**Request for Applications (RFA)**

**RFA No. RMO SMH 071318**

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**Government of the District of Columbia**

**Department of Behavioral Health (DBH)**

**RFA Title: Comprehensive Expansion of School-Based Mental Health**

**RFA Release Date: Friday, July 13, 2018**

**Application Submission Deadline: Monday, August 6, 2018 4:45 p.m. ET**

 **ATTACHMENTS A, F and H – WORD VERSION**

**Section XII:** **ATTACHMENTS TO THE RFA**

Attachment A Application Profile

Attachment F Budget and Budget Narrative Justification Form

Attachment G DBH Receipt

**ATTACHMENT A**

Government of the District of Columbia

Department of Behavioral Health (DBH)

**Comprehensive Expansion of School-Based Mental Health
RFA No. RMO SMH 071318**

Applicant Profile

|  |  |
| --- | --- |
| *APPLICANT NAME:* |  |
| *TYPE OF ORGANIZATION:* | \_\_\_\_ Non-Profit Organization \_\_\_\_ For-Profit Organization \_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Federal Tax ID No.:**DUNS No.:**Contact Person:* |  |
|  |
|  |
| *Title:* |  |
| *Street Address:*  |  |
| *City, State ZIP:* |  |
| *Telephone:* |  |
| *Fax:* |  |
| *Email:* |  |
| *Ward:*  |  |
| *Organization Website:* |  |
| *Names of Organization Officials:* | Board Chair/President:  |
|  | Board Treasurer: |
|  | Chief Executive Officer/Executive Director: |
|  | Chief Financial Officer:  |

|  |
| --- |
| *RFA Abstract (Limit 200 words)**Signature of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**ATTACHMENT F**

 **BUDGET JUSTIFICATION AND NARRATIVE**

1. **Personnel:**

|  |  |  |  |
| --- | --- | --- | --- |
| Position  | Annual Salary/Rate | Level of Effort | Cost |
| Clinician |  |  |  |
| Supervisor |  |  |  |

Justification: Describe the role and responsibilities of each position.

2.

1. **Fringe Benefits**

|  |  |  |  |
| --- | --- | --- | --- |
| Position  | Rate | Wage | Cost  |
| Clinician |  |  |  |
| Supervisor |  |  |  |

Justification: Fringe reflects current rate for the organization.

1.

2.

1. **Prevention/Early Intervention and Non-Billable Activities:**

|  |  |  |
| --- | --- | --- |
| Activity  | Rate | Cost |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Justification: Describe the purpose of travel and how costs were determined.

1. **Equipment (useful life of more than one year and an acquisition cost of $5,000 or more per unit):**

|  |  |  |
| --- | --- | --- |
| Item | Rate | Cost  |
|  |  |  |
|  |  |  |

Justification: Describe the need and include an adequate justification of how each cost was estimated.

1. **Therapeutic Supplies (materials costing less than $5,000 per unit and often have a one-time use):**

|  |  |  |
| --- | --- | --- |
| Item | Rate | Cost  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Justification: Describe the need and include an adequate justification of how each cost was estimated.

1. **Subontractual: A subcontractual agreement to carry out a portion of the programmatic effort or for the acquisition of routine goods or services:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name  | Service | Rate | Other | Cost |
|  |  |  |  |  |
|  |  |  |  |  |

Justification: Explain the need for each contractual agreement and how they relate to the overall project.

1. **Consultant: A consultant is an individual retained to provide professional advice or services for a fee:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name  | Service | Rate | Other | Cost |
|  |  |  |  |  |
|  |  |  |  |  |

Justification: Explain the need for each agreement and how they relate to the overall project.

1. **Other: Expenses not covered in any of the previous budget categories.**

|  |  |  |
| --- | --- | --- |
| Item | Rate | Cost  |
|  |  |  |
|  |  |  |

Justification: Break down costs into cost/unit. Explain the use of each item requested.

**Indirect Cost Rate:**Indirect costs can only be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. Effective with 45 CFR 75.414(f), any non-federal entity that has never received a negotiated indirect cost rate, may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely.

|  |  |  |  |
| --- | --- | --- | --- |
| **Percentage** | **Budget Category** | **Amount** | **Total** |
| **%** |  | **$** | **$** |

**Total Direct Costs: $**

**Total Indirect Costs: $**

**TOTAL: $**

**Budget Summary**

|  |  |
| --- | --- |
| **Category**  | **Budget Request** |
| **Personnel**  | **$** |
| **Fringe** | **$** |
| **Prevention Early Intervention/Non-Billable Activities** | **$** |
| **Equipment**  | **$** |
| **Supplies** | **$** |
| **Contractual** | **$** |
| **Other Direct Costs** | **$** |
| **Total Direct Costs** | **$** |
| **Indirect Costs** | **$** |
| **Total Project Costs** | **$**  |

**ATTACHMENT G**

**DBH RECEIPT**

**RFA Title: Comprehensive Expansion of School-Based Mental Health**

**RFA No. RMO SMH 071318**

**ATTACH TWO (2) COPIES OF THIS RECEIPT TO THE OUTSIDE OF THE ENVELOPE**

The DC DEPARTMENT OF BEHAVIORAL HEALTH IS IN RECEIPT OF

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Contact Name/ Please Print Clearly)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Organization Name)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Address, City, State, Zip Code)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Telephone/Facsimile/Email)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Project Name)**

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Budget Amount)**

**DBH USE ONLY:**

**Please Indicate Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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RECEIVED ON THIS DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/2018

 **Received By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_