Request for Applications (RFA): Early Mental Health Initiative

Clinical Services

First 5 Shasta
Shasta Children and Families First Commission
1135 Pine St. Suite 21
Redding, CA 96001
Phone: (530)229-8300
www.first5shasta.org

Request for Applications: Early Mental Health Initiative Clinical Services

I. First 5 Shasta Overview

First 5 Shasta, *the Shasta Children & Families First Commission* (SCFFC), is funded by the California Children and Families Act (Proposition 10). This statewide initiative was passed by voters in 1998. Proposition 10 placed a 50 cent-per-pack tax on cigarettes to fund education, health, child care and other programs to support the healthy development of children from the prenatal stage to five years old.

The vision of First 5 Shasta is to create a system of information, services and activities that allows all young children in Shasta County to learn, play and reach their potential as contributing members of society. To realize this vision, First 5 Shasta commits 80% of its annual revenue to supporting new or expanded programs in Shasta County. Since its inception, First 5 Shasta has invested over $14 million in programs and activities that enhance the lives of young children in Shasta County. Grant opportunities have resulted in funding awards that support the areas of focus identified in First 5 Shasta's Strategic Plan. A list of First 5 Shasta's current Goals and Objectives can be found in Attachment A. For more information on First 5 Shasta, visit the First 5 Shasta website at www.first5shasta.org.

II. Early Mental Health Initiative

Overview

Attachment is the strong emotional bond that develops between an infant and his/her parent/primary caregiver. Securely attached infants trust that their parent/primary caregiver will consistently meet their physical and emotional needs, providing them with emotional security. This secure relationship provides the basis for competence in forming other relationships, managing emotions, and developing self-esteem and self-confidence. This relationship also impacts young children's confidence to explore the environment around them, to try new things, and to learn new skills, because babies and children learn best when they feel safe, calm, protected, and nurtured by their parent/primary caregiver[1].

Attachment in very young children can have a strong impact on later child development. Insecure attachment has been linked to reductions in young children's behavioral, cognitive, and social and emotional functioning. For example, a child who was insecurely attached in infancy is more likely to have poor communication skills, to have poor social skills such as withdrawal or aggression, to be impulsive, easily distracted, and disobedient, and to lack curiosity and motivation in school[2]. It is

[1] U.S. Department of Health and Human Services, Child Welfare Information Gateway. *Understanding the Effects of Maltreatment on Early Brain Development*. Available at: http://www.childwelfare.gov/pubs/focus/earlybrain/earlybraina.cfm.

[2] Appleyard K and Berlin LJ. Supporting Healthy Relationships Between Young Children and Their Parents: Lessons From Attachment Theory and Research. Available at: http://www.childandfamilypolicy.duke.edu/pdfs/pubpres/SupportingHealthyRelationships.pdf.

important to note that an insecure attachment does not dictate a child's future; however, early intervention is most likely to lead to positive change[3].

Parents'/primary caregivers' ability to nurture and to be responsive to their children directly impacts their children's attachment. Many things can negatively impact infant attachment, including family and environmental stressors, parent/primary caregiver personal history (including a history of adverse childhood experiences), maternal depression, and parent/primary caregiver mental illness. For a discussion of Adverse Childhood Experiences and their impact, please see Attachment B.

In recognition of the significant impact impaired attachment can have on young children's growth and development, First 5 Shasta is implementing the Early Mental Health Initiative. This initiative includes two components, Clinical Services and Family Support Services, both of which are intended to serve families with children from the prenatal stage up to age 24 months and to develop services and supports that address parent/primary caregiver issues interfering with attachment. In order to develop a range of services that address the varied needs of families, two separate Request for Applications (RFA) processes are being conducted. Applicants may apply to one or both RFAs. A comparison of the two RFAs is presented below.

Early Mental Health RFA Comparison		
	Clinical Services RFA and Family Support Services RFA	
Target Population	Families with children from the prenatal stage up to age 24 months where there are parent/primary caregiver issues interfering with attachment	
Focus Areas	• Addressing parent/primary caregiver social-emotional challenges to developing healthy attachment • Addressing maternal depression • Providing parenting support for parents/primary caregivers with chronic and persistent mental illness	
Funding Period	July 1, 2010 – June 30, 2013	
	Clinical Services RFA	**Family Support Services RFA**
Intervention Types	• Clinical support	• Parent-to-parent support • Social activity • Parenting skill development • Connections to community resources
Funding Available	Approximately $350,000-400,000	Approximately $200,000-250,000
Number of funded programs	Up to two	Up to four

[3] Appleyard K. and Berlin LJ.

Programs funded through this initiative are intended to address the SCFFC outcome objective of increasing access to evidence-informed mental health services, and its related goal, that children live free of abuse, neglect, and exposure to violence. First 5 Shasta is interested in incorporating the Strengthening Families approach, developed by the Center for the Study of Social Policy, into prevention and early intervention efforts. This approach focuses on promoting protective factors in families, which in turn strengthen parents/primary caregivers' ability to parent effectively, even when under stress. These protective factors include:

1. Nurturing and attachment - Having a close parent-child bond, in which parents better understand, respond to, and communicate with their children;
2. Parental resilience - The ability to cope and bounce back from all types of challenges;
3. Social connections - Friends, family members, neighbors, and other members of a community who provide emotional support and concrete assistance to parents;
4. Knowledge of parenting and child development - Accurate information about raising young children and appropriate expectations for their behavior;
5. Children's social and emotional development - A child's ability to interact positively with others and communicate his or her emotions effectively;
6. Concrete support in times of need – Services and resources to help families move beyond the stress of meeting basic needs, including access to formal supports like Temporary Assistance for Needy Families (TANF) and Medicaid, and informal support from social networks.

Research demonstrates that these protective factors can reduce the incidence of child abuse and neglect. For more information on the Strengthening Families approach, please visit www.strengtheningfamilies.net and www.childwelfare.gov/preventing.

Initiative Focus Areas

The Early Mental Health Initiative focuses on three areas related to attachment:

1. Addressing parent/primary caregiver social-emotional challenges to developing healthy attachment
2. Addressing maternal depression
3. Providing parenting support for parents/primary caregivers with chronic and persistent mental illness

Intervention Collaborative Network

The purpose of this initiative is to develop a continuum of services that address barriers to attachment. Programs funded are expected to create a "collaborative network" that offers a range of services for families, and to refer families to other network partners when most appropriate for a family's needs. This collaborative network of services is intended to incorporate the concept of

minimum sufficiency: the least amount of intervention to solve the problem at hand and prevent future difficulties.

Programs funded through this initiative will be required to develop and use coordinated care protocols in partnership with other organizations funded through the Early Mental Health Initiative RFA processes. Programs also must implement plans for referrals across network organizations and to outside organizations as needed. For example, clients receiving clinical services may be referred to programs offering social activities to help them develop a social support network as they progress through treatment. Similarly, clients receiving parent-to-parent support may be referred to skill development activities to strengthen skills to address a particular concern identified by a parent and his/her mentor, or to clinical support to focus on an indentified mental health need. Programs also will be expected to adopt standardized forms (including forms for intake, assessment, and referral) across all components, in order to enable smooth transitions between programs for families receiving services.

One agency will be selected to serve as the lead coordinating agency for the collaborative network for screening, assessment, and referral purposes. The collaborative lead agency will not be required to play a lead contractual role, nor are other network agencies expected to be subcontractors with the collaborative lead agency. The program selected as collaborative lead agency will have its budget revised during the contract development process to reflect additional costs associated with this role. Applicants are invited to discuss their interest in fulfilling this role in their program proposal.

Initiative Desired Results

First 5 Shasta has identified the following desired results for this initiative:

1. *Increased Family Protective Factors*

   This includes improvements in parent/primary caregiver nurturing and child attachment, parent/primary caregiver resilience, social connections, and knowledge of parenting and child development, as well as concrete support for families in times of need.

2. *Reduced Family Risk Factors*

   This includes reductions in high levels of parent/primary caregiver psychological distress, high levels of family stress and instability, lack of family social cohesion, and difficult child temperament and behavior.

3. *Increased Parental Capacity to Attach*

   Increasing protective factors and reducing risk factors will lead to this desired result.

Applicants must include a discussion of their program's desired results and how program activities will lead to the initiative desired results as a part of their application.

III. Clinical Services RFA

To address the initiative focus areas described above, First 5 Shasta envisions five interconnected intervention components, consisting of clinical support, and four family support components: parent-to-parent support, social activity, parenting skill development, and connections to community resources. Through this Early Mental Health Services Initiative: Clinical Services RFA, Approximately $350,000 - $400,000 is available to programs that provide family support services to this population of interest. This RFA is intended for providers seeking to offer the clinical support component, described in detail below. Up to two programs may be funded through this RFA. Programs will be funded for a three-year period from July 1, 2010, through June 30, 2013.

Clinical Services: Intervention Description and Requirements

Clinical Support

The clinical support component is intended to address the underlying issues of parental psycho-social/emotional barriers to attachment, adverse childhood experiences, depression, and mental illness. Programs addressing this component must provide individual or group clinical therapy. Programs providing 1-on-1 clinical support may choose to offer this service in-office or through client home visits.

Clinical service must be provided by a licensed clinical therapeutic provider (Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, or Doctor of Psychology). Interns may provide clinical services as a component of the proposed program, provided that they have a minimum of 1000 hours of supervised clinical experience, including group therapy experience, and are Marriage and Family Therapist Interns registered with the California Board of Behavioral Sciences (BBS) or BBS-registered Associate Clinical Social Workers. Interns must be provided with clinical supervision by a BBS-licensed LCSW or MFT through the therapeutic practice applying to this RFA. Licensed clinical providers in private practice are eligible to apply to provide the clinical support component.

Clinical providers must implement practices that are evidence-based or evidence-informed. Examples of evidence based practices can be found in the National Registry of Evidence-based Programs and Practices (NREPP) at http://www.nrepp.samhsa.gov/, as well as in the California Evidence-based Clearinghouse (CEBC) at http://www.cebc4cw.org/. Programs and practices must include specific sources of evidence, whether from the NREPP, CEBC, or other sources.

Providers offering clinical support must utilize validated assessment to determine client needs and appropriate level of service. Clinical providers also must include protocols for referring and providing follow-up with primary care providers for medical treatment/medication when necessary.

Clinical Services Program Guidelines

- Applicants may address one or more of the three focus areas related to attachment: parent/primary caregiver social-emotional challenges to developing healthy attachment,

maternal depression, and parenting support for parents/primary caregivers with chronic and persistent mental illness.

  - Interventions addressing maternal depression will be required to have a system of referral to and follow-up with primary care providers

- Proposition 10 legislation does not allow First 5 Shasta to use funds to supplant or take the place of funding for existing services. Funds must be used to create, enhance, or expand services.

- Programs funded through this RFA may address substance abuse only as a peripheral issue. This RFA is not intended to address substance abuse intervention as a primary issue/need. We recognize that active substance abuse can interfere with mental health treatment; therefore, clients with substance abuse issues must address those issues prior to moving on to mental health treatment.

- Programs funded through this RFA must serve families with children from prenatal through age 24 months.

- Applicants will be expected to link/partner with other initiative grantees to form a collaborative network of services and interventions as described above.
  - One applicant will be selected in the award process to serve as the lead collaborative network agency for the purposes of coordinated screening, assessment, and referral.
  - Programs will coordinate services among agencies in order to meet client needs using standardized protocols.
  - Programs must develop and implement standardized forms across all components.

- Providers funded through this RFA will have their proposed workplans reviewed and revised as appropriate during the contract development process. These finalized workplans shall become part of the program contract.

- Each funded program/provider will be required to submit regular reports to First 5 Shasta on the progress of their workplans as a term of the contract. Programs must submit:
  - Quarterly interim reports including demographic data.
  - Semi-annual progress reports including demographic data and data on program deliverables and network participation and activities.

- Providers may be required to utilize the First 5 Shasta web-based data management system to collect demographic, program, and evaluation data.

- Providers must participate in ongoing program results evaluation activities, described below.

Program Evaluation

First 5 Shasta's evaluation focus is equally driven by a "Program Improvement" and an "Accountability" agenda. Specifically, First 5 Shasta's evaluation activities seek to:

1. Inform decision-making.
2. Guide program implementation and ongoing improvement to ensure program effectiveness.
3. Communicate key findings and best practices for supporting children 0-5 and their families, as well as the value of investing in early childhood.
4. Provide accountability and visibility to the community regarding the use of First 5 funds.

To support First 5 Shasta's commitment to accountability, the Commission contracts with evaluation professionals to conduct results evaluations of funded programs. Programs funded under this RFA will be required to participate in program results evaluation activities in conjunction with First 5 Shasta's team of evaluators and First 5 Shasta staff.

First 5 Shasta's grantee-level evaluation seeks to support grantees' evaluation capacity, document the impact of their work with families, and identify lessons learned about what worked and what could be improved. First 5 Shasta staff and evaluators will work with programs funded through this RFA to develop an abbreviated logic model specific to their funded programs as part of the contract development process. Each logic model will include:

- Program Description - what the program is and its overarching goal;
- Inputs - the resources needed to accomplish the activities, such as staff time and materials;
- Activities - the activities designed to produce the expected changes;
- Outputs - what is created or produced by the program activities;
- Program outcomes - the expected short-term and long-term changes for specific populations addressed by the program.

Once the logic model is in place, First 5 staff and evaluators will work with each grantee to develop an evaluation plan that will detail how the evaluation will be conducted. This evaluation plan will become part of the program's contract.

First 5 Shasta staff and evaluators will provide technical assistance to grantees on data collection instrument development and data management. Grantees will be required to collect data as described in their specific evaluation plans. This may include the use of First 5 Shasta's web-based data management system to collect demographic, program, and evaluation data.

Program Sustainability

Programs selected through this RFA will be funded for a three-year period from July 1, 2010 through June 30, 2013. This initiative is not expected to be repeated in future funding cycles. Applicants to this RFA must develop concrete plans to ensure sustainability of their programs once First 5 Shasta

funding concludes. In discussing sustainability in their applications, applicants may consider such options as linkages with other funding sources, leveraging of funds, the identification of non-grant-funded options for sustainability, and the incorporation of the program's activities into the core operations of the organization. Potential for program sustainability will be utilized as part of the application review criteria. Continued progress to sustainability will be an element of contract workplans for funded programs.

IV. Application Process

Proposal Guidelines: Clinical Services

Please be sure to follow these guidelines exactly. Proposals not in this format will not be reviewed.

1. Answer items in the order given; write the item number and restate the question before each answer.
2. Type your answers to items 1-14 of Proposal Instructions. Question 14 is optional.
3. Keep the proposal to no more than fifteen pages (not including Cover Sheet and attachments).
4. Proposals must use 11 or 12-point font size with one-inch margins all around.
5. Complete the Cover Sheet (Attachment D). If one section does not apply, please indicate with N/A. If you print, please use black ink and write clearly.
6. Have the Cover Sheet signed and dated by the person in your organization who is legally authorized to sign agreements. This signature certifies that the information and statements made are correct.
7. Attach the original signed Cover Sheet to the front of your proposal.
8. Submit 1 original and 5 copies of your completed proposal, including Cover Sheet and attachments.
9. Proposals must be received by 4:00 p.m. on or before April 29, 2010. Please deliver to:

   First 5 Shasta
   Early Mental Health RFA
   1135 Pine St., Suite 21
   Redding, CA 96001

10. For assistance or questions regarding this RFA, contact Elizabeth Poole at (530)229-8300 or at epoole@first5shasta.org. Questions will be accepted through April 15, 2010. A Q&A document listing all questions received and responses will be available at www.first5shasta.org on March 29, 2010, with updates on April 5 and April 19, 2010.

11. An applicant meeting will be held at First 5 Shasta on April 1, 2010, from 10 am to 1 pm. Applicants will be provided with an overview of the initiative and provided with the opportunity to have questions addressed. Attendance at this meeting is optional.

Proposal Instructions: Clinical Services

Please keep your answers to the items listed below to no more than 15 pages. Attach the Workplan (Attachment D), Budget Summary and Narrative (Attachment E), and any other required documentation to the proposal.

1. Please provide an overview of your organization, addressing the following points:
    a. Describe your organization, its mission, and services provided.
    b. Describe how your group or organization is funded.
    c. Provide a description of your organizational structure, including information on boards or committees that provide agency oversight, if applicable.
    d. Include a list of board/committee members as an attachment. Clinicians in private practice must include a copy of their license as an attachment.

2. Describe your proposed clinical scope of service, discussing each of the following:
    a. Discuss which of the three focus areas listed on page 3 your proposed services will address.
    b. Describe the services and activities to be provided. Include discussion of frequency, duration, and structure of activities. Also include a discussion of any client needs assessments and/or curricula used, if applicable. Refer to page 5 for requirements.
    c. If addressing maternal depression, describe your linkages to primary care services.
    d. If using an evidence-based or evidence-informed practice, discuss:
        i. The model being implemented;
        ii. Supporting evidence for the model;
        iii. Your implementation plan, including assurances of fidelity to the model.
    e. Please discuss the risk factors affecting attachment that are to be addressed by your clinical services.
    f. Utilizing the Strengthening Families framework, what are the protective factors that will be strengthened as a result of your clinical services?
    g. Please describe your organization's previous experience related to this proposed program. Include a discussion of previous program outcomes.
    h. Describe how the program will be staffed. Include a discussion of the qualifications of program staff. If using interns to provide services, please discuss how they will be supervised.

i. Attach a Workplan. See Attachment D for an example.

3. Address the following points regarding your program's population of interest:
   a. Describe the population that your program will serve. Include an estimate of how many unduplicated parents/caregivers and children ages prenatal-24 months will be served each year.
   b. Identify the barriers to attachment that exist among your population of interest.
   c. Describe how you will identify and reach clients. Include a discussion of client assessments used, if applicable.
   d. Provide a discussion of your program's geographic reach.
   e. Please discuss how your program will address child care needs during group activities or other services, if applicable.
   f. Describe your proposed strategies for maintaining family engagement over the course of treatment or program involvement.
   g. Describe how you will manage the referral process for clients who may need services outside of your proposed program.

4. Describe how you will track activities and collect program and participant data. Please include a discussion of your organization's service and data quality control practices.

5. Discuss your desired results for the program/activities to be funded. If offering multiple program components, include specific desired results for each component.

6. Provide your rationale for how each program strategy and activity will lead to the desired results. Include a discussion of how these strategies and activities will lead to increased protective factors and/or reduced risk factors.

7. Describe your organization's experience conducting results evaluation.

8. Discuss your plan to measure results for this program. Please describe any validated assessment tools you plan to use, if applicable.

9. Describe your organization's experience coordinating services with other agencies.

10. Discuss any plans underway for working in partnership with other organizations and/or providers on this initiative or any preliminary planning and development that has occurred with potential partners.

11. Please describe your proposed plan for sustaining these services. Provide a discussion of the potential for program sustainability, including discussion of the potential for integration into your organization's services. Include a discussion of potential funding with emphasis on non-grant sources, and including any potential funding linkages and leveraging of funds.

12. Please give a detailed description of how your organization manages contract revenues and expenditures and describe your systems of internal financial control.

13. Complete the Budget Summary (Attachment E). Attach a budget narrative with line item detail describing how First 5 Shasta funds will be used.

14. *The following question is optional and will not be scored:*

    As a component of this Early Mental Health Initiative, one agency will be identified as the lead coordinating agency, providing screening, assessment, and referral to potential clients, as well as coordinating activities among initiative partners. Please describe your organization's interest in and capacity for filling this role, including any related experience. Also include a description of how you would propose managing the screening, assessment, and referral processes.

    If not interested in this role, please indicate N/A in response to this question.

Proposal Review: Clinical Services

Applications will be reviewed and scored on their responses to questions 1-13. The proposal review team will include representatives of SCFFC and members of the Advisory committee. Review team members will score proposals individually and meet as a team to develop consensus regarding recommendations for funding.

Proposals will be scored based on the following criteria:

1. Content and clarity of clinical scope of service and activities
2. Applicant capability of providing proposed services and activities
3. How well the proposed activities address the commission objective, initiative purpose, and stated focus area(s)
4. Whether the desired results for the proposed activities are realistic and appropriate
5. How well the proposed activities can be expected to lead to First 5 Shasta's desired results

6. How well the proposed program fits into a collaborative network of services focused on improving attachment (including geographic reach, range of services provided, and population served)
7. Evidence of pre-planning/partnership
8. Potential for sustainability
9. Appropriateness of the program budget and workplan

The review team will identify one agency to act as the lead coordinating agency for the initiative, based on applicant response to question 14 in the RFA. The budget for the selected applicant will be revised to reflect additional activities related to this role.

The Review Team will make funding recommendations directly to the Shasta Children and Families First Commission. The review team may choose to recommend funding selected components of a proposed program in order to best meet the purpose of the initiative. The Commission reserves the right to reject any or all applicants and/or to make no selection based on this RFA. The Commission makes all funding decisions and these decisions are final.

Application Timeline

March 12, 2010	RFA Released
April 1, 2010	Applicant Meeting at First 5 Shasta, 10:00 am – 1:00 pm
April 29, 2010	Applications Due by 4:00 PM
Week of May 10, 2010	Application Review
May 26, 2010	Recommendation to SCFFC
June 23, 2010	Contracts and Evaluation Plans to SCFFC for approval
July 1, 2010	Programs begin

COMMISSION GOALS and OUTCOME OBJECTIVES

2010 – 2019

GOAL 1: Children live free of abuse, neglect and exposure to violence.

Outcome Objectives

- Reduce child maltreatment and neglect
- Reduce early childhood exposure to violence in the family and community
- Reduce alcohol abuse and use of illegal drugs among pregnant women, parents, and family members of children age 0-to-5
- Increase access to evidence-informed mental health services
- Increase validated social-emotional-developmental screenings, referrals, and connections to services

GOAL 2: Children are healthy and eager to learn.

Outcome Objectives

- Decrease tobacco use among pregnant women, parents, and family members in households with children age 0-to-5
- Decrease rates of childhood obesity
- Improve family literacy and language development
- Increase access to and use of prevention and early intervention oral health services for young children
- Increase access to and use of prevention and early intervention physical health services for young children
- Increase access to quality, affordable early care and education, with emphasis on care for infants and toddlers and children with special needs
- Increase screening, referral, and follow-up on referrals for children with disabilities and special needs

GOAL 3: The community understands and values early childhood.

Outcome Objectives

- Key community leaders and decision-makers increase their knowledge and valuing of optimal early childhood development
- Service providers increase their knowledge and professional skills for serving children age 0-to-5 and their families
- Parents and primary caregivers increase their knowledge of age-appropriate child development, learning, and community resources for children age 0-to-5 and their families
- Members of the business community understand the link between optimal early childhood development and the community's future economic stability and leadership
- Members of the community increase their understanding of family and community capacity to support optimal early childhood development

Adverse Childhood Experiences: An Overview

The Adverse Childhood Experience (ACE) Study has documented a direct correlation between childhood traumas and family dysfunction, including physical and emotional neglect, parental mental illness, and adult health status. The ACE Study, a collaborative research project between the Centers for Disease Control and Prevention and the Department of Preventive Medicine at Kaiser Permanente in San Diego, involved over 17,000 members of the Kaiser Permanente Health Plan, who responded to detailed personal history surveys and provided access to medical records (Centers for Disease Control, 2008a). The study has provided information on the links between childhood experiences, behaviors, and health outcomes.

The ACE Study identified ten adverse childhood experiences (ACEs):

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- Physical neglect
- Emotional neglect
- An alcohol and/or drug abuser in the household
- Incarcerated household member
- Mother is treated violently
- One or no parents
- Household member who is chronically depressed, mentally ill, institutionalized, or suicidal

The study found that given exposure to one ACE, there is an 80% likelihood of exposure to another (Centers for Disease Control, 2008b). Approximately one in eight individuals had four or more adverse experiences during their childhood (Centers for Disease Control, 2008a). These findings reinforce the interrelatedness of traumatic childhood experiences. The ACE Study also has demonstrated a direct correlation between the number of adverse childhood experiences and adult behaviors and health impacts, including alcoholism, drug abuse, smoking, multiple sex partners, risk for intimate partner violence, depression, and suicide attempts (Centers for Disease Control, 2008b). These behaviors by adults can impact children in their households, leading to a new generation of children with ACEs.

For more information about Adverse Childhood Experiences, the ACE study, and health effects of ACEs, please visit http://www.cdc.gov/nccdphp/ACE/.

Application for First 5 Shasta Early Mental Health Services: Clinical Services
Cover Sheet

Legal Name of Applicant:____

Name of Contact Person: ____

Title:____________________**E-Mail Address:** ______________________

Phone: ______________________ **Fax:** ____________________

Mailing Address: ____

____

Tax I.D. #: ______________________

Program Name: ____

Amount Requested: ________________

Summary of Proposed Program: ______________________________________

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Agreements

1. **Applicant certifies that funding received from First 5 Shasta for this program will not be used to supplant or take the place of funding for existing services. Yes ____ No ____**

2. **Applicant certifies that the information provided in this application is true and accurate, and authorizes the Commission and its review team to verify any or all information included as a part of the application. Yes ____ No ____**

Person Authorized to Sign Contractual Agreements ______________________________
Please Print

______________________________ ________________

Signature *Date*

WORKPLAN **Project Name:**				
Strategy	**Output**	**Key Program Activities**	**Timeline**	**Products/ Documentation**

Strategy: The overall method or approach used to accomplish an objective; a logical method of action to address the problem (e.g., a cluster of programs, service types, and/or projects to pursue to achieve objectives).

Output: Counts and measures of services provided and people served (e.g. 100 parents will receive services; 80% of parents will complete x sessions) as well as tangible products or deliverables (such as curricula, plans, and systems) developed through activities undertaken.

Program Activities: Steps grantees will take to implement their program.

BUDGET SUMMARY AND NARRATIVE

a. Complete the following Budget Summary of how First 5 Shasta funds will be used.
b. List any purchases for concrete family supports under "other" and provide line-item descriptions.
c. Attach a Budget Narrative explaining each budget item.
d. List matching financial support for the proposed program in the Grantee Match Column and discuss in the budget narrative. Matching funds include any actual costs of program delivery that are to be covered by the applicant**.
e. Describe any non-financial in-kind support offered to this program in the budget narrative**.

**Note that in-kind and/or matching funds are not required as a condition for funding; however, they will be considered as an indicator of potential program sustainability.

Program Name			
	Budget Amount	***Grantee Match***	***Total***
Administration: Personnel (Include FTE percentage)			
Sub Total-Salaries			
Benefits			
Sub Total-Personnel			
Operating Expenses			
Food (for parent meetings, classes, etc.)			
Office Expenses			
Printing			
Educational/Training Materials			
Professional Services/Consultants			
Facility Rental			
Advertising			
Mileage			
Other (indicate)			
Sub Total-Operating Expenses			
Total Personnel & Operating Expenses			
Indirect (up to 10% total personnel and operating expenses			
Grand Total			