STATE OF MARYLAND
Community Health Resources Commission
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Coordinated Community Supports Partnerships

FY 2026 Request for Applications

December 4, 2024

Coordinated Community Supports Partnerships Call for Proposals

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I. BACKGROUND

America's youth are experiencing a behavioral health crisis. In a recent report, the Centers for Disease Control and Prevention (CDC) stated that young people in the United States are "collectively distressed." The CDC's most recent Youth Risk Behavior Survey (YRBS) found that 42% of high school students experience persistent feelings of sadness or hopelessness so severe, they did not engage in their usual activities for at least two consecutive weeks. Every racial and ethnic group surveyed reports experiencing these feelings at a higher rate than they had reported in the past. The YRBS results indicate a significant increase in the percentage of respondents who reported seriously considering suicide, making a suicide plan, or attempting to commit suicide, particularly for Black, female, and LGBTQ+ students.

The YRBS also reveals disturbing disparities related to race, gender, and sexual orientation. For instance, 57% of female students report persistent feelings of sadness or hopelessness and 69% of LGBTQ+ students report such feelings. Meanwhile, more Black, Hispanic, and White students are seriously considering suicide than other groups. More than half of LGBTQ+ respondents reported the same. Black, female, and LGBTQ+ students reported a higher rate of attempted suicide as well.

While statistics show consistently increasing student mental health struggles over the last 10 years, the COVID-19 pandemic exacerbated the problem. According to the U.S. Surgeon General, 25% of youth are experiencing depression-like symptoms and 20% have been experiencing anxiety-like symptoms since the pandemic began. Hospital emergency departments have admitted and treated 51% more young girls suspected to have attempted suicide compared to pre-pandemic rates. These negative trends have been especially evident among American Indian, Alaska Native, Black, Latino, Asian, Native Hawaiian, Pacific Islander, and LGBTQ+ youth.

Mental health challenges do not exist in a vacuum. Often mental wellness is a consequence of a person's school and home environments. For example, groups who report higher rates of sadness, hopelessness, and/or suicide attempts, such as LGBTQ+ students and Black students, were more likely to report experiencing unstable housing within the past year. Demographic groups who report fewer negative mental health experiences, such as male, White, and heterosexual students, tended to report higher rates of school connectedness than disparately impacted groups.

In 2021, the U.S. Surgeon General released an advisory report outlining actions that can be taken to reverse the rising tide of poor mental health among students. The report recommended empowering youth to ask for help, support others, and care for themselves. According to the report, schools can contribute to this mission by creating positive, safe, and affirming environments for their students; expanding social and emotional learning programs; recognizing changes in mental and physical health; providing a continuum of supports for mental health needs; promoting enrollment in and retainment of health coverage that includes

behavioral health services; expanding the mental health workforce; and protecting and prioritizing students with higher needs and risks.

Schools are an ideal place to deliver a Multi-Tiered System of Supports (MTSS) and services that promote mental health and prevent and address mental health challenges in youth. Delivering supports and services in schools meets students where they are. Schools are well-positioned to promote well-being and mental health for all students by fostering positive school climate, providing mental health literacy for staff and students, and developing social emotional skills. Prevention and early intervention can address behavioral health conditions before they develop or worsen. For students with identified behavioral health needs, offering services in schools increases the likelihood of engagement and completion of care, in part by overcoming transportation and other logistical barriers. Students whose behavioral health needs are supported are more likely to attend, engage, and perform well in school.

The Maryland Consortium on Coordinated Community Supports was created by the Maryland General Assembly as part of the Blueprint for Maryland's Future, Chapter 36 of 2021. The Consortium is responsible for developing a statewide framework to expand access to comprehensive behavioral health and wraparound services for Maryland students. It is comprised of 25 experts in the fields of behavioral health and education, and is chaired by former Delegate David D. Rudolph. A complete list of the Consortium's members can be found in Appendix B.

The Maryland Community Health Resources Commission (CHRC) serves as the Consortium's fiscal agent and is responsible for providing staff support for the Consortium. The CHRC was created by the Maryland General Assembly in 2005 to expand access to health care services in underserved communities across Maryland. The CHRC is an independent commission operating within the Maryland Department of Health (MDH), whose 11 members are appointed by the Governor. Since its inception, the CHRC has awarded 866 grants totaling $291.7 million, supporting programs in every jurisdiction of the state. These programs collectively have served more than 663,000 Marylanders, and grants awarded by the CHRC have enabled grantees to leverage $44.7 million in additional federal and private/non-profit resources. A list of CHRC Commissioners can be found in Appendix A.

The Consortium and its Subcommittees have been meeting regularly since the summer of 2022. All meetings are open to the public and all materials are posted on the Consortium's webpage, https://health.maryland.gov/mchrc/Pages/Maryland-Consortium-on-Consolidated-Community-Supports.aspx. The Consortium's four Subcommittees include: Framework, Design & RFA; Data Collection/Analysis & Program Evaluation; Outreach & Community Engagement; and Best Practices.

As provided by statute, the National Center for School Mental Health (NCSMH) provides technical assistance to the Consortium. The NCSMH is housed in the Division of Child and Adolescent Psychiatry at the University of Maryland School of Medicine. It was established in 1995 by the U.S. Department of Health and Human Services, Health Resources and Services

Administration to provide training and technical assistance to states/territories, districts, and schools to advance school mental health. The NCSMH engages in research, policy, training and technical assistance, and practice and has long partnered with the Maryland State Department of Education, the Maryland Behavioral Health Administration, and local communities to promote mental health and well-being for youth and families throughout Maryland. The NCSMH provides technical assistance to the CHRC, Consortium, and grantees. The NCSMH also coordinates all trainings and leads implementation support in Evidence-Based Programs.

The first Coordinated Community Supports Call for Proposals was issued in August 2023 and funded behavioral health and wraparound services for students and families. 127 service provider grants currently are under implementation, totaling approximately $110 million. These grants will end on June 30, 2025. Grantees from this initial Call for Proposals are eligible to reapply under this Request for Applications.

The second Coordinated Community Supports Call for Proposals was issued in October 2023 and funded a pilot program for Community Supports Partnership Hubs. Eligibility was limited to Local Behavioral Health Authorities (LBHAs) and Local Management Boards (LMBs). Ten Hub pilots were selected, totaling approximately $5 million. Some of these ten are eligible to apply under this Request for Applications as Community Supports Partnerships, while others will be eligible to extend the capacity-building activities of the pilot. More information on grant eligibility can be found in Appendix D.

The Consortium frequently solicits public comments and engages in public outreach campaigns to receive feedback on the model and inform communities about upcoming grant opportunities. Public comments helped to inform the first two Coordinated Community Supports Calls for Proposals issued in 2023. More recently, in October 2024, the Consortium's Framework and Best Practices Subcommittees released seven questions for public comment related to key issues for this Request for Applications. Responses were discussed by the two Subcommittees, and recommendations were presented to the full Consortium at its meeting on November 18, 2024.

GOALS OF THIS RFA AND OVERVIEW OF THREE FUNDING TRACKS

This RFA seeks to sustain and expand access to high quality behavioral health services and supports for Maryland students, while continuing to build a statewide framework of Community Supports Partnerships to coordinate the delivery of these services. Based on available funding, the CHRC is making available up to $120,000,000 in funding through this RFA.

Three types of grants will be awarded under this RFA:

- **Track 1: Grants to Community Supports Partnerships**. Community Supports Partnerships grants are available *by invitation only*. These grants will fund both behavioral health services for a geographic area, as well as the activities of a local coordinating agency, or Hub. Partnerships will be organized according to the Collective Impact model. Eligibility is

limited to selected organizations that were awarded Hub pilot grants under the previous Call for Proposals, participated in a capacity-building curriculum led by the CHRC and NCSMH, were assessed as "ready" to become full Community Supports Partnerships, and have submitted a letter of intent to the CHRC prior to the issuance of this RFA. Service providers interested in grant funding for these parts of the state should contact the Hub pilot for more information – the CHRC will not consider independent applications from service providers for areas of the state that will be funded through full Community Supports Partnerships. A list of organizations eligible to apply as Community Supports Partnerships and the geographic areas covered by each is included in Appendix D. Proposal requirements for Community Supports Partnerships grants can be found on pages 20-22.

- **Track 2: Grants to build future Partnership Hub capacity**. These grants will fund organizations to develop capacity to serve as Hubs in future Community Supports Partnerships. Eligibility is limited to Local Behavioral Health Authorities (LBHAs) and Local Management Boards (LMBs) in areas of the state not eligible to become a Community Supports Partnership under this RFA. Eligible applicants may include both existing Hub pilots awarded through the previous Request for Proposals that are not applying as Community Supports Partnerships, as well as applicants from areas of the state not previously awarded a Hub pilot grant. Applicants must be the consensus choice of their geographic region, and must have a letter of support from their local Superintendent or the Superintendent's designee. A list of jurisdictions eligible for Hub capacity-building grants is included in Appendix D. Proposal requirements for Hub capacity-building grants can be found on pages 23-27.

- **Track 3: Grants to service providers**. Grants to service providers will sustain and expand access to high-quality behavioral health and wraparound services for students and families across the state of Maryland. Applicants may include both service providers awarded through the first Coordinated Community Supports Call for Proposals, as well providers not awarded previously. For applicants that are not current grantees under the 2023 RFA, grants funds may be used to establish new programs or to expand existing programs, but may not supplant other sources of funding. Service providers funded through this track must serve areas of the state that are not eligible for Community Supports Partnerships grants – as stated above, the CHRC will not consider independent applications from service providers for areas of the state that will be funded through full Community Supports Partnerships, as service providers in those areas should contact the local Hub pilot applying under Track 1. A list of jurisdictions eligible for service provider grants is included in Appendix D. Proposal requirements for service provider grants can be found on pages 27-34.

This Request for Applications will fund grants from all three tracks for a period of twelve months, from July 1, 2025 – June 30, 2026. Current Consortium grantees as well as applicants not previously awarded may apply under this Request for Applications. Service providers must submit a separate application for each jurisdiction in which they are applying.

Grant funding must be supplemental to and may not supplant existing funds for school behavioral health. When possible, Medicaid reimbursement should be sought. More information about grants and Medicaid billing can be found on page 17.

Schools are essential partners in all grants. A letter of support from the local Superintendent or the Superintendent's designee is mandatory for all service provider and Hub applications under this RFA. Letters of support jointly signed by the Local Education Agency (LEA, or school district, i.e., the Superintendent or the Superintendent's designee) and the Local Behavioral Health Authority (LBHA) / Local Management Board (LMB) are highly encouraged. Proposals for Community Supports Partnership grants also must demonstrate ongoing collaboration with their LEAs, including the participation of the LEA in the Partnership's governance. More information about the role of schools can be found on pages 11-13.

The Consortium is committed to measuring the progress of this program. The Consortium's Data Subcommittee has identified four overall, qualifiable goals for the program: 1. Expand access to high-quality behavioral health and related services for students and families; 2. Improve student wellbeing and readiness to learn; 3. Foster positive classroom environments; 4. Promote sustainability through revenues from Medicaid, commercial insurance, hospital community benefits, and other sources. In alignment with these goals, all grantees are required to collect and submit data to demonstrate the effectiveness of interventions. More information about data and evaluation requirements can be found on pages 15-16.

All grantees are required to participate in ongoing training and technical assistance provided by the CHRC and National Center for School Mental Health. This includes mandatory monthly meetings for all grantees, ongoing participation in selected Evidence-Based Program (EBP) trainings, engagement in required implementation support calls, and other training and technical assistance for service provider, Hub, and Community Supports Partnership grantees.

Any individual who has contact with children, adolescents and students under the execution of this grant will be required to obtain a Criminal Justice Information System (CJIS) State and federal criminal background check, including fingerprinting. Criminal background checks must be completed prior to commencing any work under this grant. Applicants may request grant funds for this purpose. Criminal background checks must be completed prior to commencing any work under this grant. Applicants may request grant funds for this purpose. All grantees, including subgrantees and subcontractors, are required to report to law enforcement and school leadership any threats of harm to self or others. Grantees, subgrantees, and subcontractors may be required to participate in training related to school safety and sign a form acknowledging they will follow existing law and current policies and procedures for their jurisdiction, school, and the state of Maryland.

According to statute, at full implementation, the Consortium program should serve all students in each local school system regardless of income, insurance status, or zip code. At the same time, applicants must consider equity in their programs. The CHRC and Consortium will

consider equity when evaluating proposals and making grant awards. Services must be delivered with cultural and linguistic competence (see page 15).

GRANT AWARD CONTINGENT ON EXECUTION OF GRANT AGREEMENT

All grant awards are preliminary and contingent on the awardee's acceptance of the terms and conditions of the award, as set forth in a grant agreement, and upon execution of the written grant agreement, signed by the CHRC and the awardee. Prior to executing the grant agreement, the CHRC may exercise discretion to cancel or rescind an award for any reason. An awardee may likewise decline the grant award at any time prior to executing the written grant agreement.

CANCELLATIONS

The CHRC reserves the right to cancel this RFA, accept or reject any and all applications, in whole or in part, received in response to this RFA, waive or permit the cure of minor irregularities, and conduct discussions with all qualified or potentially qualified applicants in any manner necessary to serve the best interests of the CHRC and the State. The CHRC reserves the right, in its sole discretion, to award a grant based upon the written applications received without discussions or negotiations.

Upon receiving an award, should the grantee fail to fulfill its obligations as outlined in the scope of work and/or the documented narrative submitted in response to this RFA and/or the terms of the written grant agreement for this award, the CHRC retains the authority to terminate the grant agreement, as well as to pursue all remedies set forth in the grant agreement and as provided by law.

KEY DATES TO REMEMBER

The following are the key dates and deadlines for this RFA:	
December 4, 2024	Release of the Call for Proposals
December 18, 2024 at 10:00 a.m.	First Frequently Asked Questions call for potential applicants **Zoom link**: https://us06web.zoom.us/j/89719279058?pwd=vfSMcA4ctKin7mcbEsZxbUOe2qOdsm.1 **Dial-in #: 301-715-8592** **Meeting ID: 897 1927 9058 / Passcode: 687615**
January 15, 2025 at 10:00 a.m.	Second Frequently Asked Questions call for potential applicants **Zoom link**: https://us06web.zoom.us/j/89719279058?pwd=vfSMcA4ctKin7mcbEsZxbUOe2qOdsm.1 **Dial-in #: 301-715-8592** **Meeting ID: 897 1927 9058 / Passcode: 687615**
February 4, 2025 at 3:00 p.m.	**Deadline for receipt of applications**
April/May 2025	Award decisions
July 1, 2025- June 30, 2026	Grant period

II. PRINCIPLES OF THE COMMUNITY SUPPORTS PARTNERSHIP MODEL

The Community Supports Partnership model includes a number of key principles that apply for all three tracks.

A. Coordination. Coordination is essential for all proposals under this Request for Applications. The Consortium is building a statewide network of Hubs and service providers (Spokes) based on the Collective Impact model. Through this model, Hubs will coordinate services in the geographic area served by their Partnership. For more information on the Collective Impact model, visit: https://ssir.org/articles/entry/collective_impact.

All services must be coordinated and aligned with the priorities of the Local Education Agency (LEA, or school district). Community providers and Hubs must actively coordinate and partner with school districts and schools to support students and families. Services also should be coordinated with public health and child-serving agencies, including Local Behavioral Health Authorities (LBHAs), Local Management Boards (LMBs), Local Health Departments, Local Departments of Social Services, Local Care Teams, etc. All grant proposals must describe ongoing coordination and include letters of support committing to coordination.

A letter of support from the local Superintendent or the Superintendent's designee is mandatory for all service provider and Hub applications under this RFA. This year's RFA includes additional guidelines for LEAs (see pages 11-13) and a letter of support template (see sample in Appendix K). LEAs will have the opportunity to rank by priority the service provider applicants to whom they have provided letters of support.

Applicants also are encouraged to submit letters of support from LBHAs, LMBs, and/or other child-serving agencies or local government entities. Letters of support jointly signed by local Superintendents, LBHAs, LMBs, and other child serving agencies are highly encouraged.

Applicants should consider cross-agency coordination of services. Aspects of the 2Gen approach, a model being implemented by the Maryland Department of Human Services that seeks to address the entire family through aligned and coordinated supports, could be considered.

B. Multi-Tiered System of Supports. This RFA will support interventions at each of the three tiers of the Multi-Tiered System of Supports (MTSS): Tier 1 (universal promotion/prevention), Tier 2 (early intervention), and Tier 3 (treatment). Community Supports Partnerships applicants must describe how all Tiers are addressed in their geographic area. Service provider applicants are **not** required to offer supports and services at each tier, but should integrate into a school's overall multi-tiered approach. A description of each of the tiers is below.

Behavioral health promotion services and supports (Tier 1) are behavioral health-related activities that are designed to meet the needs of all students regardless of whether they are at risk for mental health problems. Tier 1 activities include promotion of positive social,

emotional, and behavioral skills and well-being. These activities also include efforts to improve school climate and promote positive behavior. These activities can be implemented school-wide, at the grade level, and/or at the classroom level and can be provided by school-employed and community-employed, school-based professionals. Some Tier 1 services may be available to all students and/or families, but provided only to those who "opt-in" to participate. Examples of Tier 1 services include school-wide mental health education lessons, school climate improvement efforts, parenting supports that are available to all, and classroom-based social emotional learning for all students.

Early intervention services and supports (Tier 2) address the behavioral health concerns of students who are experiencing mild distress, functional impairment, or are at risk for a given problem or concern. These students can be identified through needs assessments, screening, referral, or another school teaming processes. When behavioral health needs are identified early and culturally responsive, anti-racist, and equitable (CARE) supports are put in place, positive youth development is promoted, and the chronicity and severity of mental health concerns can be eliminated or reduced. Sometimes these are referred to as "selective" mental health "prevention" or "secondary prevention" services. Examples include small group interventions for students identified with similar needs, transition support groups for newcomers, brief individualized interventions (e.g., motivational interviewing, problem solving), mentoring, and/or low intensity classroom-based supports such as a daily report card, daily teacher check-in, and/or home/school note system.

Treatment services and supports (Tier 3) to address behavioral health concerns are provided for students who are already experiencing significant distress and functional impairment. Sometimes these are referred to as "indicated" mental health "intervention," "tertiary" or intensive services, and are individualized to specific student needs. Examples include individual, group, or family therapy for students who have identified – and often diagnosed – social, emotional and/or behavioral needs.

C. Role of schools. Schools are integral to the Consortium's approach. This model anticipates that schools will be the primary entry point for supports and services to students and families. Services do not need to be provided in the school building, but must be strategically coordinated via ongoing and regular communication and collaboration with the district and schools to augment their existing Multi-Tiered System of Supports.

All grant-funded services provided by community providers must align with priorities identified by local school districts. All service provider applicants are required to submit a letter of support from the local Superintendent or the Superintendent's designee in order to apply under this Request for Applications. Letters of support signed jointly by the LEA and the LBHA/LMB are highly encouraged.

Schools and school districts are not eligible to apply for direct grant funding. Instead, community providers will partner with schools to support students and families. This will allow schools to focus on other Blueprint requirements, give students and families access to

continuums of care, minimize disruptions to the behavioral health workforce, and build on successful models of school-community cooperation.

Grant funds will support services for students in public schools, including public charter schools. Grants funds may support services for children in nonpublic special education schools (MANSEF), if the applicant demonstrates needs that cannot be met through existing funding sources.

The Consortium recognizes the importance of early childhood interventions. This RFA will support services for students in pre-kindergarten programs that are located in public schools, schools that are partners in the Blueprint's pre-kindergarten expansion program, Judy Centers, or Head Start programs. This RFA will not support services for students in private/parochial schools or homeschooled children.

Community Schools are schools that receive Concentration of Poverty grants under the Blueprint and provide an array of "wraparound" supports to students and families. Services funded through this RFA could be provided in Community Schools, as well as schools that are not Community Schools. Applicants should describe how requested funds would be supplemental to and clearly differentiated from Concentration of Poverty grant funding and any other existing sources of funding. By definition, Community Schools serve families with higher socio-economic needs—insofar as this RFA prioritizes areas with greater need, applicants are encouraged to consider offering programs in Community Schools. A list of Community Schools can be found in Appendix N. Applicants are encouraged to consult Community Schools' Needs Assessments. Applicants are advised that the Consortium's definition of "wraparound" supports differs from the definition of wraparound used by Community Schools (see Appendix M).

Applicants under this year's Request for Applicants may request minimal funding to subcontract with school systems for the following activities, if essential for the applicant's program: the use of school buses, stipends for school staff trainings outside of contract hours, and behavioral health-related supplies.

After grants are awarded, all grantees will be required to have a Memorandum of Understanding (MOU) with the LEA before services can be initiated. If the provider and LEA have a pre-existing MOU, this may be acceptable. While grantees will report directly to the CHRC and/or their Hub, on-going collaboration between grantee and their respective LEAs is required. The CHRC will continue to consult with LEAs to address any concerns as grants are implemented.

The Consortium and NCSMH are offering training to school-employed staff in a number of Evidence-Based Programs (EBPs). Interested LEAs should fill out the form found at the following URL: https://bit.ly/SchoolsAppFY26. If desired by the LEA, service provider applicants may request grant funding to provide other trainings to school-employed staff. Service provider applicants proposing school staff training activities are encouraged also to provide

direct services to students/families that result in Unduplicated Individuals Served (see Appendix H).

D. Local needs and holistic services. The Consortium is required by statute to ensure services are holistic, nonstigmatized, and coordinated. While many shared challenges exist in communities across the state, the Consortium recognizes that the needs and strengths of each community are unique. Moreover, different subpopulations within a single jurisdiction may have different needs and require different interventions.

The Community Supports Partnership model allows each community to identify its most pressing student behavioral health needs and select those interventions and providers best suited to meet those needs. The priorities of LEAs should be considered, and all grant-programs must have the support of the LEA. In addition, Hub pilots recently developed Needs Assessments specific to school behavioral health that identify unmet needs. Areas of the state without Hub pilots should draw on other sources of data (see Attachment L) to identify needs.

This Request for Applications will support a range of different types of services for students and families. Examples of programming that may be supported include:

- School-wide preventative and mental health literacy programming
- Individual, group, and family therapy
- Navigation and case management services
- Substance Use Disorder services
- Trauma informed care
- Telehealth services
- Suicide prevention
- Early childhood interventions
- Therapeutic mentoring
- Therapeutic summer camps
- Crisis stabilization and response
- Peer supports
- Behavioral health education, support, and navigation for families
- Support groups
- Psychiatric care and medication
- Addressing dating/sexual violence
- Grief support
- Positive classroom environments
- Educator training programs
- Nature-based wellness programs
- Depression and anxiety services
- Provider participation in school meetings (e.x., IEP, disciplinary, etc.)
- Executive functioning

Applicants should select Evidence-Based Programs (EBPs) that are most relevant for their communities. Page 14 includes a menu of 15 Priority EBPs in which the Consortium and National Center for School Mental Health will provide training and implementation support. More information on Priority EBPs can be found in Appendix F. A menu of other recommended EBPs is found in Appendix G. Applicants focusing on suicide prevention should consult the Maryland Action Plan to Prevent Suicide in Schools (MAPS).

Applicants may identify EBPs and strategies not included on either the Priority or Recommended menus, but must demonstrate that these are: (1) supported by evidence of impact on target social, emotional, behavioral, and/or academic outcomes (based on research

evidence, as recognized in national registries and the scientific literature, and/or supported by practice-based evidence of success in local or similar schools or communities); (2) equitable and fit the unique strengths, needs, and cultural/linguistic considerations of students and families in the target community; (3) responsive to documented local priorities; (4) have adequate resource capacity for implementation (e.g., staffing capacity; training requirements, qualifications, and staff time; ongoing coaching); and (5) monitored for fidelity.

Applicants are responsible to coordinate any training and implementation support for EBPs not on the Priority menu. These training costs (if any) may be included in grantee budget requests (see page 18).

E. Statewide standardization and Priority Evidence-Based Programs. While the Consortium recognizes the need for local autonomy and local solutions, programs should reflect a strong evidence base. To that end, the Consortium's Best Practices Subcommittee has developed a list of 15 Evidence-Based Programs (EBPs) that are encouraged statewide.

1. Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)
2. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)
3. Safety Planning Intervention (Stanley and Brown)
4. Counseling on Access to Lethal Means (CALM)
5. Adolescent Community Reinforcement Approach (ACRA)
6. The Student Check-Up (Motivational Interviewing)
7. Therapeutic Mentoring
8. SBIRT – Screening, Brief Intervention, and Referral to Treatment
9. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back
10. Botvin Life Skills
11. Youth Aware of Mental Health (YAM)
12. Circle of Security
13. Botvin Life Skills Parent Program
14. Family Check Up
15. Chicago Parenting Program

Training costs (other than staff time) for these EBPs should not be included in an applicant's grant budget. More information about these EBPs is available in Appendix F.

Service provider applicants that commit to receive training and implementation support in one or two Priority EBPs, and to implement the EBP(s) with fidelity, will receive additional consideration during the application review process (see page 34).

As stated above, school-employed staff may participate in training in selected Evidence-Based Programs. Interested LEAs should fill out the form found at the following URL: https://bit.ly/SchoolsAppFY26.

The Consortium is also hosting a learning community to support grantee implementation of Measurement Based Care. Measurement Based Care is the routine use of patient reported outcome measures in mental health early intervention (Tier 2) and treatment (Tier 3) services

to promote communication, collaboration and shared decision-making with students and families. The Measurement Based Care Learning Community (MBC LC) is intended for clinicians and other professionals delivering Tier 2 and 3 interventions and for agency leaders supporting clinicians. The MBC LC is offered to grantees to stimulate MBC implementation through training, free resources, ongoing consultation, and peer learning. Applicants that commit to participate in this learning community will receive additional consideration during the application review process. See page 34.

In addition, the Consortium supports statewide standardization through common data metrics (see below), common assessment tools (see Appendix I), and shared learning through its mandatory grantee technical assistance program.

F. Cultural competence. Behavioral health services are most effective when delivered in a culturally and linguistically competent manner. As a matter of policy, all CHRC grantees are asked to demonstrate cultural and linguistic competency, and describe the extent to which the racial and ethnic diversity of their workforce reflects the individuals to be served. Applicants are required to consider cultural relevance in selecting Evidence-Based Programs and strategies. These factors are evaluated as part of the application review process.

G. Data and Evaluation. The Consortium is committed to collecting and reporting data to assess the impact of grants. Service provider grantees will be required to attend a metrics orientation and 1:1 meetings with CHRC and NCSMH staff to discuss data collection. Applicants must demonstrate the capacity to collect and report data required by the CHRC and Consortium. Service provider grantees and subgrantees will be required to report standardized data to the CHRC and/or their Partnership Hub. Examples of standardized measures include:

1. # unduplicated students served – total (see Appendix H) Note: Current grantees may be asked to differentiate between new students to be served under this RFA versus students served under their current grant.
2. # unduplicated students served – Tier 1, 2, 3 (see pages 10-11)
3. # unduplicated students served by race/ethnicity
4. # unduplicated students served by gender
5. # unduplicated students served by grade level (pre-k, elementary, middle, high)
6. # unduplicated schools attended by students served
7. Satisfaction surveys
    a. # of students completing surveys
    b. # of students satisfied
    c. # of family members completing surveys
    d. # of family members satisfied
8. # unduplicated new staff positions
9. # unduplicated school staff by grantee trained and assessed for competency
10. NEW: Optional demographic metrics (# LGBTQ+, # w/ Disability, # ELL/ESL)
11. Custom measures by EBP and/or by assessment tool
    a. # unduplicated who received services

   b. # unduplicated who completed pre assessment
   c. # unduplicated who completed intervention
   d. # unduplicated who completed post assessment
   e. # unduplicated who demonstrated improvement
   f. # unduplicated who demonstrated no change
   g. # unduplicated who demonstrated desired outcome
12. Other custom measures may be developed with individual grantees

Grantees are required to track and report behavioral health process measures as well as outcomes. Grantees must, to the best of the ability, have a method to track individual students for reporting metrics. The CHRC and NCSMH have developed a list of recommended assessment tools for grantees (see Appendix I). Common data definitions are provided. Custom data measures specific to the applicant's program may be developed. A sample reporting template is included in Appendix J.

As a condition of receiving grant funds, grantees must agree to participate in an ongoing CHRC evaluation of the grant program. Grantees will be required to submit regular project progress and fiscal/expenditure reports as well as deliverables produced under the grant as a condition of payment of CHRC grant funds. Performance under the current grant will be a factor in evaluating applications for continued funding.

Applicants should consider any data-sharing agreements that would need to be reached with any partners for implementation and reporting on this grant, and should discuss these considerations in their grant proposals. Grantees must ensure the protection of patient/client information. The CHRC will not accept Protected Health Information (PHI) or Personally Identifiable Information (PII).

H. Addressing Workforce Challenges. The Consortium is aware of behavioral health workforce constraints. Applicants must develop realistic staffing plans as part of their proposals. Applicants may include innovative strategies to address challenges in the behavioral health workforce, such as: use of supervised interns and other staff consistent with legal requirements, family and peer support programs, innovative use of technology, expanding Tier 1 and Tier 2 services, paid staff training and career ladders, and building the behavioral health workforce pipeline. Examples of innovative technology may include: virtual reality technology, biofeedback, remote patient monitoring, use of Artificial Intelligence to monitor client well-being, computerized medical scribes for documentation, computerized assessment, psychoeducational apps to complement treatment or aid in care coordination, and self-care and mental health promotion applications.

Note: Maryland's Department of Service and Civic Innovation is overseeing the launch of a new Youth Mental Health Corps which could be a strategy for expanding applicant staff capacity. For more information, e-mail parul.kumar@maryland.gov.

While proposals may include components that address workforce challenges, an applicant's program as a whole must directly result in expanded behavioral health and/or wraparound services for students and families during the grant period.

I. Financial Stewardship. Funds from this grant may not supplant current funding for school behavioral health services and supports. As responsible stewards of public dollars, the CHRC and Consortium believe that grant funds should not pay for activities covered by other sources. The CHRC fully expects that grantees will braid in other sources of funding to ensure the long-term sustainability of projects and encourages grantees to leverage CHRC dollars to secure funding from other sources for the purpose of program sustainability. The CHRC looks most favorably on grant applications that are transparent about other sources of funding that may partially or wholly support activities in their grant proposals.

To further ensure the best use of grant dollars, the CHRC is closely examining grant applications for potential duplicate funding, including an assessment of the applicant's request for indirect costs. Applicants may not request direct funding for any activities that are typically included in the organization's indirect cost pool/indirect rate. The CHRC will accept an indirect rate of up to 15% (unless the applicant qualifies for a higher indirect rate pursuant to Md. Code Ann., State Finance and Procurement § 2-208(c)), while also requiring applicants to describe activities to be covered within their indirect rate.

The Consortium is required by statute to maximize Medicaid revenue attainment. Service provider applicants are required to describe how requested grant funds would complement and not duplicate any anticipated Medicaid revenues. Grantees providing Medicaid-billable services are expected to bill Medicaid and use grant dollars for activities that are not billable, such as:

- School-wide programming (Tier 1)
- Prevention and mental health promotion activities
- Start-up/expansion costs
- Screenings for behavioral health and related issues
- Services and supports for uninsured students and families
- Co-pay support to expand access to services for children and families with commercial insurance and/or implement an income based sliding scale fee schedule
- Training and implementation in Evidence-Based Programs
- Provider participation in school meetings (e.x. IEP, disciplinary, etc.)
- Case management, navigation, and other services provided by community health workers and peers
- Family education and support
- Peer support
- Transportation to services
- Translation/interpretation costs
- Support groups and other programming for targeted groups of students and families

The CHRC will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards.

Upon execution of a written grant agreement and provision of an invoice, grantees will receive a portion of their award upfront. Subsequent grant payments will be made for the difference between cumulative reported expenses and prior grant payments. At least 5% of the award will be withheld until the final reports are submitted and approved by CHRC staff.

J. Permissible Uses of Grant Funds. Examples of permissible uses of grant funding under this RFA include but are not limited to:

- Staff salaries and fringe benefits
- IT hardware and software, including software/platform for outcomes measurement and Measurement-Based Care
- Supplies
- Marketing materials
- Travel/mileage/parking related to grant activities
- Training and professional development. Note: Training and materials for Priority EBPs will be supported by the NCSMH and should not be included in applicant budgets. Staff time for training, including training in Priority or other EBPs, should be included in the staff salaries section of the budget.
- Subcontractors
- Other expenses such as Incentives for program participants, translation/interpretation services, etc.
- Indirect costs

While schools and school systems will not be the direct recipients of grant funds, applicants may request minimal funding to subcontract with school systems for the following activities, if essential for the applicant's program: the use of school buses, stipends for school staff trainings outside of contract hours, and behavioral health-related supplies.

The following are ***not*** permissible uses of grant funds:

- Direct support to families to address social determinants of health (e.x., emergency funds, rent assistance, food assistance, etc.)
- Fees for student participation in extracurricular activities without a behavioral health focus, including sports
- Field trips without a behavioral health focus
- Somatic (physical) health services
- Academic and vocational supports
- Depreciation expenses
- Major equipment or new construction projects
- Clinical trials
- Lobbying or political activity
- Pre-award costs and expenses

In addition, grant funds may not be used to satisfy debts and liabilities of any kind, including, but not limited to, state or federal tax liabilities, outstanding, past due, or delinquent loan balances, individual, property or employment insurance liabilities, liens, promissory notes, offsets of any kind, or contractual debt.

III. TRACK 1: GRANTS TO COMMUNITY SUPPORTS PARTNERSHIPS

Community Supports Partnerships will fund both behavioral health services for a geographic area, as well as the activities of a local coordinating agency, or Hub. Eligibility is limited to selected organizations that were awarded Hub pilot grants under the previous Call for Proposals, participated in a capacity-building curriculum led by the CHRC and NCSMH, were assessed as "ready" to become full Community Supports Partnerships, and have submitted a letter of intent to the CHRC prior to the issuance of this RFA. A list of organizations eligible to apply as Community Supports Partnerships and the geographic areas covered by each is included in Appendix D. Service providers interested in grant funding for these parts of the state should contact the Hub pilot for more information.

Partnerships will be organized according to the collective impact model. For more information on the Collective Impact model, visit: https://ssir.org/articles/entry/collective_impact.

Community Supports Partnerships should support a continuum of holistic mental health and substance use supports and services, from prevention and mental health promotion through treatment and recovery. Partnerships should leverage existing services and relationships, and engage new and diverse partners that represent and serve the community.

Partnerships proposals should include funding both for the activities of the local Hub and for service providers as subgrantees. Proposals should be informed by the Hub pilot's Needs Assessment, Asset Map, and Referrals Plan. The Hub's governance bodies (Steering Committee, Advisory Board, etc.) should review the proposal, concur with the plan, and offer ongoing feedback as programs are implemented.

In working with service providers as subgrantees, Hubs should adhere to the same uses of grant funding, data collection, and other parameters for service providers contained in this RFA. Hubs should consult the CHRC's scoring rubric for service providers found on page 34. Hubs should encourage service providers to use evidence-based approaches, and to receive ongoing EBP training and implementation support through the Consortium and NCSMH.

Community Supports Partnership proposals are expected to include the service provider grantees awarded under the first Community Supports Partnership Call for Proposals unless the Hub has cause for not including them. Hubs should consider the effectiveness of these programs, and may adjust their funding level, scope, and other aspects.

PROPOSALS FOR COMMUNITY SUPPORTS PARTNERSHIPS

Project proposals should be clear and concise, single spaced, in 11 or 12 point font. Proposals should be approximately 10-12 pages, excluding table of contents, executive summary, budget, and appendices. Brevity is encouraged. All pages of the proposal must be numbered.

The project proposal should be structured using these topic headings:

1. **Local need and health equity**

- Describe the most pressing needs identified in the Hub pilot's Needs Assessment.
- What demographic and geographic disparities were observed in the Needs Assessment?
- How is heath equity incorporated in the overall planning?
- The Needs Assessment(s) should be included as an attachment.

2. **Selection of service providers**

- Describe the process used to select service providers for this proposal.
- How will the selected service providers address community needs?
- Provide a complete list of all subgrantees that will receive funding and perform services under the grant. Include a full description of the services each subgrantee will perform, the populations to be served and why/how each sub grantee was deemed the most qualified for this project. How many total unduplicated students will be served by each (see Appendix H)?
- How many total unduplicated students will be served in the Partnership as a whole?
- Which existing Consortium service provider grantees are included in the proposal? Describe how their programs would be the same or different under the proposed Community Supports Partnerships.
- Were any existing service provider Consortium grantees NOT included in the proposal? Why not? Hubs are required to show cause for opting not to include existing Consortium service provider grantees.
- Which service providers are included in the proposal that are not current CHRC/Consortium grantees? Why were they selected? How were they vetted?
- The Asset Map(s) should be included as an attachment.

3. **Ensuring service quality**

- List the Priority EBPs that will be utilized by service providers/subgrantees in the proposal. How many service provider and Hub staff will require training in each Priority EBP? Note: The CHRC recommends service providers focus on one or two Priority EBPs each, though additional EBPs could be selected with justification.
- Describe service providers' commitment to training in EBPs, implementation of EBPs with fidelity, and participation in EBP implementation support. Describe how this commitment is reflected in service providers' planning, budgets, and staffing.
- How will the Hub ensure service provider subgrantees participate in required EBP trainings and implementation with fidelity?

- In addition to Priority EBPs, which other EBPs and strategies will be utilized by service providers? Why were these chosen?
- Describe how services by subgrantees, non-grant-funded service providers, and school-employed staff together will address all tiers of the Multi-Tiered System of Supports (MTSS). (See page 10-11.)
- Describe how services will be holistic and address a range of needs for students and families.
- Describe how services by service provider grantees and other non-grant-funded service providers will together address all ages pre-k through grade 12.
- What percentage of schools in the district will receive grant-funded services? Which schools will not? If any schools will not receive grant-funded services, explain why.
- Discuss coordination with Community Schools (see Appendix N).

4. Coordination/Integration

- Describe coordination with the LEA in developing the proposal, identifying needs, selecting service providers, planning referral systems, and supporting services.
- How will the Hub facilitate ongoing cooperation between the Hub and service providers?
- How will the Hub facilitate ongoing cooperation between service providers and the LEA?
- How will the Hub facilitate ongoing cooperation and collaboration among service providers?
- How will the Hub facilitate ongoing cooperation between service providers and other child-serving agencies, including the LMB or LBHA, local department of social services, etc.?
- Describe the Hub's commitment to participate in ongoing technical assistance with the CHRC, Consortium, National Center for School Mental Health, and other Hubs. Describe how this commitment is reflected in the Hub's budget and staffing.
- The Governance Plan and Referral Plan should be included as an attachment.

5. Data

- Describe the status of current or future data-sharing agreements between the Hub and service providers.
- Describe the status of current or future data-sharing agreements between the Hub and LEA.
- Describe the Hub's capacity to collect and analyze service provider data (see pages 15-16).
- Describe the Hub's capacity to analyze data from other sources, including population-level data.

6. Hub staffing model

- How many staff positions will the Hub have?
- Describe the roles and responsibilities of each Hub staff member. Organizational charts may be included.
- Use CHRC budget templates.

7. Budget

- What assumptions were used to develop the overall project budget? Note: the CHRC recommends a budget of approximately $300,000-$500,000 for Hub activities and the

balance for services. Applicants are permitted to request more than $500,000 for Hub activities if justification can be provided.
- Discuss the anticipated return on investment.
- How will the Hub and service providers braid funding from other sources, including Medicaid and commercial insurance; and other federal, state, local and private grants?
- What other funding will the Partnership seek to enhance program sustainability?
- Use CHRC budget templates.
- The CHRC will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards.

8. Mandatory Appendices

a. Governance Plan
b. Needs Assessment(s)
c. Asset Map(s)
d. Referral Plan

9. Additional materials listed on pages 34-35.

SCORING RUBRIC – COMMUNITY SUPPORTS PARTNERSHIPS

Criteria	Score
• **Local need and health equity:** identifies local priorities based on Needs Assessment, incorporates health equity	15
• **Selection of service providers:** selects service providers to address identified needs, process for selecting and vetting service providers, ability to work with service providers as subgrantees, based on Asset Map	15
• **Ensuring service quality:** service providers will utilize Priority EBPs and/or other effective strategies; proposal complements existing services to: address all tiers of MTSS, serve all ages pre-k-grade 12, and provide a range of holistic services; commitment to ongoing training and TA	20
• **Coordination/Integration:** demonstrates collaboration with LEA on proposal; plans for ongoing cooperation between Hub, service providers, LEA(s), LBHA/LMB, and other child-serving agencies; able to utilize processes identified in Referral Plan; commitment to ongoing TA	20
• **Data**: plans for data-sharing between Hub, service providers, LEA(s), and others	15
• **Hub staffing model:** Hub staffing model and associated costs are reasonable	10
• **Budget**: Budget is reasonable and commensurate with project impact, overall strong return on investment	5
TOTAL	**100**

IV: TRACK 2: HUB CAPACITY-BUILDING GRANTS

Hub capacity-building grants are available to applicants from areas of the state without a Hub applying as a Community Supports Partnership. Eligibility is limited to Local Behavioral Health Authorities and Local Management Boards. Applicants must be the consensus choice of their geographic region, and must have a letter of support from their local Superintendent or the Superintendent's designee. Eligible applicants may include both existing Hub pilots awarded through the previous Request for Proposals that are not applying as Community Supports Partnerships, as well as applicants from areas of the state not previously awarded a Hub pilot grant. A list of jurisdictions eligible for Hub capacity-building grants is included in Appendix D.

Each Partnership will have one Hub. Partnerships may be formed at the jurisdictional level (i.e., county or City of Baltimore). Smaller jurisdictions may form a regional Partnership. Partnerships may not overlap. At full implementation, every school and community will be covered by one Partnership with one Hub. Partnerships and their Hubs must serve all public school students in the geographic area and may not "specialize" in certain sub-groups of students or intervention types.

Hub capacity-building grants will help organizations develop capacity to serve as Hubs in future Community Supports Partnerships. Partnerships will be organized using the Collective Impact model, with the Hub serving as the "backbone" for the Partnership. For more information on the Collective Impact model, visit: https://ssir.org/articles/entry/collective_impact. At full implementation, Partnership Hubs will have three primary functions: (1) coordinating service providers/Spokes, (2) acting as a fiduciary by managing grants from the CHRC and awarding grants to Spokes as subgrantees, and (3) collecting and reporting data. During this grant period, the CHRC will perform these functions for the service providers in a Hub's geographic area, while Hubs will engage in a statewide quality improvement learning collaborative to help prepare them to lead future Partnerships in their geographic areas. Capacity-building activities will include the development of a number of deliverables, including: Governance Plan, Needs Asset, Asset Map, and Service Referral Plan.

Hubs will ensure services within the Partnership are coordinated with other public health and child-serving agencies, including LEAs and schools, LBHAs, LMBs, Local Care Teams, Local Departments of Social Services, Local Health Departments, etc. Regardless of the organization that serves as a Hub for each area, each of these systems must be integrated into the Partnership in clearly defined ways. Partnerships should augment, and not duplicate, existing structures that are working.

HUB CAPACITY-BUILDING GRANT PROPOSAL REQUIREMENTS

Project proposals should be clear and concise, single spaced, in 11 or 12 point font. Proposals should be less than 12 pages, excluding table of contents and appendices. Brevity is encouraged. All pages of the proposal must be numbered.

Existing Hub pilots applying for continuing funding will have different requirements than applicants for new Hub capacity-building grant.

A. Existing CHRC/Consortium Hub pilot grantees only: Existing Hub pilots may apply for continuing funding as they seek to become ready to lead full Community Supports Partnerships. Proposals should be structured as follows.

1. Describe status of staff hiring under the existing Hub pilot grant.
2. Discuss ability to receive and analyze data collected by service providers, as well as data from other sources including population-level data.
3. Describe the status of any data-sharing agreements between the applicant and service providers, as well as between the applicant and the LEA.
4. Describe local procurement requirements that will need to be followed in order to subcontract with service providers in a full Community Supports Partnership.
5. Describe engagement to date with service provider grantees in the area. Describe organization's role in working with LEAs to vet service provider applicants for letters of support for this RFA.
6. What steps will be required in order for the applicant to be ready to serve as a Hub in a full Community Supports Partnership? What is the timeline for achieving these steps?
7. Describe any additional capacity-building activities to be completed by the Hub pilot during the grant period.
8. Discuss any remaining work to further refine deliverables on page 23 and below.
9. Mandatory Appendices
    - Hub pilot deliverables: Submit in the appendix updated copies of the following deliverables produced during the current grant period, including any required revisions:
        1. Hub governance plan
        2. Needs Assessment
        3. Asset Map
        4. Service referral plan
    - b. Letter of support from Local Education Agency
10. Optional Appendices
    - Letter of support from the LBHA/LMB not serving as the Hub
11. Additional materials listed on page 34-35.

B. Applicants not currently serving as Hub pilots: Organizations not currently serving as Hub pilots must use the following format in their proposals:

1. Staffing Plan

- What permanent staff positions will the applicant create in order to complete the Hub capacity-building grant deliverables listed on page 23?
- What strategies will the applicant use to recruit and hire new personnel for these positions?
- If the applicant is unable to recruit staff for the positions expeditiously, how will the applicant complete the requirements of the Hub Pilot grant?

- How will new Hub staff fit into the applicant's current staffing structure?
- Describe any additional staff positions projected after the capacity-building phase (i.e., if the applicant becomes a full Community Supports Partnership in FY 2027).

2. Collaboration and community consensus

- How will the LEA, LBHA, and LMB be integrated into the governance and operations of the Partnership? Describe any current and/or proposed contractual relationships. If applicable, include a proposed organizational chart.
- How will the Hub integrate the local Department of Social Services, Local Care Teams, and other child-serving agencies into the governance and operations of the Partnership?
- List the agencies that would be involved in the governance of the Partnership through a Steering Committee and/or Advisory Board. How will the voices of students and families be incorporated?
- For regional Hub Pilot applicants only, describe your model, i.e., does the organization currently serve all the jurisdictions in the Hub Pilot proposal, or will the organization partner with another organization(s) for the proposal? If applicable, which organization will serve as the lead applicant? What will be the roles and responsibilities of each partner? Describe the potential strengths and weaknesses of a regional approach for the communities to be served.
- Include letters of support in the appendix.

3. Service Coordination

- What is the applicant's experience coordinating behavioral health services for youth and adolescents?
- How does the applicant currently cooperate with the schools that would be served by the Partnership?
- Describe the applicant's commitment to evidence-based approaches and innovation. Provide specific examples.
- Describe the applicant's experience and capacity to coordinate services at all three Tiers of the Multi-Tiered System of Supports (MTSS).
- Describe the applicant's experience coordinating the following types of services: prevention/mental health promotion, small group interventions, substance use interventions, family supports, individual and group therapy, wraparound supports, and navigation/interventions to address Social Determinants of Health (SDOH). This description should refer to specific programs listed in the proposal's appendices.
- Describe the applicant's experience coordinating services for the following age groups: early childhood, elementary school, middle school, and high school. List specific programs currently supported and listed in the appendices.
- Comment on the applicant's commitment to work with service providers awarded by the CHRC. Describe engagement to date, if any, with existing service provider grantees and new service provider applicants in the area. Describe organization's role, if any, in working with LEAs to vet service provider applicants and provide letters of support.

- If the Hub applicant has also received a service provider grant through the previous Call for Proposals, or is applying for a service provider grant under this RFA, describe safeguards that would ensure accountability. Would the Hub and service provider functions exist in different units within the applicant organization? Would there be shared staff? Would the unit responsible for the Hub be subordinate to or under the authority of the unit responsible for service provision? (Note: The CHRC strongly discourages shared staff between Hubs and service providers, and advises that the unit responsible for the Hub not be subordinate to or under the authority of the unit responsible for service provision.)

4. Fiduciary Capacity

- How is the applicant organization currently funded?
- Describe the applicant's internal systems and software for fiscal management.
- Describe the applicant's capacity to potentially leverage additional sources of funding for Hub activities.
- Describe the applicant's procurement timeline. If awarded a Partnership grant under a future RFA, how much time would be required to distribute funds to service providers as subgrantees?

5. Data Capacity

- Describe the applicant's current systems for collecting and reporting data, including any software systems.
- Provide examples of measures currently collected and reported.
- Describe the applicant's experience analyzing data from such sources as the Youth Risk Behavioral Surveillance (YRBS) survey, MSDE school survey, MSDE attendance and discipline data, Chesapeake Regional Information System for our Patients (CRISP), Medicaid claims data, etc.
- Describe any request for modest, one-time upgrades to IT systems in order to implement the pilot program. Note: In future years, Hubs may be required to utilize a common platform; as such, requested investments in data systems should be minimal.

6. Budget Spreadsheet and Narrative

- Please use CHRC templates. You may add or remove rows as applicable.
- The CHRC anticipates that the amount awarded for each Hub grant will be in the range of $300,000 to $500,000 over a 12-month period.
- The CHRC will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards.

7. Mandatory Appendices

a. Copy of existing community needs assessment prepared by the applicant.
b. Letter of support from Local Education Agency
c. Copy of current or draft MOU with LEA (if applicable).
d. List and brief description of relevant programs currently supported, including any Tier 1 interventions.

e. Copy of applicant's overall organizational budget including all sources of funding.
f. List/table of all current grants received that the applicant has received and is currently implementing. Please include source of funding, funding amount, time period of grant, one-sentence description, and whether the grant is renewable.
g. List/table of all current grants that the applicant has awarded to other groups and is currently monitoring. Please include original source of funding, funding amount, time period of grant, one-sentence description, and whether the grant is renewable.

- **Optional Appendices**
  a. Letter of support from the LBHA/LMB not applying to be the Hub
  b. Letters of support from other child-serving agencies

- **Additional materials listed on page 34-35.**

SCORING RUBRIC – HUB CAPACITY-BUILDING GRANTS

Criteria	Score
1. Experience coordinating a broad array of behavioral health services in schools	20
2. Experience as a fiduciary	20
3. Experience collecting and reporting data	20
4. Collaboration and community consensus	20
5. Budget and staffing plan are reasonable	20
TOTAL	**100**

V: TRACK 3: GRANTS TO SERVICE PROVIDERS

This RFA will provide direct funding for service providers in areas of the state that are not eligible for Community Supports Partnerships grants. A list of jurisdictions eligible for service provider grants is included in Appendix D. The CHRC will not consider applications for direct funding for service providers in areas of the state to be covered by a Community Supports partnership; service providers in these areas must work through their pilot Hub.

Service provider applicants may request grants for more than one jurisdiction; however, a separate application must be submitted for each jurisdiction to be served.

Applicants are required to demonstrate that their programs respond to documented local needs and priorities. Applicants should use Needs Assessments and other data to justify their programming (see Appendix L). Applicants in Baltimore City, Baltimore County, and Montgomery County are encouraged to align proposals with needs identified by Hub pilots (see Appendix D).

All applicants must provide a letter of support signed by their local Superintendent or the Superintendent's designee that demonstrates genuine collaboration and alignment with their Local Education Agency (LEA). LEAs are encouraged to communicate clear priorities for their school districts and work with service providers on proposals that will address unmet needs. Collaboration can be demonstrated by identifying specific meeting dates, points of contact, commitments about when and where services will be provided, clear understandings about any physical space requirements, EBP requirements, and details about the respective roles and responsibilities of the school(s) and service provider. Specific schools should be identified if possible, including commitments from school principals. LEAs may provide additional guidance to grantees after awards are made to ensure the equitable distribution of services to schools across their jurisdictions. LEAs are asked to attest that grant funding would not supplant existing funding for student behavioral health. A sample letter is provided in Appendix K. Service provider applicants also should demonstrate collaboration with their LBHA, LMB, and/or other local child-serving agencies.

Funds from this grant may not supplant current funding for services and supports. Funds may be requested to sustain programs launched through the CHRC/Consortium's previous Request for Proposals for service providers. Grant funds may be requested for new or existing programs. An established program currently funded through another source can receive grant funding under this Request for Applications if the funding represents an expansion of services or an increase in the number of individuals served. When possible, Medicaid reimbursement should be sought, and grant funding should support activities that are not Medicaid reimbursable.

All services do not need to be provided in the school building, but must be strategically coordinated via ongoing and regular communication and collaboration with the district and schools to augment their existing Multi-Tiered System of Supports (MTSS). If applicable, applicants are encouraged to include in their proposals plans for transportation of students and/or family members to services and may request grant funding to this end.

This RFA will support interventions at each of the three tiers of the MTSS: Tier 1 (universal promotion/prevention), Tier 2 (early intervention), and Tier 3 (treatment). Providers are ***not*** required to offer supports and services at each tier. See page 10-11 for more information about MTSS.

SERVICE PROVIDER PROPOSAL REQUIREMENTS

Project proposals should be clear and concise, single spaced, in 11 or 12 point font. Proposals should be approximately 10-12 pages (approximately 5000 words or less), excluding table of contents, executive summary, budget, and appendices. Brevity is encouraged. All pages of the proposal must be numbered.

The project proposal should be structured using these topic headings:

- Table of contents (not included in page/word limit)

- Executive Summary (300-500 words, not included in page/word limit)
- Current CHRC/Consortium grantees only: Prior grant performance (300-800 words, not included in page/word limit)
- Proposal:
    1. Background and Justification
    2. Organizational Capacity
    3. Financial Capacity
    4. Project Plan
    5. Coordination/Integration
    6. Engagement with students and families
    7. Ability to demonstrate measurable outcomes
    8. Project Budget and Budget Justification (not included in page/word limit)

- Mandatory Appendices
    a. Letter of support from local Superintendent or Superintendent's designee (see sample letter in Appendix K); letters jointly signed by LEA and LBHA/LMB are strongly encouraged
    b. Resumés of key staff
    c. If indicated in application, sliding scale fee schedule
    d. Current grantees only: copy of Milestones & Deliverables report for July-December 2024, metrics plan, Progress Report #4
- Optional Appendices
    a. Additional letters of support from LBHA, LMB, Local Health Department, County Executive, County Council, other child-serving agencies, implementation partners, and/or community organizations
    b. Letters of support from principals of schools where services will be offered
- Additional materials listed on pages 34-35.

Detailed instructions follow.

Executive Summary (300-500 words, not included in page/word limit)

- What jurisdiction(s) will be served?
- How many total unduplicated students will receive grant-funded services? (see definition in Appendix H).
- How many of these unduplicated individuals will receive services at each of the three MTSS Tiers: Tier 1 (universal/prevention), Tier 2 (brief/small group), and Tier 3 (individual)? See pages 10-11.
- Briefly describe the priorities and unmet needs that the program proposes to address. Applicants serving Baltimore City, Baltimore County, and Montgomery County should reference the local Hub pilot Needs Assessment (see Appendix D).
- What is the program's overall focus?
- What key services will be provided (see page 13)?

- What key Evidence-Based Programs will be implemented (see pages 14-15)? How is the organization planning for staff training and on-going implementation support in the EBP(s), including participation in EBP implementation support calls? How will the EBP(s) be utilized in programming and implemented with fidelity?
- Briefly describe how the program will integrate with existing services in the school and community.
- Funding amount requested, and brief description of other sources of funding (Medicaid, commercial insurance, local grants, in-kind, etc.).

Prior grant performance (current CHRC/Consortium grantees only**,** 300-800 words, not included in page/word limit)

- Describe accomplishments under the current grant, qualitative and quantitative.
- Describe any proposed changes to the current grant-funded program.
- Describe any lessons learned during the current grant and how those lessons would be applied in a future grant.
- Describe applicant's efforts to maximize Medicaid revenue during the current grant period.
- Include in the appendix a copy of the applicant's:
    - Milestones & Deliverables report covering July-December 2024;
    - current metrics plan; and
    - Progress Report #4, covering November-December 2024.

1. Background and Justification

- Briefly describe the population(s) to be served (i.e., demographics, insurance coverage, income levels, etc.).
- Provide evidence that the proposed program responds to a documented local priority.
    - Applicants serving Baltimore City, Baltimore County, and Montgomery County should reference the local Hub pilot's Needs Assessments (see Appendix D).
    - Other applicants may use community health needs assessments, LBHA and/or LMB Needs Assessments, Community Schools Needs Assessments, information from LEAs, and/or other sources to describe the unmet needs and priorities. Use quantitative and/or qualitative data. Recommended data sets are included in Appendix L – select a few data points that best highlight the need for the program; do not include every measure.
- If applicable, list the schools that will receive services and explain the reasoning for selecting these schools.
- Will certain sub-groups of students/families within those schools be prioritized? Why? How?
- How will the proposed services address health equity?

2. Organizational Capacity

- Briefly describe the organization's mission, structure, and governance.

- Describe the organization's history of supporting youth and adolescent behavioral health. Describe the organization's history of working in schools. Describe the organization's history of working with the target community.
- Describe the organization's staff. Include information about staff training and cultural and linguistic competency. Describe the extent to which the staff reflects the community served. Provide an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's staff and/or the organizational approach to achieve racial and ethnic diversity proportional to the community served.
- Describe the qualifications and licensure of key staff. Provide resumés of up to five key staff in the appendix.

3. Financial Capacity

- Briefly describe the organization's history of financial management.
- Does the organization currently bill Medicaid? If so, include Medicaid provider number. Describe existing capacity to bill Medicaid and any barriers to Medicaid billing. Which services will be eligible for Medicaid reimbursement? Which services are not billable? (Note: Medicaid billing is not a prerequisite; applicants that do not bill should briefly explain the reasons.)
- Applicants are asked in the cover sheet to describe how grant funds may complement any anticipated Medicaid revenues. Restate information from the cover sheet and provide more detail as needed.
- How are any anticipated Medicaid revenues accounted for in the proposed budget (i.e., budget does not request grant funding for portions of FTEs that will be funded through anticipated Medicaid revenues)?
- If applicable, will a sliding scale fee schedule be supported? If so, include sliding scale fee schedule in the appendix.
- If applicable, will private commercial insurance be billed? If so, will grant funds be used to pay co-pays to private insurers according to an income-based sliding scale fee schedule? Describe how co-pay support will document client need (i.e., a client hardship form to request copay support, etc.). How are these anticipated revenues reflected in the proposed budget (i.e., budget does not request grant funding for portions of FTEs that will be funded through anticipated Medicaid revenues, budget includes co-pay support only, etc.)?
- What other sources of funding will support the organization's existing and new school-based services (e.g., local support, other grants, hospital community benefit, etc.)? See Appendix O for a list of other grant-making organizations. How will grant funding from this RFA be blended with funding from other sources? Describe any in-kind support that will be provided. Will matching funds be provided by the applicant?
- Applicants must fill out, sign, and attach the CHRC legal and financial disclosure form.

4. Program design and prospects for success

- Which services will be provided? Be clear and concise. Note: proposals that are overly complex may be less likely to be awarded under this RFA.
- What date will services begin? To what extent is the program "shovel-ready?"

- How many total unduplicated youth, families, and others will receive grant-supported services (see definition of Unduplicated Individuals Served in Appendix H)? How many of these unduplicated individuals will receive services at each of the three tiers of MTSS (see pages 10-11). Briefly describe your methodology for developing these estimates and how you will ensure students are not counted more than once.
- Where will services be provided? If applicable, describe commitment from schools to make confidential spaces available. If services will not be provided in the school building, describe means to facilitate access to services (e.g., transportation, etc.).
- What times during the day will services be provided? If applicable, describe commitment from schools to permit students to receive services during these times. Will services be provided over the summer?
- What evidence-based strategies will be used (see menus of Priority and Recommended evidence-based programs on page 4 and in Appendices F and G)? How is the organization planning for staff training and on-going implementation support in the EBP(s)? How will the EBP(s) be utilized in programming and implemented with fidelity? Be specific.
- Discuss the organization's plans for meeting EBP training and implementation expectations (see Appendix F). In addition to initial EBP trainings, grantees should expect 60-minute EBP implementation support calls quarterly. Budgets and staffing plans should reflect this commitment.
- Discuss the organization's willingness and commitment to participate in training, technical assistance, and grant monitoring provided or coordinated by the CHRC, Consortium, and NCSMH. Grantees should plan for CHRC mandatory technical assistance calls approximately once per month for 90 minutes, as well as individual consultations. Budgets and staffing plans should reflect these commitments.
- What other strategies will be used, and how are they justified (see pages 13-14)?
- How will the program address challenges in hiring and retaining behavioral health staff (see pages 16-17)?
- How will referrals be made to the program? How will services be "marketed" to families and school staff?

5. Coordination/Integration

- Describe collaboration with the Local Education Agency (LEA) in developing the proposal, including specific meeting dates. How will school staff be involved in the implementation of the program? How will student information be shared with school staff?
- How will the proposed program integrate with existing behavioral health services and supports for the target population and the identified schools? How will the proposed program avoid duplication?
- Describe all partners who will be involved in the program, including referral partners and others. Describe the processes and organizational structures that will be put into place to ensure that the partnership(s) are effective. Include letters of commitment in the appendix. How will information be shared between partner organizations?
- Will the program address the holistic needs of children and families, including medical needs and non-medical Social Determinants of Health? Describe any referral relationships.

- Will Community Schools be served (see Attachment N)? If so, how will the program integrate with services provided by Community Schools? If applicable, how does the program respond to Needs Assessments developed by Community Schools?
- Discuss any reservations about working with a local Partnership Hub organization in the future.
- The appendix must include a letter of support from the Superintendent or the Superintendent's designee. Include a name and contact information for the LEA. Joint letters from LEAs and Local Behavioral Health Authorities (LBHAs) and Local Management Boards (LMBs) are highly encouraged. A sample letter is included in Appendix K.

6. Engagement with families and communities

- How is youth voice incorporated in the design and implementation of the program?
- Describe the extent to which families and communities were consulted in program design.
- How will feedback from families and communities be collected and incorporated into future programming?
- How will parents and families be involved in treatment plans, if applicable?
- Please include in the appendix any letters of support from key community agencies and organizations (e.g., community-based organizations, Departments of Social Services, etc.)

7. Ability to demonstrate measurable outcomes

- Describe the organization's capacity for data management and outcomes reporting. What data systems will be used? Note: Grant funding may be requested for data systems.
- Comment on the organization's ability to collect and report standardized data measures on pages 15-16. Discuss any measures that will *not* be collected. Optional: What additional, customized process and outcome measures could be collected to demonstrate the impact of this program?
- Which validated assessment tools will be used to demonstrate impact? (See Appendix I)
- Describe how the organization currently conducts self-assessment as part of continuous quality improvement efforts. If applicable, describe support needed to build the organization's evaluation capacity. Note: grantees will be required to consult with the CHRC and NCSMH to review data and assessment strategies.
- How will student and family satisfaction be measured? Please include a copy of any satisfaction survey in the appendix.
- Does the organization utilize an EMR system?
- How will the program ensure that the count of individuals/families served is unduplicated?

8. Project Budget and Budget Justification

- Please use CHRC templates. You may add or remove rows as applicable.
- Note: The average award amount during the last round of service provider grants was approximately $750,000.
- The CHRC will examine budget requests closely and may request revisions on a case-by-case basis prior to making final awards.

Appendices and additional materials (see pages 29 and 34-35)

SCORING RUBRIC – SERVICE PROVIDERS

Criteria	Score
1. Responds to documented local priority; promotes health equity; prioritized by LEA	15
2. Organizational capacity: history of working with students and schools, cultural and linguistic competency, financial capacity	15
3. Program design and prospects for success: use of EBPs and/or other strategies, starting date for services, holistic approach, staffing plan, referral process	20
4. Priority EBP and/or Measurement-Based Care learning community are selected and integrate well into planning and programming	5
5. Coordination/Integration: integration and alignment with existing programs, ability to be a "team player"	10
6. Evidence of engagement with schools, families, and communities in the planning and execution of programming	10
7. Ability to demonstrate measurable outcomes	15
8. Budget is reasonable and commensurate with project impact, maximizes Medicaid revenue attainment where appropriate, reflects Medicaid and other revenues in budget as applicable, good return on investment	10
TOTAL	**100**

VI. HOW TO APPLY – ALL TRACKS

Full application requirements: Full grant applications must include the following items:

1. Transmittal Letter: This letter from the applicant organization's chief executive officer should specify the title of the proposal, the applicant organization, and the project director and state that the applicant organization understands that submission of a proposal constitutes acceptance of the terms of the grants program.

2. Grant Application Cover Sheet: Cover sheets will be submitted electronically through the Smart Sheet accessible at this URL: https://app.smartsheet.com/b/form/c670e21a5ce244d396cb7cbb3f35ff4a. Applicants may print a copy to include with their application package. Cover sheets should only be submitted as part of complete grant applications.

3. Grant proposal including Executive Summary (if applicable), Table of Contents, Budget Template (spreadsheet), Budget Narrative, and Required and Optional Appendices, including Letters of Support (if applicable): See requirements for the applicant's Track.

4. Other required submission materials for all proposals:

(A) Contractual Obligations, Assurances, and Certifications: The agreement should be completed and signed by either the chief executive officer or the individual responsible for conducting the affairs of the applicant organization and authorized to execute contracts on behalf of the applicant organization. LINK to form

(B) IRS Form W-9

(C) Financial and legal disclosure: LINK to form

(D) Audited financial statements and/or IRS Form 990 or other applicable IRS tax filing (prefer both financial statements and tax return)

(E) Behavioral health license, if the applicant is licensed

Electronic Submission: Full grant applications (see components listed below) must be submitted to the CHRC via Smartsheet no later than **3:00 p.m., on February 4, 2025**. Applicants may request an official confirmation of receipt by emailing: **mdh.consortium@maryland.gov** to confirm and document the uploaded submission.

Applicants will upload the following files:

File 1: Signed Transmittal Letter
File 2: Grant Obligations & Assurances and Legal & Financial Disclosure (One file - 2 individual documents)
File 3: Executive Summary and Proposal (One file containing: Executive Summary, Table of Contents, Proposal) – see requirements for each Track, searchable PDF format preferred
File 4: Budget Template (Excel format)
File 5: Budget Narrative (PDF format)
File 6: Mandatory and Optional Appendices – see requirements for each Track, PDF format
File 7: Audited financial statements and/or IRS Form 990 or other applicable IRS tax filing (prefer both financial statements and tax return)
File 8: W-9
File 9: Behavioral health license, if applicable

Courtesy Copy: The CHRC is requesting that applicants mail a "courtesy copy" of one original grant proposal. The original hard copy full grant application must include a signed original of the items listed above.

The original grant application with all items listed above, and all appendices or attachments, must be bound together and labeled "Original." The original copy of all application documents should be comb bound or spiral bound with long edge binding. Do **not** use three ring binders.

The courtesy copy of the full grant application should be sent to CHRC staff at the address below:

Jen Clatterbuck, CHRC Administrator
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Evaluation of applications will be performed by a committee established for that purpose and based on the evaluation criteria set forth in this RFA. The CHRC reserves the right to utilize the services of individuals outside of the established evaluation committee for advice and assistance, as deemed appropriate.

Frequently Asked Questions Calls: Two Frequently Asked Questions calls for potential applicants will be held on **December 18 at 10:00 AM and January 15 at 10:00 AM**. Zoom information can be found on page 9. The call will be recorded and posted on the CHRC website. A written list of Frequently Asked Questions will be posted on the CHRC website. Participation in these calls is not required for applicants. Applicants may submit questions in advance through this LINK.

CHRC staff members:

Mark Luckner, Executive Director
E-mail: mark.luckner@maryland.gov

Bob Lally, Chief Financial Officer
E-mail: bob.lally@maryland.gov

Lorianne Moss, Program Manager
E-mail: lorianne.moss@maryland.gov

Amy Yakovlev, Deputy CFO
E-mail: amy.yakovlev@maryland.gov

Angelina Oputa, Program Manager
E-mail: angelina.oputa@maryland.gov

Jen Clatterbuck, CHRC Administrator
E-mail: jen.clatterbuck@maryland.gov

Michael Fay, Program Manager
E-mail: michael.fay@maryland.gov

Emily Kilmon, Administrative Specialist
E-mail: emily.kilmon@maryland.gov

Nellie Washington, HERC Director
E-Mail: nellie.washington@maryland.gov

Ed Swartz, Financial Advisor
E-mail: ed.swartz@maryland.gov

Appendix A.

Commissioners, Maryland Community Health Resources Commission

Edward J. Kasemeyer, CHRC Chair, Former Senator and Chair of the Maryland Senate Budget & Taxation Committee

Dr. Sadiya Muqueeth, CHRC Vice Chair

Scott T. Gibson, Chief Strategy Officer, Melwood Horticultural Training Center, Inc.

Flor D. Giusti

Dr. Maria J. Hankerson, President, Visions & Outcomes, Unlimited

Dr. Terris King, CEO and Founder, King Enterprise Group

David Lehr, Chief Strategy Officer, Meritus Health

Roberta "Robbie" Loker

Destiny-Simone Ramjohn, PhD, Vice President, Community Health and Social Impact, CareFirst

TraShawn Thornton-Davis, MD, Assistant Service Chief, OB/GYN, DCSM, Mid-Atlantic Permanente Medical Group

Jonisha Toomer, LCPC, Executive Director, Right Step, LLC

Appendix B.

Members, Maryland Consortium on Coordinated Community Supports

David D. Rudolph, former Delegate and Chair, Maryland Consortium on Coordinated Community Supports

Erin McMullen, Maryland Department of Health | Chief of Staff, Office of the Secretary

Mary Gable, Maryland State Department of Education | Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy

Gloria Brown Burnett, Maryland Department of Human Services | Deputy Secretary for Operations

Edward Kasemeyer, Maryland Community Health Resources Commission | Chair

Derek Anderson, Director of Community Schools | Maryland State Department of Education

Christina Bartz, Council on Advancement of School-Based Health Centers | Director of Community Based Programs, Choptank Community Health Systems

Dr. Derek Simmons, Public School Superintendents Association of Maryland | Superintendent, Caroline County Public Schools

Tammy Fraley, Maryland Association of Boards of Education | Allegany County Board of Education

Dr. Donna Christy, Maryland State Education Association | School Psychologist, Prince George's County Public Schools

Gail Martin, Maryland Chapter of the National Association of Social Workers | former Baltimore County Public Schools Team Leader, School Social Work

Dr. John Campo, MD, Maryland Hospital Association | Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital

Sadiya Muqueeth, DrPH, MPH, member, Maryland Community Health Resources Commission | Chief Health Policy Officer, Baltimore City Health Department

Ryan Moran, representative of the Maryland Medical Assistance Program | Deputy Secretary, Health Care Financing and Medicaid Director, Maryland Department of Health

Larry Epp, Ed.D., representative of the community behavioral health community with telehealth expertise | Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System

Stephen Liggett-Creel, local Department of Social Services | Director, Prince George's County Department of Social Services

Michael A. Trader, II, representative of local departments of health | Director of Planning, Quality, and Core Services, Worcester County Health Department

Dr. Kandice Taylor, member of the public with expertise in equity in education | School Safety Manager, Baltimore County Public Schools

The Honorable Katie Fry Hester, Maryland Senate

The Honorable Eric Ebersole, Maryland House of Delegates

The Consortium currently has five vacancies

Appendix C.

Abbreviations

ADHD: Attention Deficit Hyperactivity Disorder
ACE: Adverse Childhood Experience
Blueprint: Blueprint for Maryland's Future legislation, Chapter 36 of 2021
CDC: Centers for Disease Control and Prevention
CHRC: Maryland Community Health Resources Commission
Consortium: Maryland Consortium on Coordinated Community Supports
DDA: Maryland Developmental Disabilities Administration
EBP: Evidence-Based Program
EIN: Employer Identification Number
EMR: Electronic Medical Records
FY: Fiscal Year
HPSA: Health Professional Shortage Area
HRSA: Health Resource and Services Administration
IEP: Individualized Education Program
Jurisdiction: a Maryland county or Baltimore City
LBHA: Local Behavioral Health Authority
LEA: Local Education Agency, or school district
LGBTQ+: lesbian, gay, bisexual, transgender, queer, or questioning persons or community
LMB: Local Management Board
MANSEF: Maryland Association of Nonpublic Special Education Facilities
MDH: Maryland Department of Health
MOU: Memorandum of Understanding
MSDE: Maryland State Department of Education
MTSS: Multi-Tiered System of Supports
NCSMH or National Center: National Center for School Mental Health
Partnerships: Community Supports Partnerships
PHI: Protected Health Information
PII: Personally Identifiable Information
RFA: Request for Applications, previously called Request for Proposals or Call for Proposals (RFP)
RFP: Request for Proposals, or Call for Proposals; now called Request for Applications (RFA)
SAHIE: Small Area Health Insurance Estimates program
SDOH: Social Determinants of Health
SHAPE: School Health Assessment and Performance Evaluation, assessment developed by NCSMH, https://theshapesystem.com
TCM+: Targeted Case Management Plus
YRBS: Youth Risk Behavior Surveillance System

Appendix D.

How to apply – By Jurisdiction

Track 1 – service providers should contact the Hub pilot. The Hub pilot will submit an omnibus application to the CHRC for the Partnership as a whole, including service providers.
Track 2, 3 – applicants should contact the Local Education Agency (LEA) for a letter of support, and apply directly to the CHRC. Hub pilot is listed as a point of contact for Needs Assessment and other information.

Jurisdiction	Eligible Application Track	Point of contact for applicants
Allegany Co.	1	Hub pilot: Fred Polce, Fred.Polce@maryland.gov
Anne Arundel Co.	2,3	Hub pilot: Marcie Gibbons, mgibbons@aamentalhealth.org and Adrienne Mickler mhmick00@aacounty.org
Baltimore City	2,3	LEA: Courtney Pate, Director, Office of Health and Specialized Student Services, cmpate@bcps.k12.md.us Hub pilot: Steve Johnson, Steve.Johnson@bhsbaltimore.org
Baltimore Co.	2,3	LEA: Patricia Mustipher pmustipher@bcps.org Hub pilot: Ari Blum, ablum@baltimorecountymd.gov
Calvert Co.	2,3	LEA: Suzanne McGowan, Supervisor of Student Services, mcgowans@calvertnet.k12.md.us
Caroline Co.	2,3	LEA: Cara Calloway, Mental Health Coordinator, calloway.cara@ccpsstaff.org
Carroll Co.	2,3	LEA: Karl Streaker, KarlStreaker@carrollk12.org
Cecil Co.	2,3	LEA: Kristen Lehr, Coordinator for Behavior and Mental Health Services, kblehr@ccps.org
Charles Co.	2,3	LEA: Dr. Mike Blanchard, Supervising School Psychologist, mblanchard@ccboe.com and Kathy Kiessling, Director of Student Services, kkiessling@ccboe.com
Dorchester Co.	1	Hub pilot: Taylor Garrett, tgarrett@midshorebehavioralhealth.org
Frederick Co.	2,3	LEA: Ann Workmeister Ann.Workmeister@fcps.org 240.586.8761, Dana Falls, Director of Student Services Dana.Falls@fcps.org
Garrett Co.	1	Hub pilot: Fred Polce, Fred.Polce@maryland.gov
Harford Co.	1	Hub pilot: Laurie Rajala, lrajala@harfordmentalhealth.org
Howard Co.	1	Hub pilot: Kim Eisenreich, kaeisenreich@howardcountymd.gov
Kent Co.	1	Hub pilot: Taylor Garrett, tgarrett@midshorebehavioralhealth.org

Montgomery Co.	2,3	LEA: Farrah Jones, Farrah_T_Jones@mcpsmd.org, Christina Conolly Chester, christina_n_conollychester@mcpsmd.org Hub Pilot: Shawn Lattanzio, Shawn.Lattanzio@montgomerycountymd.gov
Prince George's Co.	2,3	LEA: YCFT@pgcps.org
Queen Anne's Co.	1	Hub pilot: Taylor Garrett, tgarrett@midshorebehavioralhealth.org
Somerset Co.	1	Hub pilot: Christen Barbierri, LMSW, christen.barbierri@maryland.gov
St. Mary's Co.	1	Hub pilot: Tammy Loewe, tammym.loewe@maryland.gov
Talbot Co.	1	Hub pilot: Taylor Garrett, tgarrett@midshorebehavioralhealth.org
Washington Co.	2,3	LEA: Jeremy Jakoby, Director of Student Services, School Counseling, and School Health, JakobJer@wcps.k12.md.us, Marjorie Sharkey, Behavioral Health Services Coordinator, sharkmar@wcps.k12.md.us
Wicomico Co.	2,3	LEA: Kim Miles, Assistant Superintendent for Student & Family Services, kmiles@mywcps.org
Worcester Co.	1	Hub pilot: Christen Barbierri, LMSW, christen.barbierri@maryland.gov

Appendix E.

Budget Narrative Template
Coordinated Community Supports Grant Application

Applicant Name:

Applicant is required to use this Budget Narrative Template and the provided excel CHRC Budget Templates (see Schedule 1 Overall Project Cost and Schedule 2 CHRC Funding Request).

Grant funds cannot be used for: the purchase or lease of major equipment; construction projects; support of clinical trials; medical devices or drugs that have not received approval from the appropriate federal agency; or lobbying and political activity. Funds may not be used in contravention of the CHRC's Standard Grant Agreement.

CHRC grant funds should **not** pay for activities already covered by other sources. Accordingly, the CHRC requires applicants to disclose other sources of funding that may partially or wholly support activities in their grant proposals. This includes any other state, federal, local, or private grant, as well as anticipated revenues, including Medicaid, Medicare, Health Services Cost Review Commission (HSCRC), Maryland Department of Health (MDH), etc. CHRC funds should supplement and not supplant other sources of funding. As indicated in the RFA, **duplication of funding is prohibited**.

The CHRC will closely examine grant applications for potential duplicate funding, including an assessment of the applicant's request for indirect costs. Applicants may not request direct funding for any activities that are typically included in the organization's indirect cost pool/indirect rate. The CHRC will accept an indirect rate of **up to 15%** (unless the applicant qualifies for a higher indirect rate pursuant to Md. Code Ann., State Finance and Procurement § 2-208(c)), while also requiring applicants to describe activities to be covered within their indirect rate.

Notes

1) There will be several calculations in your budget templates (Schedule 1 and Schedule 2) that do not require any action on your part.

2) **New rows can only be inserted within the Personnel Salary and Contractual expense categories** shown on the CHRC Budget Templates (Schedule 1 and Schedule 2). Ensure formulas are picking up all numbers input into any new rows that are added on the budget templates.

Sustainability

The CHRC fully expects that grantees will braid in other sources of funding to ensure the long-term sustainability of projects and programs seeded with CHRC funding and continues to encourage grantees to leverage CHRC dollars to secure funding from other sources for the purpose of program sustainability. Proposals that have the potential to generate reductions in avoidable hospital utilization should be noted in the sustainability section of the proposal. Please comment on the potential or likelihood that cost savings or retained revenue will be re-invested to support the project after initial CHRC grant funding has been expended. The CHRC is proud that over 75% of its grants have been sustained at least one year or more after the initial grant funding has been expended.

Organization Name/Entity Current Fiscal Year Total Budget

Provide in the **Schedule 1 Budget Template** the organization name and the organization's total current fiscal year budget. **There is no action required on your part to input the same information in the Schedule 2 Budget Template as this information will automatically carry over when you complete Schedule 1.**

Revenues/Total Project Cost

Provide in the **Budget Templates (Schedule 1 and Schedule 2)** all project revenue sources for each year in the requested funding period. Details on what needs to be input in these schedules are outlined below.

Schedule 1 Overall Project Cost Template: In the **Revenue/Total Project Cost top section** of the Schedule 1 template, input the CHRC grant funding amount requested and any other types of anticipated revenue amounts (patient/program revenues/income collected, other grant/funding support, organization match, etc.) for each year in the requested funding period that will fund the overall project cost.

In the **Line-Item Expense budget section** following the Revenue/Total Cost section, provide the line-item expense details for each year in the requested funding period. The total project cost amount in the Revenues/Total Project Cost section must match the Overall Total Project Cost amount in the line-item expense detailed budget. **There is no action required on your part to input information in the CHRC Overall Budget Request column as this information will automatically carry over when you complete Schedule 2.**

Schedule 2 CHRC Funding Request Template: There is no action required on your part to input information for the CHRC grant funding amount requested and other types of revenue amounts that were input on Schedule 1 as this information will automatically carry over when you complete Schedule 1. The CHRC grant funding revenue award amount requested needs to match the CHRC grant budgeted expenses.

Provide in this **Budget Narrative Template** in the text box below a brief description of anticipated revenue (patient/program revenues/income collected, other grant/funding support, organization match, etc.) for each year in the requested funding period that will fund the overall project cost.

Personnel Salaries

Provide in the **Schedule 2 CHRC Funding Request Budget Template** salary dollars and Full Time Equivalent (FTE) details by position type for **only** W-2 employees. Contractual positions should not be included in the salary section but would be included as a line item in the Contractual section. Salary expenses should include all forms of compensation to W-2 employees including services and/or training related to this grant, should not be duplicated by indirect costs, and should be netted by any other revenue sources (i.e., Other Grants, Medicare, Medicaid, etc.).

Budget Narrative Template
Coordinated Community Supports Grant Application

Provide in this **Budget Narrative Template** in the text box below the salary cost and related FTEs by **position type** along with a brief description of work to be performed by each position type. Identify any anticipated salary increases during the life of the grant (i.e., 3% COLA raises in years 2 and 3).

Complete the table below to show the breakout of FTEs by position type, type of support provided to this grant program, and an indication of the number of FTEs already hired and number of FTEs that still need to be hired. Insert additional rows in table as needed.

In Example 1 below, 6 individuals are assumed to work as a Community Health Worker, the position is budgeted for 5 FTEs (i.e., 4 full-time and 2 part-time individuals), and all 6 individuals will provide direct patient care services to the grant program. In Example 2 below, 1 individual is assumed to work as a Program Manager, the position is budgeted for 0.5 FTEs (i.e., 1 part-time), and will provide support to the grant program.

Position Type	Type of Support Provided	Total Program FTEs	FTEs Hired to date	FTEs to be hired
Example 1 – Community Health Worker	Direct Patient Care	5	2	3
Example 2 – Program Manager	Other Grant Support	0.5	0.5	0

Personnel Fringe Benefits

Provide in the **Schedule 2 CHRC Funding Request Budget Template** a fringe benefits amount of up to 25% of overall personnel salaries. The fringe benefits percentage of overall personnel salaries of W-2 employees is automatically calculated on the Budget Template.

If the applicant requests **more than 25% of salary costs for fringe benefits**, the applicant will be required to provide a compelling rationale for exceeding this amount in this **Budget Narrative Template** in the text box below and provide other supporting documentation.

Equipment/Furniture/IT & Telecom/Minor Infrastructure Improvements/Vehicle(s)

Provide in the **Schedule 2 CHRC Funding Request Budget Template** the applicable line items associated with any Equipment, Furniture, IT & Telecom, Minor Infrastructure Improvements, and/or Vehicle(s) costs (purchase or rental costs not included in indirect costs rate).

Provide in this **Budget Narrative Template** in the text box below a brief description of any Equipment, Furniture, IT & Telecom Renovations, and/or Vehicle(s) costs with an explanation for the use of the item(s) to be purchased with grant funding in support of this project. Expenses budgeted in this category should align to one of the five-line items on the budget template: 1) Equipment, 2) Furniture, 3) IT & Telecom, 4) Minor Infrastructure Improvements, and 5) Vehicle(s).

Supplies

Provide in the **Schedule 2 CHRC Funding Request Budget Template** the overall supply costs to be used during the grant period. The supply costs do not need to be listed on separate line items in the Budget Template.

In this **Budget Narrative Template** in the text box below, list out all supply types and related costs and provide an explanation for each supply type.

Travel/Mileage/Parking

Provide in the **Schedule 2 CHRC Funding Request Budget Template** on separate line items the total costs for program participants and for applicant employees.

In this **Budget Narrative Template** in the text below, identify costs and reasons for travel that are applicable to grant specific activities for program participants and employees providing services under the grant (i.e., attending health fairs, community events, services provided under grant etc.).

Staff Trainings/Development

Provide in the **Schedule 2 CHRC Funding Request Budget Template**, the overall staff trainings/development costs. These costs do not need to be listed on separate line items in the Budget Template.

In this **Budget Narrative Template** in the text box below, identify the type of training, position types that will receive the training, and costs related to the training. Explain how this training will benefit the project. This category includes travels costs related to employee training including employee certifications required to provide services under the grant and employee travel related costs (lodging, meals, transportation, parking, etc.) to conferences, training sessions, etc. Expenses budgeted in this category **should exclude salaries** paid to employees attending the training, as those amounts **should be included in the Personnel Salary expenses section of the budget**.

Contractual

In the **Schedule 2 CHRC Funding Request Budget Template** on separate line items, list contractual arrangements over $5,000 and the related costs. For contractual arrangements less than $5,000, input costs in All Other Contractual Arrangements < $5K line items. This section should not include W-2 employees of the applicant.

In this **Budget Narrative Template** for each contract more than $5,000, identify each individual vendor/contractor, the cost of the total contract, and a brief description of what type of service the contract is providing.

Individual Vendor/Contractor	Total Cost	Description of Service Contract Being Provided

Program Marketing Related Expenses

Provide in the **Schedule 2 CHRC Funding Request Budget Template**, the overall program marketing related costs. These costs do not need to be listed on separate line items in the Budget Template.

In this **Budget Narrative Template** in the text box below, list out all marketing related costs (i.e., marketing, advertising, promotional materials/communications/ handouts related to the grant program, etc.) and provide an explanation for each marketing related cost type.

Other Expenses

Provide in the **Schedule 2 CHRC Funding Request Budget Template**, the overall other costs.

In this **Budget Narrative Template** in the text below, identify in sufficient detail any other expenses that do not fit in any of the other direct expense categories outlined above. Expenses associated with employee background checks and finger printing (if applicable) should be included in this category.

Indirect Costs

Indirect costs are for activities or services that may benefit more than one project. **Examples of indirect costs include utilities, insurance, rent, audit and legal expenses, equipment rental, and administrative staff.** The applicant should have internal controls in place to ensure expenses reported in the direct costs categories are not a duplication of reported indirect costs.

Provide in the **Schedule 2 CHRC Funding Request Budget Template** indirect costs amount of up to 15% of overall direct costs. The indirect costs percentage of overall direct costs is automatically calculated on the Budget Template (direct costs = total costs minus indirect costs).

The CHRC will closely examine grant applications for potential duplicate funding, including an assessment of the applicant's request for indirect costs. Applicants may not request direct funding for any activities that are typically included in the organization's indirect cost pool/indirect rate. The CHRC will accept an indirect rate of **up to 15%** of direct costs related to the grant program (unless the applicant qualifies for a higher indirect pursuant to Md. Code Ann., State Finance and Procurement § 2-208(c)), while also requiring applicants to describe activities to be covered within their indirect rate.

Please provide in the table below types (dollar breakdown not required) of expenses included in your indirect costs request. **Any Indirect Costs associated with staffing expenses should include the name of the position type.** Insert additional rows in the table as needed.

Administrative Staff positions that are typically included in indirect costs are clerical, accounting, compliance, human resources, general IT, Senior level positions of the organization, (CEO, Executive Director, Medical Director, Operations leader, etc.), etc. **Any Administrative Staff positions not included in the indirect cost rate but are included in the budget as salaries, must perform duties directly required by the grant. Applicant must have controls to document time spent on the grant and the positions should not already be included in the indirect costs.**

Categories of Indirect Costs (list out position type for staffing costs)
Example 1 - Utilities
Example 2 - Rent
Example 3 – Audit and Legal
Example 4 – Rental of Equipment (list the type of equipment on separate rows)
Example 5 – Administrative Staff (list the type of positions on separate rows)

Appendix E. **Budget Form Template for Schedule 1 Overall Project Cost - Coordinated Community Supports RFA #3**

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

MCHRC MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: Entity Current Fiscal Year Total Budget:

Revenues/Total Project Cost	Year 1 Revenue	Year 2 Revenue	Year 3 Revenue	Total Revenue	% of Total Project Cost
CHRC Grant Funding Request				**$0**	**0%**
Patient/Program Revenues/Income Collected				$0	0%
Other Grant/Funding Support				$0	0%
Organization Match				$0	0%
Total Project Cost	**$0**	**$0**	**$0**	**$0**	**0%**

Line Item Budget for Overall Total Project Cost (add rows if needed)	Year 1 Project Cost	Year 2 Project Cost	Year 3 Project Cost	Overall Project Cost	CHRC Overall Budget Request (see Schedule 2 for details)
Personnel Salary (enter the requested information for each position type and applicable FTEs that are **W-2 employees of the project**)					
FTE, Position Type 1				$0	$0
FTE, Position Type 2				$0	$0
FTE, Position Type 3				$0	$0
FTE, Position Type 4				$0	$0
FTE, Position Type 5				$0	$0
Personnel Salary Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**
Personnel Fringe Benefits (up to 25% of Personnel costs for only **W-2 employees of the project** listed in personnel salary section above)				**$0**	**$0**
Personnel Fringe Benefits % of Overall Personnel Salary	0.0%	0.0%	0.0%	0.0%	0.0%
Total Salary & Fringe Benefits Expense	**$0**	**$0**	**$0**	**$0**	**$0**
Total Salary & Fringe Benefits Expense % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Equipment/Furniture/IT & Telecom/Minor Infrastructure Improvements/Vehicle(s)					
a. Equipment				$0	$0
b. Furniture				$0	$0
c. IT/Telecom				$0	$0
d. Minor Infrastructure Improvements				$0	$0
e. Vehicle(s)				$0	$0
Total Equipment/Furniture/IT & Telecom/ Minor Infrastructure Improvements/ Vehicle(s)	**$0**	**$0**	**$0**	**$0**	**$0**
Total Equipment/Furniture/IT & Telecom/ Minor Infrastructure Improvements/ Vehicle(s) % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Total Supplies				**$0**	**$0**
Total Supplies % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Travel/Mileage/Parking (relates to travel for grant activities but not employee travel related to training)					
a. Program Participants (Client Costs)				$0	$0
b. Staff Costs				$0	$0
Total Travel/Mileage/Parking	**$0**	**$0**	**$0**	**$0**	**$0**
Total Travel/Mileage/Parking % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Total Staff Training/Development (includes employee certifications and employee travel related costs to conferences, training sessions, etc. and excludes salaries related to W-2 employees attending training)				**$0**	**$0**
Total Staff Training/Development % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Contractual (>$5k itemize below with details in budget justification; excludes W-2 employees of applicant/project)					
a.				$0	$0
b.				$0	$0
c.				$0	$0
d.				$0	$0
e.				$0	$0
Total Contractual Expenses	**$0**	**$0**	**$0**	**$0**	**$0**
Total Contractual Expenses % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Total Program Marketing Related Expenses				**$0**	**$0**
Total Program Marketing Related Expenses % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Total Other Expenses (expenses that do not fit in any of the other direct expense categories outlined above; i.e. expense associated with employee background checks/finger printing)				**$0**	**$0**
Total All Other Expenses % of Total Expenses	0.0%	0.0%	0.0%	0.0%	0.0%
Total Indirect Costs: up to 15% of direct costs (direct costs = total costs minus indirect costs; indirect cost rates above 15% refer to Budget Narrative and RFA)				**$0**	**$0**
Indirect Costs % of Direct Costs	0.0%	0.0%	0.0%	0.0%	0.0%
Overall Total Project Cost (must tie back to total project cost amount which is above in row 10)	**$0**	**$0**	**$0**	**$0**	**$0**

Appendix E. **Budget Form Template for Schedule 2 CHRC Funding Request - Coordinated Community Supports RFA #3**

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Organization Name: Entity Current Fiscal Year Total Budget:

Revenues/Total Project Cost	Year 1 Revenue	Year 2 Revenue	Year 3 Revenue	Total Revenue	% of Total Project Cost
CHRC Grant Funding Request	**$0**	**$0**	**$0**	**$0**	**0%**
Patient/Program Revenues/Income Collected	$0	$0	$0	$0	0%
Other Grant/Funding Support	$0	$0	$0	$0	0%
Organization Match	$0	$0	$0	$0	0%
Total Project Cost	**$0**	**$0**	**$0**	**$0**	**0%**

Line Item Budget for CHRC Grant Funding Request (add rows if needed)	Year 1 CHRC Budget Request	Year 2 CHRC Budget Request	Year 3 CHRC Budget Request	Overall CHRC Budget Request
Personnel Salary (enter the requested information for each position type and applicable FTEs that are **W-2 employees of the project**)				
FTE, Position Type 1				$0
FTE, Position Type 2				$0
FTE, Position Type 3				$0
FTE, Position Type 4				$0
FTE, Position Type 5				$0
Personnel Salary Subtotal	**$0**	**$0**	**$0**	**$0**
Personnel Fringe Benefits (up to 25% of Personnel costs for only **W-2 employees of the project** listed in personnel salary section above)				**$0**
Personnel Fringe Benefits % of Overall Personnel Salary	0.0%	0.0%	0.0%	0.0%
Total Salary & Fringe Benefits Expense	**$0**	**$0**	**$0**	**$0**
Total Salary & Fringe Benefits Expense % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Equipment/Furniture/IT & Telecom/Minor Infrastructure Improvements/Vehicle(s)				
a. Equipment				$0
b. Furniture				$0
c. IT/Telecom				$0
d. Minor Infrastructure Improvements				$0
e. Vehicle(s)				$0
Total Equipment/Furniture/IT & Telecom/ Minor Infrastructure Improvements/ Vehicle(s)	**$0**	**$0**	**$0**	**$0**
Total Equipment/Furniture/IT & Telecom/ Minor Infrastructure Improvements/ Vehicle(s) % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Total Supplies				**$0**
Total Supplies % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Travel/Mileage/Parking (relates to travel for grant activities but not employee travel related to training)				**$0**
a. Program Participants (Client Costs)				$0
b. Staff Costs				$0
Total Travel/Mileage/Parking	**$0**	**$0**	**$0**	**$0**
Total Travel/Mileage/Parking % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Total Staff Training/Development (includes employee certifications and employee travel related costs to conferences, training sessions, etc. and excludes salaries related to W-2 employees attending training)				**$0**
Total Staff Training/Development % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Contractual (>$5k itemize below with details in budget justification; excludes W-2 employees of applicant/project)				
a.				$0
b.				$0
c.				$0
d.				$0
e.				$0
Total Contractual Expenses	**$0**	**$0**	**$0**	**$0**
Total Contractual Expenses % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Total Program Marketing Related Expenses				**$0**
Total Program Marketing Related Expenses % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Total Other Expenses (expenses that do not fit in any of the other direct expense categories outlined above; i.e. expense associated with employee background checks/finger printing)				**$0**
Total All Other Expenses % of Total Expenses	0.0%	0.0%	0.0%	0.0%
Total Indirect Costs: up to 15% of direct costs (direct costs = total costs minus indirect costs; indirect cost rates above 15% refer to Budget Narrative and RFA)				**$0**
Indirect Costs % of Direct Costs	0.0%	0.0%	0.0%	0.0%
Overall CHRC Total Funding Request (must tie back to total CHRC grant funding request amount which is above in row 6)	**$0**	**$0**	**$0**	**$0**
Percent of Organization's Total Project Cost	**0%**	**0%**	**0%**	**0%**

Appendix F.

Evidence-Based Practices Menu for Coordinated Community Supports Partnerships 2025-2026

The Consortium will prioritize funding for the Evidence-Based Practices (EBPs) listed in the tables below for which free statewide training and implementation support will be offered by the National Center for School Mental Health, in partnership with intervention developers/trainers. The Consortium partnered with the National Center for School Mental Health is also providing Measurement-Based Care Learning Community (MBC LC) support for both clinicians and agency leaders.

- **Interventions 1-15 are intended for delivery by mental health clinicians and/or other community providers.** Interventions are listed by Tier below.
- **The MBC LC is intended for organizations delivering Tier 2 and 3 interventions**. The MBC LC is offered to grantees to stimulate MBC implementation through training, free resources, ongoing consultation, and peer learning. The MBC LC includes a clinician/provider track and an agency leader track.
- **Interventions 16-19 are intended for delivery by school educators** (e.g., teachers, coaches, administrators). School-employed staff and Hub staff may receive training and supported implementation in these EBPs. These EBPs are not offered to community providers. Schools and school districts should not apply through this RFA, but should use the following link: https://bit.ly/SchoolsAppFY26.

Important Considerations: When selecting interventions for your community, consider fit with the unique strengths, needs, and cultural/linguistic considerations of students and families in your school community. Training, implementation, and staff (POC/Supervisor and trainee) expectations are listed below and should be considered as you select interventions and plan for implementation.

POC/Supervisor Expectations:

Each grantee organization will be asked to designate an **EBP Point-of-Contact (POC), who will be responsible for overseeing the completion of all training and implementation requirements for each provider within their organization, as well as communicating expectations to all trainees within the organization.** Key responsibilities may include, but are not limited to: participating in initial kick-off meetings to review training and implementation plans, monitoring ongoing progress to ensure staff meet training and implementation milestones, coordinating with training teams to provide status updates, and supporting providers in their implementation efforts such as ensuring supervisory support, assistance with fidelity monitoring, and access to needed resources. The success of interventions will be helped by a strong organizational support in establishing and maintaining these new interventions.

Trainee Expectations:

Trainees who participate in priority EBPs are expected to have a plan to fully implement the EBP in their practice. Trainees involved in priority EBPs are also required to 1.) attend all designated training sessions for which they are registered, 2.) participate in quarterly post-training implementation support meetings for each EBP they are delivering, 3.) complete training evaluations for each EBP, and 4.) submit quarterly implementation and fidelity monitoring surveys.

Appendix F.

Implementation Support Requirements:

Implementation support calls are offered for each priority EBP each quarter. **Attendance is *required* at 1 implementation support call each quarter once a provider has been trained**. Supervisors/POCs should ensure that the implementation support requirement is relayed to all providers/trainees attending priority EBP training supported by the Consortium. Trained providers, from previous grant cycles, are also invited to attend implementation calls.

Cultural Responsiveness:

The Cultural Responsiveness column below includes publicly available information on national EBP repositories and/or the intervention website about characteristics of youth and caregivers involved in intervention studies (e.g., race/ethnicity, geography, gender) and/or resources to support cultural relevance. There is significant variability in the number of studies conducted across interventions and the extent to which data were disaggregated for specific population groups.

Appendix F.

Priority Evidence-Based Practices Menu

Tier 3 EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
1	Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)	Addresses emotional disorders, including anxiety, depression, and traumatic stress	6 and up	Individual	Cognitive-behavioral therapy (CBT) for anxiety disorders, depression, and related emotional disorders in children and adolescents	Licensed mental health clinicians	Two-day virtual training (7 hours per day)	**UP-C offers:** 15-treatment group sessions with directions supporting an individual modular approach **UP-A offers:** 10-15 individual sessions (youth dependent)	**UP-C/UP-A** is included in the CA Clearinghouse for Child Welfare with evidence to support use with following demographic groups: Hispanic/Latino, Non-Hispanic White, African American, Asian American, and Pacific Islander populations **Spanish-language Offerings:** **Trainings:** Yes **Materials:** Yes	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings	Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
2 Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	Addresses anxiety, depression, disruptive behaviors, and traumatic stress	5 – 15 years old	Individual (with a few sessions with caregiver) **Note: Disruptive Behavior Modules are parent/ caregiver focused**	Cognitive-behavioral therapy (CBT) protocols for anxiety, post-traumatic stress, depression, and behavioral parent training for disruptive behaviors	Licensed mental health clinicians	2-Day virtual training (8 hours per day)	33 modules available across 4 target areas that can be delivered in an individual format across multiple sessions. **Anxiety** - 7 modules **Conduct** - 12 modules **Depression** -12 modules **Traumatic Stress** - 9 modules	**MATCH-ADTC** is included in the CA Clearinghouse for Child Welfare and NIJ Crime Solutions with evidence to support use in multiple diverse populations. **Note from Developer:** MATCH-ADTC has been primarily tested and found to be effective in youths aged 5-15 in urban and suburban settings. MATCH-ADTC is based on the MAP system (Managing and Adapting Practice) which is inherently responsive to diverse clinical and cultural factors. **Spanish- language Offerings:** **Trainings:** No **Materials:** Caregiver handouts are available in Spanish	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
3	Safety Planning Intervention (Stanley-Brown)	Suicide prevention	6 and up	Individual	Assists at-risk adolescents in creating a list of coping strategies and sources of support to reduce the risk of suicide	School-based staff and related service providers (e.g., school counselors, clinicians, peer support or prevention workers, etc.)	One-day virtual training (7-hour) or split two-day mixed didactic and interactive virtual training	Brief, clinical intervention (20-45 minutes) that can be delivered in an individual format, across multiple sessions	Information not available in national repositories searched. **Spanish-language Offerings:** **Trainings:** No **Materials:** The safety plan form is translated into Spanish for clinicians to use with Spanish-speaking clientele	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
4	Counseling on Access to Lethal Means (CALM)	Suicide prevention	All ages	Individual	Counseling on reducing access to means of self-harm as a key component of suicide prevention	Clinically oriented individuals; relevant to direct service providers	Half day virtual training (3.5-hours)	Brief, clinical intervention (20-45 minutes) that is delivered in an individual format; caregiver(s) included as needed.	Information not available in national repositories searched. **Note from Developer:** The most recent version CALM-AAP is on the American Academy of Pediatrics website and includes a section geared to working with young people (young Black boys and young men in particular) who live in neighborhoods with high homicide rates and whose access to firearms might be their own or one shared among their friends. For more information on resources to support safe suicide care for specific populations, please review: Populations | Zero Suicide (edc.org) **Spanish-language Offerings:** **Trainings:** No **Materials:** A selection of promotional materials are available in Spanish	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
5	Adolescent Community Reinforcement Approach (A-CRA)	Substance Use Disorder	12 to 24 years old	Individual (with a few sessions with caregiver)	Cognitive-behavioral therapy (CBT) to reinforce substance-free lifestyles in adolescents	Master-level clinicians	Two-day training virtual training (6.5 hours per day)	10-14 sessions (10 individual sessions with adolescent, 4 sessions with caregiver)	**A-CRA** is included in the CA Clearinghouse for Child Welfare and NIJ Crime Solutions with evidence to support use with Black, American Indians/ Alaska Native, Asian/ Pacific Islander, Hispanic, White populations and in rural, suburban, and urban areas. For more information on A-CRA's research with diverse populations, please review: Cultural and Gender Relevance | Lighthouse Institute | EBTx | A-CRA | Chestnut Health Systems Cultural Responsiveness Committee Bibliography (chestnut.org) **Spanish-language Offerings:** **Training:** No **Materials:** No	Participants can receive up to 10 credits

Appendix F.

Tier 2 EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
6	The Student Check-Up (Motivational Interviewing)	Therapy/ counseling to elicit behavior change	12 and up	Individual	The Student Checkup is a semi-structured school-based motivational interview designed to help adolescents adopt academic enabling behaviors (e.g., participation in class). School-Based Motivational Interviewing (S-BMI) is a specific type of MI used in the school setting to adopt academic enabling behaviors, decrease risky behaviors, and engage in health-promoting behaviors.	Mental Health Clinicians, trainees, or school-based staff. Prior training and experience using Motivational Interviewing is recommended	Two-day virtual training (7 hours per day)	Single session interview protocol with four structured phases.	Information not available in national repositories searched. **Note from Developer:** The majority of Student Check-Up RCTs were conducted in a small urban setting with graduate students implementing the intervention with over 50% of the middle school student population identifying as Black. **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
7	Therapeutic Mentoring	Mentoring/ Modeling; Coping Strategies	Mentees under 21	Individual	Develops mentor competencies in mental health theory and practice to promote high quality, strengths-based, culturally responsive mentoring	Mentors or paraprofessionals who work directly with youth up to the age of 21. **Training not suited for clinicians; however, clinical supervision is needed**	One-day virtual training (7 hours) + 6 weekly 1- hour follow up sessions OR 12 weekly, 1-hour virtual training sessions	Structured, strength-based support services that can be offered across numerous one-to-one sessions	Information not available in national repositories searched. For more information on Therapeutic Mentoring research, please review: Publications – The Center for Evidence-based Mentoring (cebmentoring.org) **Spanish-language Offerings:** **Trainings:** Unknown **Materials:** Unknown	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
8	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Substance Use Disorder early intervention	9 and up	Individual	Screening, brief intervention, and referral to treatment for substance use disorders	Clinically oriented individuals; relevant to direct service providers	One-day virtual training (5.5 hours	Brief, counseling session; Extended Treatment can be 4-6 sessions (up to 1 hr. each)	**School-Based Brief Interventions for Substance Use Among Youth** is included in NIJ Crime Solutions with evidence to support use with Black and White students **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Participants can receive up to 4 credits

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
9	Cognitive Behavioral Intervention for Trauma in Schools and Bounce Back (CBITS/BB)	Early intervention for students experiencing post-traumatic stress reactions	6th-12th grade (**CBITS**) K-5th grade (**BB**)	**CBITS** weekly group plus 1-3 individual sessions with students **BB** weekly group plus 3 individual sessions	Games and activities that teach skills for healing from traumatic events, as well as cognitive/behavioral therapy to address trauma symptoms	Master-level licensed clinician	**CBITS** is a two-day virtual training (7 hours per day) **Bounce Back** is a two-day virtual training (7 hours per day) **CBITS/BB combination** is a three-day virtual training (7 hours per day)	**CBITS** is a ten-session group delivered over 10-12 weeks (weekly group sessions are 45 mins- 1hr) plus 1-3 individual sessions with students **BB** is a ten-session group delivered over 10-12 weeks (weekly group sessions are 45 mins- 1hr) plus 3 individual sessions **(the last session has to be with a caregiver)**	**CBITS** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic/Latino, and White youth in urban environments **Bounce Back** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with: African American, Hispanic/Latino, and White youth in urban environments **Spanish-language Offerings:** **Trainings:** Yes **Materials:** Yes	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

Tier 1 EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
10	Botvin LifeSkills	Prevention program focused on substance use, coping skills, social skills, etc. (Social-Emotional Learning)	3rd to 12th grade	Universal	A classroom intervention to help adolescents develop confidence and skills to effectively handle challenging situations	One Botvin trained teacher/provider per class lesson	This is a one-day virtual training (6 hours)	8-18, 45-minute lessons taught in the classroom at least 1x per week (total number of lessons varies based on grade level curriculum)	**Botvin LifeSkills** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, White, Hispanic/Latino, Asian, and Native American youth Blueprints for Healthy Youth Development indicates that LST is generalizable to a variety of ethnic groups. For more information on Botvin's research base, please review: Evaluation Studies - Botvin LifeSkills TrainingBotvin LifeSkills Training **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Participants can receive up to 5 credits

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
11	Youth Aware of Mental Health (YAM)	Suicide Prevention, Mental Health Literacy	9th-12th grade; Students ages 13-17	Universal	An interactive school-based program that educates students about mental health, promotes peer support, and aims to reduce depression and suicidal behavior	One Clinician/ certified YAM instructor and one trained YAM Helper per class/group	**Pre-Training Requirements:** Complete a detailed implementation plan identifying local resources, your organization's safeguarding procedures, and identifying the schools where you will implement **Training Requirements:** Five-day, **in-person** training. (8 hours per day; 5th day will be 4 hours). *Must be available to attend all days in person **Post-Training Requirements:** At least 6 paired practice sessions held with 6-10 youth from community	Five one-hour sessions taught in a group format over 3 weeks during school hours; **cannot be delivered after school**	Information not available in national repositories searched. For more information on YAM's youth driven program in diverse communities, please review: Youth Aware of Mental health (y-a-m.org) **Spanish-language Offerings:** **Trainings:** In development **Materials:** In process of translating materials into Spanish	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
12	Circle of Security	Strengthening attachment between caregivers and children, behavior problem reduction	Parents/ caregivers of children ages 4 months- 6 years	Family Support and Education	A structured, video-guided program with eight sessions that helps facilitators support parents and caregivers of children from birth to age 6, focusing on fostering secure attachment during these crucial early years	One certified COSP facilitator	This training is a one- or two-week online format including five required 2-hour online live sessions as well as self-directed learning. **The time commitment is 25-35 hours including the live and asynchronous components**, and it is suggested to spread the training over half of your work schedule across two weeks or complete it in a full workweek if choosing the one-week option.	Minimum of Eight 90-minute parent group sessions spread out over at least 8 weeks	**Circle of Security** is included in The California Evidence-based Clearinghouse for Child Welfare with evidence to support use in the following demographic groups: predominately female caregivers, African American female caregivers, children ages ~1-7, caregivers and their preschool children affected by prenatal alcohol exposure (PAE) and fetal alcohol spectrum disorder (FASD). For more information on Circle of Security's approach to cultural responsiveness, please review: Is COSP Culturally Responsive – Circle of Security International **Spanish-language Offerings:** **Trainings:** Yes **Materials:** Yes	Participants can receive up to 2.4 credits

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
13	Botvin LifeSkills Parent Program	Substance Use prevention program	Parents/ Caregivers of students in grades 6-9	Family Support and Education	Prevention tool designed to help parents strengthen communication with their children, promote responsible decision-making, and prevent substance use.	One Botvin Parent Program trained Workshop Facilitator per group	One-day virtual training (6 hours)	Seven 60–90-minute parent group sessions	For information on Botvin's research base, please review: Evaluation Studies - Botvin LifeSkills TrainingBotvin LifeSkills Training **Spanish-language Offerings:** **Trainings:** No **Materials:** No	Participants can receive up to 5 credits

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
14	Family Check Up	Parenting and family management	Families with children ages 2 through 17	Family Support and Education	A brief, strengths-based intervention designed to reduce children's problem behaviors by improving parenting and family management practices	A trained FCU facilitator	**Pre-Training Requirements:** Two implementation meetings with the FCU trainer to review program expectations ~15-20 hours of self-paced, e-learning **Training Requirements:** Four-day virtual training (3 hours per day scheduled by the trainer) **Post-Training Requirements:** ~20-25 additional hours (12 sessions) for implementation support; trainees for this EBP are not required to attend additional quarterly EBP calls offered by NCSMH	Consists of three family sessions and subsequent follow-up services tailored to the family's needs. It is an adaptive framework; as such, some families receive more follow-up services and support than others.	**Family Check Up** is included in The California Evidence-based Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Caucasian, Hispanic/Latino, Asian, & Biracial families; male and female children, and female caregivers. **Spanish-language Offerings:** **Trainings:** No **Materials:** FCU offers materials in Spanish that can be used to work with Spanish speaking populations	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
15	Chicago Parent Program	Positive parenting, behavior problem reduction	Parents/ Caregivers of children ages 2-8	Family Support and Education	Parent program focusing on positive parenting, reducing behavior problems in young children, and emotional bonding and trust within the family dynamics.	Two trained CPP group leader	This training is a four-day virtual training (3.5 hours each day)	Twelve 2-hour weekly parent group sessions	**Chicago Parenting Program** is included in CA Evidence-Based Clearinghouse and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic, and White families; some studies included male caregivers For more information on research with diverse populations, please review: Our Research (chicagoparentprogram.org) **Spanish Offerings:** **Training:** No **Materials:** Yes	Participants can receive up to 10 credits

Appendix F.

In addition to the EBPs listed above, Hubs and service providers are encouraged to participate in the Measurement Based Care Learning Community. Measurement Based Care (MBC) is the routine use of patient reported outcome measures in mental health early intervention (Tier 2) and treatment (Tier 3) services to promote communication, collaboration and shared decision-making with students and families. MBC is included in Consortium efforts as an evidence-based approach when implementing Tier 2 and 3 interventions.

MBC LC						
Focus	**Intended Audience**	**Modality**	**Description**	**Staffing Requirements**	**Time Commitment and Modality**	**Are CEUs offered?**
Mental health (or any Tier 2 or 3 interventions with individual student goals)	Agency Leader Track*	Individual, Group, or Family	Learn how to provide tailored implementation support for MBC throughout a provider organization	At least 1 agency leader per grantee organization	Minimum: 4 hours of Virtual Learning Sessions (60 minutes each, every other month during the school year) Optional: Group office hours and 1:1 consultations every other month for up to an additional 8 hours	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance
	Clinician Track	Individual, Group or Family	Learn how to implement MBC with K-12 students using the Collect, Share, Act model	At least 1 clinician or professional delivering Tier 2/3 services per grantee organization		

*Note: Hubs are welcome to join the Agency Leader Track to learn about MBC implementation from a systems lens.

Appendix F.

In addition to the EBPs above, Hub staff in partnership with school districts will be offered the opportunity to apply for training and supported implementation in the following EBPs. Interested school districts should use the following link: https://bit.ly/SchoolsAppFY26

School-Based EBPs										
EBP – Programs/ Trainings		**Focus**	**Intended Audience**	**Modality**	**Description/ Services**	**Staffing Requirements**	**Training Time Commitment and Modality**	**Number of Sessions by Modality**	**Cultural Responsiveness**	**Are CEUs offered?**
16	Mental Health Essentials for Teachers and Students	Mental Health Literacy for educators and students	Grades 6-12	Universal	Aims to enhance mental health awareness, resilience, and coping skills among both educators and students, fostering a healthier and more supportive school environment	One MHE trained educator (grades 6-12)	This is a two-day virtual training. Part I/Day I, Mental Health Literacy for Teachers (3 hours) Part II/Day 2, Student Curriculum Delivery Training (4 hours)	Six modules *6-12 hours of total classroom instruction *Meant to be taught in sequence, but can be altered *Delivery can be flexibly and creatively adapted according to teachers' pedagogical styles and student needs	**Mental Health Essentials** is a U.S. adaptation of the Canadian-developed intervention, The Guide. The Guide has been implemented throughout Canada, the U.S., and several other countries with diverse student populations. Evaluation information is available on The Guide website.	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance
17	Mental Health Essentials for Coaches	Mental Health Literacy for athletic coaches & PE/Health/ Wellness teachers	Grades K-12	Universal	Coach-training to enhance mental health literacy of coaches and promote strategies to include mental health as part of the team's culture		75-minute virtual training	No implementation requirements; however, skills can be utilized with sport teams, in wellness classrooms, and in physical education	**Mental Health Essentials** is a U.S. adaptation of the Canadian-developed intervention, The Guide. The Guide has been implemented throughout Canada, the U.S., and several other countries with diverse student populations. Evaluation information is available on The Guide website.	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
18	Good Behavior Game	Positive Behaviors/ Classroom Environments	Grades K-5	Universal	A classroom management program used to teach self-regulation skills while collaborating to make classrooms peaceful and productive learning environments	A GBG trained educator	7-hour virtual training	PAX GBG strategies are embedded daily into the regular classroom instruction	**Good Behavior Game** is included in CA Evidence-Based Clearinghouse, IES's What Works Clearinghouse, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: Black and White families, males, females, those with free/reduced lunch, & English Language Learners	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix F.

EBP – Programs/ Trainings		Focus	Intended Audience	Modality	Description/ Services	Staffing Requirements	Training Time Commitment and Modality	Number of Sessions by Modality	Cultural Responsiveness	Are CEUs offered?
19	Pyramid Model/Positive Solutions for Families (PSF)	Positive Behaviors/ Classroom Environments	PreK-K	Universal	Promotes the social, emotional, and behavioral skills of children from birth to five, incorporating universal classroom practices to foster social-emotional learning and prevent challenging behavior, targeted instructional practices for skill development, and specific interventions to support children with more significant social, emotional, and behavioral needs.	Pyramid Model trained educator	This training is available as either a two-day virtual session (7 hours per day) or a four-day virtual session (3.5 hours per day).	Daily implementation of Tier 1 and Tier 2 strategies learned in the training to be used in the classroom	Information not available in national repositories searched. For more information on resources to support cultural responsiveness, please review: Early Childhood Program-Wide PBS Benchmarks of Quality (EC-BOQ) CULTURAL RESPONSIVENESS COMPANION 2021 (challengingbehavior.org) and visit the resource library.	Maryland **CEUs are not offered** at this time; participants will receive a certificate of attendance

Appendix G

Other Recommended Evidence-Based Programs

While the Consortium *prioritizes* Evidence-Based Programs listed in Appendix F, the Consortium will also consider funding other school behavioral health practices that are:

- supported by evidence of impact on target social, emotional, behavioral, and/or academic outcomes (based on research evidence, as recognized in national registries and the scientific literature, and/or supported by practice-based evidence of success in local or similar schools or communities)
- equitable and fit the unique strengths, needs, and cultural/linguistic considerations of students and families in your community
- have adequate resource capacity for implementation (e.g., staffing capacity; training requirements, qualifications, and staff time; ongoing coaching)
- monitored for fidelity

Applicants could receive funding to implement these other interventions but would need to arrange their own training and implementation support.

Examples of practices that may be funded include, but are not limited to:

	EBP – programs/trainings	Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
1	Attachment Based Family Therapy (ABFT)	Helps a parent and child build an emotionally secure relationship	Youth between 12-18 and parents	2/3	Attachment-Based Family Therapy (ABFT) is the only manualized, empirically supported family therapy model specifically designed to target family and individual processes associated with adolescent suicide and depression. ABFT emerges from interpersonal theories that suggest adolescent depression and suicide can be precipitated, exacerbated or buffered against by the quality of interpersonal relationships in families. It is a trust-based, emotion-focused psychotherapy model that aims to repair interpersonal ruptures and rebuild an emotionally

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					protective, secure-based parent–child relationship. ABFT consists of five therapeutic tasks that are addressed and completed as the course of therapy progresses.
2	Acceptance and Commitment Therapy (ACT)	Psychological flexibility	Ages 6-18	2/3	Uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility
3	Brief Intervention for School Clinicians (BRISC)	Addresses emotional and behavioral stressors	HS students	2/3	Responsive to the typical presenting problems of high-school students, as well as their approach to help-seeking and their patterns of service participation
4	Check and Connect	Student engagement and persistence in school	k-12	2/3	The "**Check**" component refers to the process where mentors systematically monitor student performance variables (e.g., absences, tardies, behavioral referrals, grades), while the "**Connect**" component refers to mentors providing personalized, timely interventions to help students solve problems, build skills, and enhance competence
5	Check In Check Out	Addresses common classroom behavior challenges	K-12	2/3	A student receiving CICO meets with adults throughout the school day to reinforce and track behavioral goals.
6	Dialectical Behavior Therapy (DBT) for Schools	Emotional Problem Solving	Grades 6-12	2/3	Helps adolescents manage difficult emotional situations, cope with stress, and make better decisions
7	Interpersonal Psychotherapy for Adolescents (IPT-A)	Depression / Suicidal ideation and behavior	Ages 12-18	2/3	outpatient treatment for teens who are suffering from mild to moderate symptoms of a depressive disorder, including major depressive disorder, dysthymia, adjustment disorder with depressed mood, and depressive disorder not otherwise specified
8	IPT-A - Ultra-Short Crisis Intervention (IPT-A- SCI)	Suicidal ideation and behavior	Adolescents	2/3	To address the critical need in crisis intervention for children and adolescents at

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					suicidal risk, based on Interpersonal Psychotherapy (IPT), the ultra-brief acute crisis intervention is comprised of five weekly sessions, followed by monthly follow-up caring email contacts to the patients and their parents, over a period of three months.
9	Support for Students Exposed to Trauma (SSET)	Trauma	Children in late elementary school through early high school (ages 10-16)	2/3	A series of ten lessons whose structured approach aims to reduce distress resulting from exposure to trauma. SSET is designed to help schools and school systems that do not have access to school-based clinicians. Designed with and for teachers and nonclinical school counselors, this program targets students in fifth grade and above. SSET uses a lesson-plan format instead of a clinical manual.
10	Trauma-Focused CBT (TF-CBT)	Trauma	Children and adolescents	2/3	structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 8-25 sessions with the child/adolescent and caregiver
11	Executive Functioning interventions (see Brain Futures report)	Executive functioning	Various age groups, interventions available for Pre-K-12	1, 2/3	See pgs. 44-66 here Universal, group, and individual interventions that target executive functioning (I.e., planning, meeting goals, following directions, etc.)
12	Incredible Years	SEL	Infant, toddler, school-age children	1	Incredible Years is a series of interlocking, evidence-based programs for parents, children, and teachers. The goal is to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence.
13	MindUP	Mindfulness; SEL; Brain Literacy	Offered in three age-related levels,	1	MindUP is a classroom program that provides a curriculum at the intersection of neuroscience, positive psychology, mindful

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
			Pre-K–2, Grades 3-5, and Grades 6-8		awareness, and SEL. The aim of MindUP is to help students focus their attention, improve self-regulation skills, build resilience to stress, and develop a positive mindset in school and in life
14	Positive Action	Positive youth development; Behavior supports	PreK-12	1	Positive Action is a 7-unit curriculum that works through the Thoughts-Actions-Feelings (TAF) Circle to emphasize actions that promote a healthy and positive TAF cycle.
15	Second Step	SEL	PreK –12 Staff	1	Second Step programs help students build social-emotional skills—like nurturing positive relationships, managing emotions, and setting goals
16	Signs of Suicide	Suicide prevention	Students in grades 6-12	1	SOS teaches students how to identify signs of depression and suicide in themselves and their peers, while providing materials that support school professionals, parents, and communities in recognizing at-risk students and taking appropriate action.
17	Source of Strength	Suicide prevention	K-12 (separate programs for elementary and secondary)	1	Sources of Strength is a radically strength-based, upstream suicide prevention program with shown effectiveness in both preventative upstream and intervention outcomes. Sources of Strength has both an elementary and secondary model. Sources Secondary trains groups of Peer Leaders supported by Adult Advisors to run ongoing public health messaging campaigns to increase wellness and decrease risk in their schools. Sources Elementary is implemented as a universal classroom based Social Emotional Learning curriculum. The model incorporates the Sources of Strength protective factor framework, more robust language on mental

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					health, and a prevention lens that many elementary SEL models lack.
18	Teen Mental Health First Aid (T-MHFA)	Mental health literacy	Teens in grades 10-12, or ages 15-18,	1	Teaches students how to identify, understand and respond to signs of mental health and substance use challenges among their friends and peers.
19	Tools of the Mind	Social-emotional; Self-regulatory skills Teacher professional development	PreK and K staff	1	Tools of the Mind is a research-based early childhood model combining teacher professional development with a comprehensive innovative curriculum that helps young children to develop the cognitive, social-emotional, self-regulatory, and foundational academic skills they need to succeed in school and beyond.
20	Conscious Discipline	Trauma-informed SEL	Teachers; Admin; MH Professionals; Parents	1	Conscious Discipline creates a compassionate culture and facilitates an intentional shift in adult understanding of behavior via the Conscious Discipline Brain State Model. It provides specific brain-friendly, research-backed strategies for responding to each child's individual needs with wisdom.
21	Classroom Check Up	Classroom management	Teachers	1	Contains web-based tools and training in the form of intervention modules to support both teachers and coaches. Each module incorporates elements such as videos, assessment instruments, strategy tools, and action planning tools to facilitate effective and efficient implementation of evidence-based classroom management practices
22	Adolescent Depression Awareness Program (ADAP)	Depression	Adolescents	1	Includes 3 classes focused on interactive activities, video sessions, and discussions
23	Restorative Practices	Problem solving and conflict resolution	K-12	1	A classroom and school-based strategies to proactively build healthy relationships and a sense of community to prevent and address conflict and wrongdoing

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	EBP – programs/trainings	Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
24	Classroom WISE	Mental health literacy	K-12	School Staff Training	Classroom WISE is a free self-guided online course focused on educator mental health literacy, informed by and co-developed with educators and school mental health professional across the United States
25	Youth Mental Health First Aid (Y-MHFA)	Mental health literacy	Adults who regularly interact with young people	School Staff Training	Youth Mental Health First Aid, an 8-hour course, is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.
26	Facilitating Attuned Interactions (FAN)	Provider-parent relationship	Mental health, School Nurse/Health Suite, Educators and Teacher Assistants and Administration, Special Education teams	Family Support and Engagement	FAN's aims to strengthen the provider-parent relationship, resulting in parents who are attuned to their children and ready to try new ways of relating to them.
27	Teacher WISE	Educator well-being	Teachers and school staff at all levels	School Staff Training	Helps educators assess their own well-being and personalize their learning with specific strategies that enhance their well-being
28	Be Strong Families Parent Cafes	Family relationships	Families and caregivers	Family Support and Education	Cafés are structured, small group conversations to facilitate transformation and

Appendix G

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					healing within families, build community, develop peer-to-peer relationships, and engage parents as partners in the programs that serve them.
29	Family Bereavement Program	Family Bereavement	Youth who are 8 to 18 years old who have lost a parent/caregiver and the surviving parent/caregiver	Family Support and Education	A community-based or clinical program, is designed to enhance parenting skills, teach helpful coping methods, foster constructive communication, and create and sustain healthy parent-child relationships following the recent death of a parent or caregiver through group sessions.
30	Parent CRAFT- Community Reinforcement and Family Training	Substance Use	Families of teens or young adults	Family Support and Education	Community Reinforcement and Family Training, or CRAFT, is an approach to help parents and other caregivers change their child's substance use by staying involved in a positive, ongoing way.
31	Strengthening Family Coping Resources (SFCR)	Trauma; PTSD	Families living in traumatic contexts	Family Support and Education	SFCR is a manualized, trauma-focused, skill-building intervention. It is designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder and other trauma-related disorders in children and adult caregivers. SFCR provides accepted, empirically supported trauma treatment within a family format.
32	PEP - Educating Parents, Enriching Families	Family Relationships	Families with children from 5-18	Family Support and Education	Gives families the knowledge to understand the underlying causes of their children's behavior, and the practical skills and tools they need to address problems right away

Appendix H.

Definition of Unduplicated Students Served

Unduplicated: "Unduplicated" means each student is counted only once, even though they may receive multiple interventions across multiple time periods, multiple schools, or multiple grade levels. Grantees are responsible for developing systems, such as unique patient identifiers, to ensure that each student or is counted only once.

Student: Anyone in PreK-12th grade living in Maryland. A student does not need to be currently enrolled in a Maryland Public School to be counted. If your organization is providing services directly to parents/caregivers, count their pre-k-12th grade students.

Services: A "service" includes any intervention delivered at any of the three Tiers of the Multi-Tiered System of Supports. Examples of services are below:

- **Tier 1:** Services to promote positive social, emotional, and behavioral skills and well-being regardless of student or family risk or symptoms. These also include efforts to improve school climate and promote positive behavior. Tier 1 services are frequently implemented at the school-wide, classroom, and/or grade level.
    - **School- or grade-wide Tier 1:** The number of individuals served for a school- or grade-wide Tier 1 program such as social emotional learning programs or school-wide assemblies (e.g., to improve school climate, promote positive behavior, provide mental health and wellness related information, etc.) should be the total student population of the school. Grantees may use school or grade enrollment data to provide this number and may refer to the **School Report Card**.
    - **Opt-in Tier 1:** The number of individuals who "opt in" or are served by a program that is *made available* to all students/ families regardless of risk factors. For example, an afterschool program that is open to all students, but not mandatory, should only count the students that participate in that program, not the entire school. Another example is a parent informational session offered at the school where all parents are invited but only those who attend should be reported.
- **Tier 2:** Services to address mild distress, functional impairment or risk for a given problem or concern. Tier 2 services are typically implemented in small groups or low-intensity or brief interventions targeting at-risk students/families. Examples of Tier 2 EBPs recommended by the CHRC include Therapeutic Mentoring, SBIRT, and CBITS/Bounce Back. Other examples include small group interventions for students identified with similar needs, transition support groups for newcomers, brief individualized interventions (e.g., motivational interviewing, problem solving), mentoring, and/or low intensity classroom-based supports such as a daily report card, daily teacher check-in, and/or home/school note system. Tier 2 also includes case management (e.g., connecting clients to resources and social services, establishing care plans, continuous follow-up). Note: Case management **does not** include purely administrative duties.
- **Tier 3:** Services to address mental health concerns for students/families with the highest needs who are already experiencing significant distress and functional impairment. Tier

3 services include intensive individual, group or family therapy for students receiving general or special education who have identified, and often diagnosed, social, emotional and/or behavioral needs. Tier 3 also includes case management (e.g., connecting clients to resources and social services, establishing care plans, continuous follow-up). Note: Case management **does not** include purely administrative duties. A referral to another service provider(s) may be counted as a Tier 3 service if there is documentation to demonstrate that the services actually were received (ie. a closed-loop referral).

Families: "Individuals served" for this grant program are children grades pre-K through 12. Therefore, grantees serving families should count each child (grades pre-K through 12) as an unduplicated individual served. For example, if two parents of three school-aged children participate in a parenting education program, the number of individuals served should be reported as three.

Existing individuals served versus new individuals served: Grantees will report on all individuals that receive grant-funded services. This includes both: (1) new students/families not previously served; and (2) those existing students/families whose services are enhanced through grant funding for activities such as school meetings, transportation, and care coordination, as well as through support and training in EBPs and Measurement-Based Care.

Consortium grantees awarded under the previous Request for Proposals may be asked to differentiate between new students to be served under this RFA versus students served under their current grant who will continue to receive services under this RFA.

Service location: Services may be provided both in schools as well as in non-school locations. Services in non-school locations must be connected to the school in some way, such as through referrals from school staff, transportation from the school, on-going communication with the school, etc. If a service is not connected to the school in any way and is not enhanced through grant funding, it should not be counted.

Total unduplicated individuals served: Each individual should be counted only once in the total. For example, if a program is offering school-wide Tier 1 services to all students in the school as well as Tier 3 services to students with the greatest need, the total should consider that the Tier 3 students were already included in the Tier 1 count; and those students should not be counted twice in the total. As such, the total number of individuals served (reported in Measure 1) could be smaller than the sum of the Individuals served at each of the three tiers (reported in Measures 2a, 2b, and 2c).

Appendix I.

Outcome Measure Menu / Recommended Assessment Tools

About This Document

The "recommended" measures are validated, standardized measures of child and caregiver symptoms and/or functioning that are suitable across numerous EBPs. This allows us to align measurement tools across the different programs. These measures have been vetted by our team and in consultation with EBP purveyors. The “optional” measures are those included in the intervention materials or other suggestions by the purveyors. You can use these measures, but they might need extra work for outcomes monitoring (e.g., pre-post administration and scoring). Outcome measures should be selected by grantees to match the purpose of each intervention or EBP, with consideration of measure length, ease of use by students and/or caregivers, and availability in languages preferred by those respondents.

- Evidence-based programs (EBPs) prioritized by the Consortium and offered by the National Center for School Mental Health, in partnership with intervention developers/trainers, may require specific outcome measures, as detailed in the Table below.
- Grantees implementing interventions not on the list of priority EBPs are encouraged to use the preapproved outcome measures listed below. Other measures not on this list may be used if approved by the CHRC and NCSMH.
- Additional student/family outcome measures can be added as desired by the grantee or provider based on students and families served.

What outcome measures are preapproved?

Global Symptom / Functioning Outcome Measures	Problem-Specific Outcome Measures
• Pediatric Symptom Checklist (PSC-17) (preferred) • Mood and Feelings Questionnaire (MFQ) • Global Appraisal of Individual Needs-Short Screener (GAIN-SS) • Strengths and Difficulties (SDQ) • Brief Problems Checklist (BPC) • Student Subjective Wellbeing Questionnaire (SSWQ)	• Patient Health Questionnaire (PHQ-9): Mood / depression including Suicide Risk • Generalized Anxiety Disorder (GAD-7): Anxiety • Screen for Child Anxiety Related Disorders (SCARED): Anxiety • Revised Child Anxiety and Depression Scale (RCADS): Anxiety and Mood • Swanson, Nolan and Pelham Teacher and Parent Rating Scale (SNAP-IV): Attention / Concentration and Behavior • Vanderbilt ADHD Diagnostic Rating Scale: Attention / Concentration, Behavior, Anxiety, Mood, Social Skills

What if our EBPs or preferred measure(s) are not on the preapproved list?

After awards are made, CHRC and NCSMH staff will meet with grantees individually to approve outcomes measures and other program evaluation details.

Where can I find other outcome measures?

The School Mental Health Assessment and Performance Evaluation (SHAPE) System Screening and Assessment Library is available for school and community partners to locate free and low-cost measures. More information about the SHAPE Screening and Assessment Library can be found at https://theshapesystem.com/assessmentlibrary/. To access the Screening and Assessment Library and any other resources in The SHAPE System, create a free account as an individual or with a school or district team at www.theshapesystem.com ***Measures on the SHAPE Screening and Assessment library are NOT automatically approved for CHRC grantees.***

Priority Evidence-Based Programs	Recommended Individual Outcome Measures	Optional/Supplementary Individual Outcome Measures
Adolescent Community Reinforcement Approach (A-CRA)	***Mental Health and Substance Use Measure:*** GAIN – Short Screener *5-year paper/pencil license costs $150, electronic version available at cost.*	***Mental Health and Substance Use Measure*** PROMIS *In EPIC and possible other EHRs. Items can be modified beyond alcohol use only.* CRAFFT/CAGE-AID *Can be used if items are modified to a timeframe that can facilitate pre-post comparisons.* ***Global Symptom/Functioning Measure*** PSC-17 *may complement, not replace, GAIN-SS or other substance use measure*
Botvin LifeSkills	***Symptom-Specific Measure*** Botvin LifeSkills Pre/Post Evaluation	***Global Resilience or Wellbeing Measure*** Children's Hope Scale
Botvin LifeSkills Parent Program	***Global Symptom/Functioning Measure*** Parental Stress Scale (PSS)	Botvin LifeSkills Parent Program Health Survey
Chicago Parent Program	***Symptom-Specific Measure*** Parenting Questionnaire *Caregiver Measure, from CPP Evaluation Toolkit* Strength and Difficulties Questionnaire *Child Measure, from CPP Evaluation Toolkit* Parental Stress Scale (PSS) *Caregiver Measure*	
Circle of Security	***Symptom-Specific Measure*** Parental Stress Scale (PSS)	
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back	***Trauma Exposure and PTSD Symptoms (select one):*** Child Trauma Screen UCLA PTSD Index: Trauma Exposure Checklist & Child PTSD Symptoms Scale Traumatic Events Screening Inventory for Children (TESI-C)	***Global Symptom/Functioning Measure*** PSC-17 *may complement but not replace trauma exposure and PTSD symptoms measure*

Priority Evidence-Based Programs	Recommended Individual Outcome Measures	Optional/Supplementary Individual Outcome Measures
Counseling on Access to Lethal Means (CALM)	*Outreach to NCSMH team to discuss options as needed*	
Family Check Up	FCU Parent Caregiver Questionnaire on Family and Self FCU Parent Caregiver Questionnaire on Child (11-17 Years) FCU Parent Caregiver Questionnaire on Child (6-10 Years) FCU Parent Caregiver Questionnaire on Child (2-5 Years) FCU Adolescent Self Questionnaire (11-17 Years)	Parental Stress Scale (PSS)
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	***Global Symptom/Functioning Measure:*** PSC-17	***Any Approved Problem-Specific Measure(s) listed above***
Safety Planning Intervention (Stanley and Brown)	***Suicidal Ideation and Behavior Measure:*** Columbia – Suicide Severity Rating Scale (C-SSRS) *may require training*	Ask Suicide-Screening Scale (ASQ) Open-Source Suicidality Scale (SS)
SBIRT – Screening, Brief Intervention, and Referral to Treatment	***Mental Health and Substance Use Measure:*** GAIN – Short Screener *5-year paper/pencil license costs $150, electronic version available at cost.*	***Mental Health and Substance Use Measure*** PROMIS *In EPIC and possible other EHRs. Items can be modified beyond alcohol use only.* CRAFFT/CAGE-AID *Can be used if items are modified to a timeframe that can facilitate pre-post comparisons.* ***Global Symptom/Functioning Measure*** PSC-17 *may complement, not replace, GAIN-SS or other substance use measure*
The Student Check-Up (Motivational Interviewing)	***Global Symptom/Functioning Measure:*** Student Subjective Wellbeing Questionnaire Re-administer pre-assessment included in manual	PSC-17 EPOCH Measure of Adolescent Well-Being School Engagement Scale Morgan Jinks Academic Self-Efficacy School Records (Grades, Discipline Referrals, Attendance)
Therapeutic Mentoring	***Global Symptom/Functioning Measure:*** PSC-17 and/or Student Subjective Wellbeing Questionnaire	***Problem-Specific Measure:*** Youth Strength of Relationship Measure
Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)	***Global Symptom/Functioning Measure:*** PSC-17 (Internalizing scale only)	***Problem-Specific Measure(s):*** RCADS (anxiety and depression) PHQ-9 (depression only) GAD-7 (anxiety only)
Youth Aware of Mental Health (YAM)	***Mental health literacy measure:*** Youth Mental Health Literacy Scale (YMHL) ***Suicidal ideation and behavior measure:*** Columbia – Suicide Severity Rating Scale (C-SSRS) *may require training*	Ask Suicide-Screening Scale (ASQ) Open source Suicidality Scale (SS) *Outreach to NCSMH team to discuss options as needed*

Appendix J.

Coordinated Community Supports Grantee Monitoring Report - Standard Metrics					
Grantee Name:	SAMPLE - will be customized for FY 2026 grantees				
Grantee #:	C-26-XXX				
Jurisdiction:					
NOTE #1: Metrics that count "UNDUPLICATED" participants **CANNOT** count these same participants over different reporting periods. The "TOTALS" column for these metrics should sum only unduplicated participants (e.g., a participant counted in reporting period 1, **CANNOT** be counted again in reporting period 2 or 3.					
NOTE #2: The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.					
NOTE #3: CHRC will utilize output **1** for its "**Total unduplicated individuals served**" measure.					
(Do NOT alter or enter data into shaded cells)					
Domain	**Output**	**Report Period #1 (JUL 1, 2025 - DEC 31, 2025)**	**Report Period #2 (JAN 1, 2026 - JUN 30, 2026)**	**TOTALS**	**Goal**
1. TOTAL # of unduplicated students served	1. TOTAL # of unduplicated students served			**0**	
2. # of unduplicated students served by tier	2a. # of unduplicated students served - Tier 1			**0**	
	2b. # of unduplicated students served - Tier 2			**0**	
	2c. # of unduplicated students served - Tier 3			**0**	
3. # of unduplicated students served by race and ethnicity	3a. # of unduplicated students who receive grant services - African American/Black			**0**	
	3b. # of unduplicated students who receive grant services - Asian or Pacific Islander			**0**	
	3c. # of unduplicated students who receive grant services - Hispanic/Latino/a/x/e			**0**	
	3d. # of unduplicated students who receive grant services - Middle Eastern/North African			**0**	
	3e. # of unduplicated students who receive grant services - multi-racial			**0**	
	3f. # of unduplicated students who receive grant services - White			**0**	
	3g. # of unduplicated students who receive grant services - race/ethnicity not listed			**0**	
	3h. # of unduplicated students who receive grant services - unknown/prefer not to respond			**0**	

Domain	Output	Report Period #1 (JUL 1, 2025 - DEC 31, 2025)	Report Period #2 (JAN 1, 2026 - JUN 30, 2026)	TOTALS	Goal
4. # of unduplicated students served by gender	4a. # of unduplicated students who receive grant services - female/woman/girl			**0**	
	4b. # of unduplicated students who receive grant services - male/man/boy			**0**	
	4c. # of unduplicated students who receive grant services - non-binary			**0**	
	4d. # of unduplicated students who receive grant services - unknown/prefer not to respond			**0**	
5. # of unduplicated students served by grade	5a. # of unduplicated students who receive grant services - pre-kindergarten			**0**	
	5b. # of unduplicated students who receive grant services - elementary (kindergarten-grade 5)			**0**	
	5c. # of unduplicated students who receive grant services - middle (grades 6-8)			**0**	
	5d. # of unduplicated students who receive grant services - high (grades 9-12)			**0**	
6. # of unduplicated schools served	6. # of unduplicated schools served			**0**	
7. Satisfaction surveys	7a. # of students completing satisfaction surveys			**0**	
	7b. # of students reporting satisfaction with services			**0**	
	7c. # of family members completing satisfaction surveys			**0**	
	7d. # of family members reporting satisfaction with services			**0**	
8. School staff training	8a. # of school staff completing training by grantee			**0**	
	8b. # of school staff completing training assessment			**0**	
	8c. # of school staff demonstrating mastery of training			**0**	
9. # of unduplicated new positions that provide direct services	9a. # of unduplicated filled new positions that provide services to students or families and require licensure or supervision from a licensed professional			**0**	
	9b. # of unduplicated filled new positions that provide services to students or families and do not require licensure or supervision from a licensed professional			**0**	
10. Tier 1 outcomes	10a. # of individuals receiving Tier 1 supports who were then assessed using assessment tool or survey			**0**	
	10b. # of individuals demonstrating desired outcome, using assessment tool or survey			**0**	

Domain	Output	Report Period #1 (JUL 1, 2025 - DEC 31, 2025)	Report Period #2 (JAN 1, 2026 - JUN 30, 2026)	TOTALS	Goal
11. Tier 2 outcomes	11a. # of individuals receiving Tier 2 supports who were then assessed using assessment tool or survey			**0**	
	11b. # of individuals receiving Tier 2 supports demonstrating improvement in social, emotional, behavioral, or academic functioning, using the outcome assessment tool(s)			**0**	
	11c. # of individuals receiving Tier 2 supports demonstrating no change in social, emotional, behavioral, or academic functioning, using the outcome assessment tool(s)			**0**	
	11d. # of individuals receiving Tier 2 supports demonstrating deterioration in social, emotional, behavioral, or academic functioning, using the outcome assessment tool(s)			**0**	
12. Tier 3 outcomes	12a. # of individuals receiving Tier 3 supports who were then assessed using tool(s)			**0**	
	12b. # of students/families receiving Tier 3 supports demonstrating improvement in social, emotional, behavioral, or academic functioning, using outcome assessment tool(s)			**0**	
	12c. # of students/families receiving Tier 3 supports demonstrating no change in social, emotional, behavioral, or academic functioning, using outcome assessment tool(s)			**0**	
	12d. # of students/families receiving Tier 3 supports demonstrating deterioration in social, emotional, behavioral, or academic functioning, using assessment tool(s)			**0**	

Coordinated Community Supports Grantee Monitoring Report - Custom Metrics

NOTE #1: Metrics that count "UNDUPLICATED" participants **CANNOT** count these same participants over different reporting periods. The "TOTALS" column for these metrics should sum only unduplicated participants (e.g., a participant counted in reporting period 1,**CANNOT** be counted again in reporting period 2 or 3.

NOTE #2: The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.

(Do NOT alter or enter data into shaded cells)

Intervention	Output	Report Period #1 (JUL 1, 2025 - DEC 31, 2025)	Report Period #2 (JAN 1, 2026 - JUN 30, 2026)	TOTALS	Goal
Intervention #1	14a. # of unduplicated students/families served through intervention #1			**0**	
	14b. # of students/families assessed via measure #1			**0**	
	14c. # of students/families assessed via measure #1 who demonstrated improvement			**0**	
Intervention #2	15a. # of unduplicated students/families served through intervention #2			**0**	
	15b. # of students/families assessed via measure #2			**0**	
	15c. # of students/families assessed via measure #2 who demonstrated improvement			**0**	
Intervention #3	16a. # of unduplicated students/families served through intervention #3			**0**	
	16b. # of students/families assessed via measure #3			**0**	
	16c. # of students/families assessed via measure #3 who demonstrated improvement			**0**	
Intervention #4	17a. # of unduplicated students/families served through intervention #4			**0**	
	17b. # of students/families assessed via measure #4			**0**	
	17c. # of students/families assessed via measure #4 who demonstrated improvement			**0**	

Additional customized grantee metrics

Appendix K.

Sample letter of support from Superintendent or Designee

[LEA LETTERHEAD]

Date

Dear Maryland Community Health Resources Commission,

XXXX Public Schools is pleased to support the application of [APPLICANT ORGANIZATION] for a service provider grant under the Community Supports Partnerships Request for Applications (RFA) issued by the Maryland Community Health Resources Commission in December 2024.

XXXX Public Schools has been working/planning with [APPLICANT ORGANIZATION] since [DATE]. [DESCRIBE PREVIOUS INTERACTIONS.] [NAME(s) OF LEA STAFF MEMBER(S)] has reviewed [APPLICANT ORGANIZATION'S] proposal and determined that it aligns with the priorities of XXXX Public Schools. XXXX Public Schools has reviewed the applicant's proposed budget and Evidence-Based Programming.

If [APPLICANT ORGANIZATION] is funded under the RFA, XXXX Public Schools commits to:

- Permit [APPLICANT ORGANIZATION] to provide the following services: XXXX
- [IF KNOWN] Permit services to be provided in the following schools OR for students from the following schools: XXXX
- Permit services to be provided during the following times: XXXX
- [IF APPLICABLE] Provide confidential spaces in schools for the provision of services
- [IF APPLICABLE] Refer students to services provided by [APPLICANT ORGANIZATION] in the following way(s): XXXX
- OTHER

OPTIONAL: [APPLICANT ORGANIZATION] commits to the following: XXXX

[APPLICANT ORGANIZATION] currently has a Memorandum of Understanding with XXXX Public Schools OR XXXX Public Schools will develop a Memorandum of Understanding by [DATE] with [APPLICANT ORGANIZATION] if [APPLICANT ORGANIZATION] is selected for funding under this RFA.

If awarded, grant funds will not supplant existing funding for student behavioral health.

XXXX Public Schools requests a favorable review of [APPLICANT ORGANIZATION'S] proposal under the Community Supports Partnerships RFA.

Sincerely,

Superintendent/Designee

Appendix L.

Data Toolkit for Applicants

As part of the Coordinated Community Supports Partnerships Call for Proposals, the CHRC and Consortium are providing potential applicants with recommended databases and measures to support the preparation of grant proposals. These data sets can be used by applicants to identify unmet needs and develop programs and priorities. These data sets are recommended, not required. Applicants may use other data and sources to describe need in their communities.

Examples of jurisdiction-level measures that could be used to identify priorities include: prevalence of ACEs, substance misuse, depression and suicidality; number of justice-involved students; behavioral health provider shortages; gaps in school mental health services; number of disciplinary incidents/violence; behavioral health emergency department and overall utilization rates for Medicaid-covered youth; and percentage of uninsured children. Examples of measures at the school level that could be used to target interventions to areas of greatest need include: socioeconomic need (free and reduced lunches), chronic absenteeism, graduation rates, number of Limited English proficient students, and student homelessness counts.

The following databases are recommended for jurisdiction-level data:

- HRSA Mental Health Professional Shortage Areas (HPSAs): https://data.hrsa.gov/tools/shortage-area/hpsa-find
- Youth Risk Behavior Surveillance System (YRBS): https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx
- Department of Juvenile Services Data Resource Guide: https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2023.pdf
- MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools 2022 – 2023: https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20222023Student/2022-2023-MD-PS-Suspensions-Expulsions-and-Health-Related-Exclusions.pdf
- U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program: https://www.census.gov/data-tools/demo/sahie/#/
- Report on Behavioral Health Services for Children Required by Section 7.5-209 of the Health-General Article: https://dlslibrary.state.md.us/publications/Exec/MDH/BHA/HG7.5-209(e).FY_2022.pdf
- Maryland Behavioral Health Workforce Assessment Report: https://dlslibrary.state.md.us/publications/Exec/MDH/MHCC/SB283Ch286HB418Ch287(2)(2023)_2024.pdf
- SHAPE system analyses by LEAs: if applicable, contact local school district
- Local Community Health Needs Assessments: optional, contact local health departments and health systems
- Local Behavioral Health Authority Needs Assessments: optional, contact Local Behavioral Health Authorities
- Local Management Board Needs Assessments: optional, contact Local Management Board

Appendix L.

The following databases are recommended for school-level data:

- School Report Card: https://reportcard.msde.maryland.gov/
- LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/local-school-systems.aspx
- Community schools' needs assessments: if applicable, contact local Community Schools
- List of Community Schools: see RFA

A description of each data set, suggested measures from each, and tips for utilizing these data sets are included in the Application Data Toolkit posted on the Call for Proposals website. Applicants should select measures that correlate to their programs and should ***not*** include every suggested measure. Applicants may use other verifiable data sources, and should describe these in their proposals.

Recommended online databases:

1. Health Professional Shortage Areas (HPSAs): https://data.hrsa.gov/tools/shortage-area/hpsa-find

Suggested measures:

- Geographic HPSA for Mental Health
- Population HPSA for Mental Health

Other tips:

- Jurisdiction-level data.
- Use the following filters:
    - Maryland
    - County
    - HPSA Discipline: Mental Health
    - HPSA Status: Designated
    - HPSA Designation Types: All Geographic, All Population
- May include HPSA score, on a scale of 0-26.

2. Youth Risk Behavior Surveillance System (YRBS):
https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx
Suggested measures (High School):

- Percentage of students who felt sad or hopeless almost every day for more than two weeks in a row (QN25)
- Percentage of students who seriously considered attempting suicide (QN26)
- Percentage of students who reported that their mental health was most of the time or always not good (QN85)
- Percentage of students who ever took prescription pain medicine without a doctor's prescription (QN49)
- Percentage of students who ever used heroin (QN52)

- Percentage of students who ever used methamphetamine (QN53)
- Percentage of students who reported that a parent or other adult in their home most of the time or always swore at them, insulted them, or put them down (QN110)
- Percentage of students who have ever been separated from a parent or guardian because they went to jail, prison, or a detention center (QN113)
- Percentage of students who reported that their parents or other adults in their home most of the time or always slapped, hit, kicked, punched, or beat each other up (QN114)

Suggested measures (Middle School):

- Percentage of students who felt sad or hopeless almost every day for more than two weeks in a row (QN49)
- Percentage of students who ever seriously thought about killing themselves (QN14)
- Percentage of students who reported that their mental health was most of the time or always not good (QN44)
- Percentage of students who ever took prescription pain medicine without a doctor's prescription (QN29)
- Percentage of students who reported that a parent or other adult in their home most of the time or always swore at them, insulted them, or put them down (QN79)
- Percentage of students who have ever been separated from a parent or guardian because they went to jail, prison, or a detention center (QN82)
- Percentage of students who ever saw someone get physically attacked, beaten, stabbed, or shot in their neighborhood (QN11)

Other tips:

- Jurisdiction-level data.
- Use County Level Summary Tables for Middle School and/or High School.
- Compare with State Level Summary Tables and with other County Level Summary Tables.
- Some measures indicate Adverse Childhood Experiences (ACEs).
- Measures above correspond to the 2022-2023 YRBS report. A new version may become available and questions may vary.

3. Department of Juvenile Services Data Resource Guide:
https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2023.pdf

Suggested measures:

- Number of referrals to DJS per thousand youth ("Total complaints" x 1000/total youth population)

Other tips:

- Jurisdiction level data begins on page 36.
- Compare with statewide data found on page 26 or data from other jurisdictions.
- Numerator is "Total Complaints" found at the bottom of the Complaint Source table.

- Denominator is the total youth population listed under "U.S. Census and Maryland Department of Planning Estimation Data" at the top right of the page.
- Race and ethnicity data is also available, data on types of offenses, trends.

4. MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools
2022 – 2023:
https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20222023Student/2022-2023-MD-PS-Suspensions-Expulsions-and-Health-Related-Exclusions.pdf

Suggested measures:
- Percentage of students suspended or expelled for the jurisdiction

Other tips:
- Jurisdiction-level data.
- Summary table on page 1.
- Compare with statewide data or data from other jurisdictions.
- Includes data tables disaggregated by race and ethnicity, grade, frequency/repeated offenses, elementary vs middle vs high school, types of offenses, etc.

5. U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program:
https://www.census.gov/data-tools/demo/sahie/#/

Suggested measures:
a. Percentage of uninsured individuals under the age of 18

Other tips:
- Jurisdiction-level data.
- Use the following filters:
  - Maryland
  - County
  - Age group: Under 19
  - HPSA Designation Types: All Geographic, All Population
- Filters for race subgroups are not available for the Under 19 age group or Counties.
- Compare rate with statewide benchmark or other jurisdictions.

6. Report on Behavioral Health Services for Children Required by Section 7.5-209 of the Health-General Article, FY 2022:
https://dlslibrary.state.md.us/publications/Exec/MDH/BHA/HG7.5-209(e).FY_2022.pdf

Suggested measures:

- Number of 30-Day Readmissions to Psychiatric Inpatient and Residential Treatment Facilities (page 43)
- Number and Percent Eligible for Public Behavioral Health System Services within each Jurisdiction (page 54)
- Number and Percent of Child and Young Adult Recipients of Public Behavioral Health System Services (page 54-55)
- Number and Percent of Public Behavioral Health System Recipients of Inpatient Psychiatric Hospitalization (page 56)

Other tips:
- Compare rates with statewide averages or other jurisdictions.

7. Maryland Behavioral Health Workforce Assessment Report:
https://dlslibrary.state.md.us/publications/Exec/MDH/MHCC/SB283Ch286HB418Ch287(2)(2023)_2024.pdf

Suggested measures:
- Maryland BH Professionals Per Capita by County (page 18)
- Counselors, Therapists, Psychologists, and Social Workers Employment Estimates By County (page 21)
- Employment Estimates by County Per 30,000 Residents (pages 108-109)
- Demographic Estimates by BH Occupation and County (pages 110-121)

Other tips:
- Include rank as compared with other jurisdictions
- Compare rates with statewide averages or other jurisdictions.

8. MSDE School Report Card: https://reportcard.msde.maryland.gov/

Suggested measures:
- Socioeconomic need (look at "Free and Reduced Meals" under "Demographics/Student Group Populations")
- Limited English proficient students (look at "English Learner" under "Demographics/Student Group Populations")
- Student homelessness counts (look at "Homeless" under "Demographics/Student Group Populations")
- Chronic absenteeism (look at "Attendance" under Demographics/Student Group Populations;" left side menu includes several different measures of chronic absenteeism)
- Graduation rates (for High School only, look at "Report Card")

Other tips:

Appendix L.

- School-level data.
- Compare data with benchmarks for the state or the jurisdiction.
- Demographic data sets may be the most useful for demonstrating need, though academic data can also be referenced.
- Look at data definitions.
- Report Card details include Equity Data for academic measures; can be disaggregated by race and economic disadvantage).

9. LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/local-school-systems.aspx

10. List of Community Schools: See Appendix N

Appendix M.

Wraparound Supports

Consistent with the Consortium's legislative mandate, this RFA will support funding for wraparound supports. Under this RFA, wraparound supports are defined as holistic supports that address a student's behavioral health needs but are not considered traditional behavioral health services. Wraparound supports funded under this RFA must meet four criteria:

1. Limited to students with identified behavioral health challenges, or at significant risk, and their families;
2. When appropriate, should be connected to traditional behavioral health services;
3. Ineligible for reimbursement through Medicaid, the Developmental Disabilities Administration (DDA), or other State support (e.g., not Targeted Case Management (TCM), TCM+, or High-Fidelity Wraparound models); and
4. Must involve schools in planning and/or implementation.

Examples of wraparound supports include:

1. Transportation to behavioral health services;
2. Peer support;
3. Parenting classes;
4. Afterschool activities that implement evidence-based behavioral health programming;
5. Evidence-based mentoring programs;
6. Developing and monitoring care plans for students with identified behavioral health needs; and
7. Navigation to ***link*** students and families to essential supports such as:
    - Somatic health services and health insurance
    - Academic and vocational supports
    - Extra-curricular activities that do not implement behavioral health EBPs
    - Services that address non-medical Social Determinants of Health (SDOH) needs.

The Consortium's definition of wraparound for this RFA differs from the definition of wraparound in other programs:

- Community Schools: When compared with the Community Schools' definition of wraparound, the Consortium's approach is more focused on behavioral health, and is only available to targeted students and families. This RFA will not support direct funding for activities such as extended learning, field trips, tutoring, somatic health services, vision, dental, etc. that are within the Community Schools' definition of wraparound. Instead, this RFA will support programs that *link* students and families to a broad array of supports.
- High Fidelity Wraparound/Targeted Case Management: When compared to these approaches to wraparound, the Consortium's approach is less intensive and available to more students and families. This RFA will not support direct funding for models that are reimbursable through Medicaid and the 1915(i) program. Instead, programs funded by this RFA and the Partnership model should help to educate and connect families to resources for higher intensity wraparound supports.

SCHOOL NAME	LOCAL EDUCATION AGENCY
BEALL ELEMENTARY	ALLEGANY COUNTY
BRADDOCK MIDDLE	ALLEGANY COUNTY
CASH VALLEY	ALLEGANY COUNTY
CENTER FOR CAREER & TECH EDUC	ALLEGANY COUNTY
CRESAPTOWN ELEMENTARY	ALLEGANY COUNTY
GEORGE'S CREEK ELEMENTARY	ALLEGANY COUNTY
JOHN HUMBIRD ELEMENTARY	ALLEGANY COUNTY
MT SAVAGE ELEMENTARY	ALLEGANY COUNTY
NORTHEAST ELEMENTARY	ALLEGANY COUNTY
SOUTH PENN ELEMENTARY	ALLEGANY COUNTY
WASHINGTON MIDDLE	ALLEGANY COUNTY
WEST SIDE ELEMENTARY	ALLEGANY COUNTY
WESTERNPORT ELEMENTARY	ALLEGANY COUNTY
WESTMAR MIDDLE	ALLEGANY COUNTY
ANNAPOLIS ELEMENTARY	ANNE ARUNDEL COUNTY
ANNAPOLIS MIDDLE	ANNE ARUNDEL COUNTY
BELLE GROVE ELEMENTARY	ANNE ARUNDEL COUNTY
BROCK BRIDGE ELEMENTARY	ANNE ARUNDEL COUNTY
BROOKLYN PARK ELEMENTARY	ANNE ARUNDEL COUNTY
BROOKLYN PARK MIDDLE	ANNE ARUNDEL COUNTY
CORKRAN MIDDLE SCHOOL	ANNE ARUNDEL COUNTY
EASTPORT ELEMENTARY	ANNE ARUNDEL COUNTY
FREETOWN ELEMENTARY	ANNE ARUNDEL COUNTY
GEORGE CROMWELL ELEMENTARY	ANNE ARUNDEL COUNTY
GEORGETOWN EAST ELEMENTARY	ANNE ARUNDEL COUNTY
GERMANTOWN ELEMENTARY	ANNE ARUNDEL COUNTY
GLEN BURNIE PARK ELEMENTARY	ANNE ARUNDEL COUNTY
GLENDALE ELEMENTARY	ANNE ARUNDEL COUNTY
HEBRON HARMAN ELEMENTARY	ANNE ARUNDEL COUNTY
HILLTOP ELEMENTARY	ANNE ARUNDEL COUNTY
LOTHIAN ELEMENTARY	ANNE ARUNDEL COUNTY
MARLEY ELEMENTARY	ANNE ARUNDEL COUNTY
MARLEY MIDDLE	ANNE ARUNDEL COUNTY
MARY MOSS @ J. ALBERT ADAMS ACADEMY	ANNE ARUNDEL COUNTY
MARYLAND CITY ELEMENTARY	ANNE ARUNDEL COUNTY
MEADE MIDDLE	ANNE ARUNDEL COUNTY
MILLS PAROLE ELEMENTARY	ANNE ARUNDEL COUNTY
MONARCH ACADEMY ANNAPOLIS	ANNE ARUNDEL COUNTY
NORTH COUNTY HIGH	ANNE ARUNDEL COUNTY
NORTH GLEN ELEMENTARY	ANNE ARUNDEL COUNTY
OAKWOOD ELEMENTARY	ANNE ARUNDEL COUNTY
OVERLOOK ELEMENTARY	ANNE ARUNDEL COUNTY
PARK ELEMENTARY	ANNE ARUNDEL COUNTY
PHOENIX ACADEMY	ANNE ARUNDEL COUNTY
POINT PLEASANT ELEM	ANNE ARUNDEL COUNTY
RICHARD HENRY LEE ELEMENTARY	ANNE ARUNDEL COUNTY
RIPPLING WOODS ELEMENTARY	ANNE ARUNDEL COUNTY
SOUTHGATE ELEMENTARY	ANNE ARUNDEL COUNTY
TRACEYS ELEMENTARY	ANNE ARUNDEL COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
TYLER HEIGHTS ELEMENTARY	ANNE ARUNDEL COUNTY
VAN BOKKELEN ELEMENTARY	ANNE ARUNDEL COUNTY
WOODSIDE ELEMENTARY	ANNE ARUNDEL COUNTY
ABBOTTSTON ELEMENTARY	BALTIMORE CITY
ACCE ACADEMY	BALTIMORE CITY
ACHIEVEMENT ACADEMY @ HARBOR CITY HIGH SCHOOL	BALTIMORE CITY
ARLINGTON ELEMENTARY/MIDDLE	BALTIMORE CITY
ARMISTEAD GARDENS ELEMENTARY/MIDDLE	BALTIMORE CITY
ARUNDEL ELEMENTARY/MIDDLE	BALTIMORE CITY
AUGUSTA FELLS SAVAGE INSTITUTE OF VISUAL ARTS HIGH	BALTIMORE CITY
BALTIMORE CITY COLLEGE HIGH	BALTIMORE CITY
BALTIMORE COLLEGIATE SCHOOL FOR BOYS	BALTIMORE CITY
BALTIMORE DESIGN SCHOOL	BALTIMORE CITY
BALTIMORE INTERNATIONAL ACADEMY	BALTIMORE CITY
BALTIMORE INTERNATIONAL ACADEMY WEST	BALTIMORE CITY
BALTIMORE LEADERSHIP SCHOOL FOR YOUNG WOMEN	BALTIMORE CITY
BALTIMORE MONTESSORI PUBLIC CHARTER SCHOOL	BALTIMORE CITY
BALTIMORE POLYTECHNIC INSTITUTE	BALTIMORE CITY
BALTIMORE SCHOOL FOR THE ARTS	BALTIMORE CITY
BARCLAY ELEMENTARY/MIDDLE	BALTIMORE CITY
BARD HIGH SCHOOL EARLY COLLEGE BALTIMORE	BALTIMORE CITY
BAY-BROOK ELEMENTARY/MIDDLE	BALTIMORE CITY
BEECHFIELD ELEMENTARY/MIDDLE	BALTIMORE CITY
BELAIR-EDISON SCHOOL, THE	BALTIMORE CITY
BELMONT ELEMENTARY	BALTIMORE CITY
BENJAMIN FRANKLIN HIGH AT MASONVILLE COVE	BALTIMORE CITY
BILLIE HOLIDAY ELEMENTARY SCHOOL (FORMERLY JAMES MOSHER ES)	BALTIMORE CITY
BLUFORD DREW JEMISON STEM ACADEMY WEST	BALTIMORE CITY
BOOKER T WASHINGTON MIDDLE	BALTIMORE CITY
CALLAWAY ELEMENTARY	BALTIMORE CITY
CALVIN M RODWELL ELEMENTARY	BALTIMORE CITY
CARVER VOCATIONAL-TECHNICAL HIGH	BALTIMORE CITY
CECIL ELEMENTARY	BALTIMORE CITY
CHARLES CARROLL BARRISTER ELEMENTARY	BALTIMORE CITY
CHERRY HILL ELEMENTARY/MIDDLE	BALTIMORE CITY
CITY NEIGHBORS CHARTER ELEMENTARY/MIDDLE	BALTIMORE CITY
CITY NEIGHBORS HAMILTON	BALTIMORE CITY
CITY NEIGHBORS HIGH	BALTIMORE CITY
CITY SPRINGS ELEMENTARY/MIDDLE	BALTIMORE CITY
CLAREMONT SCHOOL	BALTIMORE CITY
CLAY HILL PUBLIC CHARTER SCHOOL	BALTIMORE CITY
COLLINGTON SQUARE ELEMENTARY/MIDDLE	BALTIMORE CITY
COMMODORE JOHN ROGERS ELEMENTARY/MIDDLE	BALTIMORE CITY
CONNEXIONS: A COMMUNITY BASED ARTS SCHOOL	BALTIMORE CITY
COPPIN ACADEMY	BALTIMORE CITY
CREATIVE CITY PUBLIC CHARTER SCHOOL	BALTIMORE CITY
CROSS COUNTRY ELEMENTARY	BALTIMORE CITY
CURTIS BAY ELEMENTARY/MIDDLE	BALTIMORE CITY

SCHOOL NAME	LOCAL EDUCATION AGENCY
DALLAS F NICHOLAS SR ELEM	BALTIMORE CITY
DICKEY HILL ELEMENTARY/MIDDLE	BALTIMORE CITY
DIGITAL HARBOR HIGH	BALTIMORE CITY
DOROTHY I. HEIGHT ELEMENTARY SCHOOL	BALTIMORE CITY
DR BERNARD HARRIS ELEMENTARY	BALTIMORE CITY
DR NATHAN A PITTS-ASHBURTON ELEMENTARY/MIDDLE	BALTIMORE CITY
EAGER STREET ACADEMY	BALTIMORE CITY
EDGEWOOD ELEMENTARY	BALTIMORE CITY
EDMONDSON-WESTSIDE HIGH	BALTIMORE CITY
ELMER A. HENDERSON: A JOHNS HOPKINS PARTNERSHIP SC	BALTIMORE CITY
EMPOWERMENT ACADEMY	BALTIMORE CITY
EXCEL ACADEMY @ FRANCIS M WOOD HIGH	BALTIMORE CITY
FALLSTAFF ELEMENTARY/MIDDLE	BALTIMORE CITY
FEDERAL HILL PREPARATORY ACADEMY	BALTIMORE CITY
FOREST PARK HIGH	BALTIMORE CITY
FORT WORTHINGTON ELEMENTARY/MIDDLE	BALTIMORE CITY
FRANCIS SCOTT KEY ELEMENTARY/MIDDLE	BALTIMORE CITY
FRANKLIN SQUARE ELEMENTARY/MIDDLE	BALTIMORE CITY
FREDERICK DOUGLASS HIGH	BALTIMORE CITY
FREDERICK ELEMENTARY	BALTIMORE CITY
FURLEY ELEMENTARY	BALTIMORE CITY
FURMAN L TEMPLETON ELEMENTARY	BALTIMORE CITY
GARDENVILLE ELEMENTARY	BALTIMORE CITY
GARRETT HEIGHTS ELEMENTARY/MIDDLE	BALTIMORE CITY
GEORGE WASHINGTON ELEMENTARY	BALTIMORE CITY
GLENMOUNT ELEMENTARY/MIDDLE	BALTIMORE CITY
GOVANS ELEMENTARY	BALTIMORE CITY
GRACELAND PARK/ODONNELL HEIGHTS ELEMENTARY/MIDDLE	BALTIMORE CITY
GREEN STREET ACADEMY	BALTIMORE CITY
GWYNNS FALLS ELEMENTARY	BALTIMORE CITY
HAMILTON ELEMENTARY/MIDDLE	BALTIMORE CITY
HAMPDEN ELEMENTARY/MIDDLE	BALTIMORE CITY
HAMPSTEAD HILL ACADEMY	BALTIMORE CITY
HARFORD HEIGHTS ELEMENTARY	BALTIMORE CITY
HARLEM PARK ELEMENTARY/MIDDLE	BALTIMORE CITY
HAZELWOOD ELEMENTARY/MIDDLE	BALTIMORE CITY
HIGHLANDTOWN ELEMENTARY/MIDDLE #215	BALTIMORE CITY
HIGHLANDTOWN ELEMENTARY/MIDDLE #237	BALTIMORE CITY
HILTON ELEMENTARY	BALTIMORE CITY
HOLABIRD ELEMENTARY/MIDDLE	BALTIMORE CITY
JAMES MCHENRY ELEMENTARY/MIDDLE	BALTIMORE CITY
JOHN RUHRAH ELEMENTARY/MIDDLE	BALTIMORE CITY
JOHNSTON SQUARE ELEMENTARY	BALTIMORE CITY
JOSEPH C. BRISCOE ACADEMY	BALTIMORE CITY
KATHERINE JOHNSON GLOBAL ACADEMY/CALVERTON ELEMENTARY/MIDDLE	BALTIMORE CITY
KIPP ACADEMY	BALTIMORE CITY
LAKELAND ELEMENTARY/MIDDLE	BALTIMORE CITY
LAKEWOOD ELEMENTARY	BALTIMORE CITY

SCHOOL NAME	LOCAL EDUCATION AGENCY
LEITH WALK ELEMENTARY/MIDDLE	BALTIMORE CITY
LIBERTY ELEMENTARY	BALTIMORE CITY
LILLIE MAY CARROLL JACKSON SCHOOL	BALTIMORE CITY
LOIS T MURRAY ELEMENTARY/MIDDLE	BALTIMORE CITY
MAREE G. FARRING ELEMENTARY/MIDDLE	BALTIMORE CITY
MARGARET BRENT ELEMENTARY/MIDDLE	BALTIMORE CITY
MARY ANN WINTERLING ELEMENTARY @ BENTALOU	BALTIMORE CITY
MARY E RODMAN ELEMENTARY	BALTIMORE CITY
MATTHEW A HENSON ELEMENTARY	BALTIMORE CITY
MEDFIELD HEIGHTS ELEMENTARY	BALTIMORE CITY
MERGENTHALER VOC TECH HIGH	BALTIMORE CITY
MIDTOWN ACADEMY	BALTIMORE CITY
MONTEBELLO ELEMENTARY/MIDDLE	BALTIMORE CITY
MORAVIA PARK PRIMARY	BALTIMORE CITY
MORRELL PARK ELEMENTARY/MIDDLE	BALTIMORE CITY
MOUNT ROYAL ELEMENTARY/MIDDLE	BALTIMORE CITY
NATIONAL ACADEMY FOUNDATION	BALTIMORE CITY
NEW SONG ACADEMY	BALTIMORE CITY
NORTH BEND ELEMENTARY/MIDDLE	BALTIMORE CITY
NORTHWOOD ELEMENTARY	BALTIMORE CITY
PARK HEIGHTS ACADEMY	BALTIMORE CITY
PATTERSON HIGH	BALTIMORE CITY
PATTERSON PARK PUBLIC CHARTER	BALTIMORE CITY
PAUL LAURENCE DUNBAR HIGH	BALTIMORE CITY
PIMLICO ELEMENTARY/MIDDLE	BALTIMORE CITY
REGINALD F LEWIS HIGH SCHOOL	BALTIMORE CITY
RENAISSANCE ACADEMY	BALTIMORE CITY
ROBERT W COLEMAN ELEMENTARY	BALTIMORE CITY
ROLAND PARK ELEMENTARY/MIDDLE	BALTIMORE CITY
ROSEMONT ELEMENTARY/MIDDLE	BALTIMORE CITY
SANDTOWN-WINCHESTER ACHIEVEMENT ACADEMY	BALTIMORE CITY
SHARP-LEADENHALL ELEMENTARY	BALTIMORE CITY
SINCLAIR LANE ELEMENTARY	BALTIMORE CITY
SOUTHWEST BALTIMORE CHARTER	BALTIMORE CITY
STADIUM SCHOOL	BALTIMORE CITY
TENCH TILGHMAN ELEMENTARY/MIDDLE	BALTIMORE CITY
THE CROSSROADS SCHOOL	BALTIMORE CITY
THE GREEN SCHOOL OF BALTIMORE	BALTIMORE CITY
THE HISTORIC SAMUEL COLERIDGE-TAYLOR ELEMENTARY	BALTIMORE CITY
THE MOUNT WASHINGTON SCHOOL	BALTIMORE CITY
THE REACH! PARTNERSHIP SCHOOL	BALTIMORE CITY
THOMAS JEFFERSON ELEMENTARY/MIDDLE	BALTIMORE CITY
THOMAS JOHNSON ELEMENTARY/MIDDLE	BALTIMORE CITY
TUNBRIDGE PUBLIC CHARTER ELEMENTARY	BALTIMORE CITY
VANGUARD COLLEGIATE MIDDLE	BALTIMORE CITY
VIOLETVILLE ELEMENTARY/MIDDLE	BALTIMORE CITY
VIVIEN T THOMAS MEDICAL ARTS ACADEMY	BALTIMORE CITY
WALTER P CARTER ELEMENTARY/MIDDLE	BALTIMORE CITY

SCHOOL NAME	LOCAL EDUCATION AGENCY
WAVERLY ELEMENTARY/MIDDLE	BALTIMORE CITY
WESTERN HIGH	BALTIMORE CITY
WESTPORT ACADEMY	BALTIMORE CITY
WILDWOOD ELEMENTARY MIDDLE SCHOOL	BALTIMORE CITY
WILLIAM PACA ELEMENTARY	BALTIMORE CITY
WILLIAM S BAER SCHOOL	BALTIMORE CITY
WINDSOR HILLS ELEMENTARY/MIDDLE	BALTIMORE CITY
WOLFE STREET ACADEMY	BALTIMORE CITY
WOODHOME ELEMENTARY/MIDDLE	BALTIMORE CITY
YORKWOOD ELEMENTARY	BALTIMORE CITY
ARBUTUS ELEMENTARY	BALTIMORE COUNTY
BALTIMORE HIGHLANDS ELEMENTARY	BALTIMORE COUNTY
BATTLE GROVE ELEMENTARY	BALTIMORE COUNTY
BATTLE MONUMENT SCHOOL	BALTIMORE COUNTY
BEAR CREEK ELEMENTARY	BALTIMORE COUNTY
BEDFORD ELEMENTARY	BALTIMORE COUNTY
BERKSHIRE ELEMENTARY	BALTIMORE COUNTY
CAMPFIELD EARLY CHILDHOOD CTR	BALTIMORE COUNTY
CARNEY ELEMENTARY	BALTIMORE COUNTY
CATONSVILLE CTR FOR ALTER STUD	BALTIMORE COUNTY
CHADWICK ELEMENTARY	BALTIMORE COUNTY
CHARLESMONT ELEMENTARY	BALTIMORE COUNTY
CHASE ELEMENTARY	BALTIMORE COUNTY
CHESAPEAKE HIGH	BALTIMORE COUNTY
CHURCH LANE ELEMENTARY	BALTIMORE COUNTY
COLGATE ELEMENTARY	BALTIMORE COUNTY
CROSSROADS CENTER	BALTIMORE COUNTY
DEEP CREEK ELEMENTARY	BALTIMORE COUNTY
DEEP CREEK MIDDLE	BALTIMORE COUNTY
DEER PARK ELEMENTARY	BALTIMORE COUNTY
DOGWOOD ELEMENTARY	BALTIMORE COUNTY
DUNDALK ELEMENTARY	BALTIMORE COUNTY
DUNDALK HIGH	BALTIMORE COUNTY
DUNDALK MIDDLE	BALTIMORE COUNTY
EDMONDSON HEIGHTS ELEMENTARY	BALTIMORE COUNTY
ELMWOOD ELEMENTARY	BALTIMORE COUNTY
ESSEX ELEMENTARY	BALTIMORE COUNTY
FEATHERBED LANE ELEMENTARY	BALTIMORE COUNTY
GENL JOHN STRICKER MIDDLE	BALTIMORE COUNTY
GLENMAR ELEMENTARY	BALTIMORE COUNTY
GLYNDON ELEMENTARY	BALTIMORE COUNTY
GOLDEN RING MIDDLE	BALTIMORE COUNTY
GRANGE ELEMENTARY	BALTIMORE COUNTY
HALETHORPE ELEMENTARY	BALTIMORE COUNTY
HALSTEAD ACADEMY	BALTIMORE COUNTY
HAWTHORNE ELEMENTARY	BALTIMORE COUNTY
HEBBVILLE ELEMENTARY	BALTIMORE COUNTY
HERNWOOD ELEMENTARY	BALTIMORE COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
HOLABIRD MIDDLE	BALTIMORE COUNTY
JOHNNYCAKE ELEMENTARY	BALTIMORE COUNTY
KENWOOD HIGH	BALTIMORE COUNTY
LANSDOWNE ELEMENTARY	BALTIMORE COUNTY
LANSDOWNE HIGH	BALTIMORE COUNTY
LANSDOWNE MIDDLE	BALTIMORE COUNTY
LOCH RAVEN TECH ACADEMY	BALTIMORE COUNTY
LOGAN ELEMENTARY	BALTIMORE COUNTY
MAIDEN CHOICE SCHOOL	BALTIMORE COUNTY
MARS ESTATES ELEMENTARY	BALTIMORE COUNTY
MARTIN BLVD ELEMENTARY	BALTIMORE COUNTY
MCCORMICK ELEMENTARY	BALTIMORE COUNTY
MEADOWOOD EDUCATION CTR	BALTIMORE COUNTY
MIDDLE RIVER MIDDLE	BALTIMORE COUNTY
MIDDLESEX ELEMENTARY	BALTIMORE COUNTY
MILBROOK ELEMENTARY	BALTIMORE COUNTY
NORTHWEST ACADEMY OF HEALTH SCIENCE	BALTIMORE COUNTY
NORWOOD ELEMENTARY	BALTIMORE COUNTY
OAKLEIGH ELEMENTARY	BALTIMORE COUNTY
OREMS ELEMENTARY	BALTIMORE COUNTY
OVERLEA HIGH	BALTIMORE COUNTY
OWINGS MILLS ELEMENTARY	BALTIMORE COUNTY
OWINGS MILLS HIGH	BALTIMORE COUNTY
PADONIA INTERNATIONAL ELEMENTA	BALTIMORE COUNTY
PATAPSCO HIGH & CTR FOR THE AR	BALTIMORE COUNTY
PIKESVILLE MIDDLE	BALTIMORE COUNTY
PLEASANT PLAINS ELEMENTARY	BALTIMORE COUNTY
POWHATAN ELEMENTARY	BALTIMORE COUNTY
RANDALLSTOWN ELEMENTARY	BALTIMORE COUNTY
RED HOUSE RUN ELEMENTARY	BALTIMORE COUNTY
REISTERSTOWN ELEMENTARY	BALTIMORE COUNTY
RIVERVIEW ELEMENTARY	BALTIMORE COUNTY
ROSEDALE CENTER	BALTIMORE COUNTY
ROSSVILLE ELEMENTARY	BALTIMORE COUNTY
SANDALWOOD ELEMENTARY	BALTIMORE COUNTY
SANDY PLAINS ELEMENTARY	BALTIMORE COUNTY
SCOTTS BRANCH ELEMENTARY	BALTIMORE COUNTY
SENECA ELEMENTARY	BALTIMORE COUNTY
SHADY SPRING ELEMENTARY	BALTIMORE COUNTY
SOUTHWEST ACADEMY	BALTIMORE COUNTY
STEMMERS RUN MIDDLE	BALTIMORE COUNTY
SUSSEX ELEMENTARY	BALTIMORE COUNTY
TIMBER GROVE ELEMENTARY	BALTIMORE COUNTY
VICTORY VILLA ELEMENTARY	BALTIMORE COUNTY
WELLWOOD INTERNATIONAL MAGNET	BALTIMORE COUNTY
WHITE OAK SCHOOL	BALTIMORE COUNTY
WINAND ELEMENTARY	BALTIMORE COUNTY
WINDSOR MILL MIDDLE	BALTIMORE COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
WINFIELD ELEMENTARY	BALTIMORE COUNTY
WOODBRIDGE ELEMENTARY	BALTIMORE COUNTY
WOODHOLME ELEMENTARY	BALTIMORE COUNTY
WOODLAWN HIGH	BALTIMORE COUNTY
WOODLAWN MIDDLE	BALTIMORE COUNTY
WOODMOOR ELEMENTARY	BALTIMORE COUNTY
COL RICHARDSON HIGH	CAROLINE COUNTY
COL RICHARDSON MIDDLE	CAROLINE COUNTY
DENTON ELEMENTARY	CAROLINE COUNTY
FEDERALSBURG ELEMENTARY	CAROLINE COUNTY
GREENSBORO ELEMENTARY	CAROLINE COUNTY
LOCKERMAN MIDDLE	CAROLINE COUNTY
PRESTON ELEMENTARY	CAROLINE COUNTY
RIDGELY ELEMENTARY	CAROLINE COUNTY
CROSSROADS MIDDLE SCHOOL	CARROL COUNTY
TANEYTOWN ELEMENTARY	CARROL COUNTY
BAINBRIDGE ELEMENTARY	CECIL COUNTY
BAY VIEW ELEMENTARY	CECIL COUNTY
CECIL MANOR ELEMENTARY	CECIL COUNTY
CECILTON ELEMENTARY	CECIL COUNTY
ELKTON MIDDLE	CECIL COUNTY
GILPIN MANOR ELEMENTARY	CECIL COUNTY
HOLLY HALL ELEMENTARY	CECIL COUNTY
NORTH EAST ELEMENTARY	CECIL COUNTY
THOMSON ESTATES ELEMENTARY	CECIL COUNTY
BENJAMIN STODDERT MIDDLE	CHARLES COUNTY
DR GUSTAVUS BROWN ELEMENTARY	CHARLES COUNTY
DR SAMUEL A MUDD ELEMENTARY	CHARLES COUNTY
EVA TURNER ELEMENTARY	CHARLES COUNTY
GENERAL SMALLWOOD MIDDLE	CHARLES COUNTY
INDIAN HEAD ELEMENTARY	CHARLES COUNTY
J P RYON ELEMENTARY	CHARLES COUNTY
JENIFER ELEMENTARY SCHOOL	CHARLES COUNTY
JOHN HANSON MIDDLE SCHOOL	CHARLES COUNTY
THOMAS STONE HIGH SCHOOL	CHARLES COUNTY
CAMBRIDGE-SOUTH DORCHESTER HI	DORCHESTER COUNTY
CHOPTANK ELEMENTARY	DORCHESTER COUNTY
HURLOCK ELEMENTARY	DORCHESTER COUNTY
MACES LANE MIDDLE	DORCHESTER COUNTY
MAPLE ELEMENTARY	DORCHESTER COUNTY
NORTH DORCHESTER HIGH	DORCHESTER COUNTY
NORTH DORCHESTER MIDDLE	DORCHESTER COUNTY
SANDY HILL ELEMENTARY	DORCHESTER COUNTY
SOUTH DORCHESTER SCHOOL	DORCHESTER COUNTY
VIENNA ELEMENTARY	DORCHESTER COUNTY
WARWICK ELEMENTARY	DORCHESTER COUNTY
BUTTERFLY RIDGE ELEMENTARY	FREDERICK COUNTY
CRESTWOOD MIDDLE SCHOOL	FREDERICK COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
HEATHER RIDGE HIGH SCHOOL	FREDERICK COUNTY
HILLCREST ELEMENTARY	FREDERICK COUNTY
LINCOLN ELEMENTARY	FREDERICK COUNTY
MONOCACY ELEMENTARY	FREDERICK COUNTY
MONOCACY MIDDLE	FREDERICK COUNTY
WAVERLEY ELEMENTARY	FREDERICK COUNTY
WEST FREDERICK MIDDLE	FREDERICK COUNTY
BROAD FORD ELEMENTARY	GARRETT COUNTY
CRELLIN ELEMENTARY	GARRETT COUNTY
FRIENDSVILLE ELEMENTARY	GARRETT COUNTY
GRANTSVILLE ELEMENTARY	GARRETT COUNTY
YOUGH GLADES ELEMENTARY	GARRETT COUNTY
ABERDEEN MIDDLE	HARFORD COUNTY
BAKERFIELD ELEMENTARY	HARFORD COUNTY
DEERFIELD ELEMENTARY	HARFORD COUNTY
EDGEWOOD ELEMENTARY	HARFORD COUNTY
EDGEWOOD HIGH	HARFORD COUNTY
EDGEWOOD MIDDLE	HARFORD COUNTY
G D LISBY ELEMENTARY HILLSDALE	HARFORD COUNTY
HALLS CROSS ROADS ELEMENTARY	HARFORD COUNTY
HAVRE DE GRACE ELEMENTARY	HARFORD COUNTY
JOHN ARCHER SCHOOL	HARFORD COUNTY
JOPPATOWNE ELEMENTARY	HARFORD COUNTY
JOPPATOWNE HIGH	HARFORD COUNTY
MAGNOLIA ELEMENTARY	HARFORD COUNTY
MAGNOLIA MIDDLE	HARFORD COUNTY
RIVERSIDE ELEMENTARY	HARFORD COUNTY
WM PACA OLD POST	HARFORD COUNTY
CRADLEROCK ELEMENTARY	HOWARD COUNTY
DEEP RUN ELEMENTARY	HOWARD COUNTY
DUCKETTS LANE ELEMENTARY	HOWARD COUNTY
GUILFORD ELEMENTARY	HOWARD COUNTY
HOMEWOOD SCHOOL	HOWARD COUNTY
LAKE ELKHORN MIDDLE	HOWARD COUNTY
LAUREL WOODS ELEMENTARY	HOWARD COUNTY
STEVENS FOREST ELEMENTARY	HOWARD COUNTY
H H GARNETT ELEMENTARY	KENT COUNTY
KENT COUNTY MIDDLE SCHOOL	KENT COUNTY
ROCK HALL ELEMENTARY	KENT COUNTY
ARCOLA ELEMENTARY	MONTGOMERY COUNTY
ARGYLE MIDDLE	MONTGOMERY COUNTY
BEL PRE ELEMENTARY	MONTGOMERY COUNTY
BENJAMIN BANNEKER MIDDLE	MONTGOMERY COUNTY
BROOKHAVEN ELEMENTARY	MONTGOMERY COUNTY
BROWN STATION ELEMENTARY	MONTGOMERY COUNTY
BURNT MILLS ELEMENTARY	MONTGOMERY COUNTY
CANNON ROAD ELEMENTARY	MONTGOMERY COUNTY
CAPT JAMES E DALY ELEMENTARY	MONTGOMERY COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
CARL SANDBURG LEARNING CENTER	MONTGOMERY COUNTY
CLOPPER MILL ELEMENTARY	MONTGOMERY COUNTY
CRESTHAVEN ELEMENTARY	MONTGOMERY COUNTY
FAIRLAND ELEMENTARY	MONTGOMERY COUNTY
FLOWER HILL ELEMENTARY	MONTGOMERY COUNTY
FOREST OAK MIDDLE	MONTGOMERY COUNTY
FRANCIS SCOTT KEY MIDDLE	MONTGOMERY COUNTY
GAITHERSBURG ELEMENTARY	MONTGOMERY COUNTY
GALWAY ELEMENTARY	MONTGOMERY COUNTY
GEORGIAN FOREST ELEMENTARY	MONTGOMERY COUNTY
GREENCASTLE ELEMENTARY	MONTGOMERY COUNTY
HARMONY HILLS ELEMENTARY	MONTGOMERY COUNTY
HARRIET R TUBMAN ELEMENTARY	MONTGOMERY COUNTY
HIGHLAND ELEMENTARY	MONTGOMERY COUNTY
JACKSON ROAD ELEMENTARY	MONTGOMERY COUNTY
JOANN LELECK ELEMENTARY AT BROAD ACRES	MONTGOMERY COUNTY
JOHN F KENNEDY HIGH	MONTGOMERY COUNTY
KEMP MILL ELEMENTARY	MONTGOMERY COUNTY
LAKE SENECA ELEMENTARY	MONTGOMERY COUNTY
MEADOW HALL ELEMENTARY	MONTGOMERY COUNTY
MONTGOMERY VILLAGE MIDDLE	MONTGOMERY COUNTY
NEELSVILLE MIDDLE	MONTGOMERY COUNTY
NEW HAMPSHIRE ESTATES ELEM	MONTGOMERY COUNTY
OAK VIEW ELEMENTARY	MONTGOMERY COUNTY
ODESSA SHANNON MIDDLE	MONTGOMERY COUNTY
R SARGENT SHRIVER ELEMENTARY	MONTGOMERY COUNTY
ROLLING TERRACE ELEMENTARY	MONTGOMERY COUNTY
ROSCOE E NIX ELEMENTARY	MONTGOMERY COUNTY
ROSEMONT ELEMENTARY	MONTGOMERY COUNTY
S CHRISTA MCAULIFFE ELEMENTARY	MONTGOMERY COUNTY
SOUTH LAKE ELEMENTARY	MONTGOMERY COUNTY
STEDWICK ELEMENTARY	MONTGOMERY COUNTY
STRATHMORE ELEMENTARY	MONTGOMERY COUNTY
SUMMIT HALL ELEMENTARY	MONTGOMERY COUNTY
TWINBROOK ELEMENTARY	MONTGOMERY COUNTY
VIERS MILL ELEMENTARY	MONTGOMERY COUNTY
WASHINGTON GROVE ELEMENTARY	MONTGOMERY COUNTY
WATERS LANDING ELEMENTARY	MONTGOMERY COUNTY
WATKINS MILL ELEMENTARY	MONTGOMERY COUNTY
WATKINS MILL HIGH	MONTGOMERY COUNTY
WELLER ROAD ELEMENTARY	MONTGOMERY COUNTY
WHEATON WOODS ELEMENTARY	MONTGOMERY COUNTY
WHETSTONE ELEMENTARY	MONTGOMERY COUNTY
WHITE OAK MIDDLE	MONTGOMERY COUNTY
ADELPHI ELEMENTARY	PRINCE GEORGE'S COUNTY
ALLENWOOD ELEMENTARY	PRINCE GEORGE'S COUNTY
ANDREW JACKSON ACADEMY	PRINCE GEORGE'S COUNTY
APPLE GROVE ELEMENTARY	PRINCE GEORGE'S COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
ARDMORE ELEMENTARY	PRINCE GEORGE'S COUNTY
ARROWHEAD ELEMENTARY	PRINCE GEORGE'S COUNTY
AVALON ELEMENTARY	PRINCE GEORGE'S COUNTY
BADEN ELEMENTARY	PRINCE GEORGE'S COUNTY
BARNABY MANOR ELEMENTARY	PRINCE GEORGE'S COUNTY
BEACON HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
BELTSVILLE ELEMENTARY	PRINCE GEORGE'S COUNTY
BENJAMIN STODDERT MIDDLE	PRINCE GEORGE'S COUNTY
BERWYN HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
BLADENSBURG ELEMENTARY	PRINCE GEORGE'S COUNTY
BLADENSBURG HIGH	PRINCE GEORGE'S COUNTY
BRADBURY HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
BUCK LODGE MIDDLE	PRINCE GEORGE'S COUNTY
CALVERTON ELEMENTARY	PRINCE GEORGE'S COUNTY
CARMODY HILLS ELEMENTARY	PRINCE GEORGE'S COUNTY
CAROLE HIGHLANDS ELEMENTARY	PRINCE GEORGE'S COUNTY
CARROLLTON ELEMENTARY	PRINCE GEORGE'S COUNTY
CATHERINE T REED ELEMENTARY	PRINCE GEORGE'S COUNTY
CENTRAL HIGH	PRINCE GEORGE'S COUNTY
CESAR CHAVEZ ELEMENTARY	PRINCE GEORGE'S COUNTY
CHARLES CARROLL MIDDLE	PRINCE GEORGE'S COUNTY
CHEROKEE LANE ELEMENTARY	PRINCE GEORGE'S COUNTY
CHILLUM ELEMENTARY	PRINCE GEORGE'S COUNTY
CLINTON GROVE ELEMENTARY	PRINCE GEORGE'S COUNTY
COLUMBIA PARK ELEMENTARY	PRINCE GEORGE'S COUNTY
CONCORD ELEMENTARY	PRINCE GEORGE'S COUNTY
COOL SPRING ELEMENTARY	PRINCE GEORGE'S COUNTY
COOPER LANE ELEMENTARY	PRINCE GEORGE'S COUNTY
CORA L RICE ELEMENTARY	PRINCE GEORGE'S COUNTY
CROSSLAND HIGH	PRINCE GEORGE'S COUNTY
DEERFIELD RUN ELEMENTARY	PRINCE GEORGE'S COUNTY
DISTRICT HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
DODGE PARK ELEMENTARY	PRINCE GEORGE'S COUNTY
DOSWELL E BROOKS ELEMENTARY	PRINCE GEORGE'S COUNTY
DREW FREEMAN MIDDLE	PRINCE GEORGE'S COUNTY
DUVAL HIGH	PRINCE GEORGE'S COUNTY
DWIGHT D EISENHOWER MIDDLE	PRINCE GEORGE'S COUNTY
EDWARD M. FELEGY ELEMENTARY	PRINCE GEORGE'S COUNTY
ERNEST EVERETT JUST MIDDLE	PRINCE GEORGE'S COUNTY
EXCEL ACADEMY	PRINCE GEORGE'S COUNTY
FAIRMONT HEIGHTS HIGH	PRINCE GEORGE'S COUNTY
FLINTSTONE ELEMENTARY	PRINCE GEORGE'S COUNTY
FOREST HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
FORT FOOTE ELEMENTARY	PRINCE GEORGE'S COUNTY
FRANCES SCOTT KEY ELEM	PRINCE GEORGE'S COUNTY
FRANCIS T EVANS ELEMENTARY	PRINCE GEORGE'S COUNTY
G JAMES GHOULSON MIDDLE	PRINCE GEORGE'S COUNTY
GAYWOOD ELEMENTARY	PRINCE GEORGE'S COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
GLADYS N SPELLMAN ELEMENTARY	PRINCE GEORGE'S COUNTY
GLASSMANOR ELEMENTARY	PRINCE GEORGE'S COUNTY
GLENN DALE ELEMENTARY	PRINCE GEORGE'S COUNTY
GLENRIDGE ELEMENTARY	PRINCE GEORGE'S COUNTY
GREENBELT MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
HIGH POINT HIGH	PRINCE GEORGE'S COUNTY
HIGHLAND PARK ELEMENTARY	PRINCE GEORGE'S COUNTY
HILLCREST HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
HOLLYWOOD ELEMENTARY	PRINCE GEORGE'S COUNTY
HYATTSVILLE ELEMENTARY	PRINCE GEORGE'S COUNTY
HYATTSVILLE MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
INDIAN QUEEN ELEMENTARY	PRINCE GEORGE'S COUNTY
INTERNATIONAL HIGH SCHOOL @ LANGLEY PARK	PRINCE GEORGE'S COUNTY
INTERNATIONAL HIGH SCHOOL @ LARGO	PRINCE GEORGE'S COUNTY
J FRANK DENT ELEMENTARY	PRINCE GEORGE'S COUNTY
JAMES E DUCKWORTH REGIONAL	PRINCE GEORGE'S COUNTY
JAMES H HARRISON ELEMENTARY	PRINCE GEORGE'S COUNTY
JAMES MCHENRY ELEMENTARY	PRINCE GEORGE'S COUNTY
JAMES RYDER RANDALL ELEMENTARY	PRINCE GEORGE'S COUNTY
JOHN H BAYNE ELEMENTARY	PRINCE GEORGE'S COUNTY
JUDGE SYLVANIA WOODS ELEMENTAR	PRINCE GEORGE'S COUNTY
KENMOOR MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
KETTERING ELEMENTARY	PRINCE GEORGE'S COUNTY
LAKE ARBOR ELEMENTARY	PRINCE GEORGE'S COUNTY
LAMONT ELEMENTARY	PRINCE GEORGE'S COUNTY
LANGLEY PK/MCCORMICK ELEM	PRINCE GEORGE'S COUNTY
LAUREL ELEMENTARY	PRINCE GEORGE'S COUNTY
LAUREL HIGH	PRINCE GEORGE'S COUNTY
LEWISDALE ELEMENTARY	PRINCE GEORGE'S COUNTY
LINCOLN CHARTER SCHOOL	PRINCE GEORGE'S COUNTY
LONGFIELDS ELEMENTARY	PRINCE GEORGE'S COUNTY
MAGNOLIA ELEMENTARY	PRINCE GEORGE'S COUNTY
MARTIN LUTHER KING JR MIDDLE S	PRINCE GEORGE'S COUNTY
MARY HARRIS "MOTHER" JONES ELEMENTARY	PRINCE GEORGE'S COUNTY
MONTPELIER ELEMENTARY	PRINCE GEORGE'S COUNTY
MT RAINIER ELEMENTARY	PRINCE GEORGE'S COUNTY
NICHOLAS OREM MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
NORTH FORESTVILLE ELEMENTARY	PRINCE GEORGE'S COUNTY
NORTHWESTERN HIGH	PRINCE GEORGE'S COUNTY
OAKLANDS ELEMENTARY	PRINCE GEORGE'S COUNTY
OXON HILL ELEMENTARY	PRINCE GEORGE'S COUNTY
OXON HILL MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
PAINT BRANCH ELEMENTARY	PRINCE GEORGE'S COUNTY
PANORAMA ELEMENTARY	PRINCE GEORGE'S COUNTY
PARKDALE HIGH	PRINCE GEORGE'S COUNTY
PORT TOWNS ELEMENTARY	PRINCE GEORGE'S COUNTY
POTOMAC HIGH	PRINCE GEORGE'S COUNTY
PRINCETON ELEMENTARY	PRINCE GEORGE'S COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
RIDGECREST ELEMENTARY	PRINCE GEORGE'S COUNTY
RIVERDALE ELEMENTARY	PRINCE GEORGE'S COUNTY
ROBERT FROST ELEMENTARY	PRINCE GEORGE'S COUNTY
ROBERT R GRAY ELEMENTARY	PRINCE GEORGE'S COUNTY
ROGER HEIGHTS ELEMENTARY	PRINCE GEORGE'S COUNTY
ROSA L PARKS ELEMENTARY	PRINCE GEORGE'S COUNTY
ROSE VALLEY ELEMENTARY	PRINCE GEORGE'S COUNTY
SAMUEL CHASE ELEMENTARY	PRINCE GEORGE'S COUNTY
SAMUEL P. MASSIE ACADEMY	PRINCE GEORGE'S COUNTY
SCOTCH TOWN HILLS ELEMENTARY	PRINCE GEORGE'S COUNTY
SEABROOK ELEMENTARY	PRINCE GEORGE'S COUNTY
SEAT PLEASANT ELEMENTARY	PRINCE GEORGE'S COUNTY
SONIA SOTOMAYOR MIDDLE AT ADELPHI	PRINCE GEORGE'S COUNTY
SPRINGHILL LAKE ELEMENTARY	PRINCE GEORGE'S COUNTY
STEPHEN DECATUR MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
SUITLAND ELEMENTARY	PRINCE GEORGE'S COUNTY
SUITLAND HIGH	PRINCE GEORGE'S COUNTY
TAYAC ELEMENTARY	PRINCE GEORGE'S COUNTY
TEMPLETON ELEMENTARY	PRINCE GEORGE'S COUNTY
THOMAS JOHNSON MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
THOMAS S STONE ELEMENTARY	PRINCE GEORGE'S COUNTY
THURGOOD MARSHALL MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
VALLEY VIEW ELEMENTARY	PRINCE GEORGE'S COUNTY
VANSVILLE ELEMENTARY	PRINCE GEORGE'S COUNTY
WALDON WOODS ELEMENTARY	PRINCE GEORGE'S COUNTY
WALKER MILL MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
WILLIAM BEANES ELEMENTARY	PRINCE GEORGE'S COUNTY
WILLIAM PACA ELEMENTARY	PRINCE GEORGE'S COUNTY
WILLIAM W HALL ACADEMY	PRINCE GEORGE'S COUNTY
WILLIAM WIRT MIDDLE SCHOOL	PRINCE GEORGE'S COUNTY
WOODRIDGE ELEMENTARY	PRINCE GEORGE'S COUNTY
SUDLERSVILLE ELEMENTARY	QUEEN ANNE'S COUNTY
SEED SCHOOL OF MARYLAND	SEED SCHOOL OF MARYLAND
CARTER G WOODSON ELEMENTARY	SOMERSET COUNTY
CRISFIELD HIGH	SOMERSET COUNTY
DEAL ISLAND SCHOOL	SOMERSET COUNTY
GREENWOOD ELEMENTARY	SOMERSET COUNTY
INTERMEDIATE SCHOOL	SOMERSET COUNTY
PRINCESS ANNE ELEMENTARY	SOMERSET COUNTY
WASHINGTON HIGH	SOMERSET COUNTY
GEORGE WASHINGTON CARVER ELEMENTARY SCHOOL	ST. MARY'S COUNTY
LEXINGTON PARK ELEMENTARY	ST. MARY'S COUNTY
PARK HALL ELEMENTARY	ST. MARY'S COUNTY
EASTON ELEMENTARY	TALBOT COUNTY
EASTON MIDDLE	TALBOT COUNTY
BESTER ELEMENTARY	WASHINGTON COUNTY
E RUSSELL HICKS MIDDLE	WASHINGTON COUNTY
EASTERN ELEMENTARY	WASHINGTON COUNTY

SCHOOL NAME	LOCAL EDUCATION AGENCY
EMMA K DOUB ELEMENTARY	WASHINGTON COUNTY
HANCOCK MIDDLE SENIOR HIGH	WASHINGTON COUNTY
HICKORY ELEMENTARY	WASHINGTON COUNTY
JONATHAN HAGER ELEMENTARY	WASHINGTON COUNTY
LINCOLNSHIRE ELEMENTARY	WASHINGTON COUNTY
MARSHALL STREET EDUCATION CENTER	WASHINGTON COUNTY
NORTHERN MIDDLE	WASHINGTON COUNTY
PANGBORN ELEMENTARY	WASHINGTON COUNTY
POTOMAC HEIGHTS ELEMENTARY	WASHINGTON COUNTY
RUTH ANN MONROE PRIMARY	WASHINGTON COUNTY
SALEM AVENUE ELEMENTARY	WASHINGTON COUNTY
SOUTH HAGERSTOWN HIGH	WASHINGTON COUNTY
SPRINGFIELD MIDDLE	WASHINGTON COUNTY
WESTERN HEIGHTS MIDDLE	WASHINGTON COUNTY
WILLIAMSPORT ELEMENTARY	WASHINGTON COUNTY
BEAVER RUN ELEMENTARY SCHOOL	WICOMICO COUNTY
BENNETT MIDDLE	WICOMICO COUNTY
CHARLES H CHIPMAN ELEMENTARY	WICOMICO COUNTY
DELMAR ELEMENTARY	WICOMICO COUNTY
EAST SALISBURY ELEMENTARY	WICOMICO COUNTY
FRUITLAND INTERMEDIATE	WICOMICO COUNTY
FRUITLAND PRIMARY	WICOMICO COUNTY
GLEN AVENUE ELEMENTARY	WICOMICO COUNTY
JAMES M BENNETT HIGH	WICOMICO COUNTY
NORTH SALISBURY ELEMENTARY	WICOMICO COUNTY
NORTHWESTERN ELEMENTARY	WICOMICO COUNTY
PARKSIDE HIGH	WICOMICO COUNTY
PEMBERTON ELEMENTARY	WICOMICO COUNTY
PINEHURST ELEMENTARY	WICOMICO COUNTY
PITTSVILLE ELEMENTARY MIDDLE SCHOOL	WICOMICO COUNTY
PRINCE STREET ELEMENTARY	WICOMICO COUNTY
SALISBURY MIDDLE SCHOOL	WICOMICO COUNTY
WEST SALISBURY ELEMENTARY SCHOOL	WICOMICO COUNTY
WESTSIDE INTERMEDIATE	WICOMICO COUNTY
WESTSIDE PRIMARY	WICOMICO COUNTY
WICOMICO HIGH	WICOMICO COUNTY
WICOMICO MIDDLE	WICOMICO COUNTY
WILLARDS ELEMENTARY	WICOMICO COUNTY
BUCKINGHAM ELEMENTARY	WORCESTER COUNTY
CEDAR CHAPEL SPECIAL	WORCESTER COUNTY
POCOMOKE ELEMENTARY	WORCESTER COUNTY
POCOMOKE HIGH	WORCESTER COUNTY
POCOMOKE MIDDLE	WORCESTER COUNTY
SNOW HILL MIDDLE	WORCESTER COUNTY

Appendix O.

Other Funding Opportunities for Student Mental Health Services

Federal government grant makers:

- **U.S. Substance Abuse and Mental Health Services Administration (SAMHSA**): various grant opportunities including: Mental Health Awareness and Training Grant (MHAT)/Project AWARE; Preventing Youth Overdose: Treatment, Recovery, Education, Awareness and Training; Behavioral Health Partnership for Early Diversion of Adults and Youth; Strategic Prevention Framework – Partnerships for Success; Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program; Mental Health Awareness Training Grants; National Child Traumatic Stress Initiative; and Linking Actions for Unmet Needs in Children's Health.
  Link: https://www.samhsa.gov/grants/grants-dashboard

- **U.S. Health Resources & Services Administration (HRSA):** various grant opportunities including: Rural Communities Opioid Response Program – Child and Adolescent Behavioral Health; Developmental-Behavioral Pediatrics (DBP) Training Program; Comprehensive Systems Integration for Adolescent and Young Adult Health; and Primary Care Training and Enhancement - Residency Training in Mental and Behavioral Health (PCTE-RTMB).
  Link: https://www.hrsa.gov/grants/find-funding

- **U.S. Department of Education**: various grant opportunities, applicants must be mostly schools and school districts.
  Link: https://www2.ed.gov/fund/grants-apply.html?src=pn

Maryland state/local government grant makers:

- Behavioral Health Administration, Local Behavioral Health Agencies (LBHAs), Core Service Agencies (CSAs), and Local Addictions Authorities (LAAs)
- Community Health Resources Commission (CHRC) - other RFAs
- Governor's Office of Crime Control & Prevention for Maryland - Local Management Boards (LMBs)
- MDH Office of Minority Health and Health Disparities - Minority Outreach and Technical Assistance
- MDH School-Based Health Centers program
- Opioid Operational Command Center (OOCC)
- Rural Maryland Council

Private Foundations:

- Abell Foundation
- Annie E. Casey Foundation
- Ausherman Family Foundation (Frederick County)

- Baltimore Children and Youth Fund
- Baltimore Community Foundation
- Blaustein Philanthropic Group
- Caplan Foundation for Early Childhood
- CareFirst
- Community Trust Foundation (Allegany and Garrett Counties)
- France-Merrick Foundation
- Goldseker Foundation
- Herbert Bearman Foundation
- Hoffberger Family Philanthropies
- Horizon Foundation (Howard County)
- John J. Leidy Foundation (Baltimore)
- Joseph & Harvey Meyerhoff Family Charitable Funds
- Lockhart Vaughan Foundation (Baltimore)
- M&T Charitable Foundation
- Middendorf Foundation
- PNC Foundation
- Reginald F. Lewis Foundation
- Richman Foundation
- Robert W. Deutsch Foundation
- Robert Wood Johnson Foundation
- Straus Foundation (Baltimore)
- Stulman Foundation
- United Way
- Venable Foundation
- Weinberg Foundation
- William J. and Dorothy K. O'Neill Foundation
- Women's Giving Circle (Howard County)
- Zanvyl and Isabelle Krieger Fund