Worcester County's Initiative to Preserve Families

The Local Management Board

FY 2026 Request for Proposals for
Coordinated Community Supports Partnerships
Worcester and Somerset Counties Spoke Providers

Release Date: January 8, 2025
Deadline for Submission: January 27, 2025 at 2:30pm

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Introduction

Local Management Boards (Boards) were established in the 1990s as part of a State/local collaboration committed to improving the well-being of Maryland's children, youth, and families. The Boards were created to promote improved, coordinated local decision-making that focuses on results and accountability. The premise was, and continues to be, that health, education, economic, and social outcomes are more likely to be improved if decisions about programs and strategies are made by local jurisdictions with the funding, support, guidelines, and accountability managed by the State.

The jurisdictions, through their Boards, bring the knowledge of local needs, resources, and strengths. The Boards bring together public and private agencies, local government, faith-based and civic organizations, families, youth, and community members to develop, implement, and review a community plan.

The Maryland Consortium on Coordinated Community Supports was created by the Maryland General Assembly as part of the Blueprint for Maryland's Future, Chapter 36 of 2021. The Consortium is responsible for developing a statewide framework to expand access to comprehensive behavioral health and wraparound services for Maryland students. It is comprised of 25 experts in the fields of behavioral health and education and is chaired by former Delegate David D. Rudolph. The Maryland Community Health Resources Commission (MCHRC) serves as the Consortium's fiscal agent and is responsible for providing staff support for the Consortium. The Community Supports Partnership model includes a few key principles that include:

- coordination and multi-tiered system of supports,
- importance and inclusion of schools in addressing youth behavioral health needs,
- addressing local needs and providing holistic services,
- statewide standardization and priority evidence-based programs,
- cultural competence,
- data and evaluation,
- addressing workforce challenges,
- financial stewardship and permissible uses of grant funds.

The Worcester County Local Management Board (LMB) is the Community Support Partnership (CSP) for Worcester and Somerset Counties. The Worcester County Local Management Board was the pilot Hub for Worcester and Somerset Counties in FY2025. During this time period, the Worcester County LMB solidified logistical aspects of operating a full CSP (i.e. Worcester County LMB acts as the Hub to behavioral health providers in Worcester and Somerset Counties funded by the Consortium, also referred to as Spokes), completed needs assessments and asset mapping, and created and continues to convene subcommittees focused on each County. During the pilot hub period, the Worcester County LMB has coordinated with Worcester County and Somerset County Local Education Agencies (LEAs), Spokes/behavioral health providers, and a variety of other child and family serving agencies such as Department of Social Services (DSS), Department of Juvenile Services (DJS), and the Local Behavioral Health Authority (LBHA).

For purposes of this Request for Proposal (RFP), Worcester County's Initiative to Preserve Families (Worcester County Local Management Board) and the Board of Directors are seeking proposals for Fiscal Year 2026 from providers to sustain and expand access to high-quality behavioral health and wraparound services for students and families in Worcester County and Somerset County as outlined by the Maryland Consortium on Coordinated Community Supports and the Worcester County CSP serving

Worcester and Somerset Counties. Funding is available to local 501-(c) not-for-profit organizations, faith-based organizations, and government agencies who are in good standing. LEAs are not eligible to apply.

Executive Summary

Worcester County's Initiative to Preserve Families' office is located in the central part of Worcester County in Snow Hill, Maryland. The Worcester County Local Management Board, Board of Directors is composed of five (5) ex officio members and four (4) at-large members; all of whom are committed to improving the well-being and outcomes for children, youth, and families in Worcester County.

Mission Statement: The mission of the Worcester County Local Management Board is to achieve a comprehensive system of education, health and human services that effectively and responsibly address the needs of Worcester County children and families through public and private interagency collaboration.

Vision Statement: The Worcester County Local Management Board envisions a caring, compassionate, inclusive community with leadership and government that fosters an environment which empowers all children, youth and families to thrive.

The Worcester County LMB Board of Directors along with the CSP partners such as LEAs, spokes, and other child and family serving agencies in Worcester and Somerset Counties have reviewed local, state, and national data related to youth and family's behavioral health needs and challenges. Based on these data, and aligned with local and state priorities, this RFP will outline the different types of programs and services that are eligible to apply as well as those that are highly prioritized locally.

This RFP will support interventions at each of the three tiers of the Multi-Tiered System of Supports (MTSS): Tier 1 (universal promotion/prevention), Tier 2 (early intervention), and Tier 3 (treatment). Service provider applicants are not required to offer support and services at each tier but should integrate into a school's overall multi-tiered approach.

While the Consortium recognizes the need for local autonomy and local solutions, programs should reflect a strong evidence base. To that end, the Consortium's Best Practices Subcommittee has developed a list of 15 Evidence-Based Programs (EBPs) that are encouraged statewide.

1. Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)
2. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCHADTC)
3. Safety Planning Intervention (Stanley and Brown)
4. Counseling on Access to Lethal Means (CALM)
5. Adolescent Community Reinforcement Approach (ACRA)
6. The Student Check-Up (Motivational Interviewing)
7. Therapeutic Mentoring
8. SBIRT – Screening, Brief Intervention, and Referral to Treatment
9. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back
10. Botvin Life Skills
11. Youth Aware of Mental Health (YAM)
12. Circle of Security
13. Botvin Life Skills Parent Program

14. Family Check Up
15. Chicago Parenting Program

Applicants focusing on suicide prevention should consult the Maryland Action Plan to Prevent Suicide in Schools (MAPS).

Priority Population

There are interventions at each of the three tiers of the Multi-Tiered System of Supports (MTSS): Tier 1 (universal promotion/prevention), Tier 2 (early intervention), and Tier 3 (treatment), in both Worcester and Somerset Counties. Overall, Tier 1 interventions are most common and widespread throughout the schools and in partnership with other agencies. Tier 2 and Tier 3 interventions are prioritized as greater need in both Worcester and Somerset Counties compared to Tier 1 interventions. Applicants may still apply for Tier 1 interventions, but all applications are encouraged to show strong understanding of current services in order to reduce duplication and maximize breadth and depth of services.

Needs, challenges, and gaps related to services in Worcester County and Somerset County are related to specialty services for specific populations, services, and needs. Some of the specialty services that could be brought to and/or expanded in Worcester and Somerset Counties are family and in-home intervention, specialized treatment for autism and early childhood mental health supports. Increased options for providers who are fluent in several languages would help with improving access to services for a variety of people whose native language is not English (e.g. Spanish, Haitian Creole, etc.).

Worcester County

Services and Gaps

Overall, the priority services and interventions identified are specialized services for family and in-home intervention. Other services that are limited in our rural areas are early childhood mental health supports and specialized treatment for autism.

MDH identified “White Space” (i.e. public behavioral health services for youth and adolescents not available) including services such as Mobile Response Stabilization Services (MRSS), First Episode Psychosis, Mental Health Partial Hospitalization, SUD Partial Hospitalization, a Residential Treatment Center, SOAR, Spanish Speaking Therapeutic Services, TAMAR, or TCM Plus/1915i.

There are currently no services within the schools for disordered eating or psychosis; however, referrals to community providers are made for these concerns. Tier 1 services could possibly be provided in these areas. The schools use existing Tier 1 strategies and are looking to expand Tier 2 services.

Although the district employs four school psychologists, it is less than the National Association of School Psychologists' recommended ratio of 500:1 for psychologists to students. The 21 school counselors is also less than the recommended counselor to student ratio of 250:1. The district also does not have enough social workers in order to have one social worker at every school. There are not any school-employed case managers/care coordinators, community mental health directors or substance abuse specialists; however, community employed team members staff these positions. The LEA contracts for supplemental direct services when they do not have adequate staffing. A geographic disparity is that services provided by a social worker are not available in two schools in the north part of the county because there are no social workers for those two schools at this time.

There are many students who are eligible for behavioral health services through the public behavioral health system that are not receiving services. There are 6,648 students in Worcester County, with 6,621 eligible for public behavioral health services (PBHS), 1,342 who received PBHS, 61 inpatient psychiatric hospitalizations and 82 psychiatric emergency room services (the highest percentage of those services being youth ages 13-17 at 35.8%).

The currently awarded service providers/spokes are supporting identified behavioral health needs by providing early intervention services, services that address anxiety, depression, and trauma, and programs that are family focused.

Relevant Data
Convenience sample survey data has given some information about how youth, families, and youth serving stakeholders feel about behavioral health needs and services in Worcester County.

Overall, the top concerns noted by all three groups surveys included anxiety, depression, bullying, suicide/suicidal ideation and self-harm. Feedback on how these groups thought behavioral health services for youth could be improved or enhanced based on current strengths included ideas such as, but not limited to:

- more providers, more time with counselors, and more services available during and after school.
- destigmatizing and normalizing the use of behavioral health services through actions such as more regularly scheduled times with guidance counselors, improved culture and climate of school through education of staff, encouraging kindness, and paying more attention to student behaviors outside of the classroom.
- workshops for families and more communication with families and overall publicity of behavioral health programs and services.
- increased variety of services such as early childhood services, holistic services, large group activities, presentations, and education about topics and skills like self-esteem and self-regulation.

Secondary data collected from a variety of sources highlights challenges, needs, and disparities in behavioral health services and outcomes.

<u>Early Childhood Services</u>
31.4% of youth in the birth to 6 age group are eligible for public behavioral health services, but only 10.1% of this age group are receiving these services.

<u>Gender and Racial Disparities</u>
In both middle and high school, female students reported higher percentages of being bullied, feeling sad or hopeless, suicidal, drinking and using marijuana. One of the largest disparities was that 46.9% of female middle school students had reported feeling sad or hopeless every day for more than 2 weeks, compared to 20.9% of males.

Although male students had a much higher rate of in-school and out-of-school suspensions than females, female students had a much higher arrest rate. Another disparity noted was that Black or African American students only comprise 18.5% of the student population, but they accounted for 25.6% of the in-school suspension rate, 27.7% of the out-of-school suspension/expulsion rate and 52.6% of the arrest rate.

Other Marginalized Populations Disparities

The graduation rate for English learners (multi-lingual) students, students with disabilities, and Hispanic students was much lower than the overall graduation rate. Chronic absenteeism among homeless students was much higher than for other students. The mobility rate was the highest among homeless students and English learners (multi-lingual) students.

Somerset County

Services and Gaps

Overall, the priority services and interventions identified are social, emotional learning (SEL), math and reading, school climate, and parent support. The LEAs are looking for behavioral health providers/spokes who will coordinate well with the schools to reduce barriers for students and families accessing services (e.g. time services are available). The LEA is planning for an offsite alternative learning program that will provide additional parent support and SEL.

MDH identified "White Space" (i.e. public behavioral health services for youth and adolescents not available) including services such as Court/DJS Initiatives, Crisis Intervention Team, Crisis Walk-In, Crisis Residential, Detention/Jail-Based Services, First Episode Psychosis, Inpatient Services (SUD), Opioid Maintenance Treatment, Mental Health Partial Hospitalization, SUD Partial Hospitalization, Recovery Support Pregnant Women/Children, Residential Rehabilitation, Respite Care, Safe Station, School/Preschool Programs, SOAR, Spanish-Speaking Therapeutic Services, START, and TAMAR. In addition, the LEA is not connected to the Adolescent Clubhouse.

There is currently no mental health screening or quality improvement processes in place in schools. All Tier 1 through Tier 3 services and supports, as well as evidence-based practices and programs, and community partnerships are in place in 76% or more of the schools. There is not complete consistency across the school system on how those services are implemented or shared with students/families. There is also a need for more age-appropriate interventions and supports for the youngest students (pre-K) and multi-lingual students and families.

There are many students who are eligible for behavioral health services through the public behavioral health system that are not receiving services. There are 2,894 students in Somerset County, 4,112 eligible for public behavioral health services (PBHS) (from birth 0-25), 869 receiving PBHS, 32 inpatient psychiatric hospitalizations, 67 psychiatric emergency room services.

The currently awarded service providers/spokes are supporting identified behavioral health needs by providing early intervention services, services that address anxiety, depression, and trauma, and programs that are family focused.

Relevant Data

Convenience sample survey data has given some information about how youth, families, and youth serving stakeholders feel about behavioral health needs and services in Somerset County.

Overall, the top concerns noted by all three groups surveys included depression, anxiety, bullying, suicide/suicidal ideation and self-harm, substance use, and early childhood services. Mental and developmental issues such as ADHD were also noted. Youth noted the need to reduce barriers to behavioral health by normalizing contact with behavioral health services and destigmatizing receiving behavioral health services. De-escalation skills were noted by families and caregivers as a need and area for improvement.

Secondary data collected from a variety of sources highlights challenges, needs, and disparities in behavioral health services and outcomes.

Early Childhood Services

33.2% of youth in the birth to 6 age group are eligible for public behavioral health services, but only 12.6% of this age group are receiving these services. This data supports the need for educating caregivers of children birth to age 6 on available resources and the need for a strong partnership with the Judy Center. The LEA has seen an increase in the need for therapists that serve their youngest population (PreK). They have also had situations where a student may have special needs.

Gender and Racial Disparities

In both middle and high school, female students reported higher percentages of being bullied, feeling sad or hopeless, suicidal, and drinking. One of the largest discrepancies was 40% of female middle school students reporting feeling sad or hopeless almost every day for more than 2 weeks, compared to 23.5% of male middle school students. Female middle school students also reported a much higher rate of seriously considering suicide at 30.4%, compared to 16.3% of male students.

Another discrepancy was the higher rate of Hispanic/Latino high school students reporting that they currently drink at 33.9% compared to 23.8% of White students and 14.7% of Black students. Bullying in middle school seems to be an issue across the board, with nearly 40% of all students reporting that they have been bullied on school property.

Male students had a much higher rate of in-school and out-of-school suspensions than females; however, the arrest rate of female students was nearly the same as male students. Another disparity noted was that while Black or African American students comprise 46.1% of the student population, they accounted for 68% of the in-school suspension rate, 73.5% of the out-of-school suspension/expulsion rate and 92.5% of the arrest rate. Another item that stood out was the very high number of out-of-school suspensions and expulsions. Although it is likely that the same students may have been suspended multiple times, with 2894 students in the county, there were 1183 out-of-school suspensions or expulsions.

Other Marginalized Populations Disparities

The overall graduation rate at 73.8% is lower than the State's overall graduation rate of 85.8%. Students with disabilities had the lowest graduation rate at just 50%. Chronic absenteeism was highest among homeless, ADA 504 students and FARMS students.

Please see the data toolkit in Attachment 7 for more information and data sources to use in your proposal.

Proposal Specifics

The LMB Board of Directors is asking that interested parties develop a robust, succinct and concise proposal for Worcester and/or Somerset Counties to address the behavioral health needs of our youth.

Program implementation will be expected to begin **July 1, 2025, and run through June 30, 2026**. While there is no set maximum amount for the requested budget, the average awards to service providers in the last grant cycle managed by MCHRC was approximately **$750,000.** The LMB will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards. Funding

may not be used for costs that are eligible for reimbursement through insurance. Maximizing other funding sources and providing a thoughtful efficient budget is strongly encouraged.

The LMB reserves the right to negotiate the proposed budget with the chosen vendor. Additionally, the LMB reserves the right to award a lesser amount than requested. If a lesser amount is awarded, the applicant will have the opportunity to adjust the scope of the proposal and/or decline funding.

ALL FUNDING IS CONTINGENT UPON AVAILABILITY OF FUNDS AND MAY BE AMENDED TO REFLECT CHANGES IN THE FINAL BUDGET APPROPRIATION BY THE GENERAL ASSEMBLY, OR MAY BE AMENDED BASED ON FUNDS APPROPRIATED TO THE WORCESTER COUNTY LOCAL MANAGEMENT BOARD.

Service provider applicants may request grants for more than one jurisdiction (Worcester and/or Somerset Counties); however, a separate application must be submitted for each jurisdiction to be served. Applicants are required to demonstrate that their programs respond to documented local needs and priorities. Applicants should use Needs Assessments and other data to justify their programming (see Attachment 6).

Funds from this grant may not supplant current funding for services and supports. Funds may be requested to sustain programs launched through the CHRC/Consortium's previous Request for Proposals for service providers. Grant funds may be requested for new or existing programs. An established program currently funded through another source can receive grant funding under this Request for Applications if the funding represents an expansion of services or an increase in the number of individuals served. When possible, Medicaid reimbursement should be sought, and grant funding should support activities that are not Medicaid reimbursable.

All services do not need to be provided in the school building but must be strategically coordinated via ongoing and regular communication and collaboration with the district and schools to augment their existing Multi-Tiered System of Supports (MTSS). If applicable, applicants are encouraged to include in their proposals plans for transportation of students and/or family members to services and may request grant funding to this end.

The Consortium is aware of behavioral health workforce constraints. Applicants must develop realistic staffing plans as part of their proposals. Applicants may include innovative strategies to address challenges in the behavioral health workforce, such as: use of supervised interns and other staff consistent with legal requirements, family and peer support programs, innovative use of technology, expanding Tier 1 and Tier 2 services, paid staff training and career ladders, and building the behavioral health workforce pipeline. Examples of innovative technology may include: virtual reality technology, biofeedback, remote patient monitoring, use of Artificial Intelligence to monitor client wellbeing, computerized medical scribes for documentation, computerized assessment, psychoeducational apps to complement treatment or aid in care coordination, and self-care and mental health promotion applications. While proposals may include components that address workforce challenges, an applicant's program must directly result in expanded behavioral health and/or wraparound services for students and families during the grant period.

This RFA may support interventions at each of the three tiers of the MTSS: Tier 1 (universal promotion/prevention), Tier 2 (early intervention), and Tier 3 (treatment). Providers are not required to offer supports and services at each tier. See page 10-11 in the MCHRC RFA for more information about MTSS.

This Request for Applications will support a range of different types of services for students and families. Examples of programming that may be supported include:

- School-wide preventative and mental health literacy programming
- Individual, group, and family therapy
- Navigation and case management services
- Substance Use Disorder services
- Trauma informed care
- Telehealth services
- Suicide prevention
- Early childhood interventions
- Therapeutic mentoring
- Therapeutic summer camps
- Crisis stabilization and response
- Peer supports
- Behavioral health education, support, and navigation for families
- Support groups
- Psychiatric care and medication
- Addressing dating/sexual violence
- Grief support
- Positive classroom environments
- Educator training programs
- Nature-based wellness programs
- Depression and anxiety services
- Provider participation in school meetings (e.g., IEP, disciplinary, etc.)
- Executive functioning

Applicants should select Evidence-Based Programs (EBPs) that are most relevant for their communities. The Executive Summary of this RFP includes a menu of 15 Priority EBPs in which the Consortium and National Center for School Mental Health will provide training and implementation support. More information on Priority EBPs can be found in Attachment 2. A menu of other recommended EBPs is found in Attachment 3. Applicants focusing on suicide prevention should consult the Maryland Action Plan to Prevent Suicide in Schools (MAPS).

Applicants may identify EBPs and strategies not included on either the Priority or Recommended menus, but must demonstrate that these are: (1) supported by evidence of impact on target social, emotional, behavioral, and/or academic outcomes (based on research evidence, as recognized in national registries and the scientific literature, and/or supported by practice-based evidence of success in local or similar schools or communities); (2) equitable and fit the unique strengths, needs, and cultural/linguistic considerations of students and families in the target community; (3) responsive to documented local priorities; (4) have adequate resource capacity for implementation (e.g., staffing capacity; training requirements, qualifications, and staff time; ongoing coaching); and (5) monitored for fidelity. Applicants are responsible to coordinate any training and implementation support for EBPs not on the Priority menu. These training costs (if any) may be included in grantee budget requests (see Budget section).

Applicants must demonstrate the capacity to collect and report data required by the LMB, MCHRC and Consortium. Service provider grantees and subgrantees will be required to report standardized data to the CHRC and/or their Partnership Hub. Anticipated performance and outcome measures and

recommended assessment tools can be found in Attachment 5. Performance and outcome measures are subject to change. Examples of performance and outcome measures include:

1. # unduplicated students served – total (see Attachment 4) Note: Current MCHRC grantees may be asked to differentiate between new students to be served under this RFA versus students served under their current grant.
2. # unduplicated students served – Tier 1, 2, 3
3. # unduplicated students served by race/ethnicity
4. # unduplicated students served by gender
5. # unduplicated students served by grade level (pre-k, elementary, middle, high)
6. # unduplicated schools attended by students served
7. Satisfaction surveys
    a. # of students completing surveys
    b. # of students satisfied
    c. # of family members completing surveys
    d. # of family members satisfied
8. # unduplicated new staff positions
9. # unduplicated school staff by grantee trained and assessed for competency
10. NEW: Optional demographic metrics (# LGBTQ+, # w/ Disability, # ELL/ESL)
11. Custom measures by EBP and/or by assessment tool
    a. # unduplicated who received services
    b. # unduplicated who completed pre assessment
    c. # unduplicated who completed intervention
    d. # unduplicated who completed post assessment
    e. # unduplicated who demonstrated improvement
    f. # unduplicated who demonstrated no change
    g. # unduplicated who demonstrated desired outcome
12. Other custom measures may be developed with individual grantees

The LMB reserves the right to discontinue funding if the program is not meeting deliverables or if funding is withdrawn from the MCHRC.

The LMB does not discriminate on the basis of race, color, sex, age, national origin, religion, disability or sexual orientation in matters affecting employment or in providing access to programs.

Timeline

RFP Release
Wednesday, January 8, 2025

Pre-Proposal Meeting
Friday, January 10 · 3:00 – 4:00pm
Video call link: https://meet.google.com/ydb-xhvh-rrn
Or dial: (US) +1 262-468-7244 PIN: 405 597 258#

Proposals Due
Monday, January 27, 2025, 2:30pm EST

Interested parties must submit one (1) original and five (5) copies of their proposal to the Worcester County Government by the established deadline. All copies of the Proposal Documents and any other documents required to be submitted with the Proposal Documents will be enclosed in a sealed envelope and will be identified with the project name: **WORCESTER COUNTY'S LOCAL MANAGEMENT BOARD FY2026 SPOKE PROVIDERS REQUEST FOR PROPOSALS**. The Worcester County Government will ensure that all proposals received by the deadline are given to the LMB. Proposals should be addressed and mailed or hand carried to:

Office of the County Commissioners
Procurement Officer
Worcester County Government Center
One West Market Street, Room 1103
Snow Hill, MD 21863

Evaluation Meeting
The week of January 27th 2025

Notification of inclusion in CSP application
The vendor(s) chosen to be included in the LMB's CSP application will be notified by LMB staff by close of business day on **Monday, February 3, 2025**.

Submission of CSP application to MCHRC (Hub administration costs and spokes/service provider costs)
Tuesday, February 4, 2025, 3:00pm EST

Commissioner's meeting for approval of proposal(s)
April-June 2025, specific date TBD

Notification of award
The vendor(s) chosen will be notified by LMB staff by **Tuesday, June 17, 2025 at the latest**. A follow up meeting will then be scheduled. Vendors are expected to be ready for implementation by July 1, 2022.

Questions and Requests for RFP Documents
Agencies may submit questions and requests for an electronic copy of the RFP to nrice@co.worcester.md.us

Evaluation

The LMB will utilize an Evaluation Committee to review and evaluate each proposal submitted by the guidelines established on the provided evaluation criteria. A total of five members will serve on the RFP panel. The panel will be assigned a facilitator who will assist the group through the process but will not have a vote. Members of the RFP panel will receive all proposals once they have been received from the County Administrator. Agencies that are submitting a proposal cannot be part of the panel that reviews the proposals. The Evaluation Committee will include staff of the Worcester County Local Management Board and Worcester County Local Behavioral Health Authority, both of which are housed within the Worcester County Health Department but maintain firewalls from other health department programs. *Examples* of persons/agencies who may be a part of the Evaluation Committee include:

- Local Education Agencies
- The Worcester Commission on Aging
- LMB Directors or staff
- LBHA Directors or staff
- Clergy
- Representatives from civic groups
- Representatives from SU School of Social Work or professor(s) from WorWic and/or UMES
- Pediatricians
- Representatives from the United Way
- Representatives from the Eastern Shore Community Foundation

The LMB staff will present the proposals to the Board of Directors for final discussion and considerations to move forward with presenting the selected proposal(s) to the Worcester County Commissioners. Board members can call a motion to recommend changes for the program vendor to consider, but any such change would require a unanimous vote of support by the full Board.

After the LMB Board of Directors has voted to support the selected program vendor, the LMB will then move to follow the Worcester County procurement policy where the selected vendor information will be presented to the Commissioners of Worcester County for approval.

Agencies wanting to appeal a decision reached for this RFP may do so in writing to the LMB Executive Committee within one week of the panel priorities being announced. The Executive Committee will either deny the appeal and inform the petitioner or forward the appeal for consideration by the full Board. To reverse an earlier decision concerning the RFP made by the panel it will require a unanimous vote by the full Board.

Once the Board of Directors and County Commissioners have approved the selected proposal(s), the LMB staff will notify all vendors of their status with the proposal. The LMB will contact the selected vendor(s) to meet and prepare program plans and implementation strategies.

Submission Details

The LMB Board of Directors is asking that interested parties develop a robust, succinct and concise proposal for programs to sustain and expand access to high-quality behavioral health and wraparound services for students and families in Worcester County and Somerset County. These may be new programs or existing programs looking to expand.

Project proposals should be clear and concise, single spaced, in 11 or 12 point font. Proposals should be approximately 10-12 pages (approximately 5000 words or less), excluding table of contents, executive summary, budget, and appendices. Brevity is encouraged. All pages of the proposal must be numbered.

The project proposal should be structured using these topic headings:

- Table of contents (not included in page/word limit)
- Executive Summary (300-500 words, not included in page/word limit)
- Current CHRC/Consortium grantees only: Prior grant performance (300-800 words, not included in page/word limit)
- Proposal:
    1. Background and Justification
    2. Organizational Capacity
    3. Financial Capacity
    4. Project Plan
    5. Coordination/Integration
    6. Engagement with students and families
    7. Ability to demonstrate measurable outcomes
    8. Project Budget and Budget Justification (not included in page/word limit)

- Mandatory Appendices
    a. Resumés of key staff
    b. If indicated in application, sliding scale fee schedule
    c. Current grantees only: copy of Milestones & Deliverables report for July-December 2024, metrics plan, Progress Report #4

- Optional Appendices
    a. Letters of support from LBHA, LMB, Local Health Department, County Executive, County Council, other child-serving agencies, implementation partners, and/or community organizations
    b. Letters of support from principals of schools where services will be offered

- Additional materials listed later in this section of the RFP.

Executive Summary (300-500 words, not included in page/word limit)

• What jurisdiction(s) will be served?

• How many total unduplicated students will receive grant-funded services? (see definition in Attachment 4).

• How many of these unduplicated individuals will receive services at each of the three MTSS Tiers: Tier 1 (universal/prevention), Tier 2 (brief/small group), and Tier 3 (individual)? See page 10-11 in the MCHRC RFA for more information about MTSS.

• Briefly describe the priorities and unmet needs that the program proposes to address.

- What is the program's overall focus?
- What key services will be provided (see Proposal Specifics section in this RFP)?
- What key Evidence-Based Programs will be implemented (see Attachment 2)? How is the organization planning for staff training and on-going implementation support in the EBP(s), including participation in EBP implementation support calls? How will the EBP(s) be utilized in programming and implemented with fidelity?
- Briefly describe how the program will integrate with existing services in the school and community.
- Funding amount requested, and brief description of other sources of funding (Medicaid, commercial insurance, local grants, in-kind, etc.).

Prior grant performance (current MCHRC/Consortium grantees only, 300-800 words, not included in page/word limit)

- Describe accomplishments under the current grant, qualitative and quantitative.
- Describe any proposed changes to the current grant-funded program.
- Describe any lessons learned during the current grant and how those lessons would be applied in a future grant.
- Describe applicant's efforts to maximize Medicaid revenue during the current grant period.
- Include in the appendix a copy of the applicant's:
  - Milestones & Deliverables report covering July-December 2024;
  - current metrics plan; and
  - Progress Report #4, covering November-December 2024.

1. Background and Justification

- Briefly describe the population(s) to be served (i.e., demographics, insurance coverage, income levels, etc.).
- Provide evidence that the proposed program responds to a documented local priority.
  - Applicants may use community health needs assessments, LBHA and/or LMB Needs Assessments, Community Schools Needs Assessments, information from LEAs, and/or other sources to describe the unmet needs and priorities. Use quantitative and/or qualitative data. Recommended data sets are included in Attachment 7 – select a few data points that best highlight the need for the program; do not include every measure.
- If applicable, list the schools that will receive services and explain the reasoning for selecting these schools.
- Will certain sub-groups of students/families within those schools be prioritized? Why? How?
- How will the proposed services address health equity?

2. Organizational Capacity

- Briefly describe the organization's mission, structure, and governance.
- Describe the organization's history of supporting youth and adolescent behavioral health. Describe the organization's history of working in schools. Describe the organization's history of working with the target community.
- Describe the organization's staff. Include information about staff training and cultural and linguistic competency. Describe the extent to which the staff reflects the community served. Provide an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's staff and/or the organizational approach to achieve racial and ethnic diversity proportional to the community served.

• Describe the qualifications and licensure of key staff. Provide resumés of up to five key staff in the appendix.

3. Financial Capacity

• Briefly describe the organization's history of financial management.
• Does the organization currently bill Medicaid? If so, include Medicaid provider number. Describe existing capacity to bill Medicaid and any barriers to Medicaid billing. Which services will be eligible for Medicaid reimbursement? Which services are not billable? (Note: Medicaid billing is not a prerequisite; applicants that do not bill should briefly explain the reasons.)
• Applicants are asked in the cover sheet to describe how grant funds may complement any anticipated Medicaid revenues. Restate information from the cover sheet and provide more detail as needed.
• How are any anticipated Medicaid revenues accounted for in the proposed budget (i.e., budget does not request grant funding for portions of FTEs that will be funded through anticipated Medicaid revenues)?
• If applicable, will a sliding scale fee schedule be supported? If so, include a sliding scale fee schedule in the appendix.
• If applicable, will private commercial insurance be billed? If so, will grant funds be used to pay co-pays to private insurers according to an income-based sliding scale fee schedule? Describe how co-pay support will document client need (i.e., a client hardship form to request copay support, etc.). How are these anticipated revenues reflected in the proposed budget (i.e., budget does not request grant funding for portions of FTEs that will be funded through anticipated Medicaid revenues, budget includes co-pay support only, etc.)?
• What other sources of funding will support the organization's existing and new school-based services (e.g., local support, other grants, hospital community benefit, etc.)? See Attachment 9 for a list of other grant-making organizations. How will grant funding from this RFA be blended with funding from other sources? Describe any in-kind support that will be provided. Will matching funds be provided by the applicant?
• Applicants must fill out, sign, and attach the LMB legal and financial disclosure form (see Attachment 10).

4. Program design and prospects for success

• Which services will be provided? Be clear and concise. Note: proposals that are overly complex may be less likely to be awarded under this RFA.
• What date will services begin? To what extent is the program "shovel-ready?"
• How many total unduplicated youth, families, and others will receive grant-supported services (see definition of Unduplicated Individuals Served in Attachment 4)? How many of these unduplicated individuals will receive services at each of the three tiers of MTSS. Briefly describe your methodology for developing these estimates and how you will ensure students are not counted more than once.
• Where will services be provided? If applicable, describe commitment from schools to make confidential spaces available. If services will not be provided in the school building, describe means to facilitate access to services (e.g., transportation, etc.).
• What times during the day will services be provided? If applicable, describe commitment from schools to permit students to receive services during these times. Will services be provided over the summer?
• What evidence-based strategies will be used (see menus of Priority and Recommended evidence-based programs on page 4 and in Attachments 2 and 3)? How is the organization planning for staff

training and on-going implementation support in the EBP(s)? How will the EBP(s) be utilized in programming and implemented with fidelity? Be specific.

• Discuss the organization's plans for meeting EBP training and implementation expectations (see Attachment 2). In addition to initial EBP trainings, grantees should expect 60-minute EBP implementation support calls quarterly. Budgets and staffing plans should reflect this commitment.

• Discuss the organization's willingness and commitment to participate in training, technical assistance, and grant monitoring provided or coordinated by the CHRC, Consortium, and NCSMH. Grantees should plan for CHRC mandatory technical assistance calls approximately once per month for 90 minutes, as well as individual consultations. Budgets and staffing plans should reflect these commitments.

• What other strategies will be used, and how are they justified (see Proposal Specifics section in this RFP)?

• How will the program address challenge in hiring and retaining behavioral health staff (see Proposal Specifics section in this RFP)?

• How will referrals be made to the program? How will services be "marketed" to families and school staff?

5. Coordination/Integration

• Describe collaboration with the Local Education Agency (LEA) in developing the proposal, including specific meeting dates. How will school staff be involved in the implementation of the program? How will student information be shared with school staff?

• How will the proposed program integrate with existing behavioral health services and supports for the target population and the identified schools? How will the proposed program avoid duplication?

• Describe all partners who will be involved in the program, including referral partners and others. Describe the processes and organizational structures that will be put into place to ensure that the partnership(s) are effective. Include letters of commitment in the appendix. How will information be shared between partner organizations?

• Will the program address the holistic needs of children and families, including medical needs and non-medical Social Determinants of Health? Describe any referral relationships.

• Will Community Schools be served (see Attachment 8)? If so, how will the program integrate with services provided by Community Schools? If applicable, how does the program respond to Needs Assessments developed by Community Schools?

• Discuss any reservations about working with a local Partnership Hub organization in the future.

6. Engagement with families and communities

• How is youth voice incorporated in the design and implementation of the program?

• Describe the extent to which families and communities were consulted in program design.

• How will feedback from families and communities be collected and incorporated into future programming?

• How will parents and families be involved in treatment plans, if applicable?

• Please include in the appendix any letters of support from key community agencies and organizations (e.g., community-based organizations, Departments of Social Services, etc.)

7. Ability to demonstrate measurable outcomes

• Describe the organization's capacity for data management and outcomes reporting. What data systems will be used? Note: Grant funding may be requested for data systems.

• Comment on the organization's ability to collect and report standardized data measures in the Proposal Specifics section of this RFP and in Attachment 5. Discuss any measures that will not be collected. Optional: What additional, customized process and outcome measures could be collected to demonstrate the impact of this program?
• Which validated assessment tools will be used to demonstrate impact? (See Attachment 5)
• Describe how the organization currently conducts self-assessment as part of continuous quality improvement efforts. If applicable, describe support needed to build the organization's evaluation capacity. Note: grantees may be required to consult with the MCHRC and NCSMH to review data and assessment strategies.
• How will student and family satisfaction be measured? Please include a copy of any satisfaction survey in the appendix.
• Does the organization utilize an EMR system?
• How will the program ensure that the count of individuals/families served is unduplicated?

8. Project Budget and Budget Justification

• Please use CHRC templates. You may add or remove rows as applicable.
• Please submit the Budget Template in Excel format and the Budget Narrative in PDF format.
• Note: The average award amount during the last round of service provider grants was approximately $750,000.
• The LMB will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards.
• More information about the budget can be found in the next section of this RFP.

Appendices and additional materials

Appendices

• Mandatory Appendices
  a. Resumés of key staff
  b. If indicated in application, sliding scale fee schedule
  c. Current grantees only: copy of Milestones & Deliverables report for July-December 2024, metrics plan, Progress Report #4
• Optional Appendices
  a. Letters of support from LBHA, LMB, Local Health Department, County Executive, County Council, other child-serving agencies, implementation partners, and/or community organizations
  b. Letters of support from principals of schools where services will be offered

Additional materials

1. Transmittal Letter: This letter from the applicant organization's chief executive officer should specify the title of the proposal, the applicant organization, and the project director and state that the applicant organization understands that submission of a proposal constitutes acceptance of the terms of the grants program.

2. Grant Application Cover Sheet: Cover sheets should include the following:

Date of submission
Organization Name
Federal Tax ID Number (EIN)
Street Address, City, State ZIP
Total Budget request

Name, Official Authorized to Execute Contract
Email, Official Authorized to Execute Contract
Phone, Official Authorized to Execute Contract

Name, Project Director
Email, Project Director
Phone, Project Director

Name, Primary Point of Contact (if different from the Project Director)
Email, Primary Point of Contact (if different from the Project Director)
Phone, Primary Point of Contact (if different from the Project Director)

Name, Fiscal Contact
Email, Fiscal Contact
Phone, Fiscal Contact

Any additional contact information (optional)
Attestation and electronic signature

3. Other required submission materials for all proposals:

(A) Contractual Obligations, Assurances, and Certifications: The agreement should be completed and signed by either the chief executive officer or the individual responsible for conducting the affairs of the applicant organization and authorized to execute contracts on behalf of the applicant organization (see Attachment 11).
(B) IRS Form W-9
(C) Financial and legal disclosure (see Attachment 10).
(D) Audited financial statements and/or IRS Form 990 or other applicable IRS tax filing (prefer both financial statements and tax return)
(E) Behavioral health license, if the applicant is licensed

Evaluation Criteria

Criteria	Score
1. Responds to documented local priority; promotes health equity; prioritized by LEA	15
2. Organizational capacity: history of working with students and schools, cultural and linguistic competency, financial capacity	15
3. Program design and prospects for success: use of EBPs and/or other strategies, starting date for services, holistic approach, staffing plan, referral process	20
4. Priority EBP and/or Measurement-Based Care learning community are selected and integrate well into planning and programming	5
5. Coordination/Integration: integration and alignment with existing programs, ability to be a "team player"	10
6. Evidence of engagement with schools, families, and communities in the planning and execution of programming	10
7. Ability to demonstrate measurable outcomes	15
8. Budget is reasonable and commensurate with project impact, maximizes Medicaid revenue attainment where appropriate, reflects Medicaid and other revenues in budget as applicable, good return on investment	10
TOTAL	**100**

Budget

Proposals must include projected expenses for a 12-month program beginning on July 1, 2025 running through June 30, 2026.

While there is no set maximum amount for the requested budget, the average awards to service providers in the last grant cycle managed by MCHRC was approximately **$750,000.** The LMB will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards. Maximizing and optimizing alternative funding sources and providing a thoughtful efficient budget is strongly encouraged.

Once awarded, grantees will receive funds on a reimbursement basis.

Proposals must include a detailed budget narrative with description of the cost and show the calculation of how the cost was derived. detailed budget narrative:

- Salaries: $15,000 (Coordinator 40hrs a week, at $7.20 an hr for 52 weeks (40hr x $7.20 x 52 weeks)
- Utilities: $6,000 (Telephones $203 a month (12 x 203) Electricity $297 a month (12 x 297))

The LMB reserves the right to negotiate the proposed budget with the chosen vendor. Additionally, the LMB reserves the right to award a lesser amount than requested. If a lesser amount is awarded, the applicant will have the opportunity to adjust the scope of the proposal and/or decline funding.

ALL FUNDING IS CONTINGENT UPON AVAILABILITY OF FUNDS AND MAY BE AMENDED TO REFLECT CHANGES IN THE FINAL BUDGET APPROPRIATION BY THE GENERAL ASSEMBLY.

Permissible Uses of Grant Funds.

Examples of permissible uses of grant funding under this RFA include but are not limited to:

- Staff salaries and fringe benefits
- IT hardware and software, including software/platform for outcomes measurement and Measurement-Based Care
- Supplies
- Marketing materials
- Travel/mileage/parking related to grant activities
- Training and professional development. Note: Training and materials for Priority EBPs will be supported by the NCSMH and should not be included in applicant budgets. Staff time for training, including training in Priority or other EBPs, should be included in the staff salaries section of the budget.
- Subcontractors
- Other expenses such as Incentives for program participants, translation/interpretation services, etc.
- Indirect costs

While schools and school systems will not be the direct recipients of grant funds, applicants may request minimal funding to subcontract with school systems for the following activities, if essential for the

applicant's program: the use of school buses, stipends for school staff trainings outside of contract hours, and behavioral health-related supplies.

The following are not permissible uses of grant funds:

- Direct support to families to address social determinants of health (e.g., emergency funds, rent assistance, food assistance, etc.)
- Fees for student participation in extracurricular activities without a behavioral health focus, including sports
- Field trips without a behavioral health focus
- Somatic (physical) health services
- Academic and vocational supports
- Depreciation expenses
- Major equipment or new construction projects
- Clinical trials
- Lobbying or political activity
- Pre-award costs and expenses

In addition, grant funds may not be used to satisfy debts and liabilities of any kind, including, but not limited to, state or federal tax liabilities, outstanding, past due, or delinquent loan balances, individual, property or employment insurance liabilities, liens, promissory notes, offsets of any kind, or contractual debt.

FY23 Proposed Budget				
DESCRIPTION	**FY26 Project Budget**			
	LMB Budget	Non-LMB funds that Directly Support the Project (Cash Only)	**Total**	**Detailed Budget Narrative - Show Calculations that Support How Expenses Were Derived**
Budget for FY23 Grant: Bounce Back				
Salaries			**$0**	
Fringe Costs			**$0**	
Communications			**$0**	
Postage			**$0**	
Business Travel			**$0**	
Training			**$0**	
Conferences/Conventions			**$0**	
Utilities			**$0**	
Advertising			**$0**	
Accounting/Auditing			**$0**	
Legal			**$0**	

Consultant (other than Legal & Accounting/Auditing)			**$0**	
Supplies			**$0**	
Equipment			**$0**	
Insurance			**$0**	
Rent/Mortgage			**$0**	
Printing/Duplication			**$0**	
Professional Dues/Publications/Subscriptions			**$0**	
IT Systems/Repairs/Maintenance			**$0**	
Vehicle Operating (other than Insurance)			**$0**	
TOTAL Budget	**$150,000**	**$0**	**$0**	

WORCESTER COUNTY MARYLAND
STANDARD TERMS AND CONDITIONS

The provisions below are applicable to all Worcester County ("County") contracts. These provisions are not a complete agreement. These provisions must be attached to an executed document that identifies the work to be performed, compensation, term, incorporated attachments, and any special conditions ("Contract"). If the Standard Terms and any other part of the Contract conflict, then the Standard Terms will prevail.

1. **Amendment**. Amendments to the Contract must be in writing and signed by the parties.
2. **Bankruptcy**. If a bankruptcy proceeding by or against the Contractor is filed, then:
    a. The Contractor must notify the County immediately; and
    b. The County may cancel the Contract or affirm the Contract and hold the Contractor responsible for damages.
3. **Compliance with Law.** Contractor must comply with all applicable federal, state, and local law. Contractor is qualified to do business in the State of Maryland. Contractor must obtain, at its expense, all licenses, permits, insurance, and governmental approvals needed to perform its obligations under the Contract.
4. **Contingent Fee Prohibition**. The Contractor has not directed anyone, other than its employee or agent, to solicit the Contract and it has not promised to pay anyone a commission, percentage, brokerage fee, contingent fee, or other consideration contingent on the making of the Contract.
5. **Counterparts and Signature**. The Contract may be executed in several counterparts, each of which may be an original and all of which will be the same instrument. The Contract may be signed in writing or by electronic signature, including by email. An electronic signature, a facsimile copy, or computer image of the Contract will have the same effect as an original signed copy.
6. **Exclusive Jurisdiction.** All legal proceedings related to this Contract must be exclusively filed, tried, and maintained in either the District Court of Maryland for Worcester County, Maryland or the Circuit Court of Worcester County, Maryland. The parties expressly waive any right to remove the matter to any other state or federal venue and waive any right to a jury trial.
7. **Force Majeure**. The parties are not responsible for delay or default caused by fire, riot, acts of God, County-declaration-of-emergency, or war beyond their reasonable control. The parties must make all reasonable efforts to eliminate a cause of delay or default and must, upon cessation, diligently pursue their obligations under the Contract.
8. **Governing Law**. The Contract is governed by the laws of Maryland and the County.
9. **Indemnification**. The Contractor must indemnify the County and its agents from all liability, penalties, costs, damages, or claims (including attorney's fees) resulting from personal injury, death, or damage to property that arises from or is connected to the performance of the work or failure to perform its obligations under the Contract. All indemnification provisions will survive the expiration or termination of the Contract.
10. **Independent Contractor**.
    a. Contractor is an "Independent Contractor", not an employee. Although the County may determine the delivery schedule for the work and evaluate the quality of the work, the County will not control the means or manner of the Contractor's

performance.

b. Contractor is responsible for all applicable taxes on any compensation paid under the Contract. Contractor is not eligible for any federal Social Security, unemployment insurance, or workers' compensation benefits under the Contract.

c. Contractor must immediately provide the County notice of any claim made against Contractor by any third party.

11. **Insurance Requirements**.

    a. Contractor must have Commercial General Liability Insurance in the amounts listed below. The insurance must include coverage for personal injury, discrimination, and civil rights violation claims. All insurance must name County, its employees, and agents as "ADDITIONAL INSURED". A copy of the certificate of insurance must be filed with the County before the Contract is executed, providing coverage in the amount of $1,000,000 per occurrence, $2,000,000 general aggregate, and $500,000 for property damage.

    b. Contractor must have automobile insurance on all vehicles used in the Contract to protect Contractor against claims for damages resulting from bodily injury, including wrongful death, and property damage that may arise from the operations in connection with the Contract. All insurance must name County, its employees, and agents as "ADDITIONAL INSURED".

    c. Contractor must provide the County with a certification of Workers' Compensation Insurance, with employer's liability in the minimum amount required by Maryland law in effect for each year of the Contract.

    d. All insurance policies must have a minimum 30 days' notice of cancellation. The County must be notified immediately upon cancellation.

    e. When insurance coverage is renewed, Contractor must provide new certificates of insurance prior to expiration of current policies.

12. **Nondiscrimination**. Contractor must not discriminate against any worker, employee, or applicant because of religion, race, sex, age, sexual orientation, physical or mental disability, or perceived disability. This provision must be incorporated in all subcontracts related to the Contract.

13. **Ownership of Documents; Intellectual Property**.

    a. All documents prepared under the Contract must be available to the County upon request and will become the exclusive property of the County upon termination or completion of the services. The County may use the documents without restriction or without additional compensation to the Contractor. The County will be the owner of the documents for the purposes of copyright, patent, or trademark registration.

    b. If the Contractor obtains, uses, or subcontracts for any intellectual property, then it must provide an assignment to the County of ownership or use of the property.

    c. The Contractor must indemnify the County from all claims of infringement related to the use of any patented design, device, materials, or process, or any trademark or copyright, and must indemnify the County, its officers, agents, and employees with respect to any claim, action, costs, or infringement, for royalties or user fees, arising out of purchase or use of materials, construction, supplies, equipment, or services covered by the Contract.

14. **Payments**. Payments to the Contractor under the Contract will be within 30 days of the County's receipt of a proper invoice from the Contractor. If an invoice remains unpaid 45 days after the invoice was received, interest will accrue at 6% per year.

15. **Records**. Contractor must maintain fiscal records relating to the Contract in accordance with generally accepted accounting principles. All other relevant records must be retained by Contractor and kept accessible for at least three years after final payment, termination of the Contract, or until the conclusion of any audit, controversy, or litigation related to the Contract. All subcontracts must comply with these provisions. County may access all records of the Contractor related to the Contract.

16. **Remedies**.

    a. **Corrections of errors and omissions**. Contractor must perform work necessary to correct errors and omissions in the services required under the Contract, without undue delays and cost to the County. The County's acceptance will not relieve the Contractor of the responsibility of subsequent corrections of errors.

    b. **Set-off**. The County may deduct from any amounts payable to the Contractor any back-charges, penalties, or damages sustained by the County, its agents, or employees caused by Contractor's breach. Contractor will not be relieved of liability for any costs caused by a failure to satisfactorily perform the services.

    c. **Cumulative**. These remedies are cumulative and without waiver of any others.

17. **Responsibility of Contractor**.

    a. The Contractor must perform the services with the standard of care, skill, and diligence normally provided by a Contractor in the performance of services similar the services.

    b. Notwithstanding any review, approval, acceptance, or payment for the services by the County, the Contractor will be responsible for the accuracy of any work, design, drawings, specifications, and materials furnished by the Contractor under the Contract.

    c. If the Contractor fails to conform with subparagraph (a) above, then it must, if required by the County, perform at its own expense any service necessary for the correction of any deficiencies or damages resulting from the Contractor's failure. This obligation is in addition to any other remedy available to the County.

18. **Severability/Waiver**. If a court finds any term of the Contract to be invalid, the validity of the remaining terms will not be affected. The failure of either party to enforce any term of the Contract is not a waiver by that party.

19. **Subcontracting or Assignment**. The Contractor may not subcontract or assign any part of the Contract without the prior written consent of the County. The County may withhold consent for any reason the County deems appropriate.

20. **Termination**. If the Contractor violates any provision of the Contract, the County may terminate the Contract by written notice. All finished or unfinished work provided by the Contractor will, at the County's option, become the County's property. The County will pay the Contractor fair compensation for satisfactory performance that occurred before termination less the amount of damages caused by the Contractor's breach. If the damages are more than the compensation payable to the Contractor, the Contractor will remain liable after termination and the County can affirmatively collect damages.

21. **Termination of Contract for Convenience**. Upon written notice, the County may terminate the Contract when the County determines termination is in the County's best interest. Termination for convenience is effective on the date specified in the County's written notice. The County will pay for reasonable costs allocable to the Contract for costs incurred by the Contractor up to the date of termination. But the Contractor will not be reimbursed for any anticipatory profits that have not been earned before termination.
22. **Termination of Multi-year Contract**. If funds are not available for any fiscal period of the Contract after the first fiscal period, then the Contract will be terminated automatically as of the beginning of unfunded fiscal period. Termination will discharge the Contractor and the County from future performance of the Contract, but not from their rights and obligations existing at the time of termination.
23. **Third Party Beneficiaries**. The County and Contractor are the only parties to the Contract and are the only parties entitled to enforce its terms. Nothing in the Contract gives any benefit or right to third persons unless individually identified by name and expressly described as intended beneficiaries of the Contract.
24. **Use of County Facilities**. Contractor may only County facilities that are needed to perform the Contract. County has no responsibility for the loss or damage to Contractor's personal property which may be stored on County property.
25. **Whole Contract**. The Contract, the Standard Terms, and attachments are the complete agreement between the parties and supersede all earlier agreements, proposals, or other communications between the parties relating to the subject matter of the Contract.

Attachments

Attachment 1: Abbreviations

ADHD: Attention Deficit Hyperactivity Disorder
ACE: Adverse Childhood Experience
Blueprint: Blueprint for Maryland's Future legislation, Chapter 36 of 2021
CDC: Centers for Disease Control and Prevention
CHRC: Maryland Community Health Resources Commission
Consortium: Maryland Consortium on Coordinated Community Supports
DDA: Maryland Developmental Disabilities Administration
EBP: Evidence-Based Program
EIN: Employer Identification Number
EMR: Electronic Medical Records
FY: Fiscal Year
HPSA: Health Professional Shortage Area
HRSA: Health Resource and Services Administration
IEP: Individualized Education Program
Jurisdiction: a Maryland county or Baltimore City
LBHA: Local Behavioral Health Authority
LEA: Local Education Agency, or school district
LGBTQ+: lesbian, gay, bisexual, transgender, queer, or questioning persons or community
LMB: Local Management Board
MANSEF: Maryland Association of Nonpublic Special Education Facilities
MDH: Maryland Department of Health
MOU: Memorandum of Understanding
MSDE: Maryland State Department of Education
MTSS: Multi-Tiered System of Supports
NCSMH or National Center: National Center for School Mental Health
Partnerships: Community Supports Partnerships
PHI: Protected Health Information
PII: Personally Identifiable Information
RFA: Request for Applications, also referred to as Request for Proposals or Call for Proposals (RFP)
RFP: Request for Proposals, or Call for Proposals, also referred to as Request for Applications (RFA)
SAHIE: Small Area Health Insurance Estimates program
SDOH: Social Determinants of Health
SHAPE: School Health Assessment and Performance Evaluation, assessment developed by NCSMH, https://theshapesystem.com
TCM+: Targeted Case Management Plus
YRBS: Youth Risk Behavior Surveillance System

Attachment 2: Evidence Based Practices

*Note: for access to embedded links in this attachment please see pages 51-71 in the MCHRC RFA

Evidence-Based Practices Menu for Coordinated Community Supports Partnerships 2025-2026

The Consortium will prioritize funding for the Evidence-Based Practices (EBPs) listed in the tables below for which free statewide training and implementation support will be offered by the National Center for School Mental Health, in partnership with intervention developers/trainers. The Consortium partnered with the National Center for School Mental Health is also providing Measurement-Based Care Learning Community (MBC LC) support for both clinicians and agency leaders.

- **Interventions 1-15 are intended for delivery by mental health clinicians and/or other community providers.** Interventions are listed by Tier below.
- **The MBC LC is intended for organizations delivering Tier 2 and 3 interventions**. The MBC LC is offered to grantees to stimulate MBC implementation through training, free resources, ongoing consultation, and peer learning. The MBC LC includes a clinician/provider track and an agency leader track.
- **Interventions 16-19 are intended for delivery by school educators** (e.g., teachers, coaches, administrators). School-employed staff and Hub staff may receive training and supported implementation in these EBPs. These EBPs are not offered to community providers. Schools and school districts should not apply through this RFA, but should use the following link: https://bit.ly/SchoolsAppFY26.

Important Considerations: When selecting interventions for your community, consider fit with the unique strengths, needs, and cultural/linguistic considerations of students and families in your school community. Training, implementation, and staff (POC/Supervisor and trainee) expectations are listed below and should be considered as you select interventions and plan for implementation.

POC/Supervisor Expectations:
Each grantee organization will be asked to designate an **EBP Point-of-Contact (POC), who will be responsible for overseeing the completion of all training and implementation requirements for each provider within their organization, as well as communicating expectations to all trainees within the organization.** Key responsibilities may include, but are not limited to: participating in initial kick-off meetings to review training and implementation plans, monitoring ongoing progress to ensure staff meet training and implementation milestones, coordinating with training teams to provide status updates, and supporting providers in their implementation efforts such as ensuring supervisory support, assistance with fidelity monitoring, and access to needed resources. The success of interventions will be helped by a strong organizational support in establishing and maintaining these new interventions.

Trainee Expectations:
Trainees who participate in priority EBPs are expected to have a plan to fully implement the EBP in their practice. Trainees involved in priority EBPs are also required to 1.) attend all designated training sessions for which they are registered, 2.) participate in quarterly post-training implementation support meetings for each EBP they are delivering, 3.) complete training evaluations for each EBP, and 4.) submit quarterly implementation and fidelity monitoring surveys.

Implementation Support Requirements:
Implementation support calls are offered for each priority EBP each quarter. **Attendance is *required* at 1 implementation support call each quarter once a provider has been trained**. Supervisors/POCs should ensure that the implementation support requirement is relayed to all providers/trainees attending priority EBP training supported by the Consortium. Trained providers, from previous grant cycles, are also invited to attend implementation calls.

Cultural Responsiveness:
The Cultural Responsiveness column below includes publicly available information on national EBP repositories and/or the intervention website about characteristics of youth and caregivers involved in intervention studies (e.g., race/ethnicity, geography, gender) and/or resources to support cultural relevance. There is significant variability in the number of studies conducted across interventions and the extent to which data were disaggregated for specific population groups.

Priority Evidence-Based Practices Menu

Tier 3 EBPs										
	EBP – Programs/ Trainings	**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
1	Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)	Addresses emotional disorders, including anxiety, depression, and traumatic stress	6 and up	Individual	Cognitive-behavioral therapy (CBT) for anxiety disorders, depression, and related emotional disorders in children and adolescents	Licensed mental health clinicians	Two-day virtual training (7 hours per day)	**UP-C offers:** 15-treatment group sessions with directions supporting an individual modular approach **UP-A offers:** 10-15 individual sessions (youth dependent)	**UP-C/UP-A** is included in the CA Clearinghouse for Child Welfare with evidence to support use with following demographic groups: Hispanic/Latino, Non-Hispanic White, African American, Asian American, and Pacific Islander populations **Spanish-language Offerings:** **Trainings:** Yes **Materials:** Yes	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
2	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	Addresses anxiety, depression, disruptive behaviors, and traumatic stress	5 – 15 years old	Individual (with a few sessions with caregiver) **Note: Disruptive Behavior Modules are parent/ caregiver focused**	Cognitive-behavioral therapy (CBT) protocols for anxiety, post-traumatic stress, depression, and behavioral parent training for disruptive behaviors	Licensed mental health clinicians	2-Day virtual training (8 hours per day)	33 modules available across 4 target areas that can be delivered in an individual format across multiple sessions. **Anxiety** - 7 modules **Conduct** - 12 modules **Depression** -12 modules **Traumatic Stress** - 9 modules	**MATCH-ADTC** is included in the CA Clearinghouse for Child Welfare and NIJ Crime Solutions with evidence to support use in multiple diverse populations. **Note from Developer:** MATCH-ADTC has been primarily tested and found to be effective in youths aged 5-15 in urban and suburban settings. MATCH-ADTC is based on the MAP system (Managing and Adapting Practice) which is inherently responsive to diverse clinical and cultural factors. **Spanish- language Offerings:** **Trainings:** No **Materials:** Caregiver handouts are available in Spanish	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
3	Safety Planning Intervention (Stanley-Brown)	Suicide prevention	6 and up	Individual	Assists at-risk adolescents in creating a list of coping strategies and sources of support to reduce the risk of suicide	School-based staff and related service providers (e.g., school counselors, clinicians, peer support or prevention workers, etc.)	One-day virtual training (7-hour) or split two-day mixed didactic and interactive virtual training	Brief, clinical intervention (20-45 minutes) that can be delivered in an individual format, across multiple sessions	Information not available in national repositories searched. **Spanish-language Offerings:** **Trainings:** No **Materials:** The safety plan form is translated into Spanish for clinicians to use with Spanish-speaking clientele	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
4	Counseling on Access to Lethal Means (CALM)	Suicide prevention	All ages	Individual	Counseling on reducing access to means of self-harm as a key component of suicide prevention	Clinically oriented individuals; relevant to direct service providers	Half day virtual training (3.5-hours)	Brief, clinical intervention (20-45 minutes) that is delivered in an individual format; caregiver(s) included as needed.	Information not available in national repositories searched. **Note from Developer:** The most recent version CALM-AAP is on the American Academy of Pediatrics website and includes a section geared to working with young people (young Black boys and young men in particular) who live in neighborhoods with high homicide rates and whose access to firearms might be their own or one shared among their friends. For more information on resources to support safe suicide care for specific populations, please review: Populations | Zero Suicide (edc.org) **Spanish-language Offerings:** **Trainings:** No **Materials:** A selection of promotional materials are available in Spanish	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
5	Adolescent Community Reinforcement Approach (A-CRA)	Substance Use Disorder	12 to 24 years old	Individual (with a few sessions with caregiver)	Cognitive-behavioral therapy (CBT) to reinforce substance-free lifestyles in adolescents	Master-level clinicians	Two-day training virtual training (6.5 hours per day)	10-14 sessions (10 individual sessions with adolescent, 4 sessions with caregiver)	**A-CRA** is included in the CA Clearinghouse for Child Welfare and NIJ Crime Solutions with evidence to support use with Black, American Indians/ Alaska Native, Asian/ Pacific Islander, Hispanic, White populations and in rural, suburban, and urban areas. For more information on A-CRA's research with diverse populations, please review: Cultural and Gender Relevance | Lighthouse Institute | EBTx | A-CRA | Chestnut Health Systems Cultural Responsiveness Committee Bibliography (chestnut.org) **Spanish-language Offerings:** **Training:** No **Materials:** No	Participants can receive up to 10 credits

Tier 2 EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
6	The Student Check-Up (Motivational Interviewing)	Therapy/ counseling to elicit behavior change	12 and up	Individual	The Student Checkup is a semi-structured school-based motivational interview designed to help adolescents adopt academic enabling behaviors (e.g., participation in class). School-Based Motivational Interviewing (S-BMI) is a specific type of MI used in the school setting to adopt academic enabling behaviors, decrease risky behaviors, and engage in health-promoting behaviors.	Mental Health Clinicians, trainees, or school-based staff. Prior training and experience using Motivational Interviewing is recommended	Two-day virtual training (7 hours per day)	Single session interview protocol with four structured phases.	Information not available in national repositories searched. **Note from Developer:** The majority of Student Check-Up RCTs were conducted in a small urban setting with graduate students implementing the intervention with over 50% of the middle school student population identifying as Black. **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
7	Therapeutic Mentoring	Mentoring/ Modeling; Coping Strategies	Mentees under 21	Individual	Develops mentor competencies in mental health theory and practice to promote high quality, strengths-based, culturally responsive mentoring	Mentors or paraprofessionals who work directly with youth up to the age of 21. **Training not suited for clinicians; however, clinical supervision is needed**	One-day virtual training (7 hours) + 6 weekly 1- hour follow up sessions OR 12 weekly, 1-hour virtual training sessions	Structured, strength-based support services that can be offered across numerous one-to-one sessions	Information not available in national repositories searched. For more information on Therapeutic Mentoring research, please review: Publications – The Center for Evidence-based Mentoring (cebmentoring.org) **Spanish-language Offerings:** **Trainings:** Unknown **Materials:** Unknown	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
8	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Substance Use Disorder early intervention	9 and up	Individual	Screening, brief intervention, and referral to treatment for substance use disorders	Clinically oriented individuals; relevant to direct service providers	One-day virtual training (5.5 hours	Brief, counseling session; Extended Treatment can be 4-6 sessions (up to 1 hr. each)	**School-Based Brief Interventions for Substance Use Among Youth** is included in NIJ Crime Solutions with evidence to support use with Black and White students **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Participants can receive up to 4 credits

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
9	Cognitive Behavioral Intervention for Trauma in Schools and Bounce Back (CBITS/BB)	Early intervention for students experiencing post-traumatic stress reactions	6th-12th grade (**CBITS**) K-5th grade (**BB**)	**CBITS** weekly group plus 1-3 individual sessions with students **BB** weekly group plus 3 individual sessions	Games and activities that teach skills for healing from traumatic events, as well as cognitive/behavioral therapy to address trauma symptoms	Master-level licensed clinician	**CBITS** is a two-day virtual training (7 hours per day) **Bounce Back** is a two-day virtual training (7 hours per day) **CBITS/BB combination** is a three-day virtual training (7 hours per day)	**CBITS** is a ten-session group delivered over 10-12 weeks (weekly group sessions are 45 mins- 1hr) plus 1-3 individual sessions with students **BB** is a ten-session group delivered over 10-12 weeks (weekly group sessions are 45 mins- 1hr) plus 3 individual sessions **(the last session has to be with a caregiver)**	**CBITS** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic/Latino, and White youth in urban environments **Bounce Back** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with: African American, Hispanic/Latino, and White youth in urban environments **Spanish-language Offerings:** **Trainings:** Yes **Materials:** Yes	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Tier 1 EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
10	Botvin LifeSkills	Prevention program focused on substance use, coping skills, social skills, etc. (Social-Emotional Learning)	3rd to 12th grade	Universal	A classroom intervention to help adolescents develop confidence and skills to effectively handle challenging situations	One Botvin trained teacher/provider per class lesson	This is a one-day virtual training (6 hours)	8-18, 45-minute lessons taught in the classroom at least 1x per week (total number of lessons varies based on grade level curriculum)	**Botvin LifeSkills** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, White, Hispanic/Latino, Asian, and Native American youth Blueprints for Healthy Youth Development indicates that LST is generalizable to a variety of ethnic groups. For more information on Botvin's research base, please review: Evaluation Studies - Botvin LifeSkills TrainingBotvin LifeSkills Training **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Participants can receive up to 5 credits

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
11	Youth Aware of Mental Health (YAM)	Suicide Prevention, Mental Health Literacy	9th-12th grade; Students ages 13-17	Universal	An interactive school-based program that educates students about mental health, promotes peer support, and aims to reduce depression and suicidal behavior	One Clinician/ certified YAM instructor and one trained YAM Helper per class/group	**Pre-Training Requirements:** Complete a detailed implementation plan identifying local resources, your organization's safeguarding procedures, and identifying the schools where you will implement **Training Requirements:** Five-day, **in-person** training. (8 hours per day; 5th day will be 4 hours). *Must be available to attend all days in person **Post-Training Requirements:** At least 6 paired practice sessions held with 6-10 youth from community	Five one-hour sessions taught in a group format over 3 weeks during school hours; **cannot be delivered after school**	Information not available in national repositories searched. For more information on YAM's youth driven program in diverse communities, please review: Youth Aware of Mental health (y-a-m.org) **Spanish-language Offerings:** **Trainings:** In development **Materials:** In process of translating materials into Spanish	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
12	Circle of Security	Strengthening attachment between caregivers and children, behavior problem reduction	Parents/ caregivers of children ages 4 months- 6 years	Family Support and Education	A structured, video-guided program with eight sessions that helps facilitators support parents and caregivers of children from birth to age 6, focusing on fostering secure attachment during these crucial early years	One certified COSP facilitator	This training is a one- or two-week online format including five required 2-hour online live sessions as well as self-directed learning. **The time commitment is 25-35 hours including the live and asynchronous components**, and it is suggested to spread the training over half of your work schedule across two weeks or complete it in a full workweek if choosing the one-week option.	Minimum of Eight 90-minute parent group sessions spread out over at least 8 weeks	**Circle of Security** is included in The California Evidence-based Clearinghouse for Child Welfare with evidence to support use in the following demographic groups: predominately female caregivers, African American female caregivers, children ages ~1-7, caregivers and their preschool children affected by prenatal alcohol exposure (PAE) and fetal alcohol spectrum disorder (FASD). For more information on Circle of Security's approach to cultural responsiveness, please review: Is COSP Culturally Responsive – Circle of Security International **Spanish-language Offerings:** **Trainings:** Yes **Materials:** Yes	Participants can receive up to 2.4 credits

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
13	Botvin LifeSkills Parent Program	Substance Use prevention program	Parents/ Caregivers of students in grades 6-9	Family Support and Education	Prevention tool designed to help parents strengthen communication with their children, promote responsible decision-making, and prevent substance use.	One Botvin Parent Program trained Workshop Facilitator per group	One-day virtual training (6 hours)	Seven 60–90-minute parent group sessions	For information on Botvin's research base, please review: Evaluation Studies - Botvin LifeSkills TrainingBotvin LifeSkills Training **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Participants can receive up to 5 credits

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
14	Family Check Up	Parenting and family management	Families with children ages 2 through 17	Family Support and Education	A brief, strengths-based intervention designed to reduce children's problem behaviors by improving parenting and family management practices	A trained FCU facilitator	**Pre-Training Requirements:** Two implementation meetings with the FCU trainer to review program expectations ~15-20 hours of self-paced, e-learning **Training Requirements:** Four-day virtual training (3 hours per day scheduled by the trainer) **Post-Training Requirements:** ~20-25 additional hours (12 sessions) for implementation support; trainees for this EBP are not required to attend additional quarterly EBP calls offered by NCSMH	Consists of three family sessions and subsequent follow-up services tailored to the family's needs. It is an adaptive framework; as such, some families receive more follow-up services and support than others.	**Family Check Up** is included in The California Evidence-based Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Caucasian, Hispanic/Latino, Asian, & Biracial families; male and female children, and female caregivers. **Spanish-language Offerings:** **Trainings:** No **Materials:** FCU offers materials in Spanish that can be used to work with Spanish speaking populations	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
15	Chicago Parent Program	Positive parenting, behavior problem reduction	Parents/ Caregivers of children ages 2-8	Family Support and Education	Parent program focusing on positive parenting, reducing behavior problems in young children, and emotional bonding and trust within the family dynamics.	Two trained CPP group leader	This training is a four-day virtual training (3.5 hours each day)	Twelve 2-hour weekly parent group sessions	**Chicago Parenting Program** is included in CA Evidence-Based Clearinghouse and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic, and White families; some studies included male caregivers For more information on research with diverse populations, please review: Our Research (chicagoparentprogram.org) **Spanish Offerings:** **Training:** No **Materials:** Yes	Participants can receive up to 10 credits

In addition to the EBPs listed above, Hubs and service providers are encouraged to participate in the Measurement Based Care Learning Community. Measurement Based Care (MBC) is the routine use of patient reported outcome measures in mental health early intervention (Tier 2) and treatment (Tier 3) services to promote communication, collaboration and shared decision-making with students and families. MBC is included in Consortium efforts as an evidence-based approach when implementing Tier 2 and 3 interventions.

MBC LC						
Focus	**Intended Audience**	**Modality**	**Description**	**Staffing Requirements**	**Time Commitment and Modality**	**Are CEUs offered?**
Mental health (or any Tier 2 or 3 interventions with individual student goals)	Agency Leader Track*	Individual, Group, or Family	Learn how to provide tailored implementation support for MBC throughout a provider organization	At least 1 agency leader per grantee organization	Minimum: 4 hours of Virtual Learning Sessions (60 minutes each, every other month during the school year) Optional: Group office hours and 1:1 consultations every other month for up to an additional 8 hours	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance
	Clinician Track	Individual, Group or Family	Learn how to implement MBC with K-12 students using the Collect, Share, Act model	At least 1 clinician or professional delivering Tier 2/3 services per grantee organization		

*Note: Hubs are welcome to join the Agency Leader Track to learn about MBC implementation from a systems lens.

In addition to the EBPs above, Hub staff in partnership with school districts will be offered the opportunity to apply for training and supported implementation in the following EBPs. Interested school districts should use the following link: https://bit.ly/SchoolsAppFY26

School-Based EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
16	Mental Health Essentials for Teachers and Students	Mental Health Literacy for educators and students	Grades 6-12	Universal	Aims to enhance mental health awareness, resilience, and coping skills among both educators and students, fostering a healthier and more supportive school environment	One MHE trained educator (grades 6-12)	This is a two-day virtual training. Part I/Day I, Mental Health Literacy for Teachers (3 hours) Part II/Day 2, Student Curriculum Delivery Training (4 hours)	Six modules *6-12 hours of total classroom instruction *Meant to be taught in sequence, but can be altered *Delivery can be flexibly and creatively adapted according to teachers' pedagogical styles and student needs	**Mental Health Essentials** is a U.S. adaptation of the Canadian-developed intervention, The Guide. The Guide has been implemented throughout Canada, the U.S., and several other countries with diverse student populations. Evaluation information is available on The Guide website.	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance
17	Mental Health Essentials for Coaches	Mental Health Literacy for athletic coaches & PE/Health/ Wellness teachers	Grades K-12	Universal	Coach-training to enhance mental health literacy of coaches and promote strategies to include mental health as part of the team's culture		75-minute virtual training	No implementation requirements; however, skills can be utilized with sport teams, in wellness classrooms, and in physical education	**Mental Health Essentials** is a U.S. adaptation of the Canadian-developed intervention, The Guide. The Guide has been implemented throughout Canada, the U.S., and several other countries with diverse student populations. Evaluation information is available on The Guide website.	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
18	Good Behavior Game	Positive Behaviors/ Classroom Environments	Grades K-5	Universal	A classroom management program used to teach self-regulation skills while collaborating to make classrooms peaceful and productive learning environments	A GBG trained educator	7-hour virtual training	PAX GBG strategies are embedded daily into the regular classroom instruction	**Good Behavior Game** is included in CA Evidence-Based Clearinghouse, IES's What Works Clearinghouse, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: Black and White families, males, females, those with free/reduced lunch, & English Language Learners	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
19	Pyramid Model/Positive Solutions for Families (PSF)	Positive Behaviors/ Classroom Environments	PreK-K	Universal	Promotes the social, emotional, and behavioral skills of children from birth to five, incorporating universal classroom practices to foster social-emotional learning and prevent challenging behavior, targeted instructional practices for skill development, and specific interventions to support children with more significant social, emotional, and behavioral needs.	Pyramid Model trained educator	This training is available as either a two-day virtual session (7 hours per day) or a four-day virtual session (3.5 hours per day).	Daily implementation of Tier 1 and Tier 2 strategies learned in the training to be used in the classroom	Information not available in national repositories searched. For more information on resources to support cultural responsiveness, please review: Early Childhood Program-Wide PBS Benchmarks of Quality (EC-BOQ) CULTURAL RESPONSIVENESS COMPANION 2021 (challengingbehavior.org) and visit the resource library.	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Attachment 3: Other Evidence Based Practices

*Note: for access to embedded links in this attachment please see pages 72-78 in the MCHRC RFA

Other Recommended Evidence-Based Programs

While the Consortium *prioritizes* Evidence-Based Programs listed in Appendix F, the Consortium will also consider funding other school behavioral health practices that are:

- supported by evidence of impact on target social, emotional, behavioral, and/or academic outcomes (based on research evidence, as recognized in national registries and the scientific literature, and/or supported by practice-based evidence of success in local or similar schools or communities)
- equitable and fit the unique strengths, needs, and cultural/linguistic considerations of students and families in your community
- have adequate resource capacity for implementation (e.g., staffing capacity; training requirements, qualifications, and staff time; ongoing coaching)
- monitored for fidelity

Applicants could receive funding to implement these other interventions but would need to arrange their own training and implementation support.

Examples of practices that may be funded include, but are not limited to:

	EBP – programs/trainings	Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
1	Attachment Based Family Therapy (ABFT)	Helps a parent and child build an emotionally secure relationship	Youth between 12-18 and parents	2/3	Attachment-Based Family Therapy (ABFT) is the only manualized, empirically supported family therapy model specifically designed to target family and individual processes associated with adolescent suicide and depression. ABFT emerges from interpersonal theories that suggest adolescent depression and suicide can be precipitated, exacerbated or buffered against by the quality of interpersonal relationships in families. It is a trust-based, emotion-focused psychotherapy model that aims to repair interpersonal ruptures and rebuild an emotionally

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					protective, secure-based parent–child relationship. ABFT consists of five therapeutic tasks that are addressed and completed as the course of therapy progresses.
2	Acceptance and Commitment Therapy (ACT)	Psychological flexibility	Ages 6-18	2/3	Uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility
3	Brief Intervention for School Clinicians (BRISC)	Addresses emotional and behavioral stressors	HS students	2/3	Responsive to the typical presenting problems of high-school students, as well as their approach to help-seeking and their patterns of service participation
4	Check and Connect	Student engagement and persistence in school	k-12	2/3	The "**Check**" component refers to the process where mentors systematically monitor student performance variables (e.g., absences, tardies, behavioral referrals, grades), while the "**Connect**" component refers to mentors providing personalized, timely interventions to help students solve problems, build skills, and enhance competence
5	Check In Check Out	Addresses common classroom behavior challenges	K-12	2/3	A student receiving CICO meets with adults throughout the school day to reinforce and track behavioral goals.
6	Dialectical Behavior Therapy (DBT) for Schools	Emotional Problem Solving	Grades 6-12	2/3	Helps adolescents manage difficult emotional situations, cope with stress, and make better decisions
7	Interpersonal Psychotherapy for Adolescents (IPT-A)	Depression / Suicidal ideation and behavior	Ages 12-18	2/3	outpatient treatment for teens who are suffering from mild to moderate symptoms of a depressive disorder, including major depressive disorder, dysthymia, adjustment disorder with depressed mood, and depressive disorder not otherwise specified
8	IPT-A - Ultra-Short Crisis Intervention (IPT-A- SCI)	Suicidal ideation and behavior	Adolescents	2/3	To address the critical need in crisis intervention for children and adolescents at

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					suicidal risk, based on Interpersonal Psychotherapy (IPT), the ultra-brief acute crisis intervention is comprised of five weekly sessions, followed by monthly follow-up caring email contacts to the patients and their parents, over a period of three months.
9	Support for Students Exposed to Trauma (SSET)	Trauma	Children in late elementary school through early high school (ages 10-16)	2/3	A series of ten lessons whose structured approach aims to reduce distress resulting from exposure to trauma. SSET is designed to help schools and school systems that do not have access to school-based clinicians. Designed with and for teachers and nonclinical school counselors, this program targets students in fifth grade and above. SSET uses a lesson-plan format instead of a clinical manual.
10	Trauma-Focused CBT (TF-CBT)	Trauma	Children and adolescents	2/3	structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 8-25 sessions with the child/adolescent and caregiver
11	Executive Functioning interventions (see Brain Futures report)	Executive functioning	Various age groups, interventions available for Pre-K-12	1, 2/3	See pgs. 44-66 here Universal, group, and individual interventions that target executive functioning (I.e., planning, meeting goals, following directions, etc.)
12	Incredible Years	SEL	Infant, toddler, school-age children	1	Incredible Years is a series of interlocking, evidence-based programs for parents, children, and teachers. The goal is to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence.
13	MindUP	Mindfulness; SEL; Brain Literacy	Offered in three age-related levels,	1	MindUP is a classroom program that provides a curriculum at the intersection of neuroscience, positive psychology, mindful

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
			Pre-K–2, Grades 3-5, and Grades 6-8		awareness, and SEL. The aim of MindUP is to help students focus their attention, improve self-regulation skills, build resilience to stress, and develop a positive mindset in school and in life
14	Positive Action	Positive youth development; Behavior supports	PreK-12	1	Positive Action is a 7-unit curriculum that works through the Thoughts-Actions-Feelings (TAF) Circle to emphasize actions that promote a healthy and positive TAF cycle.
15	Second Step	SEL	PreK –12 Staff	1	Second Step programs help students build social-emotional skills—like nurturing positive relationships, managing emotions, and setting goals
16	Signs of Suicide	Suicide prevention	Students in grades 6-12	1	SOS teaches students how to identify signs of depression and suicide in themselves and their peers, while providing materials that support school professionals, parents, and communities in recognizing at-risk students and taking appropriate action.
17	Source of Strength	Suicide prevention	K-12 (separate programs for elementary and secondary)	1	Sources of Strength is a radically strength-based, upstream suicide prevention program with shown effectiveness in both preventative upstream and intervention outcomes. Sources of Strength has both an elementary and secondary model. Sources Secondary trains groups of Peer Leaders supported by Adult Advisors to run ongoing public health messaging campaigns to increase wellness and decrease risk in their schools. Sources Elementary is implemented as a universal classroom based Social Emotional Learning curriculum. The model incorporates the Sources of Strength protective factor framework, more robust language on mental

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					health, and a prevention lens that many elementary SEL models lack.
18	Teen Mental Health First Aid (T-MHFA)	Mental health literacy	Teens in grades 10-12, or ages 15-18,	1	Teaches students how to identify, understand and respond to signs of mental health and substance use challenges among their friends and peers.
19	Tools of the Mind	Social-emotional; Self-regulatory skills Teacher professional development	PreK and K staff	1	Tools of the Mind is a research-based early childhood model combining teacher professional development with a comprehensive innovative curriculum that helps young children to develop the cognitive, social-emotional, self-regulatory, and foundational academic skills they need to succeed in school and beyond.
20	Conscious Discipline	Trauma-informed SEL	Teachers; Admin; MH Professionals; Parents	1	Conscious Discipline creates a compassionate culture and facilitates an intentional shift in adult understanding of behavior via the Conscious Discipline Brain State Model. It provides specific brain-friendly, research-backed strategies for responding to each child's individual needs with wisdom.
21	Classroom Check Up	Classroom management	Teachers	1	Contains web-based tools and training in the form of intervention modules to support both teachers and coaches. Each module incorporates elements such as videos, assessment instruments, strategy tools, and action planning tools to facilitate effective and efficient implementation of evidence-based classroom management practices
22	Adolescent Depression Awareness Program (ADAP)	Depression	Adolescents	1	Includes 3 classes focused on interactive activities, video sessions, and discussions
23	Restorative Practices	Problem solving and conflict resolution	K-12	1	A classroom and school-based strategies to proactively build healthy relationships and a sense of community to prevent and address conflict and wrongdoing

	EBP – programs/trainings	Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
24	Classroom WISE	Mental health literacy	K-12	School Staff Training	Classroom WISE is a free self-guided online course focused on educator mental health literacy, informed by and co-developed with educators and school mental health professional across the United States
25	Youth Mental Health First Aid (Y-MHFA)	Mental health literacy	Adults who regularly interact with young people	School Staff Training	Youth Mental Health First Aid, an 8-hour course, is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.
26	Facilitating Attuned Interactions (FAN)	Provider-parent relationship	Mental health, School Nurse/Health Suite, Educators and Teacher Assistants and Administration, Special Education teams	Family Support and Engagement	FAN's aims to strengthen the provider-parent relationship, resulting in parents who are attuned to their children and ready to try new ways of relating to them.
27	Teacher WISE	Educator well-being	Teachers and school staff at all levels	School Staff Training	Helps educators assess their own well-being and personalize their learning with specific strategies that enhance their well-being
28	Be Strong Families Parent Cafes	Family relationships	Families and caregivers	Family Support and Education	Cafés are structured, small group conversations to facilitate transformation and

	EBP – programs/trainings	Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					healing within families, build community, develop peer-to-peer relationships, and engage parents as partners in the programs that serve them.
29	Family Bereavement Program	Family Bereavement	Youth who are 8 to 18 years old who have lost a parent/caregiver and the surviving parent/caregiver	Family Support and Education	A community-based or clinical program, is designed to enhance parenting skills, teach helpful coping methods, foster constructive communication, and create and sustain healthy parent-child relationships following the recent death of a parent or caregiver through group sessions.
30	Parent CRAFT- Community Reinforcement and Family Training	Substance Use	Families of teens or young adults	Family Support and Education	Community Reinforcement and Family Training, or CRAFT, is an approach to help parents and other caregivers change their child's substance use by staying involved in a positive, ongoing way.
31	Strengthening Family Coping Resources (SFCR)	Trauma; PTSD	Families living in traumatic contexts	Family Support and Education	SFCR is a manualized, trauma-focused, skill-building intervention. It is designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder and other trauma-related disorders in children and adult caregivers. SFCR provides accepted, empirically supported trauma treatment within a family format.
32	PEP - Educating Parents, Enriching Families	Family Relationships	Families with children from 5-18	Family Support and Education	Gives families the knowledge to understand the underlying causes of their children's behavior, and the practical skills and tools they need to address problems right away

Attachment 4: Definition of Unduplicated Students Served

Definition of Unduplicated Students Served

Unduplicated: "Unduplicated" means each student is counted only once, even though they may receive multiple interventions across multiple time periods, multiple schools, or multiple grade levels. Grantees are responsible for developing systems, such as unique patient identifiers, to ensure that each student is counted only once.

Student: Anyone in PreK-12th grade living in Maryland. A student does not need to be currently enrolled in a Maryland Public School to be counted. If your organization is providing services directly to parents/caregivers, count their pre-k-12th grade students.

Services: A "service" includes any intervention delivered at any of the three Tiers of the MultiTiered System of Supports. Examples of services are below:

• **Tier 1**: Services to promote positive social, emotional, and behavioral skills and wellbeing regardless of student or family risk or symptoms. These also include efforts to improve school climate and promote positive behavior. Tier 1 services are frequently implemented at the school-wide, classroom, and/or grade level.

- o **School- or grade-wide Tier 1**: The number of individuals served for a school- or grade-wide Tier 1 program such as social emotional learning programs or schoolwide assemblies (e.g., to improve school climate, promote positive behavior, provide mental health and wellness related information, etc.) should be the total student population of the school. Grantees may use school or grade enrollment data to provide this number and may refer to the School Report Card.
- o **Opt-in Tier 1**: The number of individuals who "opt in" or are served by a program that is made available to all students/ families regardless of risk factors. For example, an afterschool program that is open to all students, but not mandatory, should only count the students that participate in that program, not the entire school. Another example is a parent informational session offered at the school where all parents are invited but only those who attend should be reported.

• **Tier 2**: Services to address mild distress, functional impairment or risk for a given problem or concern. Tier 2 services are typically implemented in small groups or low intensity or brief interventions targeting at-risk students/families. Examples of Tier 2 EBPs recommended by the CHRC include Therapeutic Mentoring, SBIRT, and CBITS/Bounce Back. Other examples include small group interventions for students identified with similar needs, transition support groups for newcomers, brief individualized interventions (e.g., motivational interviewing, problem solving), mentoring, and/or low intensity classroom-based supports such as a daily report card, daily teacher check-in, and/or home/school note system. Tier 2 also includes case management (e.g., connecting clients to resources and social services, establishing care plans, continuous follow-up). Note: Case management **does not** include purely administrative duties.

• **Tier 3**: Services to address mental health concerns for students/families with the highest needs who are already experiencing significant distress and functional impairment. Tier Appendix H. 79 3 services include intensive individual, group or family therapy for students receiving general or special education who have identified, and often diagnosed, social, emotional and/or behavioral needs. Tier 3 also includes case management (e.g., connecting clients to resources and social services, establishing care

plans, continuous follow-up). Note: Case management **does not** include purely administrative duties. A referral to another service provider(s) may be counted as a Tier 3 service if there is documentation to demonstrate that the services actually were received (i.e. a closed-loop referral).

Families: "Individuals served" for this grant program are children grades pre-K through 12. Therefore, grantees serving families should count each child (grades pre-K through 12) as an unduplicated individual served. For example, if two parents of three school-aged children participate in a parenting education program, the number of individuals served should be reported as three.

Existing individuals served versus new individuals served: Grantees will report on all individuals that receive grant-funded services. This includes both: (1) new students/families not previously served; and (2) those existing students/families whose services are enhanced through grant funding for activities such as school meetings, transportation, and care coordination, as well as through support and training in EBPs and Measurement-Based Care.

Consortium grantees awarded under the previous Request for Proposals may be asked to differentiate between new students to be served under this RFA versus students served under their current grant who will continue to receive services under this RFA.

Service location: Services may be provided both in schools as well as in non-school locations. Services in non-school locations must be connected to the school in some way, such as through referrals from school staff, transportation from the school, on-going communication with the school, etc. If a service is not connected to the school in any way and is not enhanced through grant funding, it should not be counted.

Total unduplicated individuals served: Each individual should be counted only once in the total. For example, if a program is offering school-wide Tier 1 services to all students in the school as well as Tier 3 services to students with the greatest need, the total should consider that the Tier 3 students were already included in the Tier 1 count; and those students should not be counted twice in the total. As such, the total number of individuals served (reported in Measure 1) could be smaller than the sum of the Individuals served at each of the three tiers (reported in Measures 2a, 2b, and 2c).

Attachment 5: Outcome Measure Menu/Assessment Tools/Metrics

*Note: for access to embedded links in this attachment please see pages 81-87 in the MCHRC RFA

Outcome Measure Menu / Recommended Assessment Tools

About This Document

The "recommended" measures are validated, standardized measures of child and caregiver symptoms and/or functioning that are suitable across numerous EBPs. This allows us to align measurement tools across the different programs. These measures have been vetted by our team and in consultation with EBP purveyors. The "optional" measures are those included in the intervention materials or other suggestions by the purveyors. You can use these measures, but they might need extra work for outcomes monitoring (e.g., pre-post administration and scoring). Outcome measures should be selected by grantees to match the purpose of each intervention or EBP, with consideration of measure length, ease of use by students and/or caregivers, and availability in languages preferred by those respondents.

- Evidence-based programs (EBPs) prioritized by the Consortium and offered by the National Center for School Mental Health, in partnership with intervention developers/trainers, may require specific outcome measures, as detailed in the Table below.
- Grantees implementing interventions not on the list of priority EBPs are encouraged to use the preapproved outcome measures listed below. Other measures not on this list may be used if approved by the CHRC and NCSMH.
- Additional student/family outcome measures can be added as desired by the grantee or provider based on students and families served.

What outcome measures are preapproved?

Global Symptom / Functioning Outcome Measures	Problem-Specific Outcome Measures
• Pediatric Symptom Checklist (PSC-17) (preferred) • Mood and Feelings Questionnaire (MFQ) • Global Appraisal of Individual Needs-Short Screener (GAIN-SS) • Strengths and Difficulties (SDQ) • Brief Problems Checklist (BPC) • Student Subjective Wellbeing Questionnaire (SSWQ)	• Patient Health Questionnaire (PHQ-9): Mood / depression including Suicide Risk • Generalized Anxiety Disorder (GAD-7): Anxiety • Screen for Child Anxiety Related Disorders (SCARED): Anxiety • Revised Child Anxiety and Depression Scale (RCADS): Anxiety and Mood • Swanson, Nolan and Pelham Teacher and Parent Rating Scale (SNAP-IV): Attention / Concentration and Behavior • Vanderbilt ADHD Diagnostic Rating Scale: Attention / Concentration, Behavior, Anxiety, Mood, Social Skills

What if our EBPs or preferred measure(s) are not on the preapproved list?
After awards are made, CHRC and NCSMH staff will meet with grantees individually to approve outcomes measures and other program evaluation details.

Where can I find other outcome measures?

The School Mental Health Assessment and Performance Evaluation (SHAPE) System Screening and Assessment Library is available for school and community partners to locate free and low-cost measures. More information about the SHAPE Screening and Assessment Library can be found at https://theshapesystem.com/assessmentlibrary/. To access the Screening and Assessment Library and any other resources in The SHAPE System, create a free account as an individual or with a school or district team at www.theshapesystem.com ***Measures on the SHAPE Screening and Assessment library are NOT automatically approved for CHRC grantees.***

Priority Evidence-Based Programs	Recommended Individual Outcome Measures	Optional/Supplementary Individual Outcome Measures
Adolescent Community Reinforcement Approach (A-CRA)	***Mental Health and Substance Use Measure:*** GAIN – Short Screener *5-year paper/pencil license costs $150, electronic version available at cost.*	***Mental Health and Substance Use Measure*** PROMIS *In EPIC and possible other EHRs. Items can be modified beyond alcohol use only.* CRAFFT/CAGE-AID *Can be used if items are modified to a timeframe that can facilitate pre-post comparisons.* ***Global Symptom/Functioning Measure*** PSC-17 *may complement, not replace, GAIN-SS or other substance use measure*
Botvin LifeSkills	***Symptom-Specific Measure*** Botvin LifeSkills Pre/Post Evaluation	***Global Resilience or Wellbeing Measure*** Children's Hope Scale
Botvin LifeSkills Parent Program	***Global Symptom/Functioning Measure*** Parental Stress Scale (PSS)	Botvin LifeSkills Parent Program Health Survey
Chicago Parent Program	***Symptom-Specific Measure*** Parenting Questionnaire *Caregiver Measure, from CPP Evaluation Toolkit* Strength and Difficulties Questionnaire *Child Measure, from CPP Evaluation Toolkit* Parental Stress Scale (PSS) *Caregiver Measure*	
Circle of Security	***Symptom-Specific Measure*** Parental Stress Scale (PSS)	
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back	***Trauma Exposure and PTSD Symptoms (select one):*** Child Trauma Screen UCLA PTSD Index: Trauma Exposure Checklist & Child PTSD Symptoms Scale Traumatic Events Screening Inventory for Children (TESI-C)	***Global Symptom/Functioning Measure*** PSC-17 *may complement but not replace trauma exposure and PTSD symptoms measure*

Priority Evidence-Based Programs	Recommended Individual Outcome Measures	Optional/Supplementary Individual Outcome Measures
Counseling on Access to Lethal Means (CALM)	*Outreach to NCSMH team to discuss options as needed*	
Family Check Up	FCU Parent Caregiver Questionnaire on Family and Self FCU Parent Caregiver Questionnaire on Child (11-17 Years) FCU Parent Caregiver Questionnaire on Child (6-10 Years) FCU Parent Caregiver Questionnaire on Child (2-5 Years) FCU Adolescent Self Questionnaire (11-17 Years)	Parental Stress Scale (PSS)
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	***Global Symptom/Functioning Measure:*** PSC-17	***Any Approved Problem-Specific Measure(s) listed above***
Safety Planning Intervention (Stanley and Brown)	***Suicidal Ideation and Behavior Measure:*** Columbia – Suicide Severity Rating Scale (C-SSRS) *may require training*	Ask Suicide-Screening Scale (ASQ) Open-Source Suicidality Scale (SS)
SBIRT – Screening, Brief Intervention, and Referral to Treatment	***Mental Health and Substance Use Measure:*** GAIN – Short Screener *5-year paper/pencil license costs $150, electronic version available at cost.*	***Mental Health and Substance Use Measure*** PROMIS *In EPIC and possible other EHRs. Items can be modified beyond alcohol use only.* CRAFFT/CAGE-AID *Can be used if items are modified to a timeframe that can facilitate pre-post comparisons.* ***Global Symptom/Functioning Measure*** PSC-17 *may complement, not replace, GAIN-SS or other substance use measure*
The Student Check-Up (Motivational Interviewing)	***Global Symptom/Functioning Measure:*** Student Subjective Wellbeing Questionnaire Re-administer pre-assessment included in manual	PSC-17 EPOCH Measure of Adolescent Well-Being School Engagement Scale Morgan Jinks Academic Self-Efficacy School Records (Grades, Discipline Referrals, Attendance)
Therapeutic Mentoring	***Global Symptom/Functioning Measure:*** PSC-17 and/or Student Subjective Wellbeing Questionnaire	***Problem-Specific Measure:*** Youth Strength of Relationship Measure
Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)	***Global Symptom/Functioning Measure:*** PSC-17 (Internalizing scale only)	***Problem-Specific Measure(s):*** RCADS (anxiety and depression) PHQ-9 (depression only) GAD-7 (anxiety only)
Youth Aware of Mental Health (YAM)	***Mental health literacy measure:*** Youth Mental Health Literacy Scale (YMHL) ***Suicidal ideation and behavior measure:*** Columbia – Suicide Severity Rating Scale (C-SSRS) *may require training*	Ask Suicide-Screening Scale (ASQ) Open source Suicidality Scale (SS) *Outreach to NCSMH team to discuss options as needed*

Coordinated Community Supports Grantee Monitoring Report - Standard Metrics						
Grantee Name:	SAMPLE - will be customized for FY 2026 grantees					
Grantee #:	C-26-XXX					
Jurisdiction:						
NOTE #1: Metrics that count "UNDUPLICATED" participants **CANNOT** count these same participants over different reporting periods. The "TOTALS" column for these metrics should sum only unduplicated participants (e.g., a participant counted in reporting period 1,**CANNOT** be counted again in reporting period 2 or 3.						
NOTE #2: The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.						
NOTE #3: CHRC will utilize output **1** for its "**Total unduplicated individuals served**" measure.						
(Do NOT alter or enter data into shaded cells)						
Domain	**Output**	**Report Period #1 (JUL 1, 2025 - DEC 31, 2025)**	**Report Period #2 (JAN 1, 2026 - JUN 30, 2026)**	**TOTALS**	**Goal**	
1. TOTAL # of unduplicated students served	1. TOTAL # of unduplicated students served			**0**		
2. # of unduplicated students served by tier	2a. # of unduplicated students served - Tier 1			**0**		
	2b. # of unduplicated students served - Tier 2			**0**		
	2c. # of unduplicated students served - Tier 3			**0**		
3. # of unduplicated students served by race and ethnicity	3a. # of unduplicated students who receive grant services - African American/Black			**0**		
	3b. # of unduplicated students who receive grant services - Asian or Pacific Islander			**0**		
	3c. # of unduplicated students who receive grant services - Hispanic/Latino/a/x/e			**0**		
	3d. # of unduplicated students who receive grant services - Middle Eastern/North African			**0**		
	3e. # of unduplicated students who receive grant services - multi-racial			**0**		
	3f. # of unduplicated students who receive grant services - White			**0**		
	3g. # of unduplicated students who receive grant services - race/ethnicity not listed			**0**		
	3h. # of unduplicated students who receive grant services - unknown/prefer not to respond			**0**		

Domain	Output	Report Period #1 (JUL 1, 2025 - DEC 31, 2025)	Report Period #2 (JAN 1, 2026 - JUN 30, 2026)	TOTALS	Goal
4. # of unduplicated students served by gender	4a. # of unduplicated students who receive grant services - female/woman/girl			**0**	
	4b. # of unduplicated students who receive grant services - male/man/boy			**0**	
	4c. # of unduplicated students who receive grant services - non-binary			**0**	
	4d. # of unduplicated students who receive grant services - unknown/prefer not to respond			**0**	
5. # of unduplicated students served by grade	5a. # of unduplicated students who receive grant services - pre-kindergarten			**0**	
	5b. # of unduplicated students who receive grant services - elementary (kindergarten-grade 5)			**0**	
	5c. # of unduplicated students who receive grant services - middle (grades 6-8)			**0**	
	5d. # of unduplicated students who receive grant services - high (grades 9-12)			**0**	
6. # of unduplicated schools served	6. # of unduplicated schools served			**0**	
7. Satisfaction surveys	7a. # of students completing satisfaction surveys			**0**	
	7b. # of students reporting satisfaction with services			**0**	
	7c. # of family members completing satisfaction surveys			**0**	
	7d. # of family members reporting satisfaction with services			**0**	
8. School staff training	8a. # of school staff completing training by grantee			**0**	
	8b. # of school staff completing training assessment			**0**	
	8c. # of school staff demonstrating mastery of training			**0**	
9. # of unduplicated new positions that provide direct services	9a. # of unduplicated filled new positions that provide services to students or families and require licensure or supervision from a licensed professional			**0**	
	9b. # of unduplicated filled new positions that provide services to students or families and do not require licensure or supervision from a licensed professional			**0**	
10. Tier 1 outcomes	10a. # of individuals receiving Tier 1 supports who were then assessed using assessment tool or survey			**0**	
	10b. # of individuals demonstrating desired outcome, using assessment tool or survey			**0**	

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Domain	Output	Report Period #1 (JUL 1, 2025 - DEC 31, 2025)	Report Period #2 (JAN 1, 2026 - JUN 30, 2026)	TOTALS	Goal
11. Tier 2 outcomes	11a. # of individuals receiving Tier 2 supports who were then assessed using assessment tool or survey			**0**	
	11b. # of individuals receiving Tier 2 supports demonstrating improvement in social, emotional, behavioral, or academic functioning, using the outcome assessment tool(s)			**0**	
	11c. # of individuals receiving Tier 2 supports demonstrating no change in social, emotional, behavioral, or academic functioning, using the outcome assessment tool(s)			**0**	
	11d. # of individuals receiving Tier 2 supports demonstrating deterioration in social, emotional, behavioral, or academic functioning, using the outcome assessment tool(s)			**0**	
12. Tier 3 outcomes	12a. # of individuals receiving Tier 3 supports who were then assessed using tool(s)			**0**	
	12b. # of students/families receiving Tier 3 supports demonstrating improvement in social, emotional, behavioral, or academic functioning, using outcome assessment tool(s)			**0**	
	12c. # of students/families receiving Tier 3 supports demonstrating no change in social, emotional, behavioral, or academic functioning, using outcome assessment tool(s)			**0**	
	12d. # of students/families receiving Tier 3 supports demonstrating deterioration in social, emotional, behavioral, or academic functioning, using assessment tool(s)			**0**	

Coordinated Community Supports Grantee Monitoring Report - Custom Metrics					
NOTE #1: Metrics that count "UNDUPLICATED" participants **CANNOT** count these same participants over different reporting periods. The "TOTALS" column for these metrics should sum only unduplicated participants (e.g., a participant counted in reporting period 1, **CANNOT** be counted again in reporting period 2 or 3. **NOTE #2:** The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.					
(Do NOT alter or enter data into shaded cells)					
Intervention	**Output**	**Report Period #1 (JUL 1, 2025 - DEC 31, 2025)**	**Report Period #2 (JAN 1, 2026 - JUN 30, 2026)**	**TOTALS**	**Goal**
Intervention #1	14a. # of unduplicated students/families served through intervention #1			**0**	
	14b. # of students/families assessed via measure #1			**0**	
	14c. # of students/families assessed via measure #1 who demonstrated improvement			**0**	
Intervention #2	15a. # of unduplicated students/families served through intervention #2			**0**	
	15b. # of students/families assessed via measure #2			**0**	
	15c. # of students/families assessed via measure #2 who demonstrated improvement			**0**	
Intervention #3	16a. # of unduplicated students/families served through intervention #3			**0**	
	16b. # of students/families assessed via measure #3			**0**	
	16c. # of students/families assessed via measure #3 who demonstrated improvement			**0**	
Intervention #4	17a. # of unduplicated students/families served through intervention #4			**0**	
	17b. # of students/families assessed via measure #4			**0**	
	17c. # of students/families assessed via measure #4 who demonstrated improvement			**0**	

Attachment 6: Data Toolkit

Data Toolkit for Applicants

As part of the Coordinated Community Supports Partnerships Call for Proposals, the LMB, CHRC and Consortium are providing potential applicants with recommended databases and measures to support the preparation of grant proposals. These data sets can be used by applicants to identify unmet needs and develop programs and priorities. These data sets are recommended, not required. Applicants may use other data and sources to describe needs in their communities. Examples of jurisdiction-level measures that could be used to identify priorities include: prevalence of ACEs, substance misuse, depression and suicidality; number of justice-involved students; behavioral health provider shortages; gaps in school mental health services; number of disciplinary incidents/violence; behavioral health emergency department and overall utilization rates for Medicaid-covered youth; and percentage of uninsured children.

Examples of measures at the school level that could be used to target interventions to areas of greatest need include: socioeconomic need (free and reduced lunches), chronic absenteeism, graduation rates, number of Limited English proficient students, and student homelessness counts.

The following databases are recommended for jurisdiction-level data:
• HRSA Mental Health Professional Shortage Areas (HPSAs): https://data.hrsa.gov/tools/shortage-area/hpsa-find
• Youth Risk Behavior Surveillance System (YRBS): https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx
• Department of Juvenile Services Data Resource Guide: https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2023.pdf
• MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools 2022 – 2023: https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20222023Student/2022-2023-MD-PS-Suspensions-Expulsions-and-Health-Related-Exclusions.pdf
• U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program: https://www.census.gov/data-tools/demo/sahie/#/
• Report on Behavioral Health Services for Children Required by Section 7.5-209 of the Health-General Article: https://dlslibrary.state.md.us/publications/Exec/MDH/BHA/HG7.5-209(e).FY_2022.pdf
• Maryland Behavioral Health Workforce Assessment Report: https://dlslibrary.state.md.us/publications/Exec/MDH/MHCC/SB283Ch286HB418Ch287(2)(2023)_2024.pdf
• SHAPE system analyses by LEAs: if applicable, contact local school district
• Local Community Health Needs Assessments: optional, contact local health departments and health systems
• Local Behavioral Health Authority Needs Assessments: optional, contact Local Behavioral Health Authorities
• Local Management Board Needs Assessments: optional, contact Local Management Board

The following databases are recommended for school-level data:
• School Report Card: https://reportcard.msde.maryland.gov/
• LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/local-schoolsystems.aspx
• Community schools' needs assessments: if applicable, contact local Community Schools
• List of Community Schools: see Attachment 9

A description of each data set, suggested measures from each, and tips for utilizing these data sets are included in the Application Data Toolkit posted on the MCHRC Call for Proposals website. Applicants should select measures that correlate to their programs and should ***not*** include every suggested measure. Applicants may use other verifiable data sources, and should describe these in their proposals.

Recommended online databases:

1. **Health Professional Shortage Areas (HPSAs)**: https://data.hrsa.gov/tools/shortagearea/hpsa-find

Suggested measures:

- Geographic HPSA for Mental Health
- Population HPSA for Mental Health

Other tips:

- Jurisdiction-level data.
- Use the following filters:
  - Maryland
  - County
  - HPSA Discipline: Mental Health
  - HPSA Status: Designated
  - HPSA Designation Types: All Geographic, All Population
- May include HPSA score, on a scale of 0-26.

2. **Youth Risk Behavior Surveillance System (YRBS)**:
https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx

Suggested measures (High School):

- Percentage of students who felt sad or hopeless almost every day for more than two weeks in a row (QN25)
- Percentage of students who seriously considered attempting suicide (QN26)
- Percentage of students who reported that their mental health was most of the time or always not good (QN85)
- Percentage of students who ever took prescription pain medicine without a doctor's prescription (QN49)
- Percentage of students who ever used heroin (QN52)
- Percentage of students who ever used methamphetamine (QN53)
- Percentage of students who reported that a parent or other adult in their home most of the time or always swore at them, insulted them, or put them down (QN110)
- Percentage of students who have ever been separated from a parent or guardian because they went to jail, prison, or a detention center (QN113)
- Percentage of students who reported that their parents or other adults in their home most of the time or always slapped, hit, kicked, punched, or beat each other up (QN114)

Suggested measures (Middle School):

- Percentage of students who felt sad or hopeless almost every day for more than two weeks in a row (QN49)
- Percentage of students who ever seriously thought about killing themselves (QN14)
- Percentage of students who reported that their mental health was most of the time or always not good (QN44)
- Percentage of students who ever took prescription pain medicine without a doctor's prescription (QN29)

• Percentage of students who reported that a parent or other adult in their home most of the time or always swore at them, insulted them, or put them down (QN79)
• Percentage of students who have ever been separated from a parent or guardian because they went to jail, prison, or a detention center (QN82)
• Percentage of students who ever saw someone get physically attacked, beaten, stabbed, or shot in their neighborhood (QN11)

Other tips:
• Jurisdiction-level data.
• Use County Level Summary Tables for Middle School and/or High School.
• Compare with State Level Summary Tables and with other County Level Summary Tables.
• Some measures indicate Adverse Childhood Experiences (ACEs).
• Measures above correspond to the 2022-2023 YRBS report. A new version may become available and questions may vary.

3. **Department of Juvenile Services Data Resource Guide**:
https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2023.pdf
Suggested measures:
• Number of referrals to DJS per thousand youth ("Total complaints" x 1000/total youth population)

Other tips:
• Jurisdiction level data begins on page 36.
• Compare with statewide data found on page 36 or data from other jurisdictions.
• Race and ethnicity data is also available, data on types of offenses, trends.

4. **MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools 2022 – 2023**:
https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20222023Student/2022-2023-MD-PS-Suspensions-Expulsions-and-Health-Related-Exclusions.pdf
Suggested measures:
• Percentage of students suspended or expelled for the jurisdiction

Other tips:
• Jurisdiction-level data/summary tables starting on page 7.
• Compare with statewide data or data from other jurisdictions.
• Includes data tables disaggregated by race and ethnicity, grade, frequency/repeated offenses, elementary vs middle vs high school, types of offenses, etc.

5. **U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program**:
https://www.census.gov/data-tools/demo/sahie/#/
Suggested measures:
a. Percentage of uninsured individuals under the age of 18

Other tips:
• Jurisdiction-level data.
• Use the following filters:
    • Maryland

- County
- Age group: Under 19
- HPSA Designation Types: All Geographic, All Population

- Filters for race subgroups are not available for the Under 19 age group or Counties.
- Compare rate with statewide benchmark or other jurisdictions.

6. **Report on Behavioral Health Services for Children Required by Section 7.5-209 of the Health-General Article, FY 2022**: https://dlslibrary.state.md.us/publications/Exec/MDH/BHA/HG7.5-209(e).FY_2022.pdf
Suggested measures:

- Number of 30-Day Readmissions to Psychiatric Inpatient and Residential Treatment Facilities (page 51) • Number and Percent Eligible for Public Behavioral Health System Services within each Jurisdiction (page 62)
- Number and Percent of Child and Young Adult Recipients of Public Behavioral Health System Services (page 62-64)
- Number and Percent of Public Behavioral Health System Recipients of Inpatient Psychiatric Hospitalization (page 64-65)

Other tips:

- Compare rates with statewide averages or other jurisdictions.

7. **Maryland Behavioral Health Workforce Assessment Report**:
https://dlslibrary.state.md.us/publications/Exec/MDH/MHCC/SB283Ch286HB418Ch287(2)(2023)_2024.pdf
Suggested measures:

- Maryland BH Professionals Per Capita by County (page 20)
- Counselors, Therapists, Psychologists, and Social Workers Employment Estimates By County (page 23)
- Employment Estimates by County Per 30,000 Residents (pages 110-111)
- Demographic Estimates by BH Occupation and County (pages 112-123)

Other tips:

- Include rank as compared with other jurisdictions
- Compare rates with statewide averages or other jurisdictions.

8. **MSDE School Report Card**: https://reportcard.msde.maryland.gov/
Suggested measures:

- Socioeconomic need (look at “Free and Reduced Meals” under “Demographics/Student Group Populations”)
- Limited English proficient students (look at “English Learner” under “Demographics/Student Group Populations”)
- Student homelessness counts (look at “Homeless” under “Demographics/Student Group Populations”)
- Chronic absenteeism (look at “Attendance” under Demographics/Student Group Populations;” left side menu includes several different measures of chronic absenteeism)
- Graduation rates (for High School only, look at “Report Card”)

Other tips:

- School-level data.
- Compare data with benchmarks for the state or the jurisdiction.
- Demographic data sets may be the most useful for demonstrating need, though academic data can also be referenced.
- Look at data definitions.
- Report Card details include Equity Data for academic measures; can be disaggregated by race and economic disadvantage.

9. **LEA Blueprint Implementation Plans**: https://aib.maryland.gov/Pages/local-schoolsystems.aspx

10. **List of Community Schools**: See Attachment 7

Attachment 7: Maryland Community Schools

Maryland Community Schools: Worcester and Somerset Counties

School Name	Local Education Agency
Buckingham Elementary	Worcester County
Cedar Chapel Special	Worcester County
Pocomoke Elementary	Worcester County
Pocomoke Middle	Worcester County
Pocomoke High	Worcester County
Snow Hill Middle	Worcester County

School Name	Local Education Agency
Carter G Woodson Elementary	Somerset County
Crisfield High	Somerset County
Deal Island School	Somerset County
Greenwood Elementary	Somerset County
Intermediate School	Somerset County
Princess Anne Elementary	Somerset County
Washington High	Somerset County

Attachment 8: Wraparound Supports

Wraparound Supports

Consistent with the Consortium's legislative mandate, this RFA will support funding for wraparound supports. Under this RFA, wraparound supports are defined as holistic supports that address a student's behavioral health needs but are not considered traditional behavioral health services. Wraparound supports funded under this RFA must meet four criteria:

1. Limited to students with identified behavioral health challenges, or at significant risk, and their families.
2. When appropriate, should be connected to traditional behavioral health services.
3. Ineligible for reimbursement through Medicaid, the Developmental Disabilities Administration (DDA), or other State support (e.g., not Targeted Case Management (TCM), TCM+, or HighFidelity Wraparound models); and
4. Must involve schools in planning and/or implementation.

Examples of wraparound supports include:

1. Transportation to behavioral health services:
2. Peer support;
3. Parenting classes;
4. Afterschool activities that implement evidence-based behavioral health programming;
5. Evidence-based mentoring programs;
6. Developing and monitoring care plans for students with identified behavioral health needs; and
7. Navigation to link students and families to essential supports such as:
    - Somatic health services and health insurance
    - Academic and vocational supports
    - Extra-curricular activities that do not implement behavioral health EBPs
    - Services that address non-medical Social Determinants of Health (SDOH) needs.

The Consortium's definition of wraparound for this RFA differs from the definition of wraparound in other programs:

- Community Schools: When compared with the Community Schools' definition of wraparound, the Consortium's approach is more focused on behavioral health, and is only available to targeted students and families. This RFA will not support direct funding for activities such as extended learning, field trips, tutoring, somatic health services, vision, dental, etc. that are within the Community Schools' definition of wraparound. Instead, this RFA will support programs that link students and families to a broad array of supports.

- High Fidelity Wraparound/Targeted Case Management: When compared to these approaches to wraparound, the Consortium's approach is less intensive and available to more students and families. This RFA will not support direct funding for models that are reimbursable through Medicaid and the 1915(i) program. Instead, programs funded by this RFA and the Partnership model should help to educate and connect families to resources for higher intensity wraparound supports.

Attachment 9: Other Funding Opportunities for Student Mental Health Services

Other Funding Opportunities for Student Mental Health Services

Federal government grant makers:

• **U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)**: various grant opportunities including: Mental Health Awareness and Training Grant (MHAT)/Project AWARE; Preventing Youth Overdose: Treatment, Recovery, Education, Awareness and Training; Behavioral Health Partnership for Early Diversion of Adults and Youth; Strategic Prevention Framework – Partnerships for Success; Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program; Mental Health Awareness Training Grants; National Child Traumatic Stress Initiative; and Linking Actions for Unmet Needs in Children's Health.
Link: https://www.samhsa.gov/grants/grants-dashboard

• **U.S. Health Resources & Services Administration (HRSA)**: various grant opportunities including: Rural Communities Opioid Response Program – Child and Adolescent Behavioral Health; Developmental-Behavioral Pediatrics (DBP) Training Program; Comprehensive Systems Integration for Adolescent and Young Adult Health; and Primary Care Training and Enhancement - Residency Training in Mental and Behavioral Health (PCTE-RTMB).
Link: https://www.hrsa.gov/grants/find-funding

• **U.S. Department of Education**: various grant opportunities, applicants must be mostly schools and school districts.
Link: https://www2.ed.gov/fund/grants-apply.html?src=pn

Maryland state/local government grant makers:

• Behavioral Health Administration, Local Behavioral Health Agencies (LBHAs), Core Service Agencies (CSAs), and Local Addictions Authorities (LAAs)
• Community Health Resources Commission (CHRC) - other RFAs
• Governor's Office of Crime Control & Prevention for Maryland - Local Management Boards (LMBs)
• MDH Office of Minority Health and Health Disparities - Minority Outreach and Technical Assistance
• MDH School-Based Health Centers program
• Opioid Operational Command Center (OOCC)
• Rural Maryland Council

Private Foundations:

• Abell Foundation
• Annie E. Casey Foundation
• Ausherman Family Foundation (Frederick County)
• Baltimore Children and Youth Fund
• Baltimore Community Foundation
• Blaustein Philanthropic Group
• Caplan Foundation for Early Childhood
• CareFirst
• Community Trust Foundation (Allegany and Garrett Counties)

- France-Merrick Foundation
- Goldseker Foundation
- Herbert Bearman Foundation
- Hoffberger Family Philanthropies
- Horizon Foundation (Howard County)
- John J. Leidy Foundation (Baltimore)
- Joseph & Harvey Meyerhoff Family Charitable Funds
- Lockhart Vaughan Foundation (Baltimore)
- M&T Charitable Foundation
- Middendorf Foundation
- PNC Foundation
- Reginald F. Lewis Foundation
- Richman Foundation
- Robert W. Deutsch Foundation
- Robert Wood Johnson Foundation
- Straus Foundation (Baltimore)
- Stulman Foundation
- United Way
- Venable Foundation
- Weinberg Foundation
- William J. and Dorothy K. O'Neill Foundation
- Women's Giving Circle (Howard County)
- Zanvyl and Isabelle Krieger Fund

Attachment 10: LMB Legal and Financial Disclosure Form

Worcester County's Initiative to Preserve Families

6040 Public Landing Rd.
Post Office Box 129
Snow Hill, MD 21863

Telephone: 410-632-3648

Applicant Legal and Financial Disclosure
FY 2026 LMB Spoke Providers Call for Proposals

Applicant Organization Name: _____

Legal Disclosure

Applicants must disclose information about any outstanding and potential legal actions and claims. Please respond to each of the items below.

1. Describe any outstanding legal actions or potential claims against the applicant. Include a brief description of any action.

2. Describe any settled or closed legal actions or claims against the applicant over the past five (5) years.

3. Describe any judgments against the applicant within the past five (5) years, including the court, case name, complaint number, and a brief description of the final ruling or determination.

4. In instances where litigation is ongoing and the applicant has been directed not to disclose information by the court, provide the name of the judge and location of the court.

Debts and Liabilities Disclosure

Applicants must disclose any and all current outstanding debts and liabilities that may negatively impact the project. Please respond to each of the items below.

1. Describe any outstanding state or federal tax liabilities.

2. Verify the applicant is in good standing with the Maryland State Department of Assessments and Taxation (SDAT). https://egov.maryland.gov/BusinessExpress/EntitySearch. If applicant is not in good standing, describe efforts to achieve good standing.

3. Describe any outstanding, overdue, or delinquent loans or other contractual debt.

4. Describe any other financial liability that could affect the outcome of the proposed project.

Signature: _____

Date: _____

Attachment 11: Contractual Obligations, Assurances, and Certifications

Contractual Obligations, Assurances, and Certifications

STATEMENT OF OBLIGATIONS, ASSURANCES, AND CONDITIONS

In submitting its grant application to the Worcester's Initiative to Preserve Families also known as the Worcester County Local Management Board ("LMB") and by executing this Statement of Obligations, Assurances, and Conditions, the applicant agrees to and affirms the following:

1. All application materials, once submitted, become the property of the LMB.

2. All information contained within the application submitted to the LMB is true and correct and not reasonably likely to mislead or deceive.

3. The applicant acknowledges that all grant award decisions are preliminary and contingent upon the applicant's agreement to all terms and conditions of the grant award, as determined by the LMB, and upon execution of a written grant agreement that is signed by the LMB and the applicant. Prior to execution of the written grant agreement, the LMB may cancel or rescind an award for any reason, and the applicant may decline the award for any reason.

4. The applicant affirms that in relation to employment and personnel practices, it does not and shall not discriminate based on race, creed, color, sex, country of national origin, or upon any other basis that is prohibited by State and federal law.

5. The applicant agrees to comply with the requirements of the Americans with Disabilities Act of 1990, where applicable.

6. The applicant agrees to complete and submit the Certification Regarding Environmental Tobacco Smoke, P.L. 103-227, also known as the Pro-Children Act of 1994.

7. The applicant agrees that grant funds shall be used only in accordance with applicable State and federal law, regulations and policies, the LMB's Request for Applications, and the final proposal as accepted by the LMB, including LMB-agreed modifications (if any).

8. If the applicant is an entity organization under the laws of Maryland or any other state, that is in good standing and has compiled with all requirements applicable to entities organized under that law.

9. The applicant has no overdue debts or liabilities subject to or in collections (either by the grantor/lender/payor or a third-party), nor any claims, judgments or penalties pending or assessed against it – whether administrative, civil or criminal – in any local, state or federal forum or proceeding.