**REQUIREMENTS:[[1]](#footnote-1)**

**To be eligible to apply for EPSDT Expansion Phase I funds, applicants must demonstrate that:**

* + - 1. Their organization currently meets all of the following criteria, as evidenced by BHCS records:
  + Provides program and services specified in application;
  + In compliance with quality assurance requirements over the last 18 months;
  + In compliance with timely, accurate and complete submission of all documents requested by BHCS.

1. The program for which they are requesting an augmentation meets all of the following criteria, as evidenced by BHCS records and the information in the submitted application:
   * Demonstrated focus on one of the priority categories specified in this application;
   * Demonstrated ability to fully utilize current EPSDT allocation;
   * Realistic plan for utilizing additional funds according to schedule specified by BHCS; and
   * Demonstrate currently utilization of an evidence-based or promising practice.

**If a contract augmentation results from this application, applicant agrees to:**

* + Submit completed FY 11-12 Year-End Cost Report by September 28th, 2012;
  + Hire staff within 30 days of Board of Supervisor’s approval of augmentation; and
  + Report billable hours for direct service staff at 65% or higher within 90 days of Board of Supervisor’s approval of augmentation.

If provided an augmentation, the amount requested will be prorated to the month of the Board of Supervisor’s approval of the contract augmentation.

**EPSDT Expansion Phase I funds will target the following priority categories:**

* Early Childhood: Mental health services delivered in homes and child development centers for young children, age six years and younger and their families throughout Alameda County.
* School-Based Programming in Pre-Kindergarten through 12th Grade: Short-term school-based mental health services that align with the School Based Behavioral Health Initiative models for school-aged children and youth throughout Alameda County.
* Youth involved in Probation: Community and home-based mental health services to prevent recidivism and promote positive youth development for children and youth throughout Alameda County who are involved in juvenile justice probation.
* Transition Age Youth (TAY): Mental health services for youth age 16 to 21 throughout Alameda County.
* Culturally and Linguistically Responsive Services: Mental health services, which are culturally and linguistically responsive to the unique needs of children, youth and their families who may require additional support and language access in one or more of all of Alameda County’s threshold languages.

**INSTRUCTIONS:**

**BHCS will not consider applications that do not conform to the below specifications:**

1. Fill in one application per existing EPSDT Reporting Unit (RU) for the augmentation is requested.
2. Fill in the application completely. Applications must use Arial 10.5 font and not exceed four pages.
3. Fill in one Exhibit B-1: Budget From per application and detail sheet in the Excel workbook. Fill in all yellow highlighted areas.
4. Email the completed application and Exhibit B-1 no later than **Friday, September 14, 2012 at 5:00 pm** to [**procurement@achbcs.org**](mailto:procurement@achbcs.org)with **‘EPSDT Expansion Phase I Application from <Provider Name>’** in the email subject line.

Please visit <http://www.acbhcs.org/providers/network/docs.htm> to access the frequently asked questions sheet.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | | | |  | | | | | **Organization name** | | | | | | | | |  | | |
| **Program name** | | | |  | | | | | RU# | | |  | | | | | | | | |
| **Contact person name and title** | | | |  | | | | | **Contact phone** | | | | | | | |  | | | |
| **Contact email** | | | | | | | |  | | | |
| **Current 12 month FY 12-13 Organizational budget** | | | |  | | | | | **12 month FY 12-13 Program budget** | | | | | | | | Current | |  | |
| Total *(Current plus proposed increase)* | |  | |
| **Choose the type of service provided in this RU/site.** | Early Childhood  School-Based  Probation Involved Youth  TAY Program  Culturally & Linguistically Responsive | | | | | | | **Briefly describe the services provided in this RU/site.** | | | | |  | | | | | | | |
| **Indicate the number of youth served through this RU/site.** | | **Current** | | | | | | **Additional with Augmentation** | | | | | | | | **Total Proposed *(Current plus Augmentation)*** | | | | |
| Per year | | | |  | | Per year | | | | | |  | | Per year | | | |  |
| Per month | | | |  | | Per month | | | | | |  | | Per month | | | |  |
| At any given time | | | |  | | At any given time | | | | | |  | | At any given time | | | |  |
| **Briefly describe the population served in this program *(including race/ ethnicity, age, geographic area, etc.).*** | | | | | |  | | | | | | | | | | | | | | |
| **Provide justification of the demand for additional EPSDT services at for this RU/site.** | | | | | |  | | | | | | | | | | | | | | |
| **Provide the name of the primary evidence-based practice (EBP) or promising practice (PP) utilized for this RU/site.** | | | | | | | EBP | | | **Name** | | | | |  | | | | | |
| PP | | | **Name** | | | | |  | | | | | |
| **Briefly describe the EBP or PP.** | | | | | |  | | | | | | | | | | | | | | |
| **Briefly describe how the EBP or PP is well-matched to the target population.** | | | | | |  | | | | | | | | | | | | | | |
| **Specify when this RU/site began using this EBP or PP.** | | | | | |  | | | | | | | | | | | | | | |
| **Describe how the EBP or PP is implemented in RU/site.** | | | | | |  | | | | | | | | | | | | | | |
| **If your allocation for this RU/site was not fully utilized in FY 11-12, briefly describe the rationale for how your organization will utilize current and additional funds, including any recent milestones such as the hiring of new staff.** | | | | | |  | | | | | | | | | | | | | | |
| **Will your organization be able to use existing staff to provide these services?** | | | Yes  No | | **If yes, please state the number of FTEs and briefly describe your plan for coverage.** | | | | | |  | | | | | | | | | |
| **Will additional staff be hired?** | | | Yes  No | | **If yes, explain the steps and timeline that will be used to hire.** | | | | | |  | | | | | | | | | |

1. **Please note that BHCS reserves the right to request clarification about submitted applications. Submittal of application in no way obligates BHCS to augment any applicant’s contract.**  [↑](#footnote-ref-1)