Application for TCAPES PSYCHIATRY CONSULTATION PROJECT

Attachment 1

<u>APPLICANT INFORMATION</u>

Applicants must complete all questions on page 1 and 2.

1. Legal name of applicant as it appears on its corporate charter: _____

2. Federal tax ID Number: _____

3. Is your organization a registered vendor with the State? Yes ____   No____

   (If No, please contact Angela.Okonji@tn.gov for registration details)

4. Organization contact information:

   Organization's Primary Mailing Address: _____

   _____

   Telephone Number: _____

5. Primary Contact Person Name and Title: _____

   Email Address: _____   Phone Number: _____

6. Secondary Contact Person Name and Title: _____

    Email Address: _____   Phone Number: _____

7. If awarded a grant, who will be the authorized signor of the resulting contract?

   Name and Title: _____

   Email Address: _____   Phone Number: _____

   _____

8. Please check ONE of the following as it applies to this application.

   ☐ We have reviewed the Sample Contract with legal counsel and can identify no
   objections to executing this contract in its present form.

   ☐ We have reviewed the Sample Contract with legal counsel and will request
   changes to the Sample Contract (please attach details). We understand that
   exceptions to boilerplate contract language may not be approved and may result
   in the rejection of this application.

APPLICATION

1.   Please attach a project narrative using the outline provided in Exhibit 1 (no more than 3 pages).

2.   Please complete Exhibit 2 (provided) describing the specific goals, activities and timeline for the project.

3.   What specific plans have you made to partner with other groups or organizations to accomplish your objectives?

4.   Please complete Attachment 3 which is the 2-page budget form for your project.

The applicant certifies to the best of his/her knowledge and belief that the information in this application has been duly authorized by the governing body of the applicant and that the applicant will comply with the certifications and assurances required of applicants if a grant is awarded. **DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO BIND THE PROPOSING ENTITY.**

Name: _____   Title: _____

Signature: _____Date: _____

Exhibit 1

TCAPES Psychiatry Consultation Expansion Project Narrative (maximum of 2 pages)

Applicants must write a narrative addressing the topics below. When writing your narrative, please use the headings in bold in the same order they are listed below.

1. **Organizational capacity and staffing**: Describe your organization's capacity to complete the project objectives and activities. Describe the experience and qualifications of the staff who will be involved in the project.

2. **Prior Experience**: Describe your organization's experience with psychiatry tele-consultations and how it will be used for this project. Does your organization have experience managing a mental health consult line?

3. **Project goals:** What are the goals of the project?

4. **Outreach to Community Pediatric Providers**: Describe your organization's prior experience with conducting outreach to community pediatric providers. How will your organization sustain pediatric provider involvement and use of the consult line?

5. **Local Mental Health and Community Resources:** Describe your organization's experience with compiling information about local mental health and community resources. Describe your organization's experience with developing a mechanism for referring patients to resources.

6. **Data Collection**: Describe your organization's experience with data collection on referrals and/or consultations. Please describe experience with REDCap, if applicable.

Exhibit 2

Project Goals/Activities/Timeline /Outcomes Template. Proposals should include goals and activities related to the TCAPES Psychiatry Consultation Expansion Project. Please be as specific as possible with goals and activities. Add additional goals as needed.

Description of Goals and Activities to Achieve Goals	Person/ Agency Responsible	Start Date	End Date	Description of *Expected* Outcomes/Impact
GOAL # 1				
1. Activity				
2. Activity				
3. Activity				
GOAL # 2				

1. Activity				
2. Activity				
3. Activity				
GOAL # 3				
1. Activity				
2. Activity				
3. Activity				