OMB Control Number: 1660-0085
Expiration Date: 12/31/2009

Crisis Counseling Assistance and Training Program

Immediate Services Program Application

FEMA

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Application Signature

Note: Fields marked with an * are required.

Federal Emergency Management Agency (FEMA) disaster declaration number: _____

Director, State Mental Health Authority (SMHA): The following individual is responsible for coordinating the mental health response to this disaster. This person will also have oversight authority for the application process for Federal funds to provide disaster-related mental health services.

*Name:
*Title:
*Agency:
*Address:
*Phone:
Fax:
E-Mail:

*_____ *_____

Date **Signature, Director, SMHA**

Governor's Authorized Representative (GAR): The GAR is the State official authorized to represent the Governor and apply for Crisis Counseling Assistance and Training Program (CCP) Immediate Services Program (ISP) funding.

*Name:
*Title:
*Agency:
*Address:
*Phone:
Fax:
E-Mail:

This application represents the Governor's agreement or certification of the following:

- The requirements are beyond the State and local governments' capabilities.
- The program, if approved, will be implemented according to the plan contained in the application approved by the FEMA Disaster Recovery Manager (DRM).
- The Governor will maintain close coordination with and provide reports to the FEMA regional director or the DRM as the delegate of the regional director.
- The State's emergency plan, prepared under Title II of the Stafford Act, will include mental health disaster planning.

***The State requests $_____ for immediate services.**

*_____ *_____

Date **Signature, GAR**

Attach Standard Form 424 Request for Federal Assistance (SF–424) and Standard Form 424a Budget Information: Non-Construction Programs (SF–424a) to the signature sheet.

Note: Throughout the ISP application, the terms "State" and "SMHA" are intended to include all qualified applicants (i.e., States, U.S. Territories, and federally recognized Tribes).

Note: Fields marked with an * are required.

Contact Information

Preparer Information

Prefix *First Name Middle Initial *Last Name
*Agency/Organization Name: _____
*Address Line 1: _____
Address Line 2: _____
*City: _____ *State: _____ *Zip: _____
*Phone: _____ Fax: _____
E-Mail: _____

*Is the application preparer the point of contact? ☐ Yes ☐ No

Point of Contact Information

If the application preparer is not the point of contact, please complete the information below.

Prefix *First Name Middle Initial *Last Name
*Agency/Organization Name: _____
*Address Line 1: _____
Address Line 2: _____
*City: _____ *State: _____ *Zip: _____
*Phone: _____ Fax: _____
E-Mail: _____

Alternate Point of Contact Information

To add an alternate point of contact, please complete the information below.

Prefix First Name Middle Initial Last Name
Agency/Organization Name: _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-Mail: _____

Part I. Geographic Areas and Initial Needs Assessment

⤫⤫START: COPY AND PASTE SECTION FOR EACH DESIGNATED SERVICE AREA⤫⤫

*A. Center for Mental Health Services (CMHS) Needs Assessment Formula—Estimated Crisis Counseling Needs

CMHS Needs Assessment Formula—Estimated Crisis Counseling Needs

Disaster declaration number: FEMA–XXXX–DR–State

This is an estimate for the following designated service area: _____

Date completed: _____ Completed by (print name): _____

Complete a CMHS Needs Assessment Formula sheet for the entire program service area and each designated area. To complete the sheet:

1. Identify the number of people for each loss category from collected needs assessment information.
2. Identify any disaster- or region-specific "other" loss categories, and establish a traumatic impact risk ratio for any other loss categories. Note that other loss categories are not multiplied by the household size multiplier.
3. Determine the total people who would benefit from services for each loss category by multiplying across each row as follows: (number of people) X (household size multiplier) X (traumatic impact risk ratio) = (total people who would benefit from services).
4. Add all of the results in the column of total people who would benefit from services to determine a sum for the number of people who would benefit from crisis counseling services.

Loss Category	No. of People		Household Size Multiplier[2] (ANH = 2.5)		Traumatic Impact Risk Ratio[3]		Total People Who Would Benefit from Services
Dead		x	ANH x 4	x	100%	=	
Hospitalized		x	ANH x 1	x	100%	=	
Nonhospitalized Injured		x	ANH x 1	x	50%	=	
Homes Destroyed		x	ANH x 1	x	100%	=	
Homes Major Damage		x	ANH x 1	x	20%	=	
Homes Minor Damage		x	ANH x 1	x	10%	=	
Disaster Unemployed		x	ANH x 1	x	10%	=	
Other 1 (Specify)[1]				x		=	
Other 2 (Specify)[1]				x		=	
					TOTAL:	=	

[1]If appropriate, the State may identify other loss category groups related to the disaster. These categories are not multiplied by a household size multiplier. The State should also identify a traumatic impact risk ratio for each additional loss category specified. Add rows as necessary.

[2]Household size multiplier means the average number of people per household (ANH). The national average is 2.5, but applicants should consult U.S. Census information for State or county averages.

[3]The traumatic impact risk ratio assesses the likelihood of individual and community adverse reactions to this disaster. In previous versions of this application, the term "at-risk multiplier" was used.

Note: Fields marked with an * are required.

*Provide a brief narrative description of the disaster event and its impact on individuals and communities.

*Identify the sources of data for the number of people identified in each loss category. If FEMA preliminary damage assessment data have not been collected for this disaster, or were not used in specifying the number of people for each category, please clearly identify alternate sources of data used (e.g., American Red Cross, State Emergency Management Agency, media reports).

*Describe any special circumstances not captured in the CMHS Needs Assessment Formula that will affect the need for crisis counseling services.

*Specify any high-risk groups or populations of special concern identified through the State's initial needs assessment process (e.g., children, adolescents, older adults, ethnic and cultural groups, lower income populations).

If "other" categories were added to the CMHS Needs Assessment Formula table, please describe the rationale for including these loss categories and how the Traumatic Impact Risk Ratios were determined.

Additional comments, if any:

✂✂END: COPY AND PASTE SECTION FOR EACH DESIGNATED SERVICE AREA✂✂

*B. Geographic Areas and Initial Needs Assessment

1. Complete a CMHS Needs Assessment Formula sheet (see part I.A.) for each designated service area.
2. Using the information from each CMHS Needs Assessment Formula sheet, fill in the two columns of the following chart.

Designated Service Area	Total People Who Would Benefit from Services
TOTAL:	

Additional comments, if any:

Part II. Response Activities from Date of Incident

*Describe State and local crisis counseling activities from the date of the incident to the date of application. Enter “none” if no activities have been conducted to date.

Explain the cause of any delays.

*Explain any measures taken to ensure immediate services will be implemented.

Additional comments, if any:

Part III. State and Local Resources and Capabilities

*Describe State and local mental health systems and the clients they serve. Explain why these resources cannot meet the disaster-related mental health needs.

*Does the SMHA set aside funds for disaster programs? Explain how funds are set aside.

*Are crisis counseling services beyond the SMHA’s and local providers’ scope of services?

If the State has existing resources that can be used for disaster mental health services, describe these resources. These resources should be outlined as in-kind contributions in the program plan.

Additional comments, if any:

Part IV. Staffing and Plan of Services

*A. Staffing and Plan of Services—Summary

1. Complete a staffing plan sheet (see Part IV.C. Service Providers) for the SMHA and for each service provider.
2. Fill in the following table with full-time equivalent (FTE) totals from the staffing plan sheets.
3. Identify the designated service areas that each provider will serve.

Note: Project totals in this table should equal the total identified in Part I.B. Geographic Areas and Initial Needs Assessment.

		FTEs		
Service Provider Name	**Total People Who Would Benefit from Services**	**Grant Funded**	**Projected In Kind**	**Designated Service Areas**
State				
Service Provider 1				
Service Provider 2				
Service Provider 3				
Service Provider 4				
Service Provider 5				
TOTAL:				

In the spaces below, all applicants should do the following:

- Attach an organizational chart. This chart must include the program management, fiscal, administrative, data/evaluation, and all direct and support services staff positions at the State and provider levels. The staff positions and FTEs in the organizational chart should correspond with the information included in the staffing plan sheets.
- Describe the organizational structure.

*Attach an organizational chart for this project.

*Describe the rationale for determining the number of FTEs for the program based on the total people who would benefit from services.

*Provide a brief description of the organizational and supervisory plan for the program.

Additional comments, if any:

*B. Program Management

The following section should be used by the State to describe the SMHA's overall plan for program administration, monitoring, and oversight.

*Describe the State's plan for administrative oversight of the entire program.

*Describe the State's plan for monitoring fiscal activity and fiscal accountability. Include financial documentation procedures.

*Describe the State's plan for quality control methods to ensure appropriate services reach disaster survivors.

Evaluation activities must be consistent with the guidelines provided by FEMA and CMHS. Data should be collected using the data collection tools approved by the Office of Management and Budget (OMB) and contained in *Evaluating and Monitoring the Reach, Quality, and Consistency of Crisis Counseling Programs Manual and Toolkit* included with the application materials packet sent to States from the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC).

*☐ By checking the box, the State agrees to use the OMB-approved data collection tools and conduct evaluation activities consistent with FEMA and CMHS guidelines.

Describe and justify any additional process or program evaluation that may be conducted during the ISP.

If an evaluation consultant will be used for other evaluation activities, explain why this consultant was selected and attach a résumé to the application.

*Will the State be providing, in addition to oversight, direct crisis counseling services to survivors? ☐ Yes ☐ No

If yes, the State must complete part IV.C.1–4, detailing information concerning the direct services to be provided.

Additional comments, if any:

Note: Fields marked with an * are required.

>><START: COPY AND PASTE SECTION FOR EACH SERVICE PROVIDER>><

***C. Service Providers**

Note: Part IV.C.1–4 should be completed for each service provider. The SMHA also should complete these sections for itself if State personnel will be directly providing crisis counseling services to survivors in addition to carrying out their administrative oversight role.

***1. Contact Information**

Please provide information on each service provider and the project manager point of contact for the provider.

Service Provider

*Agency/Organization Name: _____
*Address Line 1: _____
Address Line 2: _____
*City: _____ *State: _____ *Zip: _____
*Phone: _____ Fax: _____
E-Mail: _____
Director's Name: _____

CCP Provider Contact/Manager

_____
Prefix *First Name Middle Initial *Last Name
*Agency/Organization Name: _____
*Address Line 1: _____
Address Line 2: _____
*City: _____ *State: _____ *Zip: _____
*Phone: _____ Fax: _____
E-Mail: _____

Note: Fields marked with an * are required.

*2. Service Providers: Estimated Service Targets

The total number of people who would benefit from services for each designated service area was identified in Part I.B. Geographic Areas and Initial Needs Assessment of the ISP application. These figures should be included in the total provider service targets in the following table.

The provider should then identify how many people its organization proposes to serve in each designated service area. If one provider is serving the entire designated service area, the total estimated service targets will equal the number of provider estimated service targets. If more than one provider is serving a designated service area, the State will need to establish service targets for each provider to minimize duplication of service or gaps in service. Fill out the following chart for each provider.

Designated Service Area Name	Total People Who Would Benefit from Services	Provider Service Targets (total people targeted for services)
TOTAL:		

*3. Service Providers: Staffing Plan

Service Provider Staffing Plan

Disaster declaration number: FEMA–XXXX–DR–State

Service provider name: _____

This is an estimate for the following designated service areas: _____

Date completed: _____ Completed by (print name): _____

	Grant Funded		Projected In Kind	
Type of Staff	**No. of Staff**	**No. of FTEs (based on 40 hours per week)**	**No. of Staff**	**No. of FTEs (based on 40 hours per week)**
State CCP Program Manager/Director				
Provider Project Manager				
Team Leader				
Crisis Counselor				
Fiscal Coordinator				
Administrative Assistant/ Data Entry Clerk				
Evaluation Coordinator				
Other 1 (Specify)				
Other 2 (Specify)				
TOTAL:				

*Provide a brief job description (one paragraph) for each staff position included in the program. Sample job descriptions for typical positions are available in the ISP Supplemental Instructions and may be modified and inserted here.

*4. Service Providers: CCP Services Provided

Select the types of services furnished by the service provider.

***Primary services provided:**

- ☐ Brief educational or supportive contact
- ☐ Individual crisis counseling
- ☐ Group crisis counseling
- ☐ Public education
- ☐ Assessment, referral, and resource linkage
- ☐ Community networking/support

***Secondary services provided:**

- ☐ Distribution of educational materials
- ☐ Media and public service announcements

*Where and how will staff be deployed to provide identified types of services?

*What strategies are in place for targeting those identified as in need of services? Include any special population groups that are identified in the needs assessment.

*Describe the staff support mechanisms that will be available.

Additional comments, if any:

✂✂END: COPY AND PASTE SECTION FOR EACH SERVICE PROVIDER✂✂

D. Consultants (Excluding Trainers)

Please provide a list of consultants you intend to use. Complete a consultant information sheet for each consultant. Do not include any trainers.

*Consultants

Consultant Name	Agency/Organization	Phone
Consultant 1		
Consultant 2		
Consultant 3		

Additional comments, if any:

Consultant Information

Please provide the following information. If the consultant is self-employed, enter his or her name in the agency/organization field in addition to the name fields. The address of the consultant should be the address of the agency/organization applying for FEMA funds. Résumés are required for all consultants.

Consultant

Prefix *First Name Middle Initial *Last Name

*Agency/Organization Name: _____

*Address Line 1: _____

Address Line 2: _____

*City: _____ *State: _____ *Zip: _____

*Phone: _____ Fax: _____

E-Mail: _____

Types of Services Provided:

*E. Training

Note: Enter only people who are trainers; list consultants in the previous section. All program staff must receive training in the FEMA crisis counseling requirements.

*Does the State have trainers experienced in the CCP who can provide training on the CCP model?

☐ Yes ☐ No

- If yes, list these trainers in the table below.
- If no, contact SAMHSA DTAC for technical assistance or referrals for approved trainers (SAMHSA DTAC: 1-800-308-3515, dtac@esi-dc.com). The approved trainers must then be listed in the table below.

Note: Fields marked with an * are required.

*Trainers

Trainer Name	Agency/Organization	Phone	FEMA/CMHS Approved?
Trainer 1			
Trainer 2			
Trainer 3			

*Training Schedule

Type of Training	Date	Trainer	Location
[1]Core Content Training			
Other:			

[1]The Core Content Training is a mandatory training.

Attach résumés for any proposed trainers who have not been FEMA/CMHS approved.

Describe and justify other trainings to be offered.

Additional comments, if any:

***F. Facilities**

*Explain whether office space is being provided as an in-kind contribution to the project by the State or service providers.

If space will be leased for the CCP, explain why this is necessary.

Additional comments, if any:

Part V. Budget

The budget must be integrated with the needs assessment and the program plan. A separate budget must be provided for the SMHA and each service provider. A line-item budget narrative justifying costs is required for both State and service provider budgets.

- **Note that SF–424a is a required form and represents the total budget for the program**.
- The applicant should review the detailed guidance on budgeting in the ISP Supplemental Instructions and the *Crisis Counseling Assistance and Training Program Guidance.*

*A. State Budget

ISP Budget Summary for the SMHA

Disaster declaration number: FEMA–XXXX–DR–State

Budget Line Item	Interim Costs (costs incurred from date of incident to the application deadline—14 days following the declaration)	Projected Costs (costs from the immediate services application deadline to 60 days or last day of program)	Total Costs (add interim and projected costs)	In-Kind Costs (costs contributed to the project per agency)
Dates of Service				
Salaries and Wages **(a.)**[1]				
Fringe ____% **(b.)**[1]				
Subtotal Personnel Costs				
Travel **(c.)**[1]				
Equipment **(d.)**[1]				
Supplies **(e.)**[1]				
Contractual Consultant/Trainer Costs				
Contractual Media/Public Information Costs				
Other Contractual Costs				
Subtotal Contractual Costs **(f.)**[1]				
Other Direct State Costs **(h.)**[1]				
Total Contractual and Direct Costs:				

[1]Letters in parentheses indicate the corresponding budget category on the SF–424a.

In the following table, include a detailed line-item narrative justifying costs. Please review the detailed guidance on the budget narrative included in the ISP Supplemental Instructions and the *Crisis Counseling Assistance and Training Program Guidance.*

Note: Fields marked with an * are required.

ISP Line-Item Budget Narrative for the SMHA

Disaster declaration number: FEMA–XXXX–DR–State

Period of performance:

Budget Line Item	Item Description	Total Cost				
DIRECT COSTS						
Direct Personnel Costs		**No. of FTE**	**Hours**	**Weeks**	**Rate**	
Salaries and Wages	(Itemize position titles from part IV.C.3. here. Add rows as needed.)					
Subtotal Salaries and Wages						
Fringe		%				
Subtotal Direct Personnel Costs						
Direct Travel Costs			**Miles**	**Weeks**	**Rate**	
	(Itemize travel types here; include estimated mileage rate, air, lodging, and per diem costs incurred directly by the State. Do not include consultant/trainer travel costs. Add rows as needed.)					
Subtotal Direct Travel Costs						
Direct Equipment Costs				**Unit Cost**	**No.**	
	(Itemize equipment costs here. Individual expenses under $5,000 must be listed under supplies. Add rows as needed.)					
Subtotal Direct Personnel Costs						
Direct Supplies Costs				**Unit Cost**	**No.**	
	(Itemize supply costs here. Add rows as needed.)					
Subtotal Direct Personnel Costs						
Subtotal Direct Costs						
CONTRACTUAL COSTS						
Contractual Consultant/Trainer Costs				**Daily Rate**	**No. of Days**	
Rates	(Itemize contractual consultant/trainer costs here. Add rows as needed.)					
Travel	(Itemize consultant/trainer travel costs here. Add rows as needed.)					
Subtotal Contractual Consultant/Trainer Costs						
Contractual Media/Public Information Costs						
	(Itemize contractual media and public information costs here. Add rows as needed.)					
Subtotal Contractual Media/Public Information Costs						
Other Contractual Costs						
	(Itemize other contractual costs here. Add rows as needed.)					
Subtotal Other Contractual Costs						
Subtotal Contractual Costs						

Note: Fields marked with an * are required.

OTHER DIRECT COSTS		
Other Direct State Costs		
	(Itemize other direct State costs here. Add rows as needed.)	
Subtotal Other Direct State Costs		
	TOTAL CONTRACTUAL AND DIRECT COSTS:	

⤫⤫START: COPY AND PASTE SECTION FOR EACH SERVICE PROVIDER⤫⤫

***B. Individual Provider Budgets**

Complete an Individual Service Provider Budget for each service provider.

ISP Individual Service Provider Budget Summary

Name of service provider: _____

Disaster declaration number: FEMA–XXXX–DR–State

Designated areas: _____

Total people who would benefit from services: _____

Total FTE: _____

Budget Line Item	Interim Costs (costs incurred from date of incident to the application deadline—14 days following the declaration)	Projected Costs (costs from the immediate services application deadline to 60 days or last day of program)	Total Costs (add interim and projected costs)	In-Kind Costs (costs contributed to the project per agency)
Dates of Service				
Salaries and Wages				
Fringe ____%				
Subtotal Personnel Costs				
Travel				
Equipment				
Supplies				
Consultant/Trainer Costs				
Media/Public Information Costs				
Other Service Provider Costs				
Total Provider Costs (f.)[1]:				

[1]Letters in parentheses indicate the corresponding budget category on the SF–424a.

Note: Fields marked with an * are required.

*In the following table, include a detailed line-item narrative justifying costs. Complete a line-item narrative for each service provider. Please review the detailed guidance on the budget narrative included in the ISP Supplemental Instructions and the *Crisis Counseling Assistance and Training Program Guidance.*

ISP Line-Item Budget Narrative for the Individual Service Provider

Disaster declaration number: FEMA–XXXX–DR–State

Name of service provider: _____

Designated areas: _____

Total people who would benefit from services: _____

Total FTE: _____

Period of performance: _____

Budget Line Item	Item Description					Total Cost
PROVIDER COSTS						
Personnel Costs		**No. of FTE**	**Hours**	**Weeks**	**Rate**	
Salaries and Wages	(Itemize position titles from part IV.C.3. here. Add rows as needed.)					
Subtotal Salaries and Wages						
Fringe					%	
Subtotal Personnel Costs						
Travel Costs			**Miles**	**Weeks**	**Rate**	
	(Itemize travel types here; include estimated mileage rate, air, lodging, and per diem costs incurred directly by the State. Do not include consultant/trainer travel costs. Add rows as needed.)					
Subtotal Travel Costs						
Equipment Costs				**Unit Cost**	**No.**	
	(Itemize equipment costs here. Individual expenses under $5,000 must be listed under supplies. Add rows as needed.)					
Subtotal Equipment Costs						
Supplies Costs				**Unit Cost**	**No.**	
	(Itemize supply costs here. Add rows as needed.)					
Subtotal Supplies Costs						
Consultant/Trainer Costs				**Daily Rate**	**No. of Days**	
Rates	(Itemize contractual consultant/trainer costs here. Add rows as needed.)					
Travel	(Itemize consultant/trainer travel costs here. Add rows as needed.)					
Subtotal Contractual Consultant/Trainer Costs						

Note: Fields marked with an * are required.

Media/Public Information Costs		
	(Itemize contractual media and public information costs here. Add rows as needed.)	
Subtotal Contractual Media/Public Information Costs		
Other Service Provider Costs		
	(Itemize other service provider costs here. Add rows as needed.)	
Subtotal Other Service Provider Costs		
	TOTAL PROVIDER COSTS:	

⤫⤫END: COPY AND PASTE SECTION FOR EACH SERVICE PROVIDER⤫⤫