Page: Award Category

Which Behavioral Health Workforce ARPA Award program are you applying for? *

Select one Category

○ Behavioral Health Training Opportunities
○ Telebehavioral Health Support In Rural Areas
○ Behavioral Health Workforce Projects For Students And Behavioral Health Professionals (COVID-19)
○ Funding For Licensed Behavioral Health Supervisors

Page: Applicant Information

Main Organizational Contact (Project Lead) *

Organization Address *

Street:

Line2:

City:

CountryCode:

State:

Zip:

Legal Name of Entity: *

Please provide the legal name of your organization.

Federal EIN: *

DUNS Number *

Unique Entity Identifier:

If available.

Counties served *

Select one or more options

☐ Adams
☐ Antelope
☐ Arthur
☐ Banner
☐ Blaine
☐ Boone
☐ Box Butte
☐ Boyd
☐ Brown
☐ Buffalo
☐ Burt
☐ Butler
☐ Cass
☐ Cedar
☐ Chase
☐ Cherry
☐ Cheyenne
☐ Clay
☐ Colfax
☐ Cuming
☐ Custer
☐ Dakota
☐ Dawes
☐ Dawson
☐ Deuel
☐ Dixon
☐ Dodge
☐ Douglas
☐ Dundy
☐ Fillmore
☐ Franklin
☐ Frontier
☐ Furnas
☐ Gage
☐ Garden
☐ Garfield
☐ Gosper
☐ Grant
☐ Greeley
☐ Hall
☐ Hamilton

☐ Harlan
☐ Hayes
☐ Hitchcock
☐ Holt
☐ Hooker
☐ Howard
☐ Jefferson
☐ Johnson
☐ Kearney
☐ Keith
☐ Keya Paha
☐ Kimball
☐ Knox
☐ Lancaster
☐ Lincoln
☐ Logan
☐ Loup
☐ Madison
☐ McPherson
☐ Merrick
☐ Morrill
☐ Nance
☐ Nemaha
☐ Nuckolls
☐ Otoe
☐ Pawnee
☐ Perkins
☐ Phelps
☐ Pierce
☐ Platte
☐ Polk
☐ Red Willow
☐ Richardson
☐ Rock
☐ Saline
☐ Sarpy
☐ Saunders
☐ Scotts Bluff
☐ Seward
☐ Sheridan
☐ Sherman
☐ Sioux
☐ Stanton
☐ Thayer
☐ Thomas
☐ Thurston

☐ Valley
☐ Washington
☐ Wayne
☐ Webster
☐ Wheeler
☐ York

What percentage of the people impacted by your proposed project live in the following types of communities:

Urban *

50,000 or more people, includes suburbs of major urban areas.

Micropolitan *

Not part of larger metropolitan area; 10,000 to 49,999 people.

Rural towns *

Communities with 2,500 to 10,000 people.

Frontier/Remote *

Communities with less than 2,500 people and geographically remote.

Does your organization serve a HRSA-defined health professional shortage area (HPSA)? *

HRSA-defined health professional shortage area.

Select one option

○ Yes
○ No
○ N/A

Is your organization in or serve a HSRA-defined medically underserved area? *

HSRA-defined medically underserved area.

Select one option

○ Yes
○ No
○ N/A

Demographic information on the clients your organization serves. (Put N/A if your organization does not provide behavioral health services.)

What ages of clients do you serve? (check all that apply) *

Select one or more options

☐ 0-18
☐ 19-64
☐ 65+
☐ N/A

Does your organization accept Medicaid and/or sliding scale fee for payment? *

Select one option

○ Yes
○ No
○ N/A

What is the approximate percentage of non-English speaking clients that your organization serves? *

If not applicable please type N/A

What other information would you like to share about your organization as it pertains to serving clients from diverse backgrounds? *

Demographic information pertaining to your organization.

How many people work at your entire organization, including administrative staff members, providers/direct care personnel, and other non-direct care staff/personnel?

Please indicate the size for your entire organization and not just your division/department/unit.

Select one option

- ○ Large (over 30 providers and staff)
- ○ Medium (16-29 providers and staff)
- ○ Small (2-15 providers and staff)
- ○ Individual provider (solo practice)
- ○ N/A (not a behavioral health organization)

Number of licensed behavioral health providers: *

Put N/A if your organization does not provide behavioral health services.

Number of behavioral health support staff: *

Put N/A if your organization does not provide behavioral health services.

Number of behavioral health students and/or trainees: *

Put N/A if your organization does not provide behavioral health services.

How long has your organization existed? (Years) *

What specific credentials (if applicable) does your organization currently have? (e.g. ACGME, APA) *

Put N/A if your organization does not provide behavioral health services.

What other organizational demographics would you like us to know?

For example, makeup of staff, staff qualifications specifically related to serving clients from rural and/or underserved areas, organizational mission as it relates to serving clients from rural and/or underserved areas, other relevant demographic information about your organization.

Page: Budget Information

Please review the Uniform Guidance listing of allowable costs.

What is your total budget request? *

Please note that indirect costs are not allowed. Budget costs should indicate the totals for the entire duration of your program. Maximum budget totals are: Behavioral Health Training Opportunities - $500,000; Telebehavioral Health - $1,000,000; BH Workforce Projects Related to Covid - $100,000; Funding for Supervisors - $100,000

Please indicate the amount of money requested for each of the following categories (as applicable). *

Select one or more options

☐ Personnel
☐ Fringe Benefits
☐ Travel
☐ Equipment
☐ Supplies
☐ Contractual
☐ Other

Personnel *

Total personnel costs

Budget Justification: *

Please list all personnel included on the application, including percentage of FTE and role of the staff person.

Fringe Benefits *

Budget Justification: *

Please describe the fringe benefit breakdown for your organization.

Travel Costs *

Budget Justification: *

No international travel is allowed.

Equipment Costs *

Budget Justification: *

Supply Costs *

Budget Justification: *

Contractual Costs *

Budget Justification: *

Other *

Please provide sufficient amount of detail on projects placed in this category.

Budget Justification: *

Budget Form: *

Please upload the completed Budget Form Template.

[File Upload]

Who is the financial contact person for your organization should your award be funded?

Full Name: *

Title: *

Email: *

Phone: *

Contact Address: *

Street:

Line2:

City:

CountryCode:

State:

Zip:

What experience does your organization have securing and maintaining federal grant funding? *

Select one option

○ Very experienced (the organization has successfully obtained/maintained federal grant funding for over 5 years)
○ Somewhat experienced (the organization has successfully obtained/maintained federal grant funding for 2-5 years)
○ Limited experience (the organization has successfully obtained/maintained federal grant funding for less than 2 years)
○ This is the first time our organization has applied for federal grant funding.

What percentage of your budget is comprised of grant funding? *

Select one option

○ 76-100%
○ 51-75%
○ 26-50%
○ 0-25%

Are you currently receiving American Rescue Plan Act (ARPA) funding, either from the state or federal government?

Select one option

○ Yes
○ No

Please explain: *

Page: Behavioral Health Training Opportunities

Page: Telebehavioral Health Support in Rural Areas

Describe your telebehavioral health project, including the need for this project in your target community (please include relevant data), background information on the proposed project, and how your project will address the behavioral health needs of your target community. *

How will this funding increase access to behavioral healthcare in rural and underserved communities? *

Who will primarily benefit from your project request? (e.g., behavioral health trainees, patients/ clients) *

What Nebraska behavioral health regions will you serve with your telebehavioral health project? *

Link to Nebraska behavioral health regions. Select all that apply.

Select one or more options

☐ Behavioral health region 1
☐ Behavioral health region 2
☐ Behavioral health region 3
☐ Behavioral health region 4
☐ Behavioral health region 5
☐ Behavioral health region 6
☐ Urban areas (50,000 or more people, includes suburbs of major urban areas)
☐ Micropolitan areas (not part of larger metropolitan area; 10,000 to 49,999 people)
☐ Rural towns (communities with 2,500 to 10,000 people)
☐ Frontier/remote areas (communities with less than 2,500 people and geographically remote)

What is your organizational capacity to implement the proposed project? Please include information on key personnel, role of your organization in the community, and previous experience with providing telehealth services/equipment/support. *

What is your plan for capturing required data collection and reporting? Please include key personnel in your description. *

Are there matching funds for the proposed project? *

Please note that this is not required for funding.

Select one option

○ Yes
○ No

Please describe the matching funds you are receiving for this project. *

What support do you have in your community or with other organizations to complete this project? *

Would you like to submit letters of support?

Optional.

Select one option

○ Yes
○ No

Letter of Support #1

File Format: PDF

[File Upload]

Letter of Support #2

File Format: PDF

[File Upload]

Letter of Support #3

File Format: PDF

[File Upload]

Page: Behavioral Health Workforce Projects for Students and Professionals Related to COVID

Page: Stipends for Supervision of Provisionally Licensed BH Professionals

Page: Terms and Conditions

Applicant acknowledges and accepts that State and Local Fiscal Recover Funds (SLFRF) awards are subject to the requirements set forth in the Uniform Guidance and guidance provided by the US Department of Treasury: https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments/state-and-local-fiscal-recovery-funds/recipient-compliance-and-reporting-responsibilities

Select one option

○ Yes, I acknowledge and accept that the Behavioral Health Workforce ARPA Awards (through SLFRF awards) are subject to the requirements set forth in the Uniform Guidance and guidance provided by the US Department of Treasury.

BHECN Award Terms and Conditions:

Please review the BHECN Awards Terms and Conditions.

Select one option

○ I have read the BHECN Award Terms and Conditions that will be provided if we are awarded funding.