FOA Application Form

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| Section One: General Application Information (not scored) |
| Organization Information |
| 1. Organization name (Legal business name of organization)
 | Click or tap here to enter text. |
| 1. Doing Business As (DBA) or facility name
 | Click or tap here to enter text. |
| 1. Unified Entity Identification (UEI) number
 | Click or tap here to enter text.[ ]  I do not have a UEI, but acknowledge one will be needed in order to contract with HCA |
| 1. Statewide Vendor (SWV) for business identified in question #1
 | Click or tap here to enter text.[ ]  I do not have an SWV, but acknowledge one will be needed in order to contract with HCA |
| 1. Full postal address of organization (include ZIP+4)
 | Click or tap here to enter text. |
| Contact Information |
| 1. Full name of contact person and title (include preferred pronouns for communication purposes)
 | Click or tap here to enter text. |
| 1. Telephone number
 | Click or tap here to enter text. |
| 1. Email address
 | Click or tap here to enter text. |
| 1. Full name of contract signatory (include preferred pronouns)
 | Click or tap here to enter text. |
| 1. Telephone number
 | Click or tap here to enter text. |
| 1. Email address
 | Click or tap here to enter text. |
| Contract History |
| 1. Are you a current HCA contractor? If yes, please indicate what type of HCA contract you hold and your contract number.
 | [ ]  **No**[ ]  **Yes; CPWI Community Based Services** Contract Number: Click or tap here to enter text.[ ]  **Yes; CPWI School Based Services****Contract Number:** Click or tap here to enter text.[ ]  **Yes; CBO** **Contract Number:** Click or tap here to enter text.[ ]  **Yes; Other****Contract type:** Click or tap here to enter text. **Contract Number:** Click or tap here to enter text. |
| 1. Have you previously contracted with HCA? If yes, please indicate what type of HCA contract you held, your contract number, and when.
 | [ ]  **No**[ ]  **Yes; CPWI / SAPISP** **Contract Number and year(s):** Click or tap here to enter text.[ ]  **Yes; CBO / Other Project** **Contract Number and year(s):**Click or tap here to enter text.[ ]  **Yes; Other**Click or tap here to enter text.**Contract Number and year(s):** Click or tap here to enter text.) |
| 1. Has your organization had a contract terminated for default, or any other reason, in the last five years? If yes, please explain. If HCA contract, please provide the contract number.
 | [ ]  **No**[ ]  **Yes;** Click or tap here to enter text. |
| Application Details |
| 1. Applicant type
 | Choose an item. |
| 1. Fund source(s) applying for (select all that apply)
 | [ ]  **Dedicated Cannabis Account (DCA)**[ ]  **Mental Health Promotion Program (MHPP)**[ ]  **State Opioid Response (SOR)** |
| 1. Total amount of funding requested

(For two (2) year period: July 1, 2025 – June 30, 2027. Year 1 is July 1, 2025 – June 30, 2026; Year 2 is July 1, 2026 – June 30, 2027.) | **DCA** Year 1 $ Enter dollar amount.Year 2 $ Enter dollar amount.**DCA Total $** Enter dollar amount.**MHPP**Year 1 $ Enter dollar amount.Year 2 $ Enter dollar amount.**MHPP Total $** Enter dollar amount.**SOR** Year 1 $ Enter dollar amount.Year 2 $ Enter dollar amount.**SOR Total $** Enter dollar amount. |
| 1. Should your requested fund source(s) not be available, would you like to be considered for other types of funding?
 | [ ]  **No**[ ]  **Yes** |
| Dedicated Cannabis Account Area(s) ServedPlease indicate which areas will be served with this grant for each question below. |
| [ ]  N/A – Not requesting this funding source (skip to question 24) |
| 1. County(ies) served by DCA programs (select all that apply)
 | Select county.Select county, if applicable.Select county, if applicable.Select county, if applicable.Select county, if applicable.Add any additional county(ies) here. |
| 1. School district(s) served by DCA programs (list all that apply)
 | Add district here.Add district here, if applicable.Add third district here, if applicable.Add any additional districts here. |
| 1. Community(ies) to be served by DCA Programs(list all that apply)
 | Click or tap here to enter text. |
| 1. Will you serve community(ies) identified on the DCA High Risk and High Need list in the Funding Opportunity Announcement (FOA). If yes, please list which community(ies).
 | [ ]  **No**[ ]  **Yes;** Click or tap here to enter text. |
| 1. Are you collaborating with a community coalition?
 | [ ]  **No** [ ]  **Yes (Letter attached)**1. **If yes, how is this coalition funded?**[ ]  HCA/DBHR CPWI[ ]  Other
2. **If yes, please identify the community coalition.**Enter coalition name.**Funding stream (Federal / State / DFC, DOH, DCYF, etc.)**Enter funding stream.
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| Mental Health Promotion Programming Area(s) ServedPlease indicate which areas will be served with this grant for each question below. |
| [ ]  N/A – Not requesting this funding source (skip to question 29) |
| 1. County(ies) served by your MHPP programs (select all that apply)
 | Select county.Select county, if applicable.Select county, if applicable.Select county, if applicable.Select county, if applicable.Add any additional county(ies) here. |
| 1. School district(s) served by your MHPP programs (list all that apply)
 | Add district here.Add district here, if applicable.Add district here, if applicable.Add any additional districts here. |
| 1. Community(ies) to be served by your MHPP programs (list all that apply)
 | Click or tap here to enter text. |
| 1. Will you serve community(ies) identified on the MHPP High Risk and High Need list in the Funding Opportunity Announcement (FOA)? If yes, please list which community(ies).
 | [ ]  **No**[ ]  **Yes;** Click or tap here to enter text. |
| 1. Are you collaborating with a community coalition?
 | [ ]  **No** [ ]  **Yes (Letter attached)**1. **If yes, how is this coalition funded?**[ ]  HCA/DBHR CPWI[ ]  Other
2. **If yes, please identify the community coalition.**Enter coalition name.**Funding stream (Federal / State / DFC, DOH, DCYF, etc.)**Enter funding stream.
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| State Opioid Response Area(s) ServedPlease indicate which areas will be served with this grant for each question below. |
| [ ]  N/A – Not requesting this funding source (skip to question 34) |
| 1. County(ies) served by your SOR programs (select all that apply)
 | Select county.Select county, if applicable.Select county, if applicable.Select county, if applicable.Select county, if applicable.Add any additional county(ies) here. |
| 1. School district(s) served by your SOR programs (list all that apply)
 | Add district here.Add district here, if applicable.Add district here, if applicable.Add any additional districts here. |
| 1. Community(ies) to be served by your SOR Programs (list all that apply)
 | Click or tap here to enter text. |
| 1. Will you serve community(ies) identified on the SOR High Risk and High Need list in the Funding Opportunity Announcement (FOA)? If yes, please list which community(ies).
 | [ ]  **No**[ ]  **Yes;** Click or tap here to enter text. |
| 1. Are you collaborating with a community coalition?
 | [ ]  **No** [ ]  **Yes (Letter attached)**1. **If yes, how is this coalition funded?**[ ]  HCA/DBHR CPWI[ ]  Other
2. **If yes, please identify the community coalition.**Enter coalition name.**Funding stream (Federal / State / DFC, DOH, DCYF, etc.)**Enter funding stream.
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| Program and Strategy Selection  |
| 1. DCA program selection
 | **Required:**1. Direct Service (minimum of one)

Select program.Select program, if applicable.Select program, if applicable.Select program, if applicable.Add any additional program(s) here. |
| 1. MHPP program selection
 | **Required:**1. Community Awareness Event
2. Youth Mental Health First Aid Training
3. Direct Service (minimum of one) from the following areas of focus:

[ ]  **Option A: MHPP Programming Selection (EBP)**Select program.Select program, if applicable.Select program, if applicable.Select program, if applicable.Add any additional program(s) here.[ ]  **Option B: Suicide Prevention Programming Selection (EBP/Promising)**Select program.Select program, if applicable.Select program, if applicable.Select program, if applicable.Add any additional program(s) here.[ ]  **Option C: Suicide Prevention Innovative Programming Selection (Appendix 4)**Type Risk and/or Protective Factor(s) here.Type program(s) and brief description(s) here.[ ]  **Option D: Eating Disorder Innovative Programming Selection (Appendix 5)**Type Risk and/or Protective Factor(s) here.Type program(s) and brief description(s) here. |
| 1. SOR program selection
 | **Required:**1. National Take Back Day
2. Direct Service (minimum of one)

Select a SOR programSelect a SOR programSelect a SOR programSelect a SOR program**Opioid Prevention Public Education Campaign (select at least one)**[ ]  Friends for Life[ ]  Starts With One |
| 1. Do you intend to have formal or informal agreements with individuals or organizations to implement any portions of this work?

This may look like:* A subcontract
* An MOU
* A personal service agreement
* An independent contractor

If yes: Provide the name(s) and a short description of the partnership, to include the types of services provided and what services are being paid for. | [ ]  **No**[ ]  **Yes;** Click or tap here to enter text. |
| Section Two: Narrative (scored) |
| 1. ***Abstract:*** Write a brief summary of the services you are looking to provide and the community(ies) you are applying to serve. (500 words)

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| 1. ***Capacity:*** Describe your ability and experience serving populations facing the high need and risk, including youth, families, and young adults.

Click or tap here to enter text. |
| 1. ***Capacity:*** Describe your related experience with providing substance use disorder prevention, mental health promotion, suicide prevention and/or disordered eating prevention services. Include related experience for any of the related programs and funding you are requesting.

Click or tap here to enter text. |
| 1. ***Capacity:*** How will you work to ensure that you have the dedicated resources (personnel, administrative and billing capacity, data collection and entry, etc.) to implement your Action Plan as proposed and fulfill all required documentation, reporting, and billing?

Click or tap here to enter text. |
| 1. ***Capacity:*** Describe the specific technical assistance and training you will need to support the implementation of this scope of work, and your plan to address these needs.

Click or tap here to enter text. |
| 1. ***\*Assessment:*** Briefly describe the substance use disorder prevention, suicide prevention, disordered eating prevention, and/or mental health promotion needs within the community(ies) you are applying to serve. Provide data that supports these needs (such as a high-level summary with references, demographics, Healthy Youth Survey, Young Adult Health Survey, CPWI Community Survey, and/or Community Risk Profile data).

Click or tap here to enter text. |
| 1. ***\*Assessment:*** Discuss the overall demographic makeup within the community(ies) you are planning to serve. This should include:
* Community demographics, both geographic and social (i.e., age, gender, race/ethnicity, households/families, education, veteran status, income, poverty, employment, commuting, homeowner/renter status)
* A description of what populations within your community(ies) you will be serving
* Health equity barriers within the community(ies) that you plan to address

Click or tap here to enter text. |
| 1. ***\*Planning:***Explain how the program(s) and strategy(ies) you have selected will address substance use prevention, mental health promotion, suicide prevention, and/or disordered eating prevention in your community(ies).

Click or tap here to enter text. |
| 1. ***Planning:*** Explain how your selected program(s) and strategy(ies) will incorporate health equity strategies to uniquely address your community’s cultural, linguistic, and demographic needs, and what steps will be taken to ensure those needs are met.

Click or tap here to enter text. |
| 1. ***\*Implementation:*** Please provide an Action Plan Overview. This overview should describe all programs, strategies, and actions that will be taken using this grant funding.

An Action Plan Overview must include at a minimum:* All required and selected programs, strategies, and activities to be implemented
* The goal and objective being addressed by each chosen program and strategy
* How each program and strategy will be implemented (i.e., who is in charge of planning and monitoring, who will implement, who and how many people will be served, where implementation will occur, and how many times a program and strategy will be implemented during each funding year)

Click or tap here to enter text. |
| 1. ***\*Implementation:*** Describe how you plan to implement each program and strategy to fidelity or, if you have any planned program or strategy adaptations, please describe those adaptations and why those adaptations are being made. Allowable planned adaptations are modifications to:
* Training requirement(s)
* Dosage/duration
* Delivery site
* Population of focus

Click or tap here to enter text. |
| 1. ***\*Implementation:*** How will you ensure that you will be able to fully execute your Action Plan? This should include the process of selecting, recruiting, and retaining participants to the identified program, establishing partnerships with others in the community, and how you plan to monitor implementation to ensure all programming is delivered to fidelity or approved adaptations.

Click or tap here to enter text. |
| 1. ***\*Evaluation:*** Discuss the expected changes in either behavior, attitudes, beliefs and/or knowledge of participants that will demonstrate the effectiveness of the program(s) in addressing your community’s need(s).

Click or tap here to enter text. |
| 1. ***Evaluation:*** Pre and post tests are required for all reoccurring program services. How will you ensure collection of pre and post test data for each applicable program? How else will you assess program effectiveness?

Click or tap here to enter text. |
| 1. ***\*Evaluation:*** What is your plan to track the impact and/or change your selected programming will make in the community(ies) identified?

Click or tap here to enter text. |
| Section 3: Budget Narrative (scored) |
| 1. ***\****Please provide a narrative of your Project Budget. This narrative should include a description of how your organization will allocate funding for all programs and strategies proposed for this grant, including costs and explanations related to:
* Staff salary and benefits
* Program curriculum costs
* Professional services and facilitator fees
* Supplies and printing costs
* Administrative/Indirect costs (up to 10%)
* Associated capacity and staffing expenses, to include but not limited to training costs (required DBHR trainings and other proposed trainings)

This response should not only include the programs that you are selecting per fund source but should also include the programs and strategies each fund source requires (refer to questions 34, 35, and 36).A budget template is not required to be submitted with this application. However, applicants may utilize the budget template to support drafting this narrative. The budget template will be completed by Successful Applicants in Part 2.Click or tap here to enter text. |

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| I certify that minimum qualifications as outlined in the Eligible Applicants section have been met. | [ ]  **No**[ ]  **Yes** |
| I certify that I have reviewed and agree to the reporting requirements located within the Funding Opportunity Announcement (FOA). | [ ]  **No, I have not reviewed and/or do not agree to reporting requirements.**[ ]  **Yes, I have reviewed and agree to reporting requirements.** |
| I certify that, on behalf of the applicant agency, I amauthorized to submit this application to provide thedescribed services. | Enter applicant’s nameClick or tap to enter a date.Enter your graphic signature in the box below.  |