**Exhibit C – MHPP Application Packet**

(This application packet is for applicants applying for programs funded by MHPP Funds)

**Attachment 1 -MHPP- Application Cover Page**

(Mandatory/Not Scored\* Bonus Point Available)

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| 1. **Applicant type** | **Applicant Type A – Requesting funding for new services**  **Applicant Type A – Requesting funding to expand existing services**  **Applicant Type A – Requesting funding to continue existing services**  **Applicant Type B – Requesting funding for new services** | |
| 1. **Organization Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. **Fund Source(s) Applying For** | Mental Health Promotion Program (MHPP) | |
| 1. **Community(ies) Served by Applicant’s Programs**   Community is identified as High Risk/High Need per Exhibit - E [Yes  No ]  Bonus Points (5 regardless of total High Risk/High Need communities served.): | (Type in Community) | (Type in Community) |
| (Type in Community) | (Type in Community) |
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| (Type in Community) | (Type in Community) |
| 1. **County(ies) Served by Applicant’s Programs**   (Select All That Apply) | (Select County) | (Select County) |
| (Select County) | (Select County) |
| (Select County) | (Select County) |
| (Select County) | (Select County) |
| (Select County) | (Select County) |
| 1. **School District(s) Served Applicant’s Programs**   (Select All that Apply) | (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| (Select School District) | (Select School District) |
| 1. **Can Program Implementation begin within 30 days of contract execution?** | Yes  No | |
| 1. **Total Amount of Funding Requested**   (For two (2) year period) | MHPP- Year 1 $\_\_\_\_\_\_\_\_\_\_  Year 2 $\_\_\_\_\_\_\_\_\_\_ | |
| 1. **Are you collaborating with a Community Coalition?** Bonus Points(5) | Yes  No *(Skip to #10)*   * 1. If yes, how is this coalition funded?   HCA/DBHR CPWI  Drug Free Communities,  Other existing Community Coalitions  Other state funded prevention efforts  DCYF, Family and Youth support Prevention Programs  DOH Youth Cannabis and Commercial Tobacco Programs   * 1. If yes, please identify the community coalition contact person and email address.   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * 1. If yes, provide a letter of support from the community coalition(s) separate from this document. (Bonus points: 5) | |
| 1. **Is your application complete? Please check box indicating that your application includes the following:** | Application Cover Page - Attachment 1  Program Selection Form - Attachment 2  Action Plan - Attachment 3  Project Narrative - Attachment 4 | |

Mental Health Promotion Program (MHPP): a program or strategy with the overall goal of maximizing mental health and well-being among populations and individuals.

Return entire Application Packet as part of your submittal to Procurement Coordinator at:  
[HCAProcurements@hca.wa.gov](mailto:HCAProcurements@hca.wa.gov)

Attachment 2- Program Selection Form

(Mandatory/Not Scored)

This program selection form is a list of all possible evidence-based programs and strategies that an applicant can chose from to address their local conditions as. The selected program(s) and strategy (ies) will be used by the Applicant to create their Action Plan and Budget. Applicants should select the box next to each program and strategy they plan to implement. Program and strategy selection should reflect the Applicant’s capacity and budget.

Community Based Organizations applying for Mental Health Promotion Projects (MHPP) are required to use the following guidance when implementing services each year under the grant:

1) Implementation of at least one Youth Mental Health First Aid (YMHFA) training per year with a maximum cost of $5,000. Costs may include trainer and travel costs, meals, materials, and all other expenses associated with the training and must be include as part of budget. It is also acceptable to use these funds to train YMHFA facilitators who will provide training workshops for your community (though at least one training must occur within the project timeline). If Applicant has previously held a contract with HCA for MHPP/Suicide Prevention CBO services and has fully saturated their community with this training, they may submit a request for an exception to this requirement as part of their response to Attachment 4- Project Narrative, Question 7.

2) Implementation of at least one community awareness event per year, totaling a minimum of two events during the project period. Costs may include public education or multi-media expenses. Awareness messages may focus on mental health promotion, primary prevention, reducing stigma and encouraging individuals to seek help, or postvention.

3) Implement at least one Direct Service Program on the list below. Applicant will select one of the following proposal options A, B, or a combination of both:

* + - * 1. Mental Health Promotion Program Options and/or
        2. Suicide Prevention Program Options

The program is expected to be implemented on a regular annual schedule over the course of the grant year, which may mean implementing multiple series or cycles of a program. For example, if Guiding Good Choices is selected, which is a five-week program, this must be implemented at least twice during each fiscal year.

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| **A. Mental Health Promotion Options (Must include EB/RB/P programs from the list below. Innovative programs are not permitted for this option).** | | |
| Only Evidence-Based (EB) or Research-Based (RB) services are proposed.  Only Promising Program (PP) services are proposed.  Combination of EB/RB/PP program services proposed. | | |
| **Evidence-Based (EB) & Research-Based (RB) Programs for Mental Health Promotion** | | |
| Big Brothers Big Sisters – Community  Blues Program  Coping and Support Training (CAST)  Coping Power Program (Selective Version)  Family Check-up – Toddler  Family Foundations  Fostering Healthy Futures for Preteens (FHF-P)  Good Behavior Game   * Approved versions: American Institutes for Research (AIR) GBG, PAXIS Institute (PAX) GBG | Incredible Years   * Approved versions: Parent BASICS – (Toddler, Preschool, and/or School Age); Teacher Classroom management\*   KiVa Antibullying Program  LifeSkills Training (LST)  New Beginnings for Children of Divorce  Nurse Family Partnership (NFP)  ParentCorps  Parenting Through Change (PTC) by Generation PMTO, formerly known as Parent Management Training – The Oregon Model (PMTO) | Positive Action  Positive Family Support  Raising Healthy Children, formerly Seattle Social Development Project  Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14, Iowa Version)  Strong African American Families Program  Strong African American Families Program – Teen  Triple P |
| **Promising Programs (PP) for Mental Health Promotion** | | |
| Families and Schools Together (FAST)  Second Step | | |

**OR**

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| **B. Suicide Prevention Options (Must include EB/RB/P programs or identify approved Risk/protective factors from the lists in Form A).**  **For suicide prevention only, it is also allowable to implement a program or practice that is innovative. Innovative suicide prevention programs must include justification of a demonstrated need and how the principles of effectiveness were considered and incorporated in the development of the program (**[**https://www.theathenaforum.org/CSAPprinciples**](https://www.theathenaforum.org/CSAPprinciples)**). The Preventing Suicide: A Technical Package of Policy, Programs, and Practices may be a useful document to reference (**[**https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf**](https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf)**).** | | | |
| Only Evidence-Based (EB) or Research-Based (RB) services from the list below are proposed.  Only Promising Program (PP) services from the list below are proposed.  Only Innovative Program services are proposed.  Combination of EB/RB/PP/IP program services proposed (Innovative Programs are allowed for suicide prevention efforts only). | | | |
| **Evidence-Based (EB) & Research-Based (RB) Programs for Suicide Prevention** | | | |
| Coping and Support Training (CAST)  Good Behavior Game   * Approved versions: American Institutes for Research (AIR) GBG, PAXIS Institute (PAX) GBG | | | |
| **Promising Programs (PP) for Suicide Prevention** | | | |
| Sources of Strength  Question, Persuade, Refer (QPR) | | | |
| **Approved domains and Risk Factors for Innovative Suicide Prevention Programs** | | | |
| **Societal**  Media Violence | **Community**  Poor neighborhood support and cohesion  Transitions and Mobility | **Relationship**  Social isolation/Lack of social support  Poor parent-child relationships  Family History of suicide  Family Management problems  Family Conflict  High conflict or violent relationships | **Individual**  Skills in non-violent problem-solving  Poor behavioral control/impulsiveness  History of violence victimization  Witnessing violence  Psychological/mental health problems |
| **Approved domains and Protective Factors for Innovative Suicide Prevention Programs** | | | |
| **Societal**  N/A | **Community**  Coordination of resource and services among community agencies  Access to mental health and substance abuse services  Community support or connectedness | **Relationship**  Family support or connectedness  Connection to a caring  adult  Connection or commitment to school | **Individual**  Skills in solving problems non-violently |

\*Each listed Incredible Years version may be implemented as a stand-alone program: more than one version is not required

Attachment 3 – Action Plan (20 points scored)

Directions: Complete an Action Plan using the template provided below. In order to fully complete the Action Plan for submission, fill in responses to all prompts beneath all Goals/Objectives, outlining the programs and strategies you are planning on Implementing. Please include the program name(s), the number of participants being served, number of sessions, months the program(s) will be implemented, and the responsible party(ies) within the community or organization who will be running the programs/services. These programs/activities should correspond with the required programs/activities as outlined in Attachment 2. If you cannot answer a specific section on the Action Plan, you must indicate the reason within the table.

**Goal:** Write the goal you are looking to achieve within your community with the program / strategy you are choosing. Goals should be written in SMART (Specific, Measurable, Actionable, Realistic, Timely) goal form.

**Objective:** Write the specific and measurable outcomes(s) you will strive to achieve to accomplish your stated goal. Objectives should be written in SMART (Specific, Measurable, Actionable, Realistic, Timely) goal form.

**CSAP:** Choose the appropriate CSAP category that your program / strategy fits within. CSAP categories can be found in the definitions section of this RFA.

**Program / Strategy:** Write the name(s) of program / strategy(ies) from Program Selection List that you have selected to implement.

**Community Name:** Write the name of community(ies) each program will serve.

**IOM Category:** Indicate the appropriate IOM Category (Universal Direct, Universal Indirect, Selected, Indicated). IOM Categories can be found in the definitions section of this RFA.

**How much? How often?:** Write how many groups of people will be receiving the program / strategy, and how many series will be offered.

**When:** List all of the implementation months of the program.

**Who & How many:** Write who is this service for, and how many people reached.

**Survey:** Type A Applicants should indicate which survey they will implement using the survey selection guide posted on Athena, Type B Applicants should indicate N/A (Successful type B applicants will receive guidance in survey selection after award).

**Responsible party(ies) and Program Lead:** Write who (Name and/or title) within the organization will be responsible to ensure all set up for the program / strategy, and who will be the Lead in implementing it. If this is the same person, please indicate.

This template is for use with the September 1, 2023 – June 30, 2025 HCA/DHBR CBO MHPP Grants . Please complete an Action Plan for Direct Service Programs and Strategies for the first fiscal year only. If Applicant is awarded a contract, the Action Plan for Year 2 Direct Service Programs and Strategies will be resubmitted for review with HCA by June 15, 2024.

Applicants may use as many tables as needed.

Prevention Services Action Plan Template

**Action Plan for First Year: September 1, 2023 - June 30, 2024:**

***Goal 1:***



***CSAP Strategy:***Choose an item. *(See definitions in RFA)*

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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***Goal 2:***

***Objective 2.1:***

***CSAP Strategy:***Choose an item.*(See definitions in RFA)*

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| Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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**Action Plan for Second Year: July 1, 2024 - June 30, 2025:**

***Goal 1:***



***CSAP Strategy:***Choose an item. *(See definitions in RFA)*

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| Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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***Goal 2:***

***Objective 2.1:***

***CSAP Strategy:***Choose an item. *(See definitions in RFA)*

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Program/ Strategy | Community Name | IOM Category | *How much?*  *How often?* | When | Who &  How Many | Survey | Responsible Party(ies) and Program Staff Lead(s) |
| *Name of program/ strategy from Program Selection List* | *Name of community(ies) this program will serve* | *- Universal Direct*  *- Universal Indirect*  *- Selected*  *- Indicated* | *How many groups or series will be offered?* | *List all of the implementation months of the program* | *Who is this service for?*  *How many people reached?* | *Type A: Indicate Survey*  *Type B: Indicate N/A* | *Organization and person ensuring program delivery* |
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**Attachment 4 – Project Narrative**

Instructions for Project Narrative

A complete Project Narrative is required for application to be considered complete.

Please provide complete information to the following questions to describe the proposed program(s) selected. Please remember: The Project Narrative will be scored according to how well the Applicant answers each question. Each narrative question will be assessed when determining the score for each question. If an Applicant cannot answer a specific question, then the reason for this must be explained within the answer to the question.

All required responses must be submitted using the template provided. Each response may not exceed the number of pages listed in the questions described below, and any pages that exceed this limit will be deleted prior to the Health Care Authority (HCA) forwarding the applications to the evaluators. Applicants are not required to utilize the full page allotment if not needed, as long as the Applicant ensures that the answer is complete.

*Optional:* Applicant *may use the checklist below to track their response progress*

Section 1 -Overview (20 points)

Question 1.

Question 2.

Question 3.

Question 4.

Section 2- Plan for Advancing Health Equity (10 Points)

Question 5.

Question 6.

Section 3 – Implementation (25 Points)

Question 7.

Question 8.

Question 9.

Question 10.

Question 11.

1. **Describe the community(ies) that will be served with your program(s), and if the community(ies) is/are on the Communities Experiencing the Highest Need for Mental Health Promotion and Risk of Suicide list as described in Exhibit E of this RFA. Briefly describe the demographics of the community(ies) you intend to serve, including specifically who will be served with these funds. Include your ability and experience in serving the youth and parents within the community(ies).** 5 Points (Maximum 1 Page)
2. **Provide data (such as a high-level summary with references, demographics, or Healthy Youth Survey data) to support why Mental Health Promotion and Suicide Prevention services are needed in the communities identified.** 5 Points (Maximum 1 Page)
3. **Provide a brief overview of how your proposed program(s) and strategies address Mental Health Promotion and Suicide Prevention in the community you intend to serve. Explain your understanding of the factors in identified community likely increasing the need for these services.** 5 Points (Maximum 1 Page)
4. **Describe your ability and experience with providing Mental Health Promotion and Suicide Prevention services. Describe your ability and experience serving populations experiencing the highest need and risk, including youth and families.** 5 Points (Maximum 1 Page)
5. **Explain how your organization will provide culturally competent and appropriate services, using specific details that demonstrate this capacity.** 5 Points (Maximum 1 Page)
6. **Explain how your organization will be actively involved with reducing health disparities and promoting health equity, using specific details that describe strategies used and/or steps taken.** 5 Points (Maximum 1 Page)
7. **Provide a brief description of how your organization will implement the chosen approved Program(s), from the Program Selection Page(s). Please indicate if you plan to repeat implementation throughout the years of service, if you plan to implement programs according to program implementation requirements. If you have any planned adaptations or cultural considerations, please describe these. If Applicant has previously held a contract with HCA for MHPP/Suicide Prevention CBO services and has fully saturated their community with the Youth Mental Health First Aid training, you may submit a request for an exception to this requirement here.** 5 Points (Maximum 1 Page)
8. **Describe how these programs were selected for implementation in your community. Describe the overall goal(s) of the program(s). 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 communities need(s).** 5 Points (Maximum 1 Page)
9. **Discuss the process of selecting and recruiting participants to the identified program and tools you will use to assess the effectiveness of the identified program(s).** 5 Points (Maximum 1 Page)
10. **Describe your capacity to fulfill the scope of the services described for the proposed number of participants. Describe staffing levels needed to implement the program with fidelity and identify what staff position or positions will be the lead on ensuring supervision and implementation.** 5 Points (Maximum 1 Page)
11. **Describe the specific technical assistance and training you will need to implement this scope of work and your plan to address these needs.** 5 Points (Maximum 1 Page)

**{End of Exhibit C – MHPP Application Packet}**