DCCMHB Grant Year 2025 Application

DeKalb County Community Mental Health Board

Introductory Questions

New or Returning Agency?*

Choices

New Agency
Returning Agency/No Changes
Returning Agency/Requesting New Funding

Agency Name*

What is the name of the agency applying for funding?

Character Limit: 150

Agency Mission Statement*

Character Limit: 5000

Funding Guidelines - Updated 12/1/2023*

Did you read and understand the Funding Guidelines?

Choices

No
Yes

Indicate the Mental Health Board priority area in which your agency serves.*

Check all areas that apply.

Choices

Mental Health
Substance Use Disorder
Developmental Disabilities
Supportive programs for Mental Health, Substance Use Disorder, and/or Developmental Disabilities

DeKalb County Nonprofit Partnership Membership*

Please indicate if your agency is a member of the DeKalb County Nonprofit Partnership (DCNP)

Choices

No
Yes
Not Applicable

Organization Chart or Staffing Spreadsheet*

Upload an organizational chart or staffing spreadsheet for the entire organization including positions, programs (including grant programs), and Full Time Equivalents (FTE). **Compensation**

for positions funded in full or in part by this request must be included and it is encouraged to include compensation for all positions.

File Size Limit: 1 MB

Diversity, Equity, Inclusion & Belonging*

What plans have you implemented to ensure diversity, equity, inclusion and belonging in your organization? How does your organization proactively promote equity and inclusion in your work?

Character Limit: 5000

New Agencies

Agencies applying to the DeKalb County Community Mental Health Board (DCCMHB) for the first time must schedule an appointment with Mental Health Board staff to review the application. Schedule by calling 815-899-7080.
Indicate if you have called and made an appointment with DCCMHB staff. *

Choices

No
Yes

As a new organization, part of the grant process is to submit the following documents to the DeKalb County Community Mental Health Board (DCCMHB).

1. Strategic plan with latest revisions as approved by governing board.
2. Agency disaster plan.
3. List of all State grants and/or fee for service contracts.
4. This should be submitted at the New Agency meeting scheduled with the DCCMHB staff.

501c3*

Is the organization a 501c3 in the State of Illinois?

Choices

No
Yes

Type of Agency - New Agency*

Select one

Choices

Government entity
Not for profit

Geographic Location*

Is the organization located in, or serve the residents of, DeKalb County Illinois?

Choices

No
Yes

Returning Agency No Changes - Grant Year 2025 Application

Project/Program Name*

Character Limit: 250

Type of Agency - Returning Agency*

Choices

Government Entity
Not for Profit

Overview of Project/Program Request*

Give an overview of this project/program request. Since this is a returning request with no changes, a brief overview of the purpose and general details of the project/program is appropriate.

Character Limit: 7500

Amount requested*

Indicate amount of funding requested from the DeKalb County Community Mental Health Board for this project/program.

Character Limit: 20

Grant Year 2024

Since the agency received GY2024 funds for this program, indicate how DCCMHB funds were spent, the **impact** of the funds on the program and the agency.

Character Limit: 5000

Give an example of how funding has impacted the community.*

This is your opportunity to share a meaningful story about how funding for this program has impacted a client, organization or community.

Character Limit: 10000

Indicators of Quality - Staff Level Indicators

Agency Clinical Staff*

Does your organization employ clinical staff?

Choices

No
Yes

Indicators of Quality - Program Level Indicators

Does the agency currently bill Medicaid/Medicare or commercial insurance?*

For mental health, substance use or developmental disability services.

Choices

No
Yes

Agency Accreditation*

Is your agency accredited?

Choices

No
Yes
Not Applicable

Whistle blower Policy*

Does your agency have a Whistle Blower Policy?

Choices

No
Yes

Evidence-Based Practices*

Does your agency use Evidence-Based Practices as determined by research studies, clinical trials, and meta-analyses?

Choices

No
Yes

Other

Does your agency have any other program level indicators of quality? If yes, please explain.

Character Limit: 250

Certification & Insurance Panels

Attach Medicaid/Medicare Certifications*

File Size Limit: 1 MB

Provide a list of billable Insurance Panels the agency is credentialed with.*

If not credentialed, indicate status (do not accept insurance, in process, etc.).

Character Limit: 3000

Billing/Financial Management

Do any staff members of your agency have billing and/or financial management certification? Please explain.

Character Limit: 250

Have staff members taken classes about billing insurance?*

Choices

No
Yes
N/A

Agency Clinical Staff

Clinical Director Position*

Indicate if your agency has a Clinical Director and if so what are the credentials of that position.

Character Limit: 250

Clinical Staff with Graduate Degrees*

Indicate the total number of clinical staff of the program and what percentage of clinical staff members hold at least graduate level degrees.

Character Limit: 250

Certified and/or Licensed Clinical Staff

Indicate any certifications and/or licenses held by clinical staff. This is an opportunity to highlight staff expertise. Indicate the agency total number of clinical staff members, what percentage of staff hold certifications and/or a licenses, what those certifications/licenses are, and what the renewal schedule is for those certifications/licenses.

Character Limit: 7500

Clinical Staff Annual Professional Development*

Explain the requirements and annual development plan for clinical staff professional development.

Character Limit: 250

Other Indicators of Quality
Explain any additional indicators of quality regarding clinical staff.

Character Limit: 250

Accreditation

Accreditation Information*
Indicate the accreditation body, dates of accreditation and explain any accreditation reporting requirements.

Character Limit: 5000

Whistle blower

Upload Whistle Blower Policy*
File Size Limit: 1 MB

Types of Evidence-Based Practices

Use of Evidence-Based Practices*
List each Evidence-Based Practice being used. These programs must be shown effective through research studies, clinical trials, and meta-analyses. Include how the agency maintains fidelity to these practices.

Character Limit: 8000

Indicators of Quality - Organizational Level Indicators

Illinois Department of Child & Family Services Licensing*
Is your agency licensed by IDCFS?

Choices
No
Yes

Guidestar Transparency Seal
Does your agency have a Guidestar Transparency Seal, if so indicate what level.

Character Limit: 100

Other
Does your agency have any organizational level indicators of quality? Please explain.

Character Limit: 250

IDCFS Licensing

IDCFS Licensing Requirements*

Explain licensing requirements, renewal date and oversight/reporting requirements of IDCFS.

Character Limit: 5000

Support Information

Board of Directors*

Upload or add a listing of the current Board of Directors for the agency that includes board member names, term expiration, and position on the board. If the agency does not have a Board of Directors please indicate that in the text box and explain.

Character Limit: 7500 | File Size Limit: 1 MB

Organization Fee Schedule

If the organization collects client fees, upload a copy of the organization fee schedule.

File Size Limit: 1 MB

Survey Reports from Accrediting Organizations

Upload most current survey reports from accrediting organizations (include copies of plans of correction and subsequent relevant communication), if applicable. If survey reports are too large to upload, contact 815-899-4960 for options.

File Size Limit: 2 MB

Organization and/or Program Reviews

Upload the must current fiscal and /or administration organization and program review(s) by state/federal agencies (include copies of plans of correction and subsequent relevant communication), if applicable. If reviews are too large to upload, contact 815-899-4960 for options.

File Size Limit: 3 MB

Audited Financial Statement

Upload the organization Audited Financial Statement from prior year. If your organization does not have an Audit Financial Statement indicate why in the text box.

Character Limit: 3500 | File Size Limit: 4 MB

IRS Form 990

Upload the organization most recent IRS Form 990. If your organization does not have a IRS 990 Form, indicate why in the text box.

Character Limit: 3500 | File Size Limit: 4 MB

Agency Annual Report

Indicate if your agency compiles an annual report. If annual report is accessible online, include URL in text box.

Character Limit: 100

Optional Supporting Documents

Your opportunity to share graphs, photos, letters of recommendations, MOUs or other supporting documents to highlight your organizations value.

Character Limit: 10000 | File Size Limit: 1 MB

STOP HERE!

IF THE AGENCY WILL BE REQUESTING FUNDING FOR MORE THAN ONE PROJECT OR PROGRAM TAKE THE FOLLOWING STEPS:

1. **After completing** the Sections above, save application by clicking "Save" at the bottom of this form. After clicking "SAVE" you will revert to the Confirmation screen.
2. Click the **Apply** button at the top of the screen.
3. At the top right of the Grant Application process click **Apply** again.
4. Click the **Copy Previous Answers** button on the top right of the screen this will copy answers from the previous application and enter them into the new application.
5. **Review** the Agency sections and make sure the answers reflect the next Project/Program request. **Repeat** steps 1-5 until there are applications started for each Project/Program that you're applying for (ex. if requesting funding for 5 projects/programs there will be 5 applications displaying on the agency dashboard).
6. **THIS IS CRITICAL: Remember** to complete the remaining Project/Program sections below for each application and **SUBMIT** for **EACH** project/program. This is the only way to ensure **EACH** request is **SUBMITTED**.

On Applicant Home Page, once application for **each** Project/Program is complete, make sure that the status of each application is "Submitted" and the text reads "View Application". If text reads "Edit Application" that request has **NOT YET** been submitted for funding.

Returning Agencies - If you are applying for both Returning Agency/No Changes AND Returning Agency/Requesting Additional Funding, make sure to change the check-mark on the first Introductory Question after you complete the Copy process to indicate NO CHANGES ***or*** REQUESTING ADDITIONAL FUNDING to accurately reflect the funding request.

IF THE AGENCY IS APPLYING FOR ONLY ONE PROJECT OR PROGRAM YOU MAY SKIP STEPS 1 - 6 ABOVE AND CONTINUE WITH THIS APPLICATION.

Agency Information

Project/Program Name*

Name of Project/Program for which funds are requested.

Character Limit: 250

Project/Program Narrative*

Provide a narrative for project/program where funding is requested. Summarize the purpose of the program request, the need in the community for the program and organizational challenges (present and anticipated). The narrative shall include headers for Purpose, Community Need and Organizational Challenges.

Character Limit: 10000

Program Goals and Objectives*

What is the impact of this program on the community? What are the goals and objectives of this program? How will those goals and objectives be measured?

Character Limit: 10000

Project/Program Outputs*

What statistics will be collected by the agency for this project/program?

Character Limit: 10000

Outcomes/Performance Measurements*

Answer the question "How will the DeKalb County Community Mental Health Board know that the project/program and the agency is providing quality services"?

Character Limit: 10000

Services To Be Delivered*

List what services will be delivered to meet the goals and objectives of the program. Denote if the services are evidence-based. This section will be utilized in the Funding Contract as the "Scope of Work" section. Include all services to be delivered where you are seeking funding from the MHB.

Character Limit: 10000

Other Funding Sources*

List other funding sources available for this project/program. Indicate if the funding has been secured or anticipated.

Character Limit: 7500

Funding Amount Requested for Project/Program*

Indicate the amount requested from the DeKalb County Community Mental Health Board for this project/program

Character Limit: 20

501C3 Budget Information

Organization Budget and Project/Program Budget*

Provides organization's overall budget for the upcoming fiscal year. Incorporate the program/project budget using the same format as the overall budget to convey the program/project as a component of your organization. Include brief line item comments of the requested funding that indicates the use of the requested funding. See examples in "Funding Guidelines".

File Size Limit: 1 MB

Nonprofit Financial Indicators Tool (NFIT)

Download this Nonprofit Financial Indicators Tool, fill it out completely, save as a PDF, and upload below. This tool is required for nonprofit, 501C3 organizations only.

Click here to view an example of a completed tool.

File Size Limit: 1 MB

Government Budget Information

Government Unit Budget and Project/Program Budget*

Provide your Department's Budget (versus overall government unit budget) or unit of government budget if applying as a whole entity. Incorporate the program/project budget using the same format as the department budget to convey the program/project as a component of your department within the government unit. Include brief line item comments of the requested funding that indicate the use of the requested funding.
Click here for a budget example.

File Size Limit: 1 MB