

Staff Person for Submission: Ms. Lynda Stewart

PowerForm Link: [https://na3.docusign.net/Member/PowerFormSigning.aspx?](https://na3.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=9d1c0e53-0f07-445c-82cc-6fc4e1469fb1&env=na3&acct=f03caff0-d8b6-4e91-ba70-c12592a3e516&v=2)

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Mississippi Department of Mental Health Bureau
of Behavioral Health Services

Division of Children and Youth Services

System of Care Enhancement

Funding Application Request Application Due

Date: **June 9, 2023**

State of Mississippi

System of Care Enhancement

The Department of Mental Health/Bureau of Community Mental Health Services is now accepting requests for proposals for state fiscal year 2024.

Please note that all grants are contingent on the funding by the Mississippi State Legislature and/or the Federal Government. The submission of this application to the Department of Mental Health is not a guarantee of funding.

This proposal application is eligible to all Mississippi Department of Mental Health (DMH) certified providers who are in good standing. However, DMH certification is not a guarantee of funding. All submitted proposals will be evaluated by a panel of reviewers using the posted competitive grant scoring rubric. Not all submitted proposals may be funded, but comprehensive feedback will be provided to all providers, particularly if their application was not funded for the current fiscal year. The funding associated with this grant opportunity is meant to defray a proportion of the operational costs for the service.

The goal of the System of Care Enhancement grant is to improve behavioral health outcomes for children/youth with SED and their families. The three (3) core values of SOC are that services should be child centered and family focused; community-based; and, culturally competent. The Enhancement grant funds will focus on families, parents and caregivers being full participants in all aspects of the planning and delivery of services. Family-focused care provides parents/caregivers of children/youth with SED the support and education needed to improve their child's emotional or behavioral symptoms. This includes, but not limited to the following:

- Providing linkages and resources to other community agencies
- Multi-family group counseling
- Positive parenting support
- Behavioral management planning
- Conducting a Community Needs and Resources Assessment
- Developing a parent resource center

The target population includes parents/caregivers of youth involved in the juvenile justice system, child protection services, special education, alternative school, system of care programs, wraparound facilitation, and youth at-risk of out-of-home placement.

A. Application Guideline Requirements: Please submit the following required forms which can be found in the MS Department of Mental Health’s Service Provider Manual.

1. Proposed Budget Summary Form: 100-1
2. Proposed Budget Personnel Form: 100-2
3. Proposed Budget Line Item Form: 100-3
4. Budget Narrative/Justification.
5. Program Narrative (not to exceed 6 pages) which addresses B – E.

B. Outcome Measures

1. List goals and/or objectives from FY 23’s application.
 - a. Provide the outcome for each goal/objective listed.
 - b. If the goal/objective was not met, describe the barrier(s) which prevented the service from meeting the goal/objective.
 - c. Describe how the barriers listed will be addressed in the upcoming fiscal year.
2. List the new goals and/or objectives for FY 24 utilizing the chart on page 5.
 - a. Describe how the service will meet each goal/objective.
 - b. Describe how you plan to evaluate the effectiveness of the service.

Reporting on Performance Measures

DMH grant recipients must review the performance data they submit to DMH, assess their progress, and use this information to improve the management of their grant. Recipients are also required to report on their progress addressing the goals and objectives identified in the grant. The assessment should be designed to help you determine whether you are achieving the goals, objectives, and outcomes you intend to achieve and whether adjustments need to be made. You will be required to submit a monthly report on the performance measures in your grant when you submit your cash request.

C. Specific Requirements:

1. This grant requires a Program Coordinator. List the coordinator and any additional staff responsible for each activity by position/title. Include percentage of time related to this proposal per staff member.

D. Other Guidelines:

1. Any travel reimbursement listed in the budget cannot exceed the current State of Mississippi reimbursement rate (currently \$0.665 per mile.)
2. Indirect/administrative costs listed in the budget cannot exceed 8% of the budget total.
3. Provide a list of staff from the Proposed Budget Personnel Form 100-2 which also provides a portion of their time to other grant funded services, to include; the grant funded service, the position the staff holds, and the percentage of time the staff will be providing the other service(s).
5. Agencies that are not able to meet the required goals/objectives of this service funding and are not able to submit timely and accurate data as required by DMH may not be eligible for future funding for this service.

E. Required Data Report(s):

1. A monthly report must be submitted with each cash request for reimbursement.
2. Monthly reports must be submitted to the Division of Children and Youth Services for reimbursement and consideration for future funding. Please submit monthly reports to Lynda Stewart at lynda.stewart@dmh.ms.gov.

**System of Care Enhancement
Goals and Objectives
July 1, 2023– June 30, 2024**

**GOAL 1:
OBJECTIVE:**

ACTIVITIES	TIME LINES	DATA EVALUATION (EVIDENCE OF MOVEMENT TOWARDS GOALS OR ACCOMPLISHMENT OF GOALS)	STAFF RESPONSIBLE
1) A.			
1) B.			

**GOAL 1:
OBJECTIVE:**

ACTIVITIES	TIME LINES	DATA EVALUATION (EVIDENCE OF MOVEMENT TOWARDS GOALS OR ACCOMPLISHMENT OF GOALS)	STAFF RESPONSIBLE
2) A.			
2) B.			

**GOAL 1:
OBJECTIVE:**

ACTIVITIES	TIME LINES	DATA EVALUATION (EVIDENCE OF MOVEMENT TOWARDS GOALS OR ACCOMPLISHMENT OF GOALS)	STAFF RESPONSIBLE
3) A.			
3) B.			



**SYSTEM OF CARE ENHANCEMENT
Monthly Reporting Form**

Date: _____

Agency: _____

Reporting Month/Year: _____

1. Number of outreach and/or awareness activities conducted during this reporting period _____
2. _____
3. Number of families served through multi-family group counseling this reporting period _____
4. _____
5. Number of Positive Parenting Support Groups/Classes held during the reporting period _____
6. _____
7. Number of children/youth maintained in their home/community through services and supports provided through this grant during the reporting period _____
8. Number of parents/families utilizing the Parent Resource Center this reporting period _____
9. Please attach a copy of the Community Needs and Resources Assessment and results to the October 2024 monthly report.