

**Community Collective Impact Model for Change RFP
FAQ's**

1. Are all of the assurances due at the time of application?

Yes

2. Does Ohio MHAS have a specific form for applicants to fill out or some type of guidance on their expectations for the cover sheet?

No, applicants must ensure all of the components are included.

3. Per the application's RFP instructions (p. 17) attachment 2 is a certifications document, but in the word document application, attachment 2 is a map. Should I submit the map with our Executive Director's signature? Or are all of the attachments beyond the Line Item Form not required unless funded?

There are technically two documents. The RFP, which has the map as Attachment 2, and the Agreements and Assurances document which includes the certification documentation, the attachments beyond the Line Item Budget are required for submission.

4. If they are required, the instructions state that the budget and narrative do not count towards the 12 pages page limit. Would the requirement of these other attachments be counted towards the page limit or are they separate?

No, the Agreements and Assurances pages do not count toward the page limit.

5. How are counties placed in Tiers in the Collective Impact Grants? What criteria is being used?

Funding Tiers

The number and rates of opioid-related overdose deaths were determined for each ADAMH board area. Areas with the highest overdose death counts (years 2010-2015), rates (years 2010-2015) and fentanyl deaths (2015) were classified as "Tier 1." The total number of residents in Tier 1 counties is 7,030,825, or 61 percent of the state population.

Counties with the next highest overdose death rates (2010- 2015) and a high need for treatment (National Survey on Drug Use and Health 2012-2014) were classified as "Tier 2" areas. The total number of residents in Tier 2 is 1,678,383, or 14 percent of the state population.

Together, Tier 1 and Tier 2 areas equal 8,709,208 Ohioans or 75 percent of Ohio's population. This also equates to 53 percent of Ohio counties and board districts. These areas were invited to submit project level proposals for how they would use the 21st Century Cures funding to support a full continuum of care to combat opioid addiction. OhioMHAS is currently working with local the ADAMH boards in the Tier 1 and Tier 2 areas to evaluate their respective project proposals and determine specific board allocation levels.

6. Is an organization allowed to submit multiple applications? Specifically, can an organization apply to be the backbone organization in more than one county, with applications submitted for individual counties?

The organization must be able to show the capacity to work in multiple counties and have the ADAMHS/ADAS Board partnership in each county proposed. Applicant must also understand that they may not be funded for all counties proposed.

7. In the Community Collective Impact Grant Grant, attachments 7 and 8 refer to the Family and Children First Council. Since we are not the administrative agent for the Family and Children First Council, do we still need to complete those attachments?

No, you do not need to complete these sections.

8. For the CURES Collective Impact RFP "Grantee will attend required training, technical assistance and/or meetings as per SAMHSA and/or OhioMHAS request including monthly status meetings with the project director," how much direct time should be planned for these trainings and TA (i.e. 1 day vs 5 week)? Additionally, will these monthly reports with project coordinator be in person or via phone/web? If in person, where will these be located?

Much of the work done through this project will align with coalition work already in progress in communities. The exact amount of time the training and TA will take will be based on the individual coalitions and the level of their readiness. These may be done via face-to-face, phone and/or webinar/video chat.

9. It appears submissions from Tier III counties will not be accepted. Just want to confirm that is the case.

Tier III counties are not excluded from this application, Tier I and Tier II are receiving first priority.

10. We do not have a full time FTE to devote to the project, but have over 1.0 FTE of time devoted to our Opiate Task Force from: CCMHRB Associate Director (co-chair of task force), CCMHRB Executive Director, Clermont Public Health Commissioner, Clermont Public Health Nursing Director, and the Clermont Public Health Injury Prevention Coordinator. Is that allowable?

Yes

11. In 2015, our Opiate Task Force developed a Plan of Action which includes our goals and objectives. We would like to update the plan and goals and also make the goals more measureable. Is this allowable under the grant?

Part of the process will be to develop a logic model with a shared vision and agenda across the continuum of care.

12. Is the \$10,000 for the training the consultants provide or is the training provided free of cost?

The training will be provided at no cost to the communities.

13. Is the training on SPF or collective impact?

There will be a variety of training and technical assistance provided based upon community readiness.

14. If the training is on SPF, we have already received SPF training, could we use local experts in the area for SPF training for our Opiate Task Force? And receive consultation on SPF from the State?

Please see above.

15. We have identified several items that we would like to use the grant funding for:
- a. Renewal/Update of our Opiate Task Force's Action Plan and copying expense
 - b. Renewal/Update of Opiate Task Force's One page Information Sheet and copying expense
 - c. Conferences and training for Opiate Task Force members
 - d. Marketing of Opiate Task Force and stigma busting campaign
 - e. Update and additions to our Opiate Task Force website
 - f. Incentives for participating in community surveys and for engagement of youth
 - g. Travel for conferences and training

This project is to work beyond the just one task force or coalition and develop a shared vision and agenda across the continuum of services.

16. Is the primary focus children, youth and families? Can adults also be the focus?

The primary focus is community capacity building. This is not a direct service project.