

**BEHAVIORAL
HEALTHCARE
COMMUNITY
ENDOWMENT
FUND**

APPLICATION FOR GRANT

This application is made by a duly authorized Applicant's representative. **The filing of this Application does not create any right, claim or benefit inuring to Applicant. Grants are paid at BHCEF's sole and sovereign discretion. Grants are paid based on representations herein and supporting documentation provided by Applicant** to establish eligibility for a grant pursuant to grants apportionment and payment rules established by Behavioral Healthcare Community Endowment Fund Board of Directors dated 07/31/2018 reviewed 08/20/20 and updated from time to time by said Board. Eligibility criteria are published on <https://www.bhcef.org>

1: APPLICANT IDENTIFICATION

Organization legal name _____
Trade name _____ Type: LLC Corp Sole proprietorship
Address _____ State _____ Zip code _____
Name (First, Last) of authorized person executing the application: _____
Federal Tax ID # _____ State ID # _____ NPI # _____
Phone (____) ____ - ____ Facsimile (____) ____ - ____ Website address _____
Authorized signatory phone (____) ____ - ____ Email address _____

2: OPERATIONS

Type of facility: Residential w/detox Residential without detox PHP IOP OP
Starting date: __/__/__ **Maximum capacity:** ____ **Provider in network:** Yes No
Address _____ State _____ Zip code _____
Billing: In house Outsourced **Accreditation:** JC CARF Ref _____
Treatment plans: Alcohol Chemical dependency Trauma Eating disorders Gambling
Sex Addiction Dual Diagnosis Compulsory spending Other _____ _____
Staff structure: (for each category: how many) Management ____ Clinicians ____ Support ____ Admin ____

3: MODALITIES

Modalities offered to patients: Group therapy (generic) DBT CBT ACT EMDR
Psycho Analysis Psycho Drama Therapy (individual) Neurofeedback Family Therapy
Mindfulness Therapy Art Therapy Dog Therapy Equine Therapy Acupuncture
Yoga Meditation Nutrition Program & Education Wall Climbing Ropes Climbing
Detox Relaxation—Massage _____ _____ _____

4: PERFORMANCES \ ANALYTICS

Definitions & Concepts:

The year of reference means the 12 months prior to the year of payment (i.e., FY 2022 for 2023 grants)

Number of clients (NP) means the total number of clients treated during the year of reference at the facility

Number of clients at the beginning of the year (NPB) of reference means the number of clients in treatment as of the first day of the first month of the year of reference

Efficacy measurement system means any system (whether electronic or manual) that (i) keeps track of patients' successes for a period spanning from intake thru discharge, (ii) keeps tracks of all clients' successes per clinical challenge (total aggregated results), and (iii) keeps track for a period up to one year of clients' status once clients have been discharged

After care program means program(s) providing patients with support AFTER they left the facility

4: PERFORMANCES \ ANALYTICS

Definitions & Concepts:

Success Rate means the total accrued number of days without relapse divided by the total aggregated calendar days for the year of reference for all clients adjusted by deducting NPB

Example: Year of reference: Total number of clients: 160
Adjusted number of clients : $160 - 5 \text{ (NPB)} = 155 \text{ clients}$
Total aggregated calendar days for the 155 clients = 26,100
Total aggregated days without relapse = 22,020
Success rate = $22,020 : 26,100 = 84.36\%$

5: DATA

1. Efficacy Measurement system:

Do you currently have an efficacy measurement system? Yes No

Is the efficacy measurement system you currently use a specially designed software ? Yes No

Please describe the efficacy measurement system you currently use: _____

Does the efficacy measurement system cover clients while in treatment? Yes No

Does the efficacy measurement system cover clients AFTER treatment? Yes No

Does the efficacy measurement system provide progress report for each client ? Yes No **AND**

For all clients aggregated? Yes No

2. After care programs:

Describe how you maintain contact with clients after they leave treatment: _____

_____ Alumni? Yes No

Describe how you keep track of clients' successes AFTER treatment _____

3. What concrete steps do you take to improve the care provided to clients?

4. Raw Data:

Please indicate the year of reference: From ___/___ to ___/___

(NP) Please indicate the total number of clients for the year of reference: _____

Please indicate:

- Total aggregated number of days for all clients for the period spanning from month 1 to 12: _____
- Total aggregated number of days without relapse for all clients for the period spanning from month 1 to 12 _____

Have you ever benefited from a grant from BHCEF ? Yes No if Yes, when ? ___/___

Have you benefited from a grant from BHCEF for a period (*month*) covered by the period subject matter of this application? Yes No

6: SUPPORTING DOCUMENTATION

1. Efficacy Measurement system:

Please provide one print out (PDF) covering 5 clients progresses from intake to discharge *(please black out names)*

Please provide one print out (PDF) covering all clients' aggregated progresses for the year of reference *(please black out names if any)(*)*

Please provide one print out (PDF) covering all clients' progresses for month 1

Please provide one print out (PDF) covering all clients' progresses for month 12

Please provide one print out (PDF) showing monthly total census for the year of reference *(please black out names)*

2. After care programs:

Please provide a list of all alumni activities held during the year of reference

Please provide one pamphlet or any other document depicting after care program(s) offered to clients

If there is a blog, please provide with access path *(location on your site otherwise)*

3. General information:

Please provide with any additional information (PDF) that may further substantiate your actions aiming at improving clients care

7: CERTAIN TERMS

After having received one or more grants from BHCEF, You authorize BHCEF to audit the data you provided in your application by (i) requesting additional supporting data, and (ii) requesting statistical data from third parties, namely insurance carriers, billing companies to substantiate the data contained herein.

Upon request from BHCEF, you will cooperate with BHCEF to obtain from third parties the additional data requested by BHCEF. Such cooperation may include and is not limited to introduce BHCEF to the third party and provide the third party with any authorization it may require to release the data to BHCEF.

Data contained herein and data gathered thru third parties requests will be deemed CONFIDENTIAL and cannot be used by BHCEF for any other purpose than assessing your eligibility for the program developed by BHCEF and scientific purpose.

This application and its appendices must be submitted electronically at <https://www.info@bhcef.org>

8: AUTHENTICATION - CERTIFICATION

I, _____, a duly authorized representative of _____
(Applicant) hereby declare that the answers and data provided in this application are complete, truthful and correct.

_____(signature)

Name: _____

Enclosures: _____

Capacity: _____

Date: ___/___/_____