) that will provide direct service to children, youth and their families. Provide job titles, major responsibilities, and salaries. We are not looking for names of staff members. For example, Caseworker I, $40,000, provides individual and family therapy.

Immediate Supervisors’ Salaries: Include the salaries of immediate supervisors, which should be pro-rated based on the percentage of their time spent supervising their clinical staff. Specify what percentage you are using.

Staff Fringe Benefits: Include the cost of providing the following fringe benefits for the staff included as direct Clinical Staff and Immediate Supervisors’ prorated share: FICA, unemployment insurance, workmen’s compensation, health insurance and retirement.

Direct Client Service Areas: For areas in your facility where clients are served face-to-face, you may include a percentage of your rent or leasing cost, based on the percentage of total square footage.

Direct Client Service Area Utilities: Utilities may only be listed under direct costs for face-to-face client contact. As with the direct client service areas, include the same percentage of your monthly utility and maintenance bills, based upon percentage of total square footage. List the utilities that are being included (electric, gas, water and sewer and trash removal).

Telephone /Cell Phone/Internet: The cost of land lines, cell phones and Internet costs may be included. The percentage of cost should be based on the percentage of usage of these devices for this program of service. You may include a percentage of your telephone costs. Justify who and why certain staff members need cell phones and describe your policy for reimbursement of cell phone costs if staff will be utilizing personal cell phones.

Consumable Supplies: Include the cost of office supplies used in providing services to youth and their families. *Office supplies not used for providing of services to youth and their families should be included under “Indirect Costs.”*

Non-consumable Supplies: As staff is added, additional equipment may be needed, such as office furniture, computers and software, and copy machines. Include a list of items along with costs.

Printing: Include all printing costs incurred in providing services to youth and their families. *Printing costs for marketing of this program should be included under “Indirect Costs.”*

Mileage: Include the cost of reimbursing employee mileage. You may include the cost of travel should staff need to drive to various locations away from the office to provide the service. Utilize the state-approved mileage reimbursement rate for the current year*.* ***Mileage costs must be included in the unit cost. No additional or separate payments for mileage costs will be paid by the LCRB.*** *The cost of transporting clients cannot be included in your LCRB request per state statute, but can be funded through other revenue sources.*

**Indirect Budgeted Project Expenses (may not exceed 18%)**

Administration Salaries:List and total the number of indirect staff who will be providing indirect services to this program. Please detail the expenses. For example: If your CEO allots .05 percent time to the LCRB program, your explanation would indicate .05 FTE at their listed salary. Provide information about how the administrative positions support the program.

Administrative Fringe Benefits: Include the cost of providing the following fringe benefits: FICA, unemployment insurance, workmen’s compensation, health insurance and retirement.

Accounting and Fiscal Management**:** If you didn’t include fiscal management in your administrative costs, or if you use an outside source for payroll and other accounting services, you can include a percentage of this cost. Base the percentage on the total amount of your proposed funding to your overall budget.

Rent:For areas in your facility where clients are not served face-to-face, you may include a percentage of your rent or leasing cost, based on the percentage of total square footage.

Utilities:List the total of other utilities and at what percentage they are expensed to the program (may include pest control, snow removal, outdoor maintenance).

Other Office Supplies**:** List the total of other office supplies and at what percentage they are expensed to the program.

Other Printing:List the total of other printing costs and at what percentage they are expensed to the program.

Postage:List total postage expenses and at what percentage they are expensed to the program.

Cleaning Supplies: List total cleaning supplies and at what percentage they are expensed to the program.

Staff Training:Include the cost of staff trainings and travel to the trainings for direct clinical staff. If you include training costs, then you may not bill for training time, since the listed training costs would be calculated in the overall rate. Licensing costs may be included here as well.

Professional Liability Insurance:Include the cost of providing professional liability for direct clinical staff and immediate supervisors.

Advertising:List total advertising expense and at what percentage they are expensed to the program.

Accreditation Expenses:Reimbursement for expenses related to agency accreditation costs may be requested. Indicate what accreditation organization is affiliated with your organization, total amount of accreditation expense and at what percentage your agency is requesting and how often accreditation occurs.