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**REQUEST FOR PROPOSAL 2022**

“Ensuring and Enhancing the Clinical Skills of the IL Children’s Mental Health Workforce”

Please complete the following questions and return application to Michelle Churchey-Mims at mchurchey-mims@cbha.net by **6/10/22 at 5pm**.

**OVERVIEW**

|  |  |
| --- | --- |
| 1) Organization Name  |  |
| 2) Project Title  |  |
| 3) Project Abstract  |  |
| 4) Total Project Budget Request-The allowable budget is $53,000.  |  |
| 5) Project Start Date |  |
| 6) Project End Date  |  |

**ORGANIZATION INFORMATION**

|  |  |
| --- | --- |
| 7) President/CEO/Executive Director **Name/Title**  |  |
| 8) President/CEO/Executive Director **E-mail**  |  |
| 9) Address  |  |
| 10) City  |  |
| 11) State  |  |
| 12) Postal Code  |  |
| 13) County  |  |
| 14) Phone |  |
| 15) Email Address  |  |
| 16) Organizational background: Please provide a brief description of your organization, including mission and population/communities served.  |  |
| 17) Annual Budget  |  |
| 18) Tax ID |  |

**APPLICATION PRIMARY CONTACT PERSON INFORMATION**

This person will receive all communication related to the application.

|  |  |
| --- | --- |
| 19) Name/Title  |  |
| 20) E-mail  |  |
| 21) Office Phone/including extension  |  |
| 22) Mobile Phone  |  |

**PROJECT DIRECTOR INFORMATION**

This person will be the staff person in charge of operational management and implementation.

|  |  |
| --- | --- |
| 23) Name/Title  |  |
| 24) E-mail  |  |
| 25) Office Phone/including extension |  |
| 26) Mobile Phone |  |

**PROJECT DEFINITION**

|  |  |
| --- | --- |
| A) Describe your agency’s history and experience in providing children’s mental health services.  |  |
| B) How many youth received mental health services at your agency in FY21?  |  |
| C) If you provided children’s mental health services in Chicago, how many youth received mental health services in the city of Chicago at your agency in FY21?  |  |
| D) How many LPHA clinicians do you have who are trained in children’s mental health services? |  |
| E) Describe your model of clinical supervision (i.e., who provides the supervision, frequency, orientation, etc.) |  |
| F) Describe your agency’s training plan. |  |
| G) Describe your agency’s experience in training and use of Evidence Based/Informed Practices (what EB/EI practices are used; do you use an electronic clinical practice support tool?). |  |
| H) Describe your history and relationships with master’s degree programs. Describe how you would recruit, train and support four 2nd year master’s students each year. |  |
| I) How many license eligible staff do you have who need clinical supervision to advance them to licensure? |  |