

## **REGIONAL CONSUMER ADVISORY COUNCIL (RCAC)**

will be honoring requests for its RCAC Mini-Grants Proposal

Available on NCRMHB's website: September 7 - November 1, 2011

**WWW.NCRMHB.ORG/RCAC**

**Proposal Deadline: Wed., November 2, 2011, 4:30 pm. *Late proposals cannot be accepted.***

**(Must receive mailed or walk-in proposals at the address below by 4:30 p.m. deadline).**

**Attn: RCAC, NCRMHB, 367 Russell Rd., Bldg. 34, Newington, CT 06111**

**The Regional Consumer Advisory Council (RCAC)** anticipates receiving funds from CT Department of Mental Health and Addiction Services (DMHAS) in which to award grants to adults in recovery from addiction and/or psychiatric disorders who are 18+ yrs. old and residents of north central CT (Hartford County). **Selected projects are funded up to a maximum of \$2,000. Ideas must relate to at least one of the following:**

- 1. Advocacy** among persons in recovery from addiction and/or psychiatric disorders.
- 2. Leadership** among persons in recovery from addiction and/or psychiatric disorders.
- 3. Integrating people in recovery** through an activity / event which promotes mutual understanding of psychiatric / addiction disorders. (Hartford County residents)
- 4. Planning/implementing a Recovery conference or forum** educating adults on issues concerning psychiatric and/or addictive disorders.
- 5. Technology:** training, software, or hardware for use in skill development located within a non-profit agency benefiting people in recovery from psychiatric and/or addiction disorders.

**All applicants require the support of a non-profit agency with IRS 501(c)3 status to serve as fiduciary (money manager) to projects. (If this is a barrier to you please call us). Grant review will take place in mid-November. All applicants will receive notice of award via letter.**

**To obtain a copy of the RCAC Mini-Grants Recovery Proposal 2011-12, please go to our website at [www.ncrmhb.org](http://www.ncrmhb.org) and click on RCAC. (Applicants are now able to type into the grant proposal within our website and print it out). For more information regarding RCAC Mini-Grants, please contact North Central Regional Mental Health Board, 367 Russell Rd., Bldg. 34, Newington, CT. Consumer Initiatives Coordinator, Phoebe Hamilton (860) 667- 6388, E-mail: [phamilton@ncrmhb.org](mailto:phamilton@ncrmhb.org)**

**REGIONAL CONSUMER ADVISORY COUNCIL (RCAC)**  
**Mini-Grant Application Instructions 2011-12**

**Submission Deadline: Wednesday, November 2, 2011 by 4:30 p.m. (Late proposals cannot be accepted).**

**\*\*\*Please Note: One-year of recovery and an established personal residence is required to participate in the RCAC Mini-Grants project.\*\*\***

**Proposals must be typed.** You can obtain and complete a Mini-Grant application on our website located at [www.ncrmhb.org/RCAC](http://www.ncrmhb.org/RCAC). *(Applicants must complete and print the proposal in one sitting. (This document cannot be saved to your computer).*

**Please create three-Xeroxed copies of your original proposal and submit all documents together for RCAC's review process.** *\*\*\*Your application cannot be reviewed without them).\*\*\**

**Professional estimates from contracted consultants and/or retail vendors used in your project must be attached to the application's Budget Form, pg. 8 for consideration during review.** E.g., retail vendor's name, item model numbers and cost; *contractors' fees must be on company letterhead stating the service and materials to be provided.*

**Stipends / wages are not provided for leading a Mini-Grant project.**

**Transportation: Mini-Grants do not fund the purchase of motor vehicles.** Limited transportation can be built in to a project where it is needed to perform specific tasks but it cannot be the primary function of the grant.

**Repeated funding of same project idea located within the same agency cannot be considered.**

**Projects based upon recorded A/V media for public distribution must include a copy (CD/DVD) of the material for the grant review process.** *(Please include it with your proposal as RCAC cannot consider reviewing without it).*

**Projects based upon printed media for public distribution must submit a draft copy for consideration during review.** *(Please include it with your proposal as RCAC cannot consider reviewing without it).*

**New Computer equipment cannot be privately stored at a grantee's home.**

Grantees receiving funding for computer equipment must locate equipment at an agency with non-profit, 501c(3) status, benefiting adults in recovery. *(RCAC does not fund internet service).*

**\*\*\*Employees of mental healthcare or substance use treatment care agencies who also are adults in recovery are excluded from applying for grant funds within their own place of work.** *(You can locate your project elsewhere).*

**\*\*\*Employees of CT Department of Mental Health & Addiction Services (DMHAS) are excluded from applying for RCAC Mini-Grants due to a conflict of interest.**

**\*\*\*Current RCAC members are unable to apply for RCAC Mini-grants due to a conflict of interest.\*\*\***

## COVER PAGE

**Name of Applicant:** Fill in the name of the individual(s) participating in this project. These persons must be in recovery from addiction and/or mental illness. Home addresses and phone numbers are also required. (Not your agency).

**Project Name:** A descriptive title of your project is entered here.

**Amount Requested:** The maximum amount that can be requested is **\$2,000.**

**Brief Summary of the Project:** Provide four to five sentences describing your project. It should be very basic so that the reviewers will have a sense of what you want to do.

**Priority Area:** There are five priority areas, or goals, that are to be addressed with these mini-grants. Every applicant **MUST** select at least one priority area for the project and place a check before it.

**Recovery Area to be Addressed:** The mini-grants must be used to benefit consumers of Mental Health and/or Addiction Services. (*Please check one of these recovery areas.*)

**Geographic Area to be Served:** All projects must operate within the DMHAS Region IV (North Central CT) and serve persons in recovery who reside in Region IV. Your project can serve any geographic entity within the region. If you are unsure of your entity's location qualification as a Region IV area, contact North Central Regional Mental Health Board staff at (860) 667-6388.

**Estimated Number of Individuals to be Assisted:** A number must be placed here. It can be an estimate but should be realistic. *This is not limited to the number of people working in your project. How many people in total will be affected because of your project's goal?*

**Signature of Project Leader:** The project leader should be a person in recovery from addiction or psychiatric disability who is an adult (18+), and a resident of north central Connecticut, signing this application. Your project should also benefit adults who reside in this region as well. The date is also to be entered.

## AGENCY AUTHORIZATION (fiduciary)

All applicants must identify an existing agency or organization to serve as the fiduciary agent for the project. ***Funds will not be given to individual persons.*** The agency you are working with must complete this page. This can be any non-profit agency, such as a substance abuse treatment program, Local Mental Health Authority, shelter, church, etc. holding a **501(C)3 certificate**. The signature must be from the organization's executive director, chief financial officer or board president, with the authority to manage finances.

## PROJECT NARRATIVE

1. **Briefly describe your project.** This section can be expanded by one typewritten page. (You should describe your project fully here and explain how you intend to carry out the project).

2. **Please explain how this project addresses the priority area(s).** All projects must address at least one of the five priority areas: **advocacy, leadership, integration** of Persons in Recovery from Psychiatric & Addiction disorders, **conference or technology.** *Explain how this project relates to one of the selected priority areas on page 1.*
3. **Names of Other Persons. :** Since the cover page only provides space for four participants, all others who worked on developing this project, or who will be part of the project, should be listed here (if there are none, leave blank).
4. **Why is this project needed? :** Please explain how you determined this project was needed.

## PROJECT WORKPLAN

Every applicant must complete this form. However, you may not need to fill in all the rows. Your project may only have three major activities, for example, and so you would only use three rows. All columns must be completed for each major activity. *You may duplicate this page if you need more room.*

**Example:** The project below intends to train individuals in advocacy skills to be used at the State Capitol to promote certain legislation that affects people with substance abuse problems.

**PRIORITY AREA:** Ex., To develop advocacy among persons in recovery from Addiction.

<b>MAJOR ACTIVITY/OBJECTIVE: Provide 10 legislative advocacy training sessions to 15 people</b>		
<b>STEPS:</b> What are the steps you need to take to complete the major activity?	<b>WHO WILL DO IT?</b>	<b>BY WHEN WILL IT BE DONE?</b>
A. Develop the training program.	C. Smith	By 12/10/11
B. Identify speakers for the training session.	D. Carter	By 1/15/12
C. Create handouts to be given to participants	D. Carter	Currently Happening
D. Secure a location and time for the training program.	C. Smith	By 1/25/12
E. Recruit 15 people to attend the training program.	C. Smith, D. Carter, & S. Torres	By 2/20/12
F. Obtain feedback from the participants about the training.	S. Torres & C. Smith	By 4/15/12
<b>RESULT: Between 10 and 15 people recovering from addiction will be trained and ready to begin legislative advocacy.</b>		

## BUDGET

Please follow the instructions on the Budget Form, page 8. Attach professional estimates here. You may use an additional one to two pages to itemize your proposed budget using the categories and instructions.

## ATTACHMENTS: LETTERS OF SUPPORT (1 point per letter-4 max letters)

You may attach up to four letters from other persons in recovery or an agency to the application. These letters should describe how the proposal's project benefits people in recovery in developing: leadership, advocacy, integration between people in recovery from addiction and psychiatric disorders, a Recovery Conference/Forum or a technology grant.

## SELECTION CRITERIA

All applications will be reviewed initially to ensure: all sections of the applications are completed, signatures are present, applicant is a resident of north central CT, project operation is within DMHAS Region 4, fiduciary authorization is provided and professional estimates are attached. **Any application missing any of these will not be considered an eligible application and cannot be considered for review.**

*Criteria to score the application includes the following:*

**The maximum points an application can receive is 30.**

POINTS	CRITERIA
5	1. The proposed project clearly explains how it meets one of the priority areas.
5	2. The work plan is complete and understandable and realistic.
5	3. The proposed budget is realistic, affordable and cost effective.
5	4. The proposed outcome is feasible and relates to the priority area.
3	5. The project meets a need determined by persons in recovery.
3	6. The proposal addresses continuation beyond the mini-grant.
4	7. Letters of support from persons in recovery are attached and describe how this project will benefit them.

### **For questions related to mini-grant application, please contact:**

North Central Regional Mental Health Board, Consumer Initiatives Coordinator, Phoebe Hamilton  
(860) 667-6388, 10:00 - 4:30 p.m., e-mail: [pahamilton@ncrmhb.org](mailto:pahamilton@ncrmhb.org)

**Mail or personally deliver completed grant applications attention to:** RCAC Mini-Grants, North Central Regional Mental Health Board, 367 Russell Rd., Bldg. 34, Newington, CT 06111 **(Faxed copies are not accepted).** \*\*\*Mailed applications must be received by the deadline date printed on top of page 1.\*\*\*

**REGIONAL CONSUMER ADVISORY COUNCIL (RCAC)**

**MINI-GRANT APPLICATION 2011-12**

**Application Due Date: November 2, 2011**

**\*\*\*Please Xerox three copies of this application and submit with your original.\*\*\***

<b>Name(s) of Applicants</b>	<b>Home address &amp; Town</b>	<b>Phone</b>
1.		
2.		
3.		
4.		

Signature of Project Leader: \_\_\_\_\_ Date: \_\_\_\_\_

**This signature attests that I am a person in recovery from Addiction and/or Psychiatric Disorder and that this project was developed by myself and other persons in recovery, residing in north central CT (Region 4).**

**\*\*\*As project leader, I agree to complete all aspects of this grant through to its six-month deadline.**

**PROJECT NAME:** \_\_\_\_\_

**AMOUNT REQUESTED:** \$ \_\_\_\_\_

**BRIEF SUMMARY OF THE PROJECT:**

**PRIORITY AREA(S) ADDRESSED BY THIS PROJECT** (All projects must address at least one of these)

- \_\_\_ 1. **To develop advocacy** among persons in recovery from addiction and/or psychiatric disability.
- \_\_\_ 2. **To develop leadership** among persons in recovery from addiction and/or psychiatric disability.
- \_\_\_ 3. **To integrate people in recovery** to promote further understanding of both MH / SA disorders.
- \_\_\_ 4. **To plan / structure a conference or forum** educating adults in recovery.
- \_\_\_ 5. **Technology:** training, software / hardware (Technology Equipment must be located within a non-profit agency benefiting adults in recovery).

**RECOVERY AREA TO BE ADDRESSED:**

\_\_\_Addiction                      \_\_\_Psychiatric                      \_\_\_Both

**GEOGRAPHIC AREA TO BE SERVED BY THIS PROJECT:**

\_\_\_ Regional or Catchment Area: \_\_\_\_\_

\_\_\_ Town(s): \_\_\_\_\_

\_\_\_ All of Region 4 (North Central CT)

**ESTIMATED NUMBER OF INDIVIDUALS TO BE ASSISTED BY THIS PROJECT:** \_\_\_\_\_

Project Name: \_\_\_\_\_

**AGENCY AUTHORIZATION - FIDUCIARY**

By signing below, I:

State that **I am authorized by the agency's Board of Directors to sign grants and contracts**, my agency has **non-profit status with a 501(c)3 certificate**,  
and

I agree to have my agency serve as the fiduciary agent for the consumer-led project under this grant application. *I will read this proposal to discern whether it is realistic/feasible in its goal. I will support the applicant by directing an accountant to report 3x during the 6-month term during: February, March, May.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone & Fax

\_\_\_\_\_  
E-mail

\_\_\_\_\_  
Date

**Note:** *Please take the time to read the following page directed at fiduciary agents. There are certain expectations that are required and need your attention.*

**Thank you.**

Project Name: \_\_\_\_\_

## **FIDUCIARY ROLE & RESPONSIBILITY**

**In order to qualify as a fiduciary for this grant applicant**, you must be an Exec Director, Chief Financial Officer or Board Chair of a non-profit agency possessing a 501(C)3 certificate. ***You must have the authority to manage financial funds on behalf of your agency.***

**As fiduciary, you agree to provide regular reports of the grantee(s) expenditures.** RCAC/ NCRMHB prefers e-mail or faxed reports. *Please make a copy of your applicant's grant application and pay close attention to their Budget Form.* Please release funds in accordance with what is specified within the Budget Form. *Should a grantee request funds for an unspecified item, he/she should be denied and directed back to RCAC staff.*

**RCAC needs fiduciaries to serve as stop-gaps in addition to money managers in order to block attempts of fraudulent misuse of funds.** *If this is beyond your agency's ability, please do not commit to serving the named applicant on page one.* Please inform any employees in Accounting who may be given this responsibility of this additional service. Provide them with a copy of the entire proposal and initial Awards Letter as it gives specifics on expenses as directed by RCAC.

**Please cut checks promptly to enable the grantee's project to function according to their timeline.** *(Grantees are penalized if they do not spend funds in accordance to their Work Plan's timeline).* ***Checks are to be made out to vendors and contractors, not to grantees.***

**\*\*\* Unspent grant balances must be returned by: June 6, 2012**

**Please mail grant balances attention to:**

Phoebe Hamilton, Consumer Initiatives Coordinator  
North Central Regional Mental Health Board,  
367 Russell Rd., Bldg. 34, Newington, CT 06111

**Please make checks out for unspent balances to:** North Central Regional Mental Health Board and place RCAC Mini-Grant bal. in the check's memo area.

**Questions can be directed to:** Phoebe Hamilton, Consumer Initiatives Coordinator at No. Central Regional Mental Health Board (860) 667-6388, 10:00-4:00 p.m., E-mail: [phamilton@ncrmhb.org](mailto:phamilton@ncrmhb.org)

**\*\*\*Please fill out contact information on the preceding page.**

*Thank-you*

Project Name: \_\_\_\_\_

## **PROJECT DESCRIPTION**

1. Briefly describe the proposed project (please type). You may use one additional typed page to complete this section.

Project Name: \_\_\_\_\_

2. Please explain how this project addresses the priority area(s) checked off on the cover page.

3. Names of Other Persons in Recovery who helped create this project (other than previously listed applicant(s) on page one:

4. Why do you believe this project is needed?

Project Name: \_\_\_\_\_

5. How do you intend to evaluate the project? How will you know that your project was successful? (Example: If my project requires a survey to measure success, I'll create related questions and feel I've met my goal if I have 65% of a success rate.) Not all projects will need to evaluate themselves with surveys-you may feel that if you have learned a skill or accomplished what you set out to do in your summary, you have successfully met your goal. (You can state this as well)

6. If your project requires continuation after funding ends, how do you intend to fund this? For example, will you be applying for other grant money; will your agency give in-kind donations; will the initial funding assist you in generating more funding? (This is also optional, it may be a one-time need to begin the project or a temporary amount of time to complete, never intending on continuation).

Project Name: \_\_\_\_\_

### PROJECT WORKPLAN

PRIORITY AREA(S): \_\_\_\_\_

---

<i>MAJOR ACTIVITY/OBJECTIVE:</i>		
<i>STEPS: How will it be done? What are the steps you need to take to complete the major activity?</i>	<i>WHO WILL DO IT?</i>	<i>BY WHEN WILL IT BE DONE?</i>
<i>RESULT:</i>		

**\*\*\*You may duplicate this page if additional space is needed.**

Project Name: \_\_\_\_\_

## BUDGET FORM

<i>Expense Item</i>	<i>Amount Requested</i>
Materials and Supplies	
Facility Costs	
Communication Costs	
Food/Refreshments	
Consultant/Trainer	
Mileage/Travel	
Insurance	
Equipment	
Other	
<b>TOTAL</b>	<b>\$</b>

### INSTRUCTIONS FOR THE BUDGET EXPLANATION

**\*\*\* Attach professional estimates to Budget Form from contractors, retail outlets or internet sites to prove out itemized costs above). *Your grant application cannot be considered for funding without them.* \*\*\***

**Materials & Supplies:** Consumables needed for the project. These can include: paper, printing, pens, folders, etc. List the type of material and cost per item, number of items to be purchased, etc.

**Facility Costs:** Cost of room rental

**Communication Costs:** Postage, Telephone, Fax

**Food/Refreshments:** Costs connected to the project activity

**Consultant/Trainer:** If a person needs to be hired on a contracted basis, it would go here. Identify contractor to be used, rate of pay, number of hours, services they would provide, etc. (Attach the Contractor's estimate with company letterhead to the back of the Budget Form).

**Mileage/Travel:** Transportation reimbursements to yourself and/or participants using public transit or personal vehicle

**Insurance:** Costs associated with insurance needed for this activity (capped amount).

**Equipment:** Costs for a computer or other equipment that is not a consumable. (Please cost out each item on another sheet if there is more than one item here).

**Other:** Any costs that are not included in the above line items. (Please specify what this item is).