Summary and Contact Information

This section is intended to gather basic information. If you are applying as a collaborative, the following information should be completed by the fiscal lead agency. The resulting information will be used to support processes or to describe the applications. This section is not related to scoring. Additional information can be found in the RFP under section 6.1.1

What Award Tier does this proposal fall into?*

- Medium ($25K-$149k)

**Briefly summarize your proposal in three sentences or less.**

Our program provides solutions to people of all ages who are contemplating suicide or engaged in suicidal behavior. COVID-19 has increased isolation, stress, anxiety and depression, especially for people already struggling with inequities. We offer a 24-hour suicide crisis line with language translation, education, survivor and outreach services to provide life-sustaining support and referrals.

**Legal Name of Agency**

Family Service Agency of the Central Coast (FSA-CC)

**Federal Tax ID**

94-1716354

**Name of Program/Project, if different from Agency**

Suicide Prevention Service of the Central Coast

**Head of Agency**

David A. Bianchi, Executive Director

**Primary Address**
104 Walnut Avenue, Suite 208

Primary City
Santa Cruz

Primary State
CA

Primary Zip Code
95060

Primary Telephone
+1 (831) 423-9444

Website
http://fsa-cc.org

Program Address (if different from above)

Program City (if different from above)

Program State (if different from above)

Program Zip Code (if different from above)

Primary Contact First Name
David

Primary Contact Last Name
Bianchi

Primary Contact Email
bianchi.d@fsa-cc.org

Primary Contact Telephone

US/Canada
831-423-9444

Outside US

Amount of Funding Requested
$47,250

Total Program/Project Budget
$745,101

Total Agency Budget
$2,085,478

Select the service category that best describes your proposal.*

- Health
Select the service category that best describes your proposal.*

- Mental Health & Mental Disorders

Is your proposal to fund a single agency or are you the lead agency for a collaborative proposal including 2 or more agencies?

- Single Agency

Why do it?

This section inquires about the community and/or target populations' needs, challenges, and strengths. Additional information can be found in the RFP under section 6.1.1.2.

Which CORE Condition will your proposal primarily address?*

- Health & Wellness

Within the CORE Condition, what Impact Area will your program primarily address?*

- Optimal health status

Describe the primary CORE condition for equitable health and well-being selected, what is the "problem" or community need your proposal will address? What related community strengths or assets could be enhanced? Who is experiencing the needs and are they affected more than others (i.e., facing inequities)? Please include information that tells you about the extent of inequities and needs as well as information that illustrates perspectives (stories, quotes).*

Suicide is a health issue that does not discriminate; however, national and local statistical information identify common factors which put certain groups at higher risk. Target populations include: community members who have past suicide attempts or have lost someone to suicide, individuals experiencing discrimination, domestic violence, disability, job loss, abuse, drug/alcohol use, older adults, veterans, people with mental/physical health issues, relationship issues/divorce, homelessness, and loss of financial security. Statistics show that transgender and gender-nonconforming individuals, and people that are part of the LGBTQ+ community are at higher risk. Social, racial and/or economic inequities often intensify the level of despair in vulnerable
individuals.
We were a member of the local Suicide Prevention Task Force which resulted in the “Santa Cruz County Suicide Prevention Strategic Plan of 2019.” SC County has a higher rate of suicide, 15.5 per 100,000 residents, than the rest of California’s 10.6 for the period measured from 2016-18 (DataShare, SC County). There were 305 suicides in SC County from 2014-20, ages 14-97. We also have a higher concentration of suicides in the 45-64 age group. Three times as many female 9th and 10th graders have experienced suicidal ideation than male students. According to a CA Healthy Kids survey in 2019, 14% of children answered yes to the question, “In the past 12 months did you seriously consider attempting suicide?” In a CA Health indicators survey from 2019-20, 24.1% of adults in SC County answered that at some time they had thought seriously about committing suicide, compared to 13.1% for all of California.
The Covid-19 pandemic has resulted in increased call volume to suicide crisis lines. Many individuals, already at-risk, have been destabilized by isolation from friends, fellow students, family members and co-workers and have suffered the loss of pay and jobs. In response to the growing suicide epidemic, a new 988 number has been established nationally. The Federal Communications Commission is requiring phone service providers to route suicide crisis calls to the National Suicide Prevention Lifeline, a network of approximately 170 accredited crisis centers, by July 2022. Our Suicide Prevention Service is one of those centers.
The 24-hour suicide crisis line is available in over 150 languages with the use of an interpreter service. Our staff train and mentor volunteers who help maintain call response services; these volunteers are our most valuable community asset. Teachers, emergency responders, mental health professionals and other community members rely on the tools and guidance offered in our trainings. We also provide grief support and resources for those who have lost a loved one to suicide, who themselves are 40 times more at risk. We are the only program in SC County offering these services and we are accredited by the American Association of Suicidology.

Please select the dimensions of equity the program/project most focused on or concerned about.*

- other
Mental health issues, including suicide, affect people of every age, gender, race, ethnicity or other category. Racial and ethnic minorities are disproportionately affected by inequities that may exacerbate mental health status and increase suicidal thoughts. Barriers to care are the stigma of suicide and mental health problems, and a reluctance to seek help. Low-income status can reduce access to many services. Our free, multi-lingual suicide crisis line is available to everyone and we do not charge for our trainings.

What should be done?

This section focuses on the program or project proposed and the participants served. This section has 3 primary components: What are the Services? Why will it work? and Who are the people served? Additional information can be found in the RFP under section 6.1.1.3.

WHAT ARE THE SERVICES?

In this section, applicants are asked to describe their program/project and anticipated outcomes. All applicants are encouraged to be as specific as possible. Funding is awarded annually, contingent upon availability of County and City funds, at the same amount for each year of the 3-year grant term. Therefore, applicants are encouraged to consider how this may impact proposed activities and outcomes.

Please describe the program/project’s primary activities (i.e. strategies), people who will participate and the anticipated outcomes. In comparison to activities, articulate greater detail on outcomes, especially those related to the inequities stated. If the proposed program will have multiple funding sources, please identify the activities and people served due to the funds requested and also summarize accomplishments of the “entire” program)*

Our 24- hour multi-lingual suicide crisis line, community education and support services have had to transition to remote call answering, online volunteer training, supervision and meeting platforms for outreach and support in response to the pandemic. Training is available for emergency responders, teachers, police
officers, and mental health professionals seeking to de-escalate difficult situations. We work in partnership with County and City staff, businesses, therapists, behavioral health providers, teachers, school administrators, and other community stakeholders and agencies. All materials and online content are available in English and Spanish.

We follow evidence-based risk assessment and training standards for crisis telephone workers established in 2007 by the National Suicide Prevention Lifeline. Currently, our suicide crisis line responds to approximately 80 calls/month in Santa Cruz County. This CORE funding will support 654 hours of multi-lingual suicide crisis line services with total annual calls from Santa Cruz County projected at 960.

Our staff assess the skills and appropriateness of prospective volunteers, who represent a broad range of community members. After the initial screening, prospective volunteers receive 32–40 hours of class training and practice on how to screen and respond to callers who may be actively engaged in suicidal behavior, expressing suicidal feelings or are calling about other mental health crises for themselves or others. Training sessions include skill-building using the Five9 voice-over-internet platform for call-responses, our call-documentation system, and demonstrations in real-time using the communication and record-keeping technologies. Specific remote training shifts are arranged that allow new responders and experienced responders to collaborate and practice together before new responders take independent shifts on the crisis line.

In addition to technical skills, volunteer training incorporates clinically proven “Behavioral Skills Training” activities and methodology to help trainers teach connection, communication, and intervention skills to new responders. Volunteers cover weekly suicide crisis line shifts, meet monthly for supervision and quarterly for performance evaluations, and participate in annual continuing education/refresher training. Volunteers are continually monitored for quality assurance. We are currently adding paid responders to supplement our volunteer responders in order to provide adequate shift coverage and in anticipation of the rollout for 988.

Interventions for those who are in immediate danger include contracting for safety and calls to 911 or relevant resources and support for those who are concerned about family members,
friends or co-workers. The desired outcome is to leave the caller in a safe place through de-escalation and, if necessary, 911 intervention. Web-based call logs, software and client surveys track the content and quality of services according to established accreditation standards. All staff and volunteers complete training on how to use tracking and reporting programs relevant to their roles. Data on individual callers and members of our survivor groups is confidential and protected.

In addition to suicide crisis line intervention and community education to promote awareness, an important part of our program is our “Survivors Suicide Loss” groups for those who have lost a loved one to suicide. We have had to transition to online group meetings for this population and we are likely to keep offering some services online in conjunction with an eventual return to in-person groups. The desired outcome is to keep group members safe, supported by the facilitator and other group members, since they are all at higher risk.

CORE funding represents 6.3% of total program funding and is vital in supporting these suicide crisis line, education and support services for SC County residents.

OUTCOMES

Below please identify up to three specific measurable outcomes of the program/project. Include the target for whom, and how it will be measured.

Example of Outcome "Metric": Hispanic or Latino youth participating in the mentorship program will graduate from high school at the same or higher rate than the population overall.

Describe a specific measurable outcome to be completed with CORE funding by the end of the first year.

Outcome #1
24-hour multi-lingual suicide crisis line: 85% of completed calls will result in improved mental health through a willingness to stay safe as documented in our web based ICarol software. Callers assessed to be at risk of suicide receive referrals to appropriate resources and indicate improved mental health through agreement to stay safe and avoid high-risk actions, or if needed, there is a call to 911 for intervention. Some personal and demographic information is not
typically offered by the caller, including data regarding income and location by area other than county. Information about the severity of the crisis and the callers’ willingness to commit to remaining safe is recorded in our call logs.

Outcome #2

Outcome #3

If it is anticipated that progress on the measurable outcomes will be different in year 2 and 3, please describe. (If not write N/A)

Although we anticipate making progress on measurable outcomes in all three years, there is much that is unknown at this time including: how the pandemic will play out, future safety protocols, funding for services, return to in-person trainings and groups, and the implementation of 988 services that will eventually include chat and text options. The cost of adding paid responders to support our volunteer responders is considerable and state funding to support this transformation is uncertain. The general economic climate, COVID-19 and political turmoil have also negatively impacted our callers’ perception of how their life is progressing and their hopes and feelings about the future. We will continue adapting as needed to ensure that these vital suicide prevention services remain accessible for all who need them.

WHY WILL IT WORK

In this section, applicants will describe why they think the proposed services will be effective. Applicants will be asked to list programs or practices that will be implemented in order to meet the outcomes and identify where they fall on the CORE Continuum of Evidence. More information about the Continuum of Evidence can be found here.

Summarize the information that tells you the proposed program/project will meet the intended outcomes and influence the inequities stated.*

We have been evaluating the effectiveness of our services for many years. In response to the first CORE RFP, we completed an extensive review and planning process for this program that included logic models and research on evidence-based practices including
suicide crisis line interventions and community education. We follow guidelines and mandates for meeting the proven accreditation standards of the American Association of Suicidology. As a participant in the National Suicide Prevention Lifeline, we base our call assessments on a variety of recommended practices including the “Suicide Severity Rating Scale for Call Responders.” The “Santa Cruz County Suicide Prevention Strategic Plan of 2019” highlights the effectiveness of these approaches. The Strategic Plan discusses the Social-Ecological Model (SEM) to explore the relationship between individuals, their environment, and the social systems that influence their life. The SEM views negative outcomes such as suicide like the tip of an iceberg with many contributing factors, often hidden beneath the surface, that contribute to the problem.

The profile of someone who contemplates ending their own life generally reflects layers of unaddressed problems that may surface in the form of suicidal thoughts or actions. The lack of access to professional support and mental health services falls disproportionately on people of color, low-income and other at-risk populations. We address inequities by providing a suicide crisis line accessible to everyone and education on suicide prevention throughout the community, to increase awareness for all, regardless of economic status, race, ethnicity, gender, sexual orientation, age or other demographic.

CONTINUUM OF EVIDENCE

In the following questions, please name up to three programs or practices that will be implemented in order to meet the outcomes and identify where they fall on the Continuum of Evidence.

What is the name of the specific program or practice that will be implemented to meet the outcomes?
24 Hour Multi-lingual Suicide Crisis Line

Where does the specific program or practice fall on the Continuum of Evidence?
- Evidence Based Practice

What is the name of the specific program or practice that will be implemented to meet the outcomes?

Where does the specific program or practice fall on the Continuum of
Evidence?

What is the name of the specific program or practice that will be implemented to meet the outcomes?

Where does the specific program or practice fall on the Continuum of Evidence?

How will staff collect information about the program/project, including progress on outcomes, as well as other key aspects about the program (e.g., quality)? How will the collected information be integrated into the program and how will learning be promoted?*

All completed suicide crisis line calls result in a call report. Call reports are logged into our web-based system ICAROL. Information about the responder, first name of the caller, call date and time and location by county of the caller are recorded. Any information offered about the callers age, gender, sexual orientation and ethnicity are noted. Certain prompts are used to determine whether the caller is currently suicidal, if there have been any suicidal actions within 24 hours, any suicidal thoughts within the last two months or any past suicide attempts. An assessment is made as to whether the caller is at risk (suicide call vs. crisis call). If warranted, suicidal desire, capability and intent are discussed and recorded. The caller's support system and connectedness to others are discussed. Whether a safety agreement was reached is noted and what the safety plan is. If a follow up call was offered, it is recorded. A description of the call and outcome is written including if 911 was used to intervene. If a translator was used then the language used for the call is identified. Individual call reports are reviewed for supervision and quality improvement. Staff members regularly run reports from ICAROL to aggregate data for internal review and contract compliance.

CORE support for our suicide crisis line allows us to use some of the funding from other sources to support our outreach and education offerings in the community. Our trainings are all currently done online and we are working with some funders on a new evaluation tool to survey participants at the end of each session. This will provide input and responses to a broad range of questions about their experience, training materials, knowledge of suicide and mental health resources as well as suicide warning signs and ways
to help someone in crisis. We expect that the responses to these evaluations will allow us to assess positive/negative outcomes for attendees and the overall quality of the presentation. That feedback will be used to decide if any changes in our materials or approach is warranted.

NOTE: Due to confidentiality of callers who use the crisis line, information collected is tracked by CALL rather than caller. It is difficult to determine if the same person calls multiple times versus new callers. Ethnic and demographic data is recorded IF OFFERED by the caller. Call responders may determine if a caller is Latino or non-Latino, but less than half of callers answer this question. It is a high priority to protect the privacy of all callers. In the section below regarding Participant demographics, we have used the number of CALLS to represent participants. Information is given as available, as a percentage of CALLS. CALLS from SC County are funded by CORE. Total CALLS include calls from SC, Monterey and San Benito Counties.

What should be done?

WHO ARE THE PEOPLE SERVED?

This sub section focuses on the people that will participate in the direct services proposed, otherwise known as "participants". Numbers do not need to be exact; they can be an estimate. Answers should reflect the participants served by this funding request alone.

Please generally describe the participants that will be served.*

People who call the crisis line are experiencing mental health problems and/or a personal life crisis that has led them to consider ending their own life. Callers are also family members, friends or loved ones seeking information, guidance and referrals on behalf of another person. A father called the suicide crisis line concerned about his pre-teen daughter. The day before she had conspicuously left out her journal in a location that seemed odd. He had opened the journal and read what sounded like a suicide note. Recently, the family had lost a friend to suicide. As the father talked about his daughter's suicide note, he realized they hadn't talked about what had happened, and how difficult it must be for his
daughter. Not only was the caller calling about his daughter, he was calling about his own loss. He realized he hadn’t expressed his thoughts or feelings, and now the feelings were coming up again. He decided he was going to talk to his daughter openly and honestly. He was going to say the word “suicide” and he was going to honor the death of their friend by taking his daughter to the beach and lighting a candle for her. “Tonight,” he said, “we are going to openly grieve and we’re also going to talk about life. Tomorrow, I will call about your grief support services and one day I would like to be a volunteer on the suicide crisis line.”

Professionals such as counselors, teachers, faith leaders, police officers, first responders and social workers may also call the crisis line to get support and resources in order to help clients who are expressing suicidal thoughts or behaviors. Individuals potentially at-risk for increased suicidal thoughts or behaviors include: older adults, youth aged 10-24, veterans, middle aged men, trauma-exposed workers (eg. first responders), LGBTQ+, people with mental illness, people who are experiencing domestic violence, disability, job loss, abuse, drug/alcohol use, financial hardship or other life trauma.

The introduction of the new National Lifeline 988 suicide hotline this year is expected to increase the call volume dramatically. Other people served by the program are those who attend educational presentations provided by our staff and volunteers. Formerly conducted in person, these events have been offered in virtual format since the pandemic. Participants are generally groups of professionals who work with at-risk populations that may struggle with suicidal feelings. Groups include: teachers, mental and physical health providers, first responders, police officers and other professionals. Our grief support groups are for friends and family members who have lost loved ones to suicide. These participants are now more at risk of suicide and may experience despair and a sense of hopelessness if they are unable to process their feelings and response to this loss which is still stigmatized in our society. Group facilitators are trained volunteers who have experienced the loss of someone to suicide.

Please estimate the total unique number of participants (i.e. # served) by fiscal year. (Note: This number should reflect the participants served by the CORE funding request alone.)
2022–23
960 CALLS

2023–24
1104 CALLS

2024–25
1270 CALLS

If the program/project proposed will be funded by multiple sources, please estimate the total unique participants served by the entire program during FY 2022–23.
1750 CALLS

Of the total participants (i.e. people served) anticipated in FY2022–23, please estimate the percentage of unduplicated participants by age, ethnicity, gender, primary language and jurisdiction where they are likely to reside.

AGE

0–5
Percentage %
CALLS 0

6–18
Percentage %
CALLS 15.1

19–59
Percentage %
CALLS 61.2

60 and over
Percentage %
CALLS 23.7

TOTAL PERCENT SHOULD BE 100%

ETHNICITY

African American
Percentage %
NOT COLLECTED

Asian
Percentage %
NOT COLLECTED

Latino
Percentage %
(48.8% of CALLS known) Latino 15.8 %

Multi-racial
Percentage %
NOT COLLECTED

Native American/Alaskan
Percentage %
NOT COLLECTED

Native Hawaiian/Pacific Islander
Percentage %
NOT COLLECTED

White
Percentage %
NOT COLLECTED

Other
Please specify other
(48.8% of CALLS known) Non-Latino 84.2 %
Percentage %
100

TOTAL PERCENT SHOULD BE 100%

GENDER

Female
Percentage %
55.1
Male
Percentage %
42.5

Transgender - Female
Percentage %
1.2

Transgender - Male
Percentage %
1.2

Other
Please specify other
Percentage %
100

TOTAL PERCENT SHOULD BE 100%

PRIMARY LANGUAGE

English
Percentage %
CALLS 96.7

Spanish
Percentage %
CALLS 3.3

Other
Please specify other
Percentage %
100

TOTAL PERCENT SHOULD BE 100%

AREA

City of Capitola
Percentage %
City of Santa Cruz
Percentage %
34

City of Scotts Valley
Percentage %
4

City of Watsonville
Percentage %
13

Unincorporated Mid-County (e.g., Live Oak, Soquel, Aptos)
Percentage %
39

Unincorporated North County (e.g., Davenport)
Percentage %
2

Unincorporated San Lorenzo Valley (e.g., Ben Lomond)
Percentage %
4

Unincorporated South County (e.g., Freedom)
Percentage %
2

Other
Please specify other
Percentage %

Other
Please specify other
Percentage %

Other
Please specify other
Percentage %
100

TOTAL PERCENT SHOULD BE 100%

Of the total participants (i.e. people served) anticipated in FY 2022-23, what percentage of participants are estimated to have a household income below the federal poverty level? (Please use the 2021 Federal Poverty Level Guidelines below.)

<table>
<thead>
<tr>
<th>U.S. Federal Poverty Guidelines</th>
<th>2021 Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Poverty</td>
</tr>
<tr>
<td>1 Member</td>
<td>$12,880</td>
</tr>
<tr>
<td>2 Members</td>
<td>$17,420</td>
</tr>
<tr>
<td>3 Members</td>
<td>$21,960</td>
</tr>
<tr>
<td>4 Members</td>
<td>$26,500</td>
</tr>
<tr>
<td>5 Members</td>
<td>$31,040</td>
</tr>
<tr>
<td>6 Members</td>
<td>$35,580</td>
</tr>
<tr>
<td>7 Members</td>
<td>$40,120</td>
</tr>
<tr>
<td>8 Members</td>
<td>$44,660</td>
</tr>
</tbody>
</table>

For each additional member, add $4,540

Less than 100% federal poverty level (FPL)
Percentage %
NOT COLLECTED

100%-200% FPL
Percentage %
NOT COLLECTED

Above 200% FPL
Percentage %
NOT COLLECTED
Organizational Capacity

This section inquires about the agency's capacity to provide the proposed services. Capacity means the agency's experience, knowledge and/or success in achieving its mission. Additional information can be found in the RFP under section 6.1.1.4

Describe the agency's capacity (staffing, infrastructure, expertise, and history) to provide the service(s) in this request.*

Agency capacity builds on our long history that began in 1957 when 46 local residents including professionals, members of the business community and other concerned citizens formed a Family Service Agency to advance the preservation of individual and family life and to prevent family breakdown. The Committee for a Family Service Agency identified top needs, still relevant today, including marital discord, parenting issues, the needs of single mothers, adolescent behavior and issues of aging. The first program, Counseling Services, evolved from the social work model of the times. Over time, mergers expanded our services: Senior Outreach (1967), I-You Venture, (1989), Family Service Association of the Pajaro Valley (2004), Survivors Healing Center (2011), and WomenCARE, (2012). The two mergers that are at the heart of this program are: Suicide Prevention of Santa Cruz (1988) and Suicide Prevention Center of Monterey and San Benito Counties (1998). Internal program development and mergers have added strength, expertise and capacity resulting in a more efficient and effective service delivery model for the community. Suicide Prevention Service, which is the result of two other agencies that merged with FSA-CC is an illustration of that goal. The program also benefits from state and national expertise in the field of suicide intervention, education and prevention. Organizational practices, financial and management functions are integrated and streamlined throughout the agency. In recent years, investment in modern communications systems, computer hardware and software, and facility upgrades have improved client access and service efficiency.

We are proud that, in addition to fundraising, our volunteers provide direct client services, giving opportunities for community members
to work alongside our professional and program staff. Approximately 50–70 Suicide Prevention Service volunteers support our 7 dedicated program staff members. CORE funding for this program in FY 2021–22 was $38,000 (same as FY 2017–18) with $16,000 provided by the County and $22,000 provided by the City of Santa Cruz. We are experiencing a dramatic increase in costs, such as new phone systems for remote answering, laptops and headsets, and online-meeting licenses and fees. Also, as call volume increases, we are using paid responders for the first time to augment volunteer responders. Consumer Price Index increases in the Bay Area for the past five years have been well in excess of 2% annually. In order to establish a new cost basis we have used increases of 1.65% for the past five years and 1.95% for the three years of this contract and averaged the increases. This would result in an estimated cost of $42,873 for existing services. However, in order to help cover the dramatic increase in operations and costs, we are requesting a total of $47,250 with a suggestion of $19,895 from the County and $27,355 from the City of Santa Cruz.

**Describe how the agency defines and advances equity within its organizational processes (such as decisions, leadership, staff composition, and community engagement process).**

The agency follows federal guidelines for non-discrimination in hiring as well as internal policies for non-discrimination in treatment of all callers and clients. In order to engage and improve access for clients who prefer speaking Spanish, we have made all entry points to services bilingual. Web pages and printed materials are available in English and Spanish. We are known for welcoming members of LGBTQ+ community as staff and clients. Throughout the agency, we strive for diversity in our staff with six of our twenty-nine staff members’ bilingual, bicultural. Six of our twenty-nine staff members are male and twenty-three female. This program has seven staff members with four working full-time. Formal and informal training emphasizes building skills to provide a safe and nurturing environment that fosters healing and growth using culturally appropriate communications.

The management of the agency has been stable for many years with the Executive Director having served for 35 years and the CFO for 21 years. The average tenure of our six Board members is 6 years. Input from staff, volunteers and clients is encouraged and
considered when assessing current services and for quality improvement. Decisions are made by program staff in conjunction with the management team. We place a high value on providing a healthy workplace for employees and a safe haven for clients. Client feedback, solicited through surveys and call reports, is monitored for outcomes and satisfaction, and shared with staff. Any staff or client concerns are addressed immediately and in a transparent manner. We actively engage the community through our volunteers, donors and events to raise awareness and support for our clients and services.

Core values that are promoted across the program, whether among staff and volunteers or when engaged with clients, are to respect and value each individual, to honor differences and to listen to each other in a caring and supportive manner. We strive for equitable organizational processes that model fairness and safety, to support staff and volunteers in responding effectively to each caller. Our team must feel respected and valued so they can meet the clients where they are, respecting their language, background and life experience. Our success as an organization is measured in keeping callers safe and connecting them to other resources they might need. In order to help callers stay safe, our role is to guide them to identify and embrace their own support system while also knowing that we are always there if they need us.

How much money is needed?

This section requires applicants to submit a budget. Budgets are for 3 years and amounts are to be equal in each year. Additional information can be found in the RFP under section 6.1.1.5

Complete and upload the Single Agency HSD budget form. *

This includes identifying the personnel requested and their associated costs, a summary cost for all non-personnel items requested and any admin rates requested. The narrative boxes should be used for all line items. If the request is to contribute to a larger program, identify the total amount needed by line item.

Click Here to Download Form

Upload budget
Non-Collusion

Read the Below Statement
David A. Bianchi on 03/01/2022