Maryland
DEPARTMENT OF HEALTH

Maryland Department of Health, Office of Innovation, Research, and Development
SFY22 OMHCs to CSFs Transformation Small Grant Program

NOTE: Please review the OMHCs to CSFs Transformation Small Grants Program SFY22 Instructions

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Section 1: Contact Information

1a. Organization

1b. Provider Address

1c.Website

1d. Organization Phone Number

1e. Applicant Name

1f. Applicant Title

1g. Applicant E-mail

1h. Applicant Phone Number

Application Checklist

A complete application package includes the following:

- Completed Grant Application (fillable PDF) ☐
- Completed Attachment A (Excel Sheet) ☐
- PDF of Cover Letter signed by the OMHC's Medical Director ☐
- Accreditation and Licensing Information/Documentation ☐

Section 2: General Information (Fillable PDF and Attachment A)

2a. Years in Operation

2b. Services Offered: Please complete TAB 1 in Attachment A. Please refer to Page 5: Section 2b of the instructions for additional information.

2c. Full-time Employees (FTE): Please complete TAB 2 in Attachment A. Please refer to Page 5: Section 2c of the instructions for more information.

2d. Office Equipment: Please complete TAB 3 in Attachment A. Please refer to Page 5: Section 2d of the instructions for more information.

2e. Medical Equipment: Please complete TAB 4 in Attachment A. Please refer to Page 5: Section 2e of the instructions for more information.

2f. Referral Sources: Please complete TAB 5 in Attachment A. Please refer to Page 5: Section 2f of the instructions for more information.

2g. Referrals Out: Please complete TAB 6 in Attachment A. Please refer to Page 5: Section 2g of the instructions for more information.

2h. Licensing and Accreditations: Please attach PDF copies of your most up-to-date Accreditation Report and Licensing Documentation. Please see Page 5: Section 2h of the instructions document for additional information.

2i. Physical Location Type (building, in commercial space, etc.)

Section 3: Patient Population (Average of 2018, 2019, 2020)

3a. Average number of individuals aged **18 and older** served annually:

3b. Primary zip codes your practice serves?

Section 4: Payermix Population Served (Average of 2018, 2019, 2020)

4a. Percentage Medicaid:

4b. Percentage Medicare:

4c. Percentage Dually Eligible (Medicaid and Medicare):

4d. Percentage Private Insurance:

4e. Percentage Uninsured:

Section 5: Percentage of Patients Served

5a. Mental Health Disorder Only:

5b. Mental Health and Substance Use Disorder:

Section 6: Clinical Spaces

6a. Please describe your OMHC's clinical spaces. For example, the number of exam rooms available for patients.

Section 7: Security Systems

7a: Please describe your OMHC's security systems and protocols.

Section 8: Finances

8a. Please describe how your organization is currently funded. For example, are you currently grant supported? Does your OMHC obtain funds through philanthropy? Does your organization currently bill for services? If so, what payers does your organization bill?

Section 9: Partnerships with Other Providers

9a. Please provide information on any current partnerships with local EDs, inpatient facilities, hospitals, law enforcement agencies, or other community-based providers.

Section 10: Expansion Narrative

10a. Please write up to two pages on why your practice is well-suited to expand to provide Crisis Services. Consider why your community needs crisis services? Why is your practice in a good position to fill this need? Why will technical assistance be helpful to you during the transition?

Section 11: Challenges Narrative

11a. Please describe the challenges that your OMHC anticipates in expanding to provide crisis services and how technical assistance from the MDH will assist your organization in overcoming these challenges. Does your OMHC need help creating a feasibility plan? Does your organization need more information on the differences between an OMHC and a CSF? Does your practice need assistance working through an operating and expansion budget?