OMB Control Number: 1660-0085
Expiration Date: 3/31/2013
FEMA Form 003-0-1

Crisis Counseling Assistance and Training Program

Immediate Services Program Application

CCP Application Toolkit, Version 3.4
May 2012

PAPERWORK BURDEN DISCLOSURE NOTICE

Public reporting burden for this form is estimated to average 72 hours per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and submitting the form. This collection of information is required to obtain or retain benefits. You are not required to respond to this collection of information unless a valid OMB control number is displayed in the upper right corner of this form. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing the burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 1800 South Bell Street, Arlington VA 20598-3005, Paperwork Reduction Project (1660-0085). **NOTE: DO NOT SEND YOUR COMPLETED FORM TO THIS ADDRESS.**

PRIVACY ACT STATEMENT

AUTHORITY: Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended (42 U.S.C. § 5183).

PRINCIPAL PURPOSE(S): This information is being collected for the primary purpose of determining eligibility for the Crisis Counseling Assistance and Training Program, Regular Services Program funding following a Presidentially-declared disaster.

ROUTINE USE(S): The information on this form may be disclosed as generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended. This includes using this information as necessary and authorized by the routine uses published in DHS/FEMA – 004 Grant Management Information Files System of Records, 74 Fed. Reg. 39705 (August 7, 2009) and upon written request, by consent, by agreement, or as required by law.

DISCLOSURE: The disclosure of information on this form is voluntary; however, failure to provide the information requested may delay or prevent FEMA from providing the requested funding.

FEMA

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

Attention Grant Preparer

Please refer to the Immediate Services Program (ISP) Supplemental Instructions for detailed information for completing this application. You can find the ISP Supplemental Instructions in the Crisis Counseling Assistance and Training Program (CCP) Application Toolkit or by calling the Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center (SAMHSA DTAC) at 1-800-308-3515.

Please complete all footer notes with the corresponding disaster information.

Application Signature

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).

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

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

Needs Assessment Guidance

Use the Needs Assessment Formula Table to develop an estimate of the number of people who would benefit from services. Please refer to the following guidelines when completing the table:

1. Consult with your FEMA Program Specialist and Center for Mental Health Services (CMHS) Project Officer prior to completing the Needs Assessment Table.
2. Preliminary Damage Assessment (PDA):
    a. When available, you must use the PDA data in the table.
3. FEMA Individual Assistance (IA) Registration Numbers:
    a. IA data should be used only when PDA data are unavailable and requires prior approval from FEMA and CMHS.
    b. Use the "other" category to supply the IA data.
    c. Additional data should not be included when using IA numbers.
    d. Capture additional supporting information in the narrative.
    e. The Average Number of People per Household (ANH) multiplier is not to be used with IA numbers.
    f. The Traumatic Impact Risk Ratio to be used in the table should be 100%.
4. Estimated Number to be Served
    a. Primary Services—To determine the estimated number of people to be served through PRIMARY services, you may use a multiplier "between 20% and 80%." This number should be based on the nature and scope of the disaster and the capacity to address the need.
    b. Secondary Services—To determine the estimated number of people to be served through SECONDARY services, you may use a multiplier of "up to 100%."

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

A. CMHS Needs Assessment Formula—Estimated Crisis Counseling Needs

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

Date completed:_____

Complete a CMHS Needs Assessment Formula Table for each designated area to be covered by the grant. Use the following steps to complete the table:

1. Identify the number of people for each loss category from collected needs assessment information.
2. Identify any disaster- or region-specific "other"[1] 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 number of 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 Number of People Who Would Benefit from Services).
4. Add all of the results in the column of Total Number of People Who Would Benefit from Services to determine a sum for the number of people who would benefit from crisis counseling services.

Loss Category	Number of People		Household Size Multiplier[2] (ANH = 2.5)		Traumatic Impact Risk Ratio[3]		Total Number of 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.

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:

B. Estimated Number of People to Be Served Through Primary and Secondary Services

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

Date completed: _____

For each designated service area, complete the table of estimated number of people to be served (below). Use the following steps to complete the table:

1. For each Loss Category, list the Total Number of People Who Would Benefit from Services based on the CMHS Needs Assessment Formula table.
2. Identify a percent multiplier for primary services and a percent multiplier for secondary services. These multipliers indicate the percentage of people the program expects to actually serve out of the total number of people who would benefit from services in the designated area. Note that individuals may receive both primary and secondary services. Primary and secondary percent multipliers may vary according to the loss category. Please see the Needs Assessment Guidance on page 5 of this application for information on identifying Primary and Secondary Percent Multipliers.
3. To determine the estimated number of people to be served through primary services for each loss category, multiply the total number of people for each loss category by the primary percent multiplier: (Total Number of People Who Would Benefit from Services) X (Primary Percent Multiplier) = (Number of People To Be Served Through Primary Services).
4. To determine the estimated number of people to be served through secondary services for each loss category, multiply the total number of people for each loss category by the secondary percent multiplier: (Total Number of People Who Would Benefit from Services) X (Secondary Percent Multiplier) = (Number of People To Be Served Through Secondary Services).
5. Sum the column items of Number of People To Be Served to identify a total for each designated service area.

To determine the total number of people to be served, add all columns below.

Loss Category	Total Number of People Who Would Benefit from Services	Estimated Number of People To Be Served			
		Through Primary Services		Through Secondary Services	
		Primary Percent Multiplier	Number of People To Be Served	Secondary Percent Multiplier	Number of People To Be Served
Dead					
Hospitalized					
Nonhospitalized Injured					
Homes Destroyed					
Homes Major Damage					
Homes Minor Damage					
Disaster Unemployed					
Other 1 (Specify)					
Other 2 (Specify)					
TOTAL:					

Primary Services: Individual crisis counseling; group crisis counseling; assessment, referral, and resource linkage; community networking; basic supportive/educational contacts; and public education presentation/groups.

Secondary Services: Media/public service announcements, distribution of educational materials (including e-mail and Web sites).

Provide a rationale for estimating the total number of people to be served through primary and secondary services.

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

C. Summary of Geographic Areas and Initial Needs Assessment

Use the following steps to complete the chart below:

1. Complete a CMHS Needs Assessment Formula Table for each designated service area (see Part I.A.).
2. Complete the Table of Estimated Number of People To Be Served Through Primary and Secondary Services for each designated service area (see Part I.B.).
3. Using the information from each CMHS Needs Assessment Formula Table, fill in the first two columns of the chart below.
4. Using the totals from the Table of Estimated Number of People To Be Served Through Primary and Secondary Services, fill in the last two columns of the following chart. These totals should reflect the sum of the estimated number of people to be served through primary and secondary services in each designated service area.

Designated Service Area Name	Total Number of People Who Would Benefit from Services	Estimated Number of People To Be Served	
		Through Primary Services	Through Secondary 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 this application. Please include information on types of crisis counseling services and number of services provided. Enter “none” if no activities have been conducted to date.

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.

Additional comments, if any:

Part IV. Plan of Services

Complete the following Staffing Summary Table by entering information from the State and Provider Staffing Tables.

A. Staffing Summary Table

1. The State must complete a State Staffing Table (see Part IV.B.1.).
2. Each Provider must complete a Provider Staffing Table (see Part IV.C.2.).
3. Fill in the table below with FTE totals from the Staffing Plan Tables.
4. Identify the designated service areas that each provider will serve.

Note: The total Estimated Number of People To Be Served Through Primary Services in this table should equal the total identified in Part I.C. Summary of Geographic Areas and Initial Needs Assessment.

Service Provider Name	Estimated Number of People to be served through Primary Services	FTEs		Designated Service Areas
		Grant Funded	In-Kind	
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 Tables. The number of FTEs must also be included in each box, as well as the identification of any in-kind staff.
- 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 estimated number of people to be served through primary services.

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

Additional comments, if any:

B. State Staffing Plan

Please provide information on the State staffing plan. Include State leadership positions and include State service staff if the State is directly providing primary services

1. State Staffing Table

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

Date completed: _____

Type of State Staff	Grant Funded		Projected In-Kind	
	Number of Staff Members	Number of FTEs (based on 40 hours per week)	Number of Staff Members	Number of FTEs (based on 40 hours per week)
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.

2. Services and Strategies

Select the types of services furnished by the State. Please select Primary services only if the State is directly providing Primary services

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

How will you organize and deploy crisis counseling teams?

Describe your plan to reach 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.

Community stakeholders often include community mental health and substance abuse centers, schools, faith-based organizations, first responders, law enforcement, community-based cultural organizations, and local elected officials. With what organizations and community stakeholders will you network?

Additional comments, if any:

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

C. Provider Staffing Plan

1. Contact Information

Please provide information on each service provider and the project manager or 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

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

2. Provider Staffing Table

Service provider name:_____

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

Date completed:_____

Type of Staff	Grant Funded		Projected In-Kind	
	Number of Staff Members	Number of FTEs (based on 40 hours per week)	Number of Staff Members	Number of FTEs (based on 40 hours per week)
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.

3. Services and Strategies

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

How will you organize and deploy crisis counseling teams?

Describe your plan to reach 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.

Community stakeholders often include community mental health and substance abuse centers, schools, faith-based organizations, first responders, law enforcement, community-based cultural organizations, and local elected officials. With what organizations and community stakeholders will you network?

Additional comments, if any:

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

D. Program Management Plan

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.

Data collection and 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). These tools are available in *Evaluating and Monitoring the Reach, Quality, and Consistency of Crisis Counseling Programs Manual and Toolkit*, which is included with the application materials packet that SAMHSA DTAC sends to States, and through the CCP Online Data Collection and Evaluation System.

☐ 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 include in Part IV.B.1–2. detailed information concerning the direct services it will provide.

Additional comments, if any:

E. 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	Role
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:

F. Training

Note: Enter only people who are trainers; list consultants in the previous section (E). 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@samhsa.hhs.gov). The approved trainers must then be listed in the table below.

Trainers

Trainer Name	Agency/Organization Affiliation	FEMA/CMHS Approved	Attended CCP Training of State Trainers
Trainer 1			
Trainer 2			
Trainer 3			

Training Schedule

Type of Training	Date	Trainer	Location	Target Audience
[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.

Additional comments, if any:

G. Facilities

Is the State or are service providers providing office space as an in-kind contribution to the project?

☐ Yes ☐ No

If no, please provide justification for leasing office space.

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 in the *Crisis Counseling Assistance and Training Program Guidance*.

A. Budget Summary Table (Includes State and Provider Costs)

ISP Budget Summary				
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 ISP application deadline—day 15 to day 60—a 45-day period)**	**Total Costs (add interim and projected costs)**	**In-Kind (funds contributed by the SMHA)**
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				
Provider 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 SF–424a. Costs covered directly by the State and not contracted must be included in Other Direct State Costs (h.)

B. Budget Narrative Table (Includes State and Provider Costs)

In the following table, include a detailed line-item narrative for the projected period (45 days). Please review the detailed guidance on the budget narrative included in the ISP Supplemental Instructions and in the *Crisis Counseling Assistance and Training Program Guidance*.

In addition to entering itemized costs, please enter a detailed narrative justification for all line-items at the end of each budget table.

Detailed ISP Line-Item Budget Narrative/Justification—Projected Costs

Budget Line Item	Item Description					Total Cost
Direct Costs						
Direct Personnel Costs		**No. of FTE**	**Hours**	**Days (45)**	**Rate**	
Salaries and Wages	(Itemize position titles from Part IV.B.1. here. Add rows as needed. Key staff are expected at .5 FTEs and above.)					
Subtotal Salaries and Wages						
Fringe	(Itemize all benefits included in fringe here. Typical examples are health insurance and unemployment insurance.)			%		
Subtotal Direct Personnel Costs						
Direct Travel Costs			**Miles**	**Days (45)**	**Rate**	
	(Itemize travel types here; include estimated mileage rate, air, lodging, and per diem costs incurred directly by the State. The State assures that the mileage rate is usual and customary. Do not include consultant/trainer travel costs. Add rows as needed.)					
Subtotal Direct Travel Costs						
Direct Equipment Costs				**Unit Cost**	**No. of Units**	
	(Itemize equipment costs here. Individual expenses under $5,000 must be listed under supplies. Add rows as needed.)					
Subtotal Direct Equipment Costs						
Direct Supplies Costs				**Unit Cost**	**No. of Units**	
	(Itemize supply costs here. Add rows as needed.)					
Subtotal Direct Supplies 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						

Budget Line Item	Item Description		Total Cost
Contractual Media/Public Information Costs			
	(Itemize contractual media and public information costs here. Add rows as needed.)		
Subtotal Contractual Media/Public Information Costs			
Provider Contractual Costs			
	(Itemize provider contractual costs here. Add rows as needed.)		
Subtotal Provider Contractual Costs			
Subtotal Contractual Costs			
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:	
Add narrative budget justification here.			

Optional Interim Budget Narrative (Includes State and Provider Costs)

If applying to be reimbursed for interim costs, include a detailed line-item narrative in the following table. Please review the detailed guidance on interim costs included in the ISP Supplemental Instructions and in the *Crisis Counseling Assistance and Training Program Guidance*.

In addition to entering itemized costs, please enter a detailed narrative justification for all line-items at the end of each budget table.

ISP Line-Item Budget Narrative—Interim Costs (Optional)

Budget Line Item	Item Description					Total Cost
Direct Costs						
Direct Personnel Costs		**No. of FTE**	**Hours**	**Days**	**Rate**	
Salaries and Wages	(Itemize position titles from Part IV.B.1. here. Add rows as needed. Key staff are expected at .5 FTEs and above.)					
Subtotal Salaries and Wages						
Fringe	(Itemize all benefits included in fringe here. Typical examples are health insurance and unemployment insurance.)			%		
Subtotal Direct Personnel Costs						
Direct Travel Costs			**Miles**	**Days**	**Rate**	
	(Itemize travel types here; include estimated mileage rate, air,					

	lodging, and per diem costs incurred directly by the State. The State assures that the mileage rate is usual and customary. Do not include consultant/trainer travel costs. Add rows as needed.)				
Subtotal Direct Travel Costs					
Budget Line Item	**Item Description**				**Total Cost**
Direct Equipment Costs			**Unit Cost**	**No. of Units**	
	(Itemize equipment costs here. Individual expenses under $5,000 must be listed under supplies. Add rows as needed.)				
Subtotal Direct Equipment Costs					
Direct Supplies Costs			**Unit Cost**	**No. of Units**	
	(Itemize supply costs here. Add rows as needed.)				
Subtotal Direct Supplies 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					
Provider Contractual Costs					
	(Itemize provider contractual costs here. Add rows as needed.)				
Subtotal Provider Contractual Costs					
Subtotal Contractual Costs					
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:					

Add narrative budget justification here.

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

C. Individual Provider Budgets

Complete an Individual Service Provider Budget for each service provider.

ISP Individual Service Provider Budget Summary

Name of service provider:_____

Designated areas:_____

Total estimated number to be served through primary services:

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 ISP application deadline—day 15 to day 60—a 45-day period)	Total Costs (add interim and projected costs)	In-Kind (funds contributed by the provider)
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 SF–424a.

In the following table, include a detailed line-item narrative for the projected period (45 days). Please review the detailed guidance on the budget narrative included in the ISP Supplemental Instructions and in the *Crisis Counseling Assistance and Training Program Guidance*.

In addition to entering itemized costs, please enter a detailed narrative justification for all line-items at the end of each budget table.

ISP Line-Item Budget Narrative for the Individual Service Provider—Projected Costs

Name of service provider:_____

Designated areas:_____

Total estimated number to be served via primary services:

Budget Line Item	Item Description					Total Cost
PROVIDER COSTS						
Personnel Costs		**No. of FTE**	**Hours**	**Days (45)**	**Rate**	
Salaries and Wages	(Itemize position titles from Part IV.C.2. here. Add rows as needed.)					
Subtotal Salaries and Wages						
Fringe	(Itemize all benefits included in fringe here. Typical examples are health insurance and unemployment insurance.)			%		
Subtotal Personnel Costs						
Travel Costs			**Miles**	**Days (45)**	**Rate**	
	(Itemize travel types here; include estimated mileage rate, air, lodging, and per diem costs incurred directly by the provider. Do not include consultant/trainer travel costs. Add rows as needed.)					
Subtotal Travel Costs						
Equipment Costs				**Unit Cost**	**No. of Units**	
	(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. of Units**	
	(Itemize supply costs here. Add rows as needed.)					
Subtotal Supplies Costs						

Budget Line Item	Item Description			Total Cost
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				
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:	
Add narrative budget justification here.				

Optional Interim Provider Budget Narrative

If applying to be reimbursed for interim costs, include a detailed line-item narrative in the following table. Please review the detailed guidance on interim costs included in the ISP Supplemental Instructions and in the *Crisis Counseling Assistance and Training Program Guidance*.

In addition to entering itemized costs, please enter a detailed narrative justification for all line-items at the end of each budget table.

ISP Line-Item Budget Narrative for the Individual Service Provider—Interim Costs (Optional)

Name of service provider:_____

Designated areas:_____

Total estimated number to be served via primary services:_____

Budget Line Item	Item Description					Total Cost
PROVIDER COSTS						
Personnel Costs		**No. of FTE**	**Hours**	**Days**	**Rate**	
Salaries and Wages	(Itemize position titles from Part IV.C.2. here. Add rows as needed.)					
Subtotal Salaries and Wages						
Fringe	(Itemize all benefits included in fringe here. Typical examples are health insurance and unemployment insurance.)				%	
Subtotal Personnel Costs						
Travel Costs			**Miles**	**Days**	**Rate**	
	(Itemize travel types here; include estimated mileage rate, air, lodging, and per diem costs incurred directly by the provider. Do not include consultant/trainer travel costs. Add rows as needed.)					
Subtotal Travel Costs						
Equipment Costs				**Unit Cost**	**No. of Units**	
	(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. of Units**	
	(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						
Budget Line Item	**Item Description**					**Total Cost**
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:						

Add narrative budget justification here.

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