



Bureau for Behavioral Health and Health Facilities

## Announcement of Funding Availability

Children's Crisis Response Services Program



## **Proposal Guidance and Instructions**

**AFA Title: Children’s Crisis Response Services Program**  
**Targeting Region: Statewide Services**  
**AFA Number: AFA 03-2016-DD**

West Virginia Department of Health and Human Resources  
Bureau for Behavioral Health and Health Facilities  
350 Capital Street, Room 350  
Charleston, WV 25301-3702

*For Technical Assistance please include the AFA # in the subject line and forward all inquiries in writing to:*

[DHHRBHHFAnnouncement@wv.gov](mailto:DHHRBHHFAnnouncement@wv.gov)

Key Dates:	
Date of Release:	March 27, 2015
TECHNICAL ASSISTANCE MEETING:	April 13, 2015, more details to follow
Letter of Intent Deadline:	April 15, 2015 Close of Business – 5:00PM
Application Deadline:	May 22, 2015 Close of Business–5:00PM
Funding Announcement(s) To Be Made:	June 5, 2015
Funding Amount Available:	Not to exceed \$202,329.00

The following are requirements for the submission of proposals to the Bureau for Behavioral Health and Health Facilities (BBHF): The document includes general contact information, program information, administrative responsibilities, and fiscal requirements. ✓Responses must be submitted using the required AFA Application Template available at [DHHR.WV.GOV/BHMF/AFA](http://DHHR.WV.GOV/BHMF/AFA). ✓Responses must be submitted electronically via email to [DHHRBHHFAnnouncement@wv.gov](mailto:DHHRBHHFAnnouncement@wv.gov) with the AFA Title and Number in the subject line. Paper copies of the proposal *will not* be accepted. ✓All submissions must be received no later than 5:00 PM on the application deadline. It is the sole responsibility of applicant to ensure that all required documents are received by the application deadline. Notification that the proposal was received will follow. ✓A Statement of Assurance agreeing to these terms is required of all proposal submissions available at [DHHR.WV.GOV/BHMF/AFA](http://DHHR.WV.GOV/BHMF/AFA). This statement must be signed by the agency’s CEO, CFO, and Project

**Officer. ✓Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline *will not* be reviewed.**

### **LETTER OF INTENT**

Organizations planning to submit a response to this Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by to the email address: [DHHRBHFAnnouncement@wv.gov](mailto:DHHRBHFAnnouncement@wv.gov) prior to submission of the proposal. List the AFA Title and Number found on Page 1 of this document in the email subject line. These letters of intent shall serve to document the organization's interest in providing the type of service(s) described within this AFA and will not be considered binding until documented receipt of the proposal.

### **RENEWAL OF AWARD**

The Bureau for Behavioral Health and Health Facilities (BBHF) may renew or continue funding beyond the initial fiscal year award for up to one (1) additional fiscal year. Future funding will be contingent on factors including, but not limited to, availability of funds, successful implementation of goals, and documented outcomes.

### **LEGAL REQUIREMENTS**

Eligible applicants are public or private organizations with a valid West Virginia Business License and/or units of local government. If the applicant is not already registered as a vendor in the State of West Virginia, registration must either be completed by the award notification date or the vendor must demonstrate proof of such application. It is also required that the applicants have a System for Award Management (SAM) registration and have a Dun & Bradstreet or DUNS number. For more information visit: <https://www.sam.gov>

The grantee is solely responsible for all work performed under the agreement and shall assume all responsibility for services offered and products to be delivered under the terms of the award. The State shall consider the designated Grantee applicant to be the sole point of contact with regard to all contractual matters. The grantee may, with the prior written consent of the State, enter into written sub agreements for performance of work; however, the grantee shall be responsible for payment of all sub awards.

## FUNDING AVAILABILITY

The Bureau for Behavioral Health and Health Facilities (BBHFF) is requesting proposals for administration of **one (1)** residential unit for Children's Crisis Response Services Program to include staff and fiscal responsibilities. Funding in the amount of \$202,329.00 is available to support statewide development of the Children's Crisis Response Services Program. **These funds are expected to be combined or blended with funding from other sources (e.g., the Bureau for Medical Services, the Bureau for Children & Families, other public or private sources) to fully support the residential and non-residential components of this program.**

Funding for a **Children's Crisis Response Services Program** will be awarded based on accepted proposals that meet all of the required criteria contained within this document. Funding availability for this AFA is as follows:

### Start Up Costs

Applicants who wish to request reasonable startup funds for their programs must submit a separate "startup" target funded budget (TFB) and budget narrative along with their proposals. For the purposes of this funding, startup costs are defined as non-reoccurring costs associated with the initiation of a program. These include costs such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup cost requests submitted by the applicant will be considered to be necessary for the development of the proposed program. If, when taken together, the startup costs and program costs exceed funding availability BBHFF will contact the applicant organization and arrange a meeting to discuss remedial action.

### Funding Reimbursement

All grant funds are awarded and invoiced on a cost reimbursement basis. Grant invoices are to be prepared monthly and submitted with and supported by the Financial Report and Progress Report to receive grant funds. The grant total invoice should agree with amounts listed on the Financial Report and reflect actual expenses incurred during the preceding service period. All expenditures must be incurred within the approved grant project period in order to be reimbursed. Providers must maintain timesheets for grant funded personnel and activities performed should be consistent with stated program objectives.

## REGIONS IN WEST VIRGINIA

The WV Bureau for Behavioral Health and Facilities utilizes a six (6) Region approach:

Region 1: Hancock, Brooke, Ohio, Marshall, and Wetzel Counties

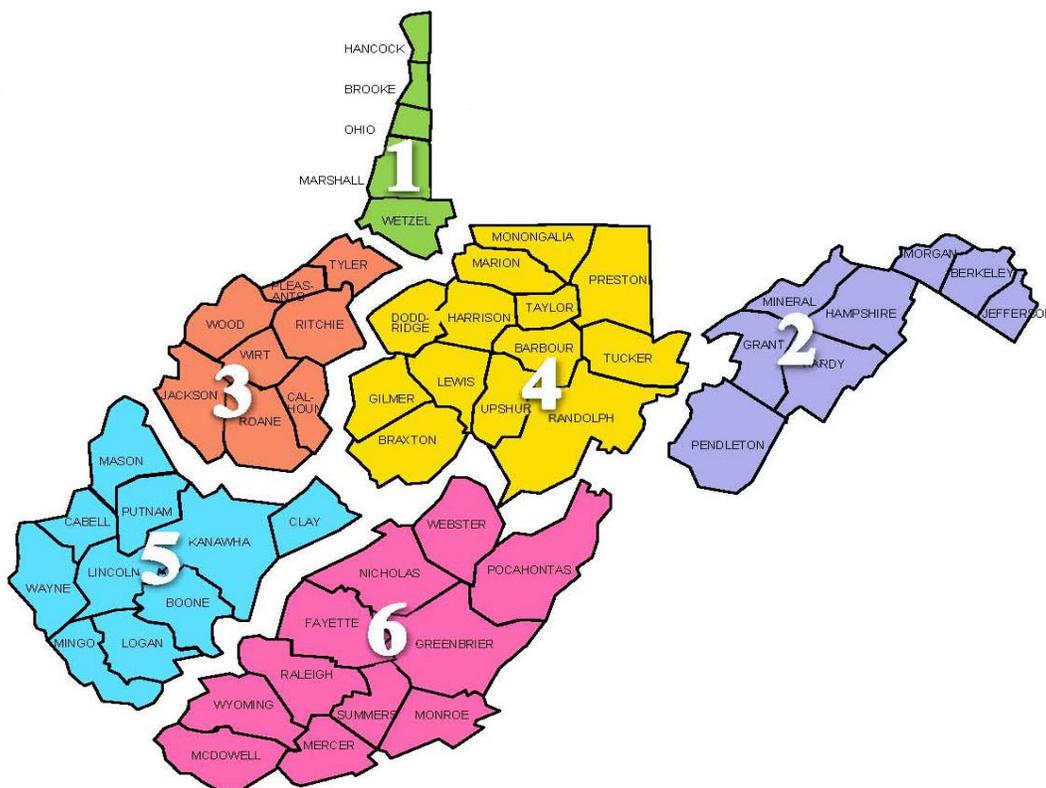
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

Region 3: Tyler, Pleasants, Wood, Ritchie, Wirt, Jackson, Roane, and Calhoun Counties

Region 4: Monongalia, Marion, Preston, Doddridge, Harrison, Taylor, Barbour, Tucker, Gilmer, Lewis, Upshur, Randolph, and Braxton Counties

Region 5: Mason, Cabell, Putnam, Kanawha, Clay, Wayne, Lincoln, Boone, Mingo, and Logan Counties

Region 6: Webster, Nicholas, Pocahontas, Fayette, Greenbrier, Raleigh, Summers, Monroe, Wyoming, McDowell, and Mercer Counties



## Section One: INTRODUCTION

The West Virginia Department of Health and Human Resources' Bureau for Behavioral Health and Health Facilities (BBHFF) envisions healthy communities where integrated resources are accessible for everyone to achieve wellness, personal goals and a self-directed future. The mission of the Bureau is to ensure that West Virginians with mental health and/or substance use disorders, intellectual/developmental disabilities, chronic health conditions or long term care needs experience quality services that are comprehensive, readily accessible and tailored to meet individual, family and community needs.

Within the Bureau, the Programs and Policy Section provides oversight and coordination of policy, planning, development, funding and monitoring of statewide community behavioral health services and supports. Emphasis is placed on function rather than disability, and improving planning and cooperation between facility and community-based services. Programs and Policy includes the Division on Alcoholism and Drug Abuse, Division of Adult Mental Health, Division of Child and Adolescent Mental Health, Division of Intellectual and Developmental Disabilities, and the Office of Consumer Affairs and Community Outreach.

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are important components of the systems of care surrounding each person. The role of the Bureau is to provide leadership in the administration, integration and coordination of the public behavioral health system. The work is informed by results of a multi-year strategic planning process that includes critical partners in planning, funding and delivering services and supports.

The following Strategic Priorities guide services and service continuum development:

<b>Behavioral Health Prevention, Treatment and Recovery System Goals</b>	
Priority 1 Assessment and Planning	Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.
Priority 2 Capacity	Build the capacity and competency of WV's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant

	services.
Priority 3 Implementation	Increase access to effective behavioral health prevention, early identification, treatment and recovery management that is high quality and person-centered.
Priority 4 Sustainability	Manage resources effectively by promoting good stewardship and further development of the WV behavioral health service delivery system.

## Section Two: **FINANCIAL, LEGAL, & PROGRAMMATIC DESCRIPTION**

Deinstitutionalization, the closure of institutions, and the expansion of community services for persons with Intellectual and Developmental Disabilities (ID/DD) have become national trends. Eleven states and the District of Columbia have closed all public residential facilities for individuals with IDD (Alabama, Alaska, Hawaii, Indiana, Maine, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and West Virginia). In West Virginia, changes in public policy were shaped in part by two primary consent decrees, commonly referred to as “Medley” and “Hartley.”

In 1981, a class action settlement (Medley v. Ginsburg Civil Action 78-2099) was reached on behalf of “All persons under the age of 23 years who suffer from mental retardation as that term is defined by [WV Code, Chapter 27 (<http://www.legis.state.wv.us>)] who are citizens of the State of WV, who are unable to live in their homes due to lack of resources in their homes or in their home communities to fulfill their special needs arising from their mental retardation, and who are now or will in the future be institutionalized by reason of the failure of the main defendants or the successors in office, to provide foster homes or other community facilities which can provide the required resources.” The Medley Decree mandated that individualized, strengths-based assessments be made and that individualized services be delivered in the “least restrictive environment”. Defendants were ordered to develop a comprehensive statewide plan for class members (“Medley Plan”) that sought to ensure that each class member live in the least restrictive treatment setting appropriate. The Medley Plan subsequently influenced the delivery of services and supports for all individuals with intellectual developmental disabilities, resulting in the closure of the state’s designated institutions.

In 1982, the West Virginia Supreme Court found that it was contrary to West Virginia Mental Health Law for the WV Dept. of Health (predecessor to WVDHHR) to merely “warehouse” an individual in a state mental institution. The Parties entered into a consent order, referred to as the Hartley Decree, which dealt with virtually every aspect of the mental health system (E.H. v. Matin Civil Action 81-585). Children’s mental health services were initially included in the “Hartley” decree, but the state was considered to be in compliance with that section of the order with the development of services specifically referenced. There remains, however, a 2001 Agreed Hartley Order that requires advocacy services for the residents of the Potomac Center, an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), to assure the program does not serve as a long-term care facility for children.

The work to serve children and adults with ID/DD is ongoing. Over the past several months, the Department of Health and Human Resources conducted a key stakeholder assessment of the in-state service continuum for youth in state custody, followed by an extensive, multidisciplinary review of youth in state custody placed out of state for services and treatment. Coupled with data from the Division of Juvenile Services and the Bureau for Medical Services, a picture emerged of West Virginia's overreliance on residential services, both within and outside the state. In addition, children were not necessarily "matched" to the most appropriate or effective program. Subsequently, an opportunity has emerged to redirect and realign resources in order to strengthen the in-state array of services and supports. The goal is to reduce reliance on unnecessarily restrictive levels of care and provide services that children need as close to their home and community as possible.

The Bureau's Division of Intellectual/Developmental Disabilities participates in the Children's System of Care Regional Clinical Review Teams and served on the teams assessing the status of youth placed out of state. Children with a diagnosis of ID/DD who exhibit "challenging" or aggressive behaviors, are being inappropriately placed in juvenile correctional programs and/or out of state treatment facilities. Once placed in a restrictive setting, these individuals are not easily reintegrated back into community settings for a variety of reasons, and often experience longer than average lengths of stay.

The WVDHHR interdisciplinary study of youth placed in out of state care determined that approximately 50% of youth had a diagnosis of intellectual disability, traumatic brain injury or other developmental disability.

In addition, surveys and focus groups conducted with families and service providers regularly reveal that the top two barriers for families seeking services are access and navigation. Even when resources are available, if families are not aware of them or cannot access them, a preventable crisis or placement may occur.

Gaps in the current West Virginia system of services for this population include:

- A segregated system of services and funding frequently based on diagnosis that does not encourage, and sometimes prevents, a holistic approach to assessment and intervention.
- Lack of specialized, knowledgeable service providers who understand evidence based interventions that work for individuals who are diagnosed with both IDD and behavioral needs.
- Limited case management capacity to help individuals, their families and the provider community learn about and navigate the existing system of services and supports.
- No connection or a limited connection to community based services and supports for individuals in crisis who come to the attention of the system.

- Lack of public or private health care coverage (eligibility for existing funding streams) for individuals in crisis.

The Bureau for Behavioral Health and Health Facilities (BBHFF) has collaborated with the Bureau for Medical Services (BMS) and the Bureau for Children & Families (BCF) to fund crisis residential programs across the state for both children and adults in order to reduce unnecessary referrals to hospital and residential levels of care. ID/DD Crisis Response Programs have expanded their knowledge and skillset to serve individuals with ID/DD other complex support needs that often present barriers to remaining in or timely return to the community. Enhanced capacity includes certified Behavior Support Professionals on staff to address challenging behaviors, and staff certified in the Child and Adolescent Needs and Strengths Assessment (CANS)/Adult Needs and Strengths Assessment (ANSA) to assure comprehensive, strengths-based assessments for residents. All programs are required to offer Positive Behavior Support (PBS) consultation and CANS/ANSA assessments to other providers and families upon request to help maintain an individual in a community placement or facilitate discharge from a hospital or correctional facility.

Funding is blended: programs bill Medicaid for residents who have IDD Waiver slots and invoice BBHFF for individuals who are not Waiver members. Additionally, the children's program receives a room and board stipend for residents who are in DHHR custody.

As a result, the following enhancements to the crisis service system have occurred:

- Increased access for more individuals in crisis by serving individuals with different levels of functioning in the residential crisis settings, as appropriate, while assuring resident safety and support;
- Maximization of funding and staff resources to support services to individuals with complex needs that cross service "silos;"
- Enhanced skills of CRU staff to assess and plan services for individuals with behavioral challenges and other complex support needs;
- Enhanced awareness by CRU staff about community resources and discharge planning; and,
- Emergence of the Crisis Response Programs as "hubs" of knowledge and expertise about individuals with ID/DD and other complex support needs.

The Crisis Response Services Grant seeks to improve supports and services in the state by building upon existing statewide crisis response services, improving and expanding those statewide services that exist but are insufficient to meet current needs, and continuing to develop needed components of a comprehensive crisis prevention and intervention system that do not exist in the state at this time.

The next step in the evolution of ID/DD crisis response is to expand and formalize regional capacity to help prevent unnecessary admission to institutional settings and to achieve successful discharge to the community should such admission be necessary. This AFA is designed to support the original intent of the Medley and Hartley consent decrees by strengthening a statewide network of crisis prevention and intervention programs and partnerships that emphasize collaboration, expertise, creativity and person-centered approaches in order to:

- Proactively identify and develop strategies for supporting individuals with a high probability of requiring short-term crisis services and long-term intensive services;
- Provide a prompt and effective response to all requests for crisis-related support;
- Identify and link individuals to appropriate resources;
- Design environments to support success;
- Deliver expert technical assistance and training to assure maximum opportunity for success in that environment;
- Establish regional acute crisis residential programs for short-term stays;
- Address the needs of families as well as providers; and
- Educate key stakeholders in the community in order to reduce referrals to inappropriate levels of care.

## Section Three: **SERVICE DESCRIPTION**

### **Children's Crisis Response Services Program**

**Target Population: Individuals who are age 7 through 18 years old with an intellectual disability who are in need of a short-term crisis placement.**

#### **Purpose**

The Bureau for Behavioral Health and Health Facilities (BBHFF) supports evidence-based practices that promote social and emotional wellbeing, prevention approaches, person-centered interventions and self-directed and/or recovery driven support services.

The Bureau for Behavioral Health and Health Facilities' (BBHFF) supports the **ID/DD Children's Crisis Response Services Program** to prevent unnecessary institutionalization of children with ID/DD and to help transition them back to home/community setting from hospitals and other restrictive settings by providing assessment, consultation and resource coordination, training/education, and provision of short term residential stabilization services.

#### **Service Overview**

The ID/DD Children's Crisis Response system will consist of two (2) residential Crisis Response Programs which will implement a cross-system, collaborative approach to crisis service delivery, at a community, regional and state level. Effective programs will operate as a statewide network to maximize knowledge and resources, and will engage community partners as team members to meet the needs of individuals and address system challenges

Each ID/DD Children's Crisis Response Services Program is designed to be a regional POINT OF ENTRY for individuals, families, caregivers, service providers, or other individuals seeking assistance with a crisis situation. The goal of the regional Point of Entry is to facilitate access to appropriate levels of care to address the crisis. Due to the geographically disbursed nature of services, each regional program must have a good working knowledge of resources available across the state.

At a regional level, the Crisis Response Program's services include short term residential services, professional collaboration, person-centered/strengths-based assessment/planning/behavioral consultation, and resource coordination, provided within the context of a trauma-informed model.

Programs will be responsive at both the individual and systems levels by providing:

1. Support and problem-solving for **individuals, families and service providers** seeking assistance with the resources they need to decrease the risk of inappropriate admissions to out of home placements or to return individuals to the most integrated setting possible, and
2. Education and information to **emergency services personnel, first responders- and other community entities** in order to help local communities respond more effectively to individuals with ID/DD experiencing a crisis.

**Services for individuals include but are not limited to:**

- Resource Coordination –
  - Assist with identification of the resources needed to decrease the risk of inappropriate admissions to out of home placements (e.g., psychiatric hospitals, in state residential placements or out of state placements), and integrate the individuals into the most integrated setting possible.
  - Conduct thorough research to find appropriate solutions for families.
  - Advocate for the individual or family to achieve desired results.
  - Develop and maintain effective relationships through effective and timely communication.
  - Development of an immediate safety plan, if necessary.
  - Use of standardized, individualized, strengths-based assessment (CANS) tool to inform an effective service plan.
  - Use of person-centered, strengths-based positive behavior support planning and consultation in order to understand and identify and understand behaviors that drive crisis situations.
  - Assessment and/or service coordination to assist in treatment planning and accessing long-term services for individuals who do not have case managers or service coordinators.
  - Consultation with community providers and individual treatment teams to facilitate transition of an individual from a crisis situation to a stable, integrated setting, including the creation of guidelines for parents and caregivers to manage difficult behaviors.
- Temporary housing to be made available in emergency situations that will ensure protective oversight, ameliorate the crisis and facilitate return of the individual to his/her own community-based home or appropriate setting within 30 days or less. Crisis response housing can also be used to facilitate return of individuals from residential care or psychiatric hospitals to home/community settings.
  - When a child is referred to a residential crisis setting, individualized services must be provided at the level of intensity necessary to achieve and maintain stability.

- All children served in a residential crisis setting will receive Resource Coordination and any other services/supports necessary to facilitate successful discharge to an integrated, community-based setting.

**Services to enhance community capacity include but are not limited to:**

- Participation in Children’s Clinical Review process to assist teams to explore all options/alternatives to “least integrated settings” for individuals referred for review, exchange information/knowledge about services, identify service gaps and share with policy-makers.
- Professional collaboration and working relationships intended to increase engagement among partners, and improve referral mechanisms and access to needed and appropriate services/supports.
- Development of linkages with the regional Comprehensive Behavioral Health Centers’ Crisis Response Teams responsible for Crisis Hot Lines, crisis response services and commitment certification and linkage services.
- Development of linkages and partnerships with law enforcement and emergency services personnel to decrease incidences of inappropriate hospitalizations and involvement in the legal system:
  - Provide awareness and connections to the ID/DD system;
  - Provide education about effective interventions in crisis situations.
- Provision of consultation, training and education to residential and foster family providers so that they are better able to maintain individuals in community and home-based settings.
- Provision of consultation and support to organizations working with youth transitioning to adulthood (ages 16-21), particularly those returning from out of state placement who no longer have in state community or family connections.

**Entities applying to provide the Crisis Response Program must do the following things:**

**1. Provide detail in their proposal narrative as to how they will meet the following assurances**

- Ensure the program operates within the framework of Trauma Informed Care, including how all staff will recognize the symptoms of trauma. Provide a sample of a Trauma Specific Plan of Care prepared for an individual you are currently serving or have recently served.
- Ensure the program can deliver trauma-focused treatment. Provide examples relevant to the population served.
- Ensure the program can implement the function of Resource Coordination.
- Ensure that program staff are trained and certified to implement the Crisis Response Program for the designated population.

- Ensure the program can provide immediate interventions to children and who are experiencing crisis due to behavioral issues.
- Ensure the program provide supports to their families (this may be accomplished through MOUs with other organizations).
- Ensure the program can accept, review and provide a disposition to all requests for crisis response services within 24 hours.
- Ensure that the program can administer the Child and Adolescent Strengths Needs Assessment (CANS) within 7 days for 100% of individuals accepted for Crisis Response services.
- Ensure that all individuals served are provided have a plan developed within 5 days of being assessed by the Crisis Response Program, that details action steps that will be needed to either maintain the individual in his/her community placement or prepare for linkage/referral to post discharge services needed for a successful community placement.
- Ensure that all individuals served have a plan developed within 5 days of being assessed by the Crisis Response Program, that details action steps that will be needed to either maintain the individual in his/her community placement or prepare for linkage/referral to post discharge services needed for a successful community placement.
- Ensure all individuals to whom services have been provided by the Crisis Response Program are connected to personal and community supports upon resolution of the crisis episode. Ensure that each individual being discharged from the program's residential component is referred/ linked to a stable and safe environment/living program.
- Ensure all individuals served in the residential component of the program receive age-appropriate, individualized services designed to maximize their ability to renew and sustain the highest possible level of independence and autonomy in community-based settings in order to prevent re-admission.
- Ensure that program staff can provide specialized technical assistance and training information relevant to resolving the crisis needs of individuals with ID/DD and individuals with other complex support needs(example multiple out of home placements or an inability to maintain placement in community setting).
- Ensure individuals, their families or guardian are provided with educational opportunities to be well-informed about all aspects of the system, outlining clear expectations, and providing opportunities for consumers, their families or guardian to make daily decisions and participate in the creation of personal goals.
- Ensure linkages and partnerships with law enforcement and other emergency services personnel, including emergency management personnel, to educate them about individuals with ID/DD and effective interventions in crisis situations.
- Ensure working partnerships with the regional Comprehensive Behavioral Health Centers' Crisis Response Teams.
- Ensure the development of staff mediation and facilitation skills in order to enhance the organization's ability to collaborate with individuals, families, community partners, law enforcement personnel, emergency management personnel and first responders.

## **Collaborations and Memorandums of Understanding**

Applicants must demonstrate that a coordinated and integrated service system is in place to meet the complex needs of the target population. In doing so, Memoranda of Understanding (MOUs) must be completed with key partnering agencies and organizations, which may include but is not restricted to:

- Local Public Housing Authorities
- Behavioral Health (Substance Use, Mental Health, I/DD)
- Primary Health
- Residential and community –based child care services
- Family Assistance Programs
- Early Intervention and Home Visiting Programs
- Emergency First Responders
- Criminal Justice Systems
- Employment, Education and/or Vocational programs

## Section Four: **PROPOSAL INSTRUCTIONS / REQUIREMENTS**

**Eligible applicants** must provide proof of a valid West Virginia business license and comply with all requirements provided within this AFA. All proposals will be reviewed by the BBHMF staff for administrative compliance. Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline will not be reviewed. A Statement of Assurance agreeing to these terms is required of all proposal submissions to BBHMF. This statement must be signed by the applicant organization's CEO, CFO, and Project Officer. All applications passing the administrative review will be subsequently forwarded to an independent grant review team which will score the proposal narrative consisting of five areas:

- A. Population of Focus and Statement of Need (5 points)
- B. Proposed Evidence-Based Service/Practice (30 points)
- C. Proposed Implementation Approach (50 points)
- D. Staff and Organizational Experience (5 points)
- E. Data Collection and Performance Measurement (10 points)

**Proposal Abstract** – All proposals must include a one-page proposal abstract. The abstract should include the project name, description of the population to be served, planned strategies/interventions, and a general overview of service goals and measurable objectives, including the number of people projected to be served annually. Proposal abstracts may be used for governmental reports and public release. As such, all applicants are encouraged to provide a well-developed abstract document not exceeding **35** lines in length.

**Proposal Narrative** – The Proposal Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be more than **15** pages; applicants **must utilize** 12pt. Arial or Times New Roman font, single line spacing, and one (1) inch margins. Page numbers must also be included as a footer.

**Supporting Documentation** – The Supporting Documentation provides additional information necessary for the review of your proposal. It consists of Sections F and G. These documents and/or attachments will not be counted towards the Proposal Narrative page limit; however, Section F and G together may not be more than **20** pages.

**Maximum number of pages permitted for proposal submission is 35 total pages;** limits for the Proposal Narrative and Supporting Documentation must also be upheld. All pages submit as

part of the proposal submission will count toward this maximum limit. Materials not requested within this AFA such as cover/heading pages, additional supporting documentation, etc. will be counted. Proposals that exceed this maximum limit and/or the limits established for the Proposal Narrative and Supporting Documentation will not be reviewed.

## Section Five: **PROPOSAL OUTLINE**

*All proposal submissions must include the following components without exception to be reviewed.*

### **Abstract:**

Provide a brief description of the proposed service as earlier set forth in this document.

### **Proposal Narrative:**

#### **A. Population of Focus and Statement of Need: (5 Points)**

- Provide a comprehensive demographic profile of the target population in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy, citing relevant data. Identify the source of all data referenced.
- Clearly indicate the proposed geographic area to be served, by Region and County (ies).
- Discuss the relationship of the target population to the overall population in the proposed geographic area to be served citing relevant data. Identify the source of all data referenced.
- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e. current prevalence rates or incidence data) for the target population based on data. Identify the source of all data referenced. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for data that could be used are key informant interviews, newspaper article, focus groups, local epidemiologic data, state data, and/or national data.
- Identify health disparities relating to access, use, and outcomes of the proposed service citing relevant data. Identify the source of all data referenced.
- Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective substance use and co-occurring substance use and mental health recovery services in the proposed geographic area to be served that is consistent with purpose of the AFA.
- Describe the existing stakeholders and resources in the proposed geographic area to be served which can help implement the needed infrastructure development.
- Include a Reference/Work Cited page for all data referenced within proposal in Attachment 1.

#### **B. Proposed Evidence-Based Service/Practice: (30 Points)**

- Describe the purpose of the proposed service.
- Clearly state the goals, objectives and strategies for the service. These must relate to the purpose of the AFA and each of the performance measures identified in Section E:

#### Data Collection and Performance Measurement.

- Describe all evidence-based practice(s) (EBP) that will be used and justify use for the target population, the proposed service, and the purpose of this AFA. To verify/review EBPs visit SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/>
- If an EBP does not exist/apply for the target population and/or service, fully describe practice(s) to be implemented, explain why it is appropriate for the target population, and justify its use compared to an appropriate, existing EBP.
- Describe how the proposed practice(s) will address the following issues in the target population, while retaining fidelity to the chosen practice: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability.
- Identify any screening tools that will be used and basis for selection. Screening tools do not include clinical assessment, admission criteria, or intake data collection instruments.
- Describe how identified behavioral health disparities will be addressed and suggested strategies to decrease the differences in access, service use, and outcomes among the target population. One strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which can be found at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.
- Describe how the applicant organization will ensure cultural competence in service implementation. All BBHFF grantees are required to receive cultural competence training and to ensure that no one will be discriminated against due to race, ethnicity, religion, gender, age, geography or socioeconomic status. All materials associated with awarded funding must be developed at low literacy levels for further understanding and comprehension in WV communities.
- Describe how privacy and confidentiality will be ensured throughout the entirety of the service, including collection and dissemination of data, consumer feedback, etc.

#### **C. Proposed Implementation Approach: (50 Points)**

- Provide a one (1) year/twelve (12) month chart or graph depicting a realistic timeline of the service. The timeline must include the key activities and staff(s)/partners responsible for action through all phases including but not restricted to planning/development, implementation, training/consultation, intervention(s) milestones (EBPs), data collection/reporting, quality assurance, etc. Be sure to show that the project can be implemented and delivery of the service can begin as soon as possible, and no later than six (6) months post award. Note: The timeline should be part of the Proposal Narrative. It should not be placed in an attachment.

- Describe how achievement of the proposed goals, objectives, and strategies identified for the service will produce meaningful and relevant results in the community (e.g. increase access, availability, prevention, outreach, pre-services, treatment and/or recovery) and demonstrate the purpose of the AFA.
- Describe the proposed service activities and how they relate to the goals, objectives and strategies, how they meet the identified infrastructure needs, how they fit within or support the development of the statewide continuum of care.
- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project with a letter of support and/or Memorandum of Understanding (MOU). Include letters of support and MOUs from community organizations and/or partners supporting the project in **Attachment 2**.
- Describe how you will work across systems to ensure that services provided to the target population are coordinated and considered by multiple levels and systems.
- Clearly state the unduplicated number of individuals to be served (annually) with grant funds, including the types and numbers of services to be provided. Include the projections for sub-population (family/primary supports) served separate from projections for the targeted population.
- Describe additional training to be sought and utilized in the development of the service, identifying key training components (by title) and their relevance.
- Describe how you will screen and/or assess clients for the presence of co-occurring mental health and substance use disorders and use the information obtained from the screening and/or assessment to facilitate appropriate referral to treatment for the persons identified as having such co-occurring disorders.
- Describe how you will ensure the input of the target population in planning, implementing, and assessing the proposed service. Describe the feedback loop between the target population, the applicant organization, partners/key stakeholders, and the BBHFF in all implementation stages of the project.
- Describe how you will facilitate the health insurance application and enrollment process for eligible uninsured individuals receiving the proposed service. Also describe how you will ensure the utilization of other revenue realized from the provision of crisis response services to the fullest extent possible, using BBHFF grant funds only to serve individuals for whom coverage has been formally determined to be unaffordable; or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of the BBHFF grant funds).
- Identify the potential barriers to successful conduct of the proposed service and describe strategies to overcome them.
- Describe your plan to continue the proposed service after the funding period ends.

Also, describe how service continuity will be maintained when there is a change in the operational environment (e.g. staff turnover, change in project leadership) to ensure stability over time.

- Describe the facility (ies) to be utilized, if any, for the service. This includes an existing facility already owned and operated by the applicant organization, or a facility for which the applicant organization has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHF is available to discuss what options may exist for securing a building or other location in the event that a location is not readily available. If the applicant organization chooses to speak to the BBHF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any architectural plans or diagrams that may exist may be included in **Attachment 1**

**D. Staff and Organization Experience: (5 Points)**

- Discuss the capability and experience of the applicant organization. Demonstrate that the applicant organization has linkages to the target population and ties to grassroots/community-based organizations that are rooted in the culture of the target population.
- Provide a complete list of staff positions for the service, including the Project Officer and other key personnel, showing the role of each, their level of effort/involvement and qualifications.
- Discuss how the key personnel have demonstrated experience, are qualified to serve the target population and are familiar with the applicable culture.
- Discuss the applicant organization's current level of participation in crisis response services in the proposed region and document your ability to attend future meetings. (??)

**E. Data Collection and Performance Measurement: (10 Points)**

- Describe the plan for data collection, management, analysis, and reporting on the required performance measures, as specified in Section Six: Expected Outcomes / Products of this AFA. Specify and justify any additional measures or instruments to be used.
- Describe the data-driven, quality improvement process by which target population disparities in access, use, and outcomes will be tracked, assessed, and reduced.
- Describe how data will be used to manage the service at a systems level to ensure that the goals, objectives, and strategies are tracked and achieved.
- Describe how information related to process and outcomes will be routinely communicated to the target population, staff, governing and advisory bodies, and stakeholders.

**Supporting Documentation:**

- F. Budget Form and Budget Narrative:** *All requirements set forth in Section F must be included in **Attachment 3***
- Include a proposed Target Funding Budget (TFB) with details by line item, including sources of other funds where indicated on the TFB form.
    - Include expenses for attending BBHFF-required meetings and trainings.
  - Include a Budget Narrative word document with specific details on how funds are to be expended.
    - The Budget Narrative clarifies and supports the TFB. The Budget Narrative should clearly/specify the intent of and justify each line item in the TFB.
  - Describe any potential for other funds or in kind support. Please include a description of such funds as a supplement to the Budget Narrative word document.
  - Prepare and submit a separate TFB form for any capital or start-up expenses and attach this separate TFB form to the coordinating Budget Narrative word document.
  - Additional financial information and requirements are located in **Appendix A**.

All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHFF web-site at: <http://www.dhhr.wv.gov/bhhf/forms/Pages/FinancialForms.aspx>  
Targeted Funding Budget (TFB) Instructions available at:  
<http://www.dhhr.wv.gov/bhhf/forms/Documents/FY%202014%20BBHFF%20TFB%20Instructions.pdf>

**G. Attachments 1 through 3:**

- **Attachment 1:** Reference/Work Cited Page (to include all proposal data citations); Facility/site diagrams (if applicable/available)
- **Attachment 2:** Letters of Support / Memorandum's of Understanding (MOU)
- **Attachment 3:** Targeted Funding Budget(s) and Budget Narrative(s)

## Section Six: **EXPECTED OUTCOMES / PERFORMANCE MEASURES**

### **Expected Outcomes:**

1. Increase support and problem-solving for individuals, families and service providers seeking assistance with the resources needed to decrease the risk of inappropriate admissions to out of home placements or to return individuals to the most integrated setting possible
2. Provide Education and information to their respective local emergency first responders and other local community entities in order to facilitate local communities in responding more effectively to individuals with ID/DD experiencing a crisis
3. Provide trauma informed care
4. Improve access and referral to appropriate level of crisis support.
5. Increase access to positive, strengths-based assessment, planning and behavior support strategies.
6. Increase the number and type of community linkages to support the population.
7. Facilitate transition into the next appropriate level of care.
8. Reduce referrals to out of home care due to behavioral reasons.

### **Performance Measures:**

1. Maintain and provide documentation of ALL activities related to service area(s) indicated by:
  - a. Number of Unduplicated Persons Served by Type of Activity
  - b. Number of Unduplicated Persons Served by Age, Gender, Race and Ethnicity
2. Maintain and provide documentation related to the following:
  - a. Number of Cross Planning (partnering/multi-system collaborative) initiatives, service activities implemented with other sectors indicating type and number
  - b. Number and type of professional development trainings attended and provided
  - c. Number, type (focus groups, surveys, or key-informant interviews), and aggregate results of consumer feedback activities conducted
3. Provide additional service information to include:
  - a. Data to demonstrate what impact program education has made in maintaining adults in the community
  - b. Data to demonstrate what impact program intervention has made in maintaining children in the community
  - c. Data to demonstrate what impact program resource coordination has made in maintaining children in the community, educating community agencies and assisting family/guardians with accessing supports and services.

4. Submit all data as related to the Expected Outcomes/Performance Measures within 25 calendar days of the end of each month in accordance with applicable BBHFF Data Reporting located at <http://www.dhhr.wv.gov/bhhf/Sections/administration/DAT/Pages/measures.aspx>

## Section Seven: **TECHNICAL ASSISTANCE**

The **Bureau for Behavioral Health and Health Facilities (BBHFF)** will provide technical assistance to all applicants through a scheduled technical assistance meeting and/or conference call as indicated on Page 1 of this document.

Technical assistance needs may also be submitted via email to: [DHHRBHFFAnnouncement@wv.gov](mailto:DHHRBHFFAnnouncement@wv.gov). All emailed technical assistance inquiries will be addressed by the BBHFF and posted to a Frequently Asked Questions (FAQ) document on the BBHFF website available at <http://www.dhhr.wv.gov/bhhf/AFA/Pages/default.aspx>.

### **Appendix A** **Other Financial Information**

#### **Allowable Costs:**

*Please note that Departmental Policies are predicated on requirements and authoritative guidance related to Federal grants management and administrative rules and regulations, Grantees shall be required to adhere to those same requirements when administering other DHHR grants or assistance programs, the source of which is non-Federal funds (e.g. state-appropriated general revenue and appropriated or non-appropriated special revenue funds) unless specifically provided direction to the contrary.*

#### **Cost Principles:**

For each kind of grantee organization, there is a set of Federal cost principles for determining allowable costs. Allowable costs are determined in accordance with the cost principles applicable to the organization incurring the costs. The following chart lists the kinds of organizations and the applicable cost principles. The Grantee agrees to comply with the applicable cost principles as set forth below.

<b>If the Grantee is a:</b>	<b>OMB Circulars Codified at:</b>
State, local or Indian tribal government use the cost principles in <b>OMB Circular A-87</b> .	DHS codified at <b>45 C.F.R. § 92</b> and <b>45 C.F.R. § 95</b> USDA codified at <b>7 C.F.R. § 3016</b> ; EDUC codified at <b>34 C.F.R. § 80</b> ; EPA codified at <b>40 C.F.R. § 31</b> .
Private nonprofit organization other than an (1) institution of higher education, (2) hospital, or (3) organization named in <b>OMB Circular A-122</b> as not subject to that circular use the cost principles in <b>OMB Circular A-122</b> .	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .
Educational Institution use the cost principles in <b>OMB Circular A-21</b> .	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .
Hospital use the cost principles in <b>Appendix E of 45 C.F.R. § 74</b> .	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .
For-profit organization other than a hospital and an organization named in <b>OMB Circular A-122</b> as not subject to that circular use the cost principles in <b>48 C.F.R. pt. 31</b> Contract Cost Principles and Procedures.	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .

**Grantee Uniform Administrative Regulations:**

For each kind of grantee organization, there is a set of Federal uniform administrative regulations. The following chart lists the kinds of organizations and the applicable uniform administrative regulations for each listed type of grantee.

<b>If the Grantee is a:</b>	<b>OMB Circulars Codified at:</b>
State, local or Indian tribal government use	Department of Health and Human Services

<p>the uniform administrative requirements in <b>OMB Circular A-102.</b></p>	<p>(DHS) codified at <b>45 C.F.R. § 92</b> and <b>45 C.F.R. § 95</b>;          Department of Agriculture (USDA) codified at <b>7 C.F.R. § 3016</b>;          Department of Education (EDUC) codified at <b>34 C.F.R. § 80</b>;          Environmental Protection Agency (EPA) codified at <b>40 C.F.R. § 31.</b></p>
<p>Private nonprofit organization, institutions of higher education, or a hospital use the uniform administrative requirements in <b>OMB Circular A-110.</b></p>	<p>DHS codified at <b>45 C.F.R. § 74</b>;          USDA codified at <b>7 C.F.R. § 3019</b>;          EDUC codified at <b>34 C.F.R. § 74</b>;          EPA codified at <b>40 C.F.R. § 30.</b></p>
<p>For-profit organization use the uniform administrative requirements in <b>OMB Circular A-110.</b></p>	<p>DHS codified at <b>45 C.F.R. § 74</b>          USDA codified at <b>7 C.F.R. § 3019</b>;          EDUC codified at <b>34 C.F.R. § 74</b>;          EPA codified at <b>40 C.F.R. § 30.</b></p>