**Youth Resource and Opportunity Collaborative (Youth ROC) - Assessment Provider - Grant Application**

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| --- | --- |
| Organization: | Tax ID Number: |
| Address: | City & Zip: |
| Primary Contact Name: | Primary Contact Title: |
| Primary Contact Phone: | Primary Contact Email: |
| Financial Contact Name: | Financial Contact Title: |
| Financial Contact Phone: | Financial Contact Email: |
| D-U-N-S Number:  (Dun & Bradstreet (D&B) provides a D-U-N-S Number, a unique nine-digit identification number, for each physical location of your business. D-U-N-S Number assignment is FREE for all businesses required to register with the US Federal government for contracts or grants.) | |

*\*If awarded, a W-9 will be required to have on file prior to subgrant initiation*

**Applications will be accepted until funds have been exhausted**

**Please concisely address the following application components:**

1. *Cover Letter*

Describe your team’s interest and commitment in providing screening and assessment services for the YouthROC program. The letter shall be signed by a person authorized to negotiate a contract in Region 3.

1. *Staffing, Team Experience and Understanding of Project & Objectives*

Describe the qualifications and experience of the team members expected to be assigned to conduct screenings and assessments. The description shall include previous experience with conducting clinical assessments. A narrative demonstrating the proposer’s understanding of the project, the goals, the services to be provided, and their organization’s mission and vision aligns with the desired outcomes of the YouthROC program.

1. *Work Plan Approach and Schedule*

Discuss your organization’s understanding of the scope of work to be performed and level of effort expected to be performed by each assessment. Include an itemized table of estimated person hours by professional classification (or team member) to quantify the level of effort. Describe the method that will be used for scheduling, coordination, management of activities and costs associated, continuous quality improvement, and list key or potential issues/risk you may deem critical to the assessment and screening process.

Provide information regarding your organization’s ability to implement the work plan within the timeline provided in Appendix B.

1. *Budget*

Provide an overview of the anticipated budget needed to meet the Scope of Services described above with consideration given to Funding Availability. Organizations should consider the estimated number of youth and families who can be served during the contract period. Southwest District Health is estimating up to 945 initial assessments and up to 1,282 follow-up visits will be completed during the budget period across the six-county region. Please include and budget for incentive payments based on how many individualized plans your organization anticipates completing. Keep in mind that not all assessments may result in an individualized plan.

1. *Other Relevant Information*

Provide additional relevant information that may be helpful in the selection process.

**Applications should be sent electronically to:**

Southwest District Health at [communityhealth@phd3.idaho.gov](mailto:communityhealth@phd3.idaho.gov)