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| **Region 7 IDN Sub-Recipient Concept Paper Application**  Please read through the entire application form before beginning the application process. This form should be saved to your computer before you complete it. Complete the application in full, and submit it by 3 p.m. on 06/15/2018 via email to IDN7@nchcnh.org | | | | | |
| **Primary Applicant:** | |  | | | |
| **Date:** | |  | | | |
| **Physical address:** | | | | **Mailing address: (if different)** | |
| **Telephone number:** | | | | **Website:** | |
| **Which of the following best describes your organization type?**  **Mental Health Organization**  **Substance Use Disorder Treatment Facility**  **Healthcare Facility**  **Social Service Organization**  **Other – please specify:** | | | | **Tax ID:** | |
| **What is your corporate structure?**  **501C3**  **LLC**  **Corporation** | |
| **Has your organization completed a Certificate of Authorization? Yes No** | | | | | |
| **Is your organization a statewide agency? If yes, please state how you will ensure your organization will not accept duplicative payments from multiple IDNs for providing the same services to the same beneficiary throughout a project activity.** | | | | | |
| **Primary contact person:** | | **Name:** | | | |
| **Title:** | | | |
| **Email:** | | | |
| **Telephone number:** | | | |
| **Organizational Capacity: Provide a brief overview of your organization including mission, year founded, organization type and size.** | | | | | |
| **Project Title:** | | | | | |
| **Purpose of funding request: The funding from Region 7 IDN will be used to… (please keep response to less than 25 words)** | | | | | |
| **Project start date: Project end date:**  **Purpose** | | | | | |
| **Organizational Capacity: Provide a brief overview (2-3 paragraphs) of your organization including mission, year founded, organization type and size.**   |  |  |  |  | | --- | --- | --- | --- | | **Please select one funding category which best addresses your project – see Region 7 IDN Basecamp for additional information on project criteria and metrics.** | |  | | --- | | **Core Competency - Integrated Healthcare**  **Behavioral Health Workforce Capacity**  **Health Information Technology**  **Care Transition Teams – Critical Time Intervention**  **Expansion in Intensive Substance Use Disorder Treatment Options**  **Enhanced Care Coordination in High Needs Population** | |  | | |  |  | |  |  | |  |  | |  |  | |  |  | | **The following are identified needs for Region 7 IDN. Please explain in a few sentences which need(s) you will be addressing in your proposal:**   * **Access to Mental Health Services** * **Access to Primary Care Services** * **Opioid Crisis** * **Supportive Housing** * **Addressing Social Determinants of Health (financial security, housing, education, social isolation, transportation, employment, legal)** |  | | | | | | |
| **The following are identified needs in Region 7 IDN. Please explain in a few sentences which of the following need(s) will be addressing in your proposal. Use qualitative and quantitative data as appropriate. How does the proposed project address the social determinants of health, including supportive housing?**   * **Access to Mental Health Services** * **Access to Primary Care Services** * **Opioid Crisis** * **Supportive Housing** * **Addressing Social Determinants of Health (financial security, housing, education, social isolation, transportation, employment, and legal services)** | | | | | |
| **Summary of proposal:** | | | | | |
| **How will your proposed project impact the opioid crisis?** | | | | | |
| **If funded, how will this project make a lasting impact?** | | | | | |
| **Please address sustainability for the proposed project.** | | | | | |
| **Briefly describe the goals, objectives, and activities for the proposed project. How does the proposed project align with the goals and objectives of the NH Delivery System Reform Incentive Payment (DSRIP) Program and help Region 7 IDN meet the deliverables within the region’s implementation plan? DSRIP goals: (1) deliver integrated physical and behavioral health care that better addresses the full range of individuals’ needs; (2) expand capacity to address emerging and ongoing behavioral health needs in an appropriate setting; (3) reduce gaps in care during transitions across care settings by improving coordination across providers and linking Medicaid beneficiaries with community supports; and (4) Alternative Payment Models for 50% of Medicaid payments by 12/31/2020.** | | | | | |
| **List 3 measurable outcomes you expect to achieve as a result of this funding. How will you measure these outcomes?** | | | | | |
| **Collaboration: Describe the collaborative relationships needed for the project to be successful, and who you will be partnering with, if anyone. Explain what partnerships have already been established, and what additional partners bring to the project. (250 words)** | | | | | |
|  | | **Project Budget: please complete the budget template below** | |
| **Salary** | |  | |
| **Benefits** | |  | |
| **Marketing/Communications** | |  | |
| **Supplies** | |  | |
| **Postage & Delivery** | |  | |
| **Printing & Copying** | |  | |
| **IT Needs** | |  | |
| **Travel** | |  | |
| **Indirect** | |  | |
| **Other – please explain** | |  | |
| **Total Budget Request** | |  | |