Tennessee

UNIFORM APPLICATION
FY 2026/2027 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 07/08/2026 4.16.14 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2027
End Year	2028

State Unique Entity Identification

Unique Entity ID	KNUHYRCNLJC5

I. State Agency to be the Grantee for the Block Grant

Agency Name	Tennessee Department of Mental Health and Substance Abuse Services
Organizational Unit	Division of Planning, Policy and Legislation
Mailing Address	5th Floor Andrew Jackson Building 500 Deaderick Avenue
City	Nashville
Zip Code	37243

II. Contact Person for the Grantee of the Block Grant

First Name	Marie
Last Name	Williams
Agency Name	Tennessee Department of Mental Health and Substance Abuse Services
Mailing Address	6th Floor Andrew Jackson Building 500 Deaderick Street
City	Nashville
Zip Code	37243
Telephone	615-253-3049
Fax	
Email Address	Marie.Williams@tn.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	7/2/2026 9:54:20 AM

VI. Contact Person Responsible for Application Submission

First Name	Avis
Last Name	Easley

Telephone 615-253-6397
Fax
Email Address Avis.Easley@tn.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2027

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Marie Williams, LCSW

Signature of CEO or Designee[1]: _____

Title: TDMHSAS Commissioner

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Marie Williams, LCSW

Signature of CEO or Designee[1]:

Title: TDMHSAS Commissioner

Date Signed: 6.24.26

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Marie Williams, LCSW

Title

TDMHSAS Commissioner

Organization

Tennessee Department of Mental Health and Substance Abuse Services

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

This form is not applicable.

Planning Tables

Table 2: MHBG Planned State Agency Budget for SFY2027

States are asked to present their projected one-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027).

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2026 Planning Period End Date: 6/30/2027

Activity	Source of Funds						
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Use Disorder Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children (PWWDC)							
b. All Other							
2. Recovery Support Services							
3. Primary Prevention							
4. Early Intervention Services for HIV							
5. Tuberculosis Services							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[a]		$2,197,300.00		$0.00	$326,000.00		
7. State Hospital			$35,470,900.00	$2,840,700.00	$157,651,550.00	$0.00	$2,863,105.00
8. Other Psychiatric Inpatient Care			$132,549,508.00	$0.00	$8,291,600.00		
9. Other 24-Hour Care (Residential Care)		$4,959,003.00	$52,246,019.00	$0.00	$25,793,258.00		
10. Ambulatory/Community Non-24 Hour Care		$9,422,635.00	$384,141,793.00	$16,064,744.00	$137,227,450.00		
11. Crisis Services (5 percent set-aside) Set Aside[b]		$1,317,530.00	$21,190,968.00	$6,656,144.00	$29,507,779.00		
12. Other Capacity Building/Systems Development							
13. Administration[c]		$894,823.00	$405,600.00	$535,500.00	$20,936,133.00		
14. Total		**$18,791,291.00**	**$626,004,788.00**	**$26,097,088.00**	**$379,733,770.00**	**$0.00**	**$2,863,105.00**

[a] Row 6 in Column B: per statute, states are required to set-aside 10 percent of the total MHBG award for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[b] Row 11 in Column B: per statute, states are required to set-aside 5 percent of the total MHBG award for Behavioral Health Crisis Services (BHCS) programs.

[c] Per statute, administrative expenditures for the MHBG cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned SFY 2027 budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 12-month period (for most states, it is July 1, 2026 - June 30, 2027).

Planning Period Start Date: 7/1/2026 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	$4,959,003.00
1b. Crisis Services for Adults	$1,317,530.00
1c. CSC/ESMI program for Adults	$0.00
1d. Other outpatient/ambulatory services for Adults	$1,716,428.00
1e. *Other Direct Services for Adults	$0.00
2. Subtotal of Services for Adults	$$7,992,961.00
3. Services for Children	
3a. EBPs for Children	$2,934,042.00
3b. Crisis Services for Children	$0.00
3c. CSC/ESMI program for Children	$2,197,300.00
3d. Other outpatient/ambulatory services for Children	$3,824,535.00
3e. *Other Direct Services for Children	$0.00
4. Subtotal of Services for Children	$$8,955,877.00
5. Other Capacity Building/Systems Development	$947,630.00
6. Administrative Costs	$894,823.00
7. *Any Other Cost	$0.00
8. Total MHBG Allocation[c]	**$$18,791,291.00**

Please provide brief explanation for services with an asterisk* below:

[a]This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6 for a 12 month period.

[b]Administrative Costs should not exceed 5 percent of total MHBG allocation.

[c]The total budget should be equal to your MHBG allocation for the FY2027 12 month period.

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan Table 6 address MHBG funds to be expended on other capacity building /systems development activities during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027). Please use these columns to capture how much the state plans to expend over a 12-month period.

MHBG Planning Period Start Date: 07/01/2026 MHBG Planning Period End Date: 06/30/2027

Activity	FFY 2026 MHBG[1]	FFY 2026 BSCA Funds[2]	FFY 2027 MHBG[3]
1. Information Systems			$0.00
2. Infrastructure Support	$2,530,402.00	$105,508.00	$1,265,201.00
3. Partnerships, Community Outreach, and Needs Assessment			$0.00
4. Planning Council Activities	$982,800.00		$491,379.00
5. Quality Assurance and Improvement	$1,732,088.00	$70,441.00	$866,044.00
6. Research and Evaluation			$0.00
7. Training and Education	$2,275,899.00	$571,073.00	$1,073,630.00
8. Total	**$7,521,189.00**	**$747,022.00**	**$3,696,254.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

[3] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [**July 1, 2026 – June 30, 2027**, for most states].

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care (CSC)	7.00
Multi-Family Group (MFG)	7.00
Transition to Independence (TIP) Model	7.00
Cognitive Behavioral Therapy for Psychosis (CBTp)	7.00

Recovery-Oriented Cognitive Therapy (CT-R)	7.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
	2,092,600.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Currently, Medicaid does have bundled case rates, but other insurance companies in TN do not cover ESMI/FEP bundle rates. The First-Episode Psychosis Initiative (FEPI) program sites exhaust all billing sources, including Medicaid when applicable, before billing the grant. FEPI program sites can bill Medicaid and other insurance for billable service components of the coordinated specialty care model. Program sites can bill insurance for therapy, case management, medication, and peer-related services. If a program participant does not have insurance, FEPI sites will screen and enroll eligible participants in the Behavioral Health Safety Net (BHSN), a TDMHSAS grant program providing essential outpatient mental health services to uninsured Tennesseans. BHSN can pay for FEPI services such as psychiatric medication management, individual and group therapy, peer support services, and case management.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

Coordinated Specialty Care (CSC)/OnTrack teams also utilize the Individual Placement and Support (IPS) model for supported employment and education, as well as peer support through Certified Peer Recovery Specialists (CPRSs)/Certified Young Adult Peer Support Specialists (CYAPSSs). TDMHSAS has expanded its grant contracts from four to six providers. Each program site implements the OnTrackNY CSC evidence-based model for structuring the program for youth and young adults experiencing their first episode of psychosis. In addition to the CSC evidence-based practice, each program site utilizes the Individual Placement and Support (IPS) model for supported employment and education services. Each program site also offers peer support services through the Certified Peer Recovery Specialists and Certified Young Adult Peer Support Specialists Programs. TDMHSAS has implemented programs across various regions of the state. Alliance Healthcare Services provides FEPI programming in Shelby County, and Carey Counseling Center, Inc. offers FEPI programming in rural northwest Tennessee across seven counties, including Lake, Obion, Weakley, Henry, Benton, Carroll, and Gibson. Mental Health Cooperative (MHC) provides services in Davidson County, and Helen Ross McNabb Center provides FEPI programming in Knox, Blount, Loudon, Monroe, and Hamilton counties. Each OnTrackTN program team is provided with opportunities for further training in youth and young adult engagement (e.g., the Transition to Independence Process (TIP) model) through the TDMHSAS Training & Technical Assistance Center (TTAC). The TDMHSAS collaborates with Alliance Healthcare Services to provide a Critical High Risk for Psychosis Program, aimed at assisting youth and young adults aged 12 to 24. This program serves young individuals in Shelby County who are at risk for psychosis by using a STEP Care Model Approach, which is similar to the evidence- based practice known as Coordinated Specialty Care (CSC). The program incorporates the Individual Placement and Support (IPS) model to offer supported employment and educational services. Additionally, it provides peer support services through the CPRS and CYAPSS Programs. Other services available at the program site include medication management, case management, and individual therapy. The program also maintains a relationship with the FEPI program at Alliance, ensuring that young people experiencing their first episode of psychosis receive coordinated care.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

TDMHSAS contracts with Park Center to employ a statewide trainer who provides training, technical assistance, and fidelity monitoring to CSC/OnTrackTN teams across the state. To ensure the promotion of evidence-based best practices with individuals with ESMI, the statewide trainer collaborates with OnTrackUSA for ongoing training and consultation. Currently, TDMHSAS collects a Quarterly Program Report from each OnTrackTN program that tracks data on items such as staffing, outreach and engagement activities, team meetings, numbers served, etc. In addition, TDMHSAS collects semi-annual client-level data pulled from Admission, Follow-Up, and Discharge Forms that capture items such as education and employment status, hospitalizations, global functioning, medication side effects, services received, etc. TDMHSAS develops semi-annual reports based on this data. The state has developed a fidelity scale to determine each OnTrackTN team's adherence to the Coordinated Specialty Care model. Since the program's inception, OntrackTN has provided FEPI services to 754 Youth and Young Adults with psychosis-related concerns across 22 counties. In FY2025, clients enrolled in the FEPI program reported an 81% increase in employment among participants and a decrease in hospitalization days from 1,243 days at admission to 269 days at the most recent follow-up.

In addition to FEPI program sites providing services to young people with psychosis across the state, the First Episode Psychosis Statewide Trainer played a key role in workforce development and program support. The trainer hosted eight (8) trainings in collaboration with national psychosis consultants, reaching ninety-five (95) mental health providers and building capacity in early psychosis care across Tennessee. To further support program fidelity and implementation, the trainer conducted one-hundred forty (140) consultation and technical assistance calls with First Episode Psychosis teams, strengthening the delivery of evidence-based practices statewide.

Additionally, the trainer led three trainings for sixty-six (66) mental health providers from partner agencies not specialized in psychosis, helping to expand awareness and understanding of psychosis beyond specialty programs. These efforts occurred throughout FY25 and into the FY26 reporting period, contributing to the continued growth and effectiveness of early psychosis services in Tennessee.

8. Please describe the planned activities in FY2027 for your state's ESMI programs.

The goal for Tennessee's FEPI program for FY2026-FY2027 is to expand services into a true continuum of care for early psychosis across our existing FEPI program sites. A central component of this plan is broadening the age criteria to serve individuals ages 12–30, allowing teams to reach and potentially enroll more young people who are at clinical high risk for psychosis and provide earlier, more comprehensive support. To achieve this, we will increase evidence-based training for FEPI teams, cross-train more therapists within partner agencies in early psychosis care, and train organizations with tools such as the Structured Interview for Psychosis-Risk Syndromes (SIPS) assessment, which will assess the eligibility potential of a young person at clinical high risk for psychosis. In addition, FEPI teams will participate in ongoing learning collaboratives such as the Beck Institute to implement Recovery-Oriented Cognitive Therapy (CT-R), a proven approach that fosters recovery among individuals experiencing psychosis. The program will also continue to strengthen its partnerships with national leaders in first-episode psychosis and evidence-based practice, including OnTrack NY, The PIER Institute, and the STARS Training Academy, to ensure program fidelity and alignment with early psychosis best-practice standards. The FEPI programs will also expand TDMHSAS evaluation procedures by developing more robust data-collection metrics and engaging national consultants to learn strategies for braiding funding resources to support long-term sustainability. These efforts are designed to increase enrollment across the state, improve the quality of care, reduce hospitalizations, strengthen psychosis symptom reduction, and ultimately build a sustainable early psychosis continuum of care that meets the needs of young people and families throughout Tennessee.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

Be between fifteen through thirty (15-30) years of age; Be currently living physically present in Davidson, Shelby, Benton, Carroll, Gibson, Henry, Lake, Obion, Weakley, Knox, Anderson, Montgomery, Hamilton Blount, Loudon, and Monroe Counties, currently have, or anytime in the past twenty four (24) months had, a diagnosable psychosis spectrum condition including schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, or other serious mental illness that warrants psychosis interventions such as depression with psychosis, bipolar disorder with psychosis, or others that meet diagnostic criteria in the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5), or more current edition.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

Using the most recent U.S. Census population estimate for Tennessee (2024 population estimate: 7,227,750), the estimated incidence for Tennessee is approximately 2,168 individuals, based on an estimated incidence rate of 0.0003.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

The FEPI will continue to provide outreach, educational awareness, and engage those at clinical high risk for psychosis or experiencing psychosis by providing awareness and education to the general public and community partners. Program sites will continue monthly outreach to private mental health practitioners, school systems, primary care doctors, hospitals, and crisis units. In addition, the first episode psychosis initiative will continue its cross-collaboration and referral system with other youth and young adult-serving programs across TN.

12. Please indicate area of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an Advisory: **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

TDMHSAS contracts with twelve community behavioral health providers to provide mobile crisis and crisis hotline services. Tennessee has a vast statewide crisis system, with 24-hour crisis line services, that reached over 112,000 individuals in fiscal year 2025.

Each contracted agency operates a local crisis hotline and provides mobile crisis services.
Services provided local crisis provider responder lines, include "live" answering by qualified and trained crisis triage personnel within three (3) minutes, telephonic crisis assessment, intervention, and triage. All crisis call centers are required to be adequately staffed to respond in "real time

to meet the needs of the population served.

Tennessee's 988 Network is comprised of eight (8) crisis call centers across the state. Four include state-contracted crisis services providers, and the remaining providers are not crisis services providers. Funds from the MHBG 5% set-aside continue to support the TN 988 Network in efforts to improve the infrastructure needed for 988 implementation. TN 988 centers will continue to contract with TDMHSAS through this funding to maintain staffing capacity, increase call handle rates, and enhance service monitoring. All funds from the MHBG 5% crisis set aside support the TN 988 Network in efforts to continue these improvements.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☐	☑

3. Briefly explain your stages of implementation selections here.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) directly funds, supports, and oversees the Tennessee Statewide Crisis Services System. This continuum includes local provider crisis lines, adult mobile crisis response, children and youth mobile crisis response, walk-in centers (WICs), which also offer 23-hour observation services, crisis stabilization units (CSUs), crisis respite, and follow-up services. Tennessee's Crisis Services Continuum comprises a comprehensive array of services designed to support eligible individuals experiencing a behavioral health crisis. These services aim to address immediate needs in the least restrictive, most appropriate setting, with the goal of alleviating or stabilizing symptoms while enhancing support systems and coping skills. This approach enables individuals to remain safely in their communities during and after a crisis. The full continuum, consisting of crisis call centers, mobile crisis response services, crisis WICs, and CSUs, is available statewide. All four components are currently considered to be in the Program Sustainment stage.

Someone to talk to: TDMHSAS contracts with twelve community behavioral health providers who provide crisis hotline services and mobile crisis response. Tennessee has a vast statewide crisis hotline system reaching over 112,897 individuals in the state fiscal year 2025.

Services provided as the local crisis provider lines, include "live" answering by qualified and trained crisis triage personnel within three (3) minutes, telephonic crisis assessment, intervention, and triage.

Tennessee's 988 Network is comprised of eight (8) crisis call centers across the state. Four include state-contracted crisis services providers, and the remaining providers are not crisis services providers. Funds from the MHBG 5% set-aside continue to support the TN 988 Network's improvement efforts across the state of TN. TN 988 centers will continue to contract with TDMHSAS through this funding to maintain staffing capacity, increase call answer rates, enhance service monitoring, and strengthen the chat/text workforce. All funds from the MHBG 5% crisis set-aside support the TN 988 Network in its efforts to continue these improvements.

All twelve crisis hotline service providers, along with all eight (8) 988 service providers, have crisis follow-up protocols in place. At present, TDMHSAS is unable to gather data on the total percentage of mental health-related calls made to the 911 system.

Someone to respond: TDMHSAS contracts with twelve (12) community behavioral health providers to operate adult, and children and youth mobile crisis services. These services are non-hospital, community-based interventions available twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) for behavioral health illnesses, crisis situations, or perceptions of crisis situations. Services can be accessed by calling 988.

Adult Mobile Crisis Services are provided to adults who are eighteen (18) years of age and older, while Children and Youth Mobile Crisis Services serve individuals ages 17 years of age and younger. Four (4) regional Children and Youth Mobile Crisis Response Teams provide statewide coverage across 95 Tennessee counties. The scope of services and deliverables in the department's grant contracts with the community providers is a response time of two (2) hours or less for at least 90% of the crisis calls that necessitate a mobile crisis team response. For calls originating from local schools, the state standard for response time is one (1) hour.

Both the Adult and the Children and Youth's Mobile Crisis Services are fully implemented and currently in the Program Sustainment stage. These services are supported through a combination of state appropriations and TennCare (Tennessee's Medicaid authority) funding. All Mobile Crisis teams incorporate peer support specialists in various roles to enhance the delivery and effectiveness of crisis services.

Crisis Walk-in Triage Services include assessment and evaluation; early intervention; prevention; stabilization; referral(s) to appropriate behavioral health services; and follow-up care. Individuals may be maintained in the WIC pending final disposition to the recommended level of care. All eleven (11)WICs also provide 23-hour observation services as appropriate. CSUs are licensed by the State to offer (24/7/365) intensive, short- term stabilization and behavioral health treatment. Currently, there are fourteen (14) CSUs across the state, offering a total of one hundred and sixty-one (161) beds for adults and forty-two (42) beds for children and youth. To expand access to these critical services, TDMHSAS will be adding one (1)new WIC/CSUs to further strengthen the statewide availability of community stabilization services.

Tennessee crisis services providers operate eleven (11)Crisis WICs, which are non-hospital, facility-based programs affiliated with each of the State -licensed CSUs. The WIC/CSUs operate twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) and serve as entry points for individuals experiencing symptoms of a behavioral health condition or crisis.

Crisis Walk-in Triage Services include assessment and evaluation; early intervention; prevention; stabilization; referral(s) to appropriate behavioral health services; and follow-up care. Individuals may be maintained in the WIC pending final disposition to the recommended level of care. All ten (11) WICs also provide 23-hour observation services as appropriate. CSUs are licensed by the State to offer (24/7/365) intensive, short- term stabilization and behavioral health treatment. Currently, there are fourteen (14)CSUs across the state, offering a total of one hundred and sixty-one (161) beds for adults, forty-two (42)beds for children and youth. To expand access to these critical services, TDMHSAS will be adding one (1) new WIC/CSUs to further strengthen the statewide availability of community stabilization services.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

TDMHSAS initiated the development of the state's crisis system in 1991 by implementing crisis call lines and mobile crisis services, providing statewide coverage across all 95 counties for children, youth, and adults. In 2008, the continuum of crisis services was expanded to include Walk-In Centers, Crisis Stabilization Units, and Respite services.

In Fiscal Year 2022, TDMHSAS began formally supporting the national 988 Suicide & Crisis Lifeline system through recurring funding from the Mental Health Block Grant. As of June 1, 2022, this support was further bolstered by funding from the SAMHSA.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 8
   ii. Not in the suicide lifeline network: 4

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 8
   ii. Not in the suicide lifeline network: 4

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 0

b. Integrated with public safety first responder structures (police, paramedic, fire): 0

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 0

b. Number of Emergency Departments that operate a specialized behavioral health component: 0

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 11

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The crisis set aside is used to enhance Tennessee's 988 Network. Funds from the MHBG 5% crisis set-aside support the TN 988 Network in efforts to improve and expand infrastructure, while enabling ongoing data collection to identify service gaps and ongoing needs. TDMHSAS helps support funding for the eight Tennessee National Suicide Prevention Lifeline Center Network providers. Funding is primarily for supporting

staffing needs at these agencies. Each call center has identified counties of service where they are designated as the “primary” call center. If the primary call center does not answer within a certain time, the call is routed to a “backup” 988 center in Tennessee. There has been an emphasis in the improvement grants on maintaining a 90% in-state answer rate, and grants have supported additional staffing to handle the increased call volume. If a call is not answered by the state primary or back-up center, then the call goes to a national backup center.

Through the 988 Improvement Grants, Tennessee has prioritized strengthening the state's 988 chat and text response. Currently, the state has four chat/text centers. One center is 24/7, two centers are funded for 3 FTEs, and one center has 1 FTE to manage 988 chat/text across Tennessee. If one of the four chat/text centers does not have the capacity to respond to a chat/text message, it is routed to a 988 national backup center.

There are currently two funding sources that support 988 programming, with a focus on supporting 988 centers. The first is a recurring set -aside from the Community Mental Health Services Block grant. Additionally, Tennessee received a federal SAMHSA Cooperative Agreement that provides recurring funds to support the same 988 centers. This federal agreement also includes funds for statewide evaluation. Funds from these two sources are focused on supporting the enhanced infrastructure, data collection and service evaluation for the 988 centers in Tennessee.

7. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

Once the DRAFT documents of the Mental Health and Substance Abuse Block Grants, both applications and reports, are completed, they are shared with the seven Regional Planning and Policy Councils (RPPCs) and the Statewide Planning and Policy Council (SPPC) for review with the opportunity to ask questions and make recommendations.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — ○ Yes ◉ No

b. State Report — ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) oversees seven RPPCs across the state. The RPPCs meet quarterly to advocate for and discuss the needs of Tennesseans and their family members diagnosed with mental health, substance use, and co-occurring disorders (CODs). Membership and meetings are open to the public and, per T.C.A. §33-2-203, are required to provide citizen participation in policy planning and to be representative of service recipients and their families, advocates for children, adults, and the elderly, service providers, agencies, and other affected persons and organizations. The RPPCs participate in an annual needs assessment that helps to guide the Department's Three-Year Plan, which is updated annually with input from the RPPCs.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The TDMHSAS Statewide and Regional Planning and Policy Council system serves as a formal advisory structure to help the Department plan, evaluate, and improve Tennessee's behavioral health system. The Council's duties include advising TDMHSAS on needs across the service system, policy development, legislative proposals, budget requests, system evaluation, and monitoring. Under Tennessee law, the Statewide Council advises the Commissioner on plans and policies for the service system and Department programs, recommends legislation and appropriations to the General Assembly, advocates for and publicizes those recommendations, and makes known the needs of people with mental health conditions, children and youth with serious emotional disturbance, people with substance use disorders, and their families.

The Council gathers meaningful input through its broad membership and annual planning processes. The Planning and Policy

Councils are composed of behavioral health providers, community partners, people receiving services, family members, and advocates, and their mission is to advise the Department on the service system, policy, legislation, budget requests, system evaluation, and monitoring. State law also requires that at least a majority of the Statewide Council's membership consist of current or former service recipients and family members of service recipients, ensuring that people with lived experience and families have a central voice in planning and policy discussions.

Meaningful input is also gathered through the annual Needs Assessment process. Each spring, the seven Regional Planning and Policy Councils, the Statewide Council's Adult and Children's Committees, and the advisory board for people with lived experience independently identify and prioritize mental health and substance use needs. These priorities are supported by data, compiled into a Needs Assessment summary, shared with TDMHSAS leadership, and used to inform the Department's Three-Year Plan. Participants include people receiving services, people with lived experience, family members, caregivers, advocates, service providers, and other community partners. Public comment is also permitted at Statewide Council meetings without prior notice, and meeting notices and minutes are made available through TDMHSAS processes.

The Council has advocated for people with serious mental illness and children and youth with serious emotional disturbance by elevating their needs in formal recommendations, needs assessments, reports, and policy discussions. Its statutory duties specifically include publicizing the situation and needs of people with mental health conditions, children and youth with serious emotional disturbance, and their families; reviewing needs assessments and budget proposals; identifying common service-area concerns; and reporting annually to the Commissioner and the Governor on Department programs, services, supports, and facilities. Through Regional Council input, Mental Health Block Grant review, legislative-proposal review, and the Joint Annual Report process, the Council helps ensure that planning and resource decisions reflect local needs and the experiences of people in recovery, families, and other community partners.

7. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES PLANNING AND POLICY COUNCIL
c/o 500 DEADERICK STREET
ANDREW JACKSON BUILDING, 5th FLOOR
NASHVILLE, TENNESSEE 37243

PAUL FUCHCAR
CHAIR

AMBER HAMPTON
VICE-CHAIR

June 23, 2026

Marie Williams, Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
Andrew Jackson Building, 6th Floor
500 Deaderick Street
Nashville, TN 37243

RE: FY2027 Mental Health Block Grant Application

Dear Commissioner Williams:

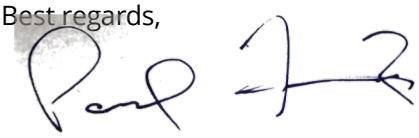
The Tennessee Department of Mental Health and Substance Abuse Services Planning and Policy Council (TDMHSAS P&PC) is proud to support the Department in its work to serve people of all ages who have mental illness, serious emotional disturbance, and substance use disorders through an application for the FY2027 Mental Health Block Grant.

The members of the Statewide Council, along with its seven Regional Planning and Policy Councils, meet at least quarterly throughout the year to share information across regions and with TDMHSAS leadership and staff. Each year, the Council requests and receives information and data from the regional councils about mental health needs, substance use needs, and service gaps across the state. These needs are then prioritized and communicated to TDMHSAS to support the development of the Department's Three-Year Plan and block grant application. TDMHSAS also provides annual reporting on progress made on the prior year's identified needs. Once a draft of the block grant application is prepared, Council members review, ask questions, and provide feedback to TDMHSAS.

The Councils represent all geographic areas of the state and are comprised of a wide range of service providers and individuals with lived experience of mental illness and substance use disorders. This representation helps ensure TDMHSAS has a deep understanding of the needs and gaps in Tennessee.

As a partner and support system for the Department's work, we gladly support TDMHSAS in pursuing this grant.

Best regards,



Paul Fuchcar
TDMHSAS Planning and Policy Council Chair

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2027 End Year: 2028

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Sarah Adams	State Employees	Tennessee Bureau of TennCare (Medicaid)	310 Great Circle Road Nashville TN, 37243 PH: 615-925-2192	sarah.e.adams@tn.gov
Richard Barber	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		153 Willow Branch Jackson TN, 38305 PH: 731-694-0252	barberrichard07@gmail.com
Melissa Birdwell	Providers	Frontier Health	2001 Stonebrook Place Kingsport TN, 37660 PH: 423-224-1000	mbirdwel@frontierhealth.org
Amy Blackwell	Parents of children with SED		1830 Clydesdale Street Maryville TN, 37801 PH: 865-724-2325	director@cccmaryville.org
Renee Bouchillon	State Employees	Tennessee Department of Human Services District Office	1400 College Park Drive Columbia TN, 38401 PH: 931-380-4636	renee.bouchillon@tn.gov
Jim Casey	State Employees	Tennessee Department of Correction	320 6th Avenue North Nashville TN, 37243 PH: 615-253-8163	jim.casey@tn.gov
Regina Clark	Providers	Frontier Health	128 Oak Drive Unicoi TN, 37692 PH: 423-956-2426	rclark@frontierhealth.org
Amy Coleman	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		28 Thornfield Drive Bells TN, 38006 PH: 731-513-4145	amy.coleman2@uhsinc.com
Courtney Collier	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		648 Bowman Road Medon TN, 38356 PH: 731-426-5688	firstclass1906@outlook.com
Lindsey Crowder	Providers	Aspell Recovery Center	PO Box 2412 Jackson TN, 38305 PH: 731-499-3929	lindsey@aspellrecovery.com
	Individuals in recovery (including		1921 Ransom Place	

Jeremy Davis	adults with SMI who are receiving or have received mental health services)		Nashville TN, 37217 PH: 629-309-3745	jeremy.davis@centerstone.org
Ben Dickey	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		2390 West Monica Drive Bartlett TN, 38134 PH: 901-517-0681	bendickey7@gmail.com
Paul Fuchcar	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		207 Spears Avenue Chattanooga TN, 37405 PH: 423-667-3311	paul.fuchcar@cadas.org
Melvin Gatewood	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		1310 24th Avenue South Nashville TN, 37212 PH: 615-983-7833	gatewoodmelvin83@gmail.com
Katrina Gay	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		131 Sanders Ferry Road , 37075 PH: 615-545-2548	kgay@namitn.org
Becky Grando	Advocates/representatives who are not state employees or providers		710 Spence Lane Nashville TN, 37217 PH: 615-425-5846	becky.grando@tnpca.org
Amber Hampton	Advocates/representatives who are not state employees or providers		446 Metroplex Drive Nashville TN, 37211 PH: 615-312-3113	ahampton@mhamidsouth.org
Ben Harrington	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		P.O. Box 37231 Knoxville TN, 37231 PH: 865-584-9125	ben@mhaet.com
Rikki Harris	Parents of children with SED		500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	rharris@tnvoices.org
Debbie Hillin	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		5465 Village Way Nashville TN, 37211 PH: 615-975-0196	debbiehillin@buffalovalley.org
Amy Howell	State Employees	Tennessee Department of Human Services-Voc Rehab	710 James Robertson Parkway Nashville TN, 37243 PH: 615-313-3182	amy.howell@tn.gov
Robert Humphreys	Providers	Cherokee Health	5600 Brainerd Road Chattanooga TN, 37411 PH: 423-266-4588	robert.humphreys@cherokeehealth.com
Amy Irvin	Advocates/representatives who are not state employees or providers		241 Autumn Drive Chattanooga TN, 37415 PH: 423-544-4815	ashpanic@aol.com
Jennifer Jones	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		1321 Murfreesboro Pike Nashville TN, 37217 PH: 615-780-5901	jennifer@taadas.org
Melinda Jones	Parents of children with SED		3235 Royal Knight Drive Memphis TN, 38118 PH: 901-428-6494	mlindaj73@yahoo.com

Susan Langenus	Providers	Centerstone	2400 White Avenue Nashville TN, 37204 PH: 615-460-4451	susan.langenus@centerstone.org
Brock Martin	State Employees	Tennessee House of Representatives	425 Rep John Lewis Way N Nashville TN, 37243 PH: 615-741-7478	rep.brock.martin@capitol.tn.gov
Elton Maupins	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		1428 Goodnight Court Nashville TN, 37207 PH: 615-424-3542	elton@giduniversity.org
Dawn Mitchell	Parents of children with SED		1010 Drummond Drive Nashville TN, 37211 PH: 615-293-0676	dawnmmitchell@yahoo.com
Morenike Murphy	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		909 Meadow Lark Lane Goodlettsville TN, 37072 PH: 615-756-4898	mmurphy@centerofhopebh.org
Tomill Newsom	Providers	Metro Health Department	5510 Country Drive Nashville TN, 37207 PH: 615-713-8429	tomill.newsom@nashville.gov
Lori Paisley	State Employees	Tennessee Department of Education	710 James Robertson Parkway Nashville TN, 37243 PH: 615-854-2713	lori.paisley@tn.gov
Kim Parker	Providers	Pathways	238 Summar Drive Jackson TN, 38301 PH: 731-541-8988	kim.parker@wth.org
Jennifer Phillips	Providers	Helen Ross McNabb Center	205 West Springdale Avenue Knoxville TN, 37917 PH: 865-315-6155	jennifer.phillips@mcnabb.org
Erin Read	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		140 Dameron Avenue Knoxville TN, 37917 PH: 615-585-4066	erin.read@knoxtnhousing.org
Albert Richardson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		4041 Knight Arnold Road Memphis TN, 38118 PH: 901-360-0442	arichardson@caapincorporated.com
Mary Linden Salter	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		6649 Sugar Valley Drive Nashville TN, 37211 PH: 615-579-8808	marylinden@taadas.org
Pamela Sessions	Providers	Renewal House	3600 Clarksville Pike Nashville TN, 37218 PH: 615-255-5222	psessions@renewalhouse.org
Jodi Smith	State Employees	Tennessee Housing Development Agency	502 Deaderick Street Nashville TN, 37243 PH: 615-815-2200	jsmith@thda.org

Alysia Smith Knight	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		201 Seaboard Lane Franklin TN, 37067 PH: 615-519-3985	asmithknight@tamho.org
Patrick Starnes	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		607 Neil Avenue Nashville TN, 37206 PH: 615-330-1832	trucare10@yahoo.com
Angel Townsend	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		5751 Uptain Road Chattanooga TN, 37411 PH: 423-290-3269	atownsend@homelesscoalition.org
Page Walley	State Employees	Tennessee Senate	425 Rep John Lewis Way N Nashville TN, 37243 PH: 615-741-2368	sen.page.walley@capitol.tn.gov
Allison White	Providers	Methodist Le Bonheur Healthcare	5050 Poplar Avenue Memphis TN, 38157 PH: 901-826-9720	allison.white@mlh.org
Eula Whittaker	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		3323 Foxwood Drive Memphis TN, 38115 PH: 901-949-0661	eleewhit0611@gmail.com
Marie Williams	State Employees	Tennessee Department of Mental Health and Substance Abuse Services	500 Deaderick Street Nashville TN, 37243 PH: 615-532-6500	marie.williams@tn.gov
Evelyn Yeargin	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		1700 Litton Avenue Nashville TN, 37216 PH: 615-294-6523	eryeargin@yahoo.com

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2027 End Year: 2028

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	13	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	8	
3. Parents of children with SED	4	
4. Vacancies (individuals and family members)		
5. Total individuals in recovery, family members, and parents of children with SED	**25**	**53.19%**
6. State Employees	9	
7. Providers	10	
8. Vacancies (state employees and providers)		
9. Total State Employees & Providers	**19**	**40.43%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	3	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)		
15. Total non-required but encouraged members	**3**	**6.38%**
16. Total membership (all members of the council)	**47**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

The draft plan was posted on the Tennessee Department of Mental Health and Substance Abuse Services' website at the following link:https://www.tn.gov/behavioral-health/planning.html

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

The final version was posted for the previous year at this link: https://www.tn.gov/behavioral-health/planning.html

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

d) Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes: