



## Sioux Rivers Regional MHDS Special Project Funding Request

Provider Name:	Tax ID:
Provider Address:	Provider CSN ID# (optional)
Person Submitting Request:	Date of Request:
Email:	Phone:

**Please identify the funding being requested.**

You will be contacted by Sioux Rivers to discuss this request.

Project Name:	
Core or Core Plus Program Area	
Item or service funding is requesting:	
Total Cost:	
Provider Funding Amount:	
Regional Funding Request:	
Sioux Rivers Counties/Communities Served with Proposed Funding Request:	
Project Start Date:	
Project End Date:	

Explain how funding this project will benefit the individuals of Sioux Rivers and how it complies with the Sioux Rivers Management Plan and Core or Core Plus Services:

Explain why you need Regional Funding to complete proposed project:

If you require additional space, please attach a separate sheet with request.

**Unsolicited Requests for Funds- the following criteria will apply when reviewing unsolicited requests.**

**Provider Criteria:**

Providers receiving funds must be licensed or accredited to provide the requested service. Organizations must demonstrate the following:

- Provider experience in providing the services
- Documented individual outcomes, and family/consumer satisfaction
- Retention of individuals in other programs
- Coordination with other provider agencies
- Evidence of individualized services
- Funding source for the service
- Financial viability of the agency
- Strong organizational leadership

- A mission that supports person centeredness, rehabilitation, recovery, cultural competency, multi-occurring capable
- Capability to pan and develop financial flexibility to support services
- Ability to integrate all services into the community
- Aptitude to create infrastructure to support staff supervision
- Capacity to involve individuals served in the implementation and evaluation of the services

**Required Elements:**

Providers must submit a written proposal that includes the following:

**Business Plan:**

- Description of the service and the market
- Funding sources
- Non-financial outcomes
- Organizational Chart
- Financial needs (startup cost summary, personnel cost)
- Current business position

**Documentation of Current Needs:**

- Current waiting list for the service
- Demographics of potential individuals served.
- Access standard criteria (if applicable)

**Two Letters of Support to include but not limited to:**

- CEO of other regions (if applicable)
- Local Community Service Directors
- Integrated Health Homes or Case Managers

**Funding Options:**

Providers must identify funding options through sources at the federal, state and local levels. It is expected that costs recouped through billing fee for services would be repaid to Sioux Rivers.

**Request Considerations:**

Does the request meet the following priorities?

- Priority for core and core plus services
- Unmet need for the proposed services
- Unmet access standard for proposed services
- Evidence based practice services.
- Sioux Rivers proposed project coverage area

If the request is approved, an agreement will be drafted to include the request in the provider agreement. Both the request and the agreement will be taken to the Governing Board for consideration. Sioux Rivers will notify you of the Governance Board Meeting date and time if you choose to be present during the consideration. Sioux Rivers will also notify you of the decision on funding in writing with either approval or denial of funding request.

Thank You for your Special Funding Request Proposal and serving the individuals of Sioux Rivers Regional MHDS with continued quality services and care.

Submit completed proposal to: [brennak@siouxcounty.org](mailto:brennak@siouxcounty.org)  
Any questions please contact: Brenna Koedam, LMHC IADC  
Sioux Rivers Region MHDS CEO  
712-209-9979