**Open, EOHHS-Solicitated Rolling Grant Process:**

Homelessness Prevention for Priority Populations

**To Apply:**

Organizations should identify which activities they are interested in implementing. Prepare a comprehensive application addressing the threshold evaluation and technical criteria.

**Please also refer to the full grant description document as a guide**.  
Applications can be submitted at any time, but priority will be given to activities outlined in the phased approach to review.

Applications will be reviewed and categorized as “Received,” “Under Review,” and “Approved/Denied.” Applicants will be updated regarding their application status throughout the process.

**For any questions related to this grant or the application process, please contact us at:** [OHHS.OpioidSettlement@ohhs.ri.gov](mailto:OHHS.OpioidSettlement@ohhs.ri.gov)

1. **Name of Agency:**

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**2. Partner Agency (or Agencies) if Applicable:**

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**3. Is Your Organization currently a Medicaid billing provider for Home Stabilization Services, Case Management, Medical Services, Certified Peer Recovery Specialists and Certified Community Health Workers (as an organization or with a third-party)?**

**Yes\***  **No**  ( \*If yes, please check all that apply below )

**​​**  **Home Stabilization Services**  **Case Management**  **Medical Services**

**​​**   **Certified Peer Recovery Specialists**  **Certified Community Health Workers**

**4. Have you previously or currently been awarded funding through the Consolidated Homeless Fund (CHF)?**

**Yes**  **No**

**5. Does your organization agree to comply with OSAC and HCBS e-FMAP Requirements?**

**Yes**  **No**

1. **Does your organization agreed to comply with performance measure reporting requirements?**

**Yes**  **No**

1. **What funding area is your organization applying for?  (Select all that apply)**   
   (Organizations can apply for funds in multiple areas)

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|  | 1. Statewide Mitigation Fund for Priority Populations |  | 1. ​​Night Outreach |
|  | 1. ​Landlord Incentives for Housing Priority Populations |  | 1. ​Housing First Trainings |
|  | 1. Subsidies for Individuals or Families with OUD/SUD |  | 1. Recovery House Accessibility Fund |
|  | 1. Housing First Policy and Technical Assistance |  | 1. Recovery House Startup Assistance Fund and Incentives |
|  | 1. ​​Harm Reduction Model Implementation for Shelters and Providers |  | 1. ​​Equity Supports |
|  | 1. Supportive Services Partnership Incentives |  | 1. ​​Housing is Healthcare Coordination |
|  | 1. Warming Station and Emergency Shelter Supportive Services |  | 1. ​​Supportive Services Toolkit Development |
|  | 1. Interagency Partner Convening and Case Conferencing |  | 1. Quality Improvement |
|  | 1. Infectious Disease Supports |  | ​​ |

1. **What geographic area of Rhode Island does your organization serve?**(Please be as specific as possible)

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1. **Are there specific geographic areas that you do not serve?**

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1. **What priority populations will you service with these funds?**(Select all that apply)

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|  | High-Density Communities or Health Equity Zones (HEZ) |  | Opioid or Substance-Involved Individuals |
|  | Individuals Who Are Unhoused or Unsheltered |  | People who use drugs (PWUD) |
|  | BIPOC Community |  | Justice-Involved Individuals (current or former) |
|  | Individuals with Disabilities |  | Older Adults |
|  | Individuals with Behavioral Health Conditions |  | Households with Children |
|  | Individuals Enrolled in Medicaid/Medicare |  |  |

1. **Please provide an overview of your organization’s mission, core values, and experience in serving priority populations.**

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1. **What resources and expertise does your agency possess to effectively implement the proposed program? How does the proposed program fit within the organization’s priorities?**

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1. **How does your agency plan to collaborate with other stakeholders and community partners to maximize program impact? How do these proposed partnerships enhance the effectiveness and reach of your organization’s programs and services?**

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1. **What is the annual operational budget of your organization?**\*If your budget exceeds $750,000.00 annually, when was your last Single Audit and what were the results? If you have not, but one is scheduled, please indicate the timeline.

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1. **How many full time and part time staff members does your organization employ?**

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1. **What is the average salary or wage rate of your direct care staff, including outreach workers?**

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1. **In what languages are your organization’s services currently available?**

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1. **How does your organization ensure accessibility and cultural   
   competency in service delivery?**

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1. **What supportive services does your organization provide?** (Please check all that apply)

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| **Translational Services and Multi-Lingual Supports (Including American Sign Language)** | | |
| My organization provides this | | A partner organization provides this |
|  | | |
| **Medical Care and Infectious Disease Supports** | | |
| My organization provides this | | A partner organization provides this |
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| **Medicated Assisted Treatment (MAT)** | | |
| My organization provides this | | A partner organization provides this |
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| **Behavioral Health/ Trauma-Informed Services** | | |
| My organization provides this | | A partner organization provides this |
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| **Harm Reduction, Mobile Outreach, and Peer Recovery Supports** | | |
| My organization provides this | | A partner organization provides this |
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| **Criminogenic Supports** | | |
| My organization provides this | | A partner organization provides this |
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| **Hospital Coordination and Assistance** | | |
| My organization provides this | | A partner organization provides this |
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| **Emergency Medical Services (EMS) – Local EMS** | | |
| My organization provides this | | A partner organization provides this |
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| **Place-Based Community Supports** | | |
| My organization provides this | | A partner organization provides this |
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| **Veterans Supports** | | |
| My organization provides this | A partner organization provides this | |
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| **Benefits Enrollment** | | |
| My organization provides this | A partner organization provides this | |
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| **Medicaid Home Stabilization Services** | | |
| My organization provides this | A partner organization provides this | |
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| **Employment Assistance Providers** | | |
| My organization provides this | A partner organization provides this | |
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| **Nutritional Services** | | |
| My organization provides this | A partner organization provides this | |
|  | | |
| **Healthy Aging Supports** | | |
| My organization provides this | A partner organization provides this | |
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| **Transportation Services** | | |
| My organization provides this | A partner organization provides this | |
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| **Family and Child Supports** | | |
| My organization provides this | A partner organization provides this | |
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| **Pet Care and Animal Service Supports** | | |
| My organization provides this | A partner organization provides this | |
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1. **Please detail all plans for sustaining the targeted work under this funding award. Please use bullet points as needed**. (Example: Leveraging Medicaid billing, seeking additional grants, cost sharing with other partners…)

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1. **Please provide an example of an issue that your organization identified and made a change to improve**.

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1. **Please document your organization’s strategic approach to strategy and equity.**

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1. **Please provide a brief description of your overarching goal for this work, the proposed initiative, and a bulleted list of key activities.**

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1. **Please list any success factors that are critical to meet your goal.**

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1. **Please include details about staff members that will be involved with the grant funded project(s) (including oversight and implementation) and *briefly* describe their relevant experience and role. Add or delete rows as necessary.**

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| **Name of Staff** | **Title** | **Experience and Role in this Project** |
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1. **Please provide a detailed work plan and timeline, listing *all* steps of   
   the grant project implementation including key milestones and deliverables, with the approximate start and end dates. Add or delete rows as necessary.**

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| **Activities** | **Start Date** | **End Date** |
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**SMARTIE Goals Guide**

SMARTIE Stands for Specific, Measurable, Achievable, Realistic, Time-Bound, Inclusive, and Equitable.

**Specific**

* Objective clearly states, so anyone reading it can understand, what will be done and who will do it.

**Measurable**

* Objective includes how the action will be measured. Measuring your objectives helps you determine if you are making progress. It keeps you on track and on schedule.

**Achievable**

* Objective is realistic given the realities faced in the community. Setting reasonable objectives helps set the project up for success

**Realistic**

* A relevant objective makes sense, that is, it fits the purpose of the grant, it fits the culture and structure of the community, and it addresses the vision of the project.

**Time-Bound**

* Every objective has a specific timeline for completion.

**Inclusive**

* An opportunity to bring traditionally excluded individuals and groups into processes, activities, decisions and policy making in a way that shares power

**Equitable**

* Including an element of fairness or justice to address systemic injustice, inequity, or oppression.

**Tips for Writing SMARTIE Objectives**

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| **Specific** | * Define what you expect * Determine who will do it * Detail accountability * Use action verbs, expressing physical or mental action, as much as possible * Provide enough detail - this depends on the objective but should be enough to be clear |
| **Measurable** | * Identify how you will know objective was accomplished – This can mean quantity or quality-(for instance, “80% of participants agree or strongly agree on the feedback form”) |
| **Achievable** | * Make sure you have the time, manpower, resources, and authority to accomplish the objective * Consider if there may be factors beyond your control |
| **Realistic** | * The objective helps you meet the purpose of the grant * The objective is aligned with the Community Readiness Assessment scores |
| **Time-Bound** | * Specify when the objective should be completed * Include time-lined benchmarks for long-range goals and all objectives |
| **Inclusion** | * Is there an opportunity to bring traditionally excluded individuals and groups into processes, activities, decisions and policy making in a way that shares power? |
| **Equity** | * Include an element of fairness or justice to address systemic injustice, inequity or oppression. |

(SMARTIE Objective source: <https://www.cdc.gov/cancer/ncccp/pdf/smartie-objectives-508.pdf>)

1. **What are the short-term outcomes of the grant project?** For example, what products will be developed, how many people do you expect to reach? How will progress towards these goals be monitored and evaluated? How will you collect data and measure progress and success? Please use SMARTIE objectives. Add or delete rows as necessary. (More details about SMARTIE objectives on the previous page).

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| **Project Outcome(s)** | **How will you measure outcome success?** | **Proposed monthly metric for reporting** |
| *EXAMPLE:*  ***Launch a statewide mitigation fund by October 1, 2024, to support at least xx landlords and xx rental units, providing financial protections and improving housing stability for individuals with OUD/SUD, with initial reporting by January 2025.*** | *EXAMPLE:*  *Outcome Success will be measures by tracking the number of landlords and rental units supported, the amount of funds allocated for property damage and renovations, and collecting feedback from landlords and tenants on the fund’s effectiveness.* | *EXAMPLE:*  *Number of Landlords enrolled: report the # of new landlords participating each month.*  *Total units supported: Provide a monthly count of rental units under the fund.*  *Amount of funds distributed: Track and report monthly fund disbursements*  *Categories of fund usage: Detail monthly expenditures by category.*  *Feedback and testimonials: Summarize monthly feedback from landlords and tenants on the fund’s impact and effectiveness.* |
| 1. | 1. |  |
| 2. | 2. |  |
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1. **Please describe your organization’s approach to the following:**
2. **Maintaining documentation to ensure fiscal resources can be tracked to original funding sources, allowable uses, and intended recipients.**

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1. **Ensuring capacity to collect data, evaluate outcomes, and meet reporting requirements of this grant.**

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1. **Agency budgets will be reviewed and approved prior to an official agreement.** Please list and describe each item in your proposed budget for the grant funding. Please be as specific as possible. Add or delete rows as necessary.

**EXAMPLE:**

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| **Item** | **Amount** | **Justification** |
| **Personnel** | $2160 | Staff time for community canvassing:  [Name1\_Title1] $18/hr. x 60 hrs.  [Name2\_Title2] $18/hr. x 60 hrs.  **(allows for 10 person hrs per month spanning 12 months)** |

1. **Please list your finance staff's name and email address here:**

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| **Name** | **Email** |
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1. **Please answer the following questions:**
2. **How does your organization actively support and implement housing first principles?**

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1. **How does your organization implement harm reduction strategies?**

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1. **How does your organization incorporate stigma reduction in your work?**

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1. **What is your process for client engagement and quality improvement?**

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**If you have any questions, please contact us at** [OHHS.OpioidSettlement@ohhs.ri.gov](mailto:OHHS.OpioidSettlement@ohhs.ri.gov)