

Adams County Opioid Settlement Fund Application

1. Applicant Information

- a. Organization Name
- b. Address
- c. Address 2
- d. City, State, Zip
- e. Website (if applicable)
- f. Telephone #
- g. Email of primary program contact

Chief Executive Officer Information

- a. Name
- b. Title
- c. Email

All funded projects are required to cover Adams County, Illinois

Funding source for projects is National Opioid Settlement funds distributed to Adams County, Illinois. Therefore, projects funded by this source are intended to primarily serve the residents of Adams County. However, if other jurisdictions are impacted by the project as well, this should be indicated below.

- | | | |
|--|-----|----|
| a. Will the project funds primarily serve Adams County, Illinois | YES | NO |
| b. What, if any, other areas will the project cover | | |
| a. Brown County, IL | YES | NO |
| b. Schuyler County, IL | YES | NO |
| c. Pike County, IL | YES | NO |
| d. Hancock County, IL | YES | NO |
| e. Other Illinois Counties (please list) | YES | NO |
| | | |
| f. Counties in other States (please list) | YES | NO |

2. Project Information

- a. Project Name
- b. Brief Project Description

- c. Project Start Date
- d. Project End Date
- e. Funding Amount Requested
- f. Will applicant accept partial funding? YES NO
- g. Will Subcontractors be used under this application YES NO
 - a. If yes, please list subcontractors:

3. Applicant History

- a. Description of Applicant Organization

- b. How long has the applicant been in business?
- c. Is applicant in good standing with the Illinois Office of the Secretary of State? YES NO
- d. Has the applicant or any principal experienced foreclosure, repossession, civil judgment or criminal penalty (or been a part to a consent decree) within the past seven years as a result of any violation of federal, state or local law applicable to its business? YES NO

- If yes, please identify the nature of the action and the disposition.

- e. Is the applicant or any principal the subject of any proceedings that are pending, or to the best of the applicant's knowledge threatened against applicant and/or any principal that may result in any adverse change in the applicant's financial condition or materially and adversely affect applicant's operations? YES NO

If yes, identify the nature of the proceedings and how they may affect the applicant's financial situation and/or operations.

d. Describe how your organization will develop evidence-based OUD/SUD recovery focused Programming to the residents and families of Adams County, Illinois. Outline resources that will be required to reach those deliverables.

e. What key staffing will need to be educated or hired to create recovery focused OUD/SUD programming for your organization? Do you foresee challenges or barriers that will impact your ability to staff your project?

f. Does your project build upon existing community resources in Adams County? If so, how will you collaborate with other organizations to reduce redundancies and increase sustainability for your project?

g. Outline your organization's current evidence based practices which contribute to the success of your organization in the implementation of this project.

h. What barriers do you anticipate that might challenge your organization during the programming implementation. How will you overcome these barriers?

i. Is there additional information not captured in the above questions that you would like the review committee to consider in your application?

j. Are you willing to present your project in person to the committee if requested?

YES NO

6. Budget

a. Personnel

| Name | Total Hours | Rate of Pay | Total Request |
|------|-------------|-------------|---------------|
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b. Travel

| Travel Type | Quantity | Rate | Total Request |
|--------------------------------|----------|------|---------------|
| Mileage (local) | | | |
| Mileage (outside service area) | | | |
| Airfare | | | |
| Lodging | | | |
| Meals (outside service area) | | | |
| Other (explain in narrative) | | | |
| | | | |

- a. Narrative for Travel – Explain use of funding for travel related expenses, including names of travelers, events, how travel supports the project, and clarification for quantities of mileage, lodging and meals. If other travel expense types are requested, please detail:

c. Equipment (Items per unit over \$1,000)

| Name of item | Unit Cost | # of Units | Total Request |
|--------------|-----------|------------|---------------|
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| | | | |

- a. Narrative for Equipment – Provide justification for equipment’s purpose in achieving program outcomes.

d. Supplies (Items per unit under \$1,000)

| Name of item | Unit Cost | # of Units | Total Request |
|--------------|-----------|------------|---------------|
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a. Narrative for Supplies – Provide justification for supply purchases in achieving program outcomes.

e. Subcontractors (if applicable)

| Name of subcontractor | Contact Person | Total Request |
|-----------------------|----------------|---------------|
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a. Narrative for subcontractors. Provide justification for the use of each subcontractor, including purpose for which you are utilizing the subcontractor, a template subcontract to be utilized to outline terms of the subcontract and other relevant information:

f. Other Expenses

| Name of Expense | Justification | Total Request |
|-----------------|---------------|---------------|
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- a. Narrative for Other Expenses – Provide justification for each listed expense, including the expenses purpose in achieving program outcomes.

g. Budget Summary

| Name of item | Total Request |
|-------------------------------|---------------|
| <i>Personnel</i> | |
| <i>Travel</i> | |
| <i>Equipment</i> | |
| Supplies | |
| Subcontractors | |
| Other Expenses | |
| | |
| Matching Funds (not required) | |
| | |

This amount should equal your funding request on Page 2

This is the total project cost including any match by you

7. Certification

By signing this application, I certify that the statements herein are true, complete and accurate to the best of my knowledge. I also agree to comply with any resulting terms if I accept an award. I certify to the best of my knowledge and belief that all the details in the budget are true, complete and accurate and that any false, fictitious, or fraudulent information or the omission of any material fact, could result in the immediate termination of my grant award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil or administrative penalties. (U.S. Code, Title 218, Section 1001)

Organization name and mailing address:

Name of authorized representative:

Signature of Authorized Representative: _____ Date: _____

Email of authorized representative:

Phone Number of authorized representative:

Complete applications may be submitted to opioidfund@adamscountyil.gov with a subject line of Opioid Settlement Fund Committee – Application for Funding --OR-- delivered in person or by US Mail, UPS, FedEx or other carrier to the Adams County Health Department, 330 Vermont St., Quincy, IL 62301 with attention to the Opioid Settlement Fund Committee.

Competed applications will be reviewed by the Committee approximately one time per quarter with recommendations will be made for funding to the Adams County Board. Notice of awards, clarifications or rejections will be provided to the addressee listed on the application.