WHEELING TOWNSHIP COMMUNITY MENTAL HEALTH BOARD
2026-27 (3/1/2026 - 2/28/2027) AGENCY APPLICATION FOR FUNDING

GENERAL INSTRUCTIONS

Completed applications must be returned to Wheeling Township CMHB by August 1, 2025

General Application Requirements

The following provides a brief description of the mandatory components of the application package. The application package must include and address each component. An incomplete application may be considered unqualified for consideration.

Program Information

Every question must be answered. Be specific on government and non-government funding on page 1-list each funding source by name. If you need additional space use a separate page and attach to application. Please put your program name at the top of each page in the upper right hand corner.

Budget

The budget should be completed using current year operating information. A budget narrative may be included if further explanation is needed on how fringe benefits were calculated, why particular items of supplies or equipment must be purchased, etc.

Attachments

Should include:

- 10 Copies of the Application for Funding signed and dated
- 10 Copies of the current budget (including itemized revenues by source)
- 10 Copies of the Agency certification (form provided)
- 10 Copies of the Organizational Chart
- 10 Copies of a most recent Balance Sheet
- 1 Copy of the Certificate of Insurance
- 1 Copy of the Articles of Incorporation
- 1 Copy of the Agency by-laws
- 1 Copy of the Agency audit (most recent)
- 1 Copy Form 990 and AG990IL

THIS APPLICATION MUST NOT BE ALTERED IN ANY WAY OR IT WILL BE REJECTED.

WHEELING TOWNSHIP COMMUNITY MENTAL HEALTH BOARD

2026-27 (3/1/26 - 2/28/27) *Application for Funding*

"Our mission is to ensure that services related to mental illness, intellectual/developmental disability, and substance use disorder are available and known to the residents of Wheeling Township."

www.wheelingtownship.com

Name of Organization	
Contact Person/Title	
Address	
City, State, Zip	
Phone & Fax	
Email	

No. Years in Existence		**Agency Fiscal Year**		**TO**	

Requested Funding 2026-27 (3/1/26 - 2/28/27)	***$***

SEPARATELY LIST BY ENTITY 3/1/25 - 2/28/26 Sources of Governmental Funding		**SEPARATELY LIST BY ENTITY 3/1/25 - 2/28/26 Sources of Non Governmental Funding**	
	$		**$**
	$		**$**
	$		**$**
	$		**$**
	$		**$**
	$		**$**
	$		**$**
	$		**$**
	$		**$**
	$		**$**

Please briefly describe the purpose of the program and of your request, using only the space provided:

I/We hereby certify that all information contained in this application for funding is true and correct to the best of my/our knowledge and agree to comply with all requirements of the program if this agency is awarded and accepts funding.

Name and Title of Representative _____ Signature _____ Date _____

THIS APPLICATION MUST NOT BE ALTERED IN ANY WAY OR IT WILL BE REJECTED.

IN-KIND FUNDING		
Wheeling Township In-Kind Funding *		**$**
Other In-Kind Funding		**$**
***Agencies occupying space in the Wheeling Township Community Center should include rent in basement @ $12.00 per square foot and second floor @16.00 per square foot.**		

Service Category

Identify the primary service type of the program for which you are seeking funding

- ☐ **Mental Health**
- ☐ **Substance Use Disorder**
- ☐ **Intellectual / Developmental Disability**

Identify the primary service categories of the program for which you are seeking funding (select all that apply)

- ☐ **Youth**
- ☐ **Adult**
- ☐ **Senior**
- ☐ **Outreach**
- ☐ **Prevention**
- ☐ **Intervention**

Program Information

Describe the program's unit of service by activity

Number of Program Clients Served	2024-25 (3/1/24 -2/28/25)
Total number clients served for the ENTIRE program	
Total number Wheeling Township clients served	
Total number direct service hours provided to Wheeling Township clients	

Number of Program Clients Projected to be Served	2026-27 (3/1/26 - 2/28/27)
Total number of clients projected for the ENTIRE program	
Total number of Wheeling Township clients projected to be served	
Total number of direct service hours projected to be provided to Wheeling Township clients	

Provide estimated timeline for when specific activities will be conducted and/or completed. Some activities may be ongoing and should be so noted

Provide days and hours services are available

Explain any fees charged for this program, including use of sliding scale fees. Please attach a fee schedule

Identify demand for this service from the community

Explain why your agency is best suited to undertake this program

Describe how the agency will publicize Wheeling Township CMHB funding

Discuss efforts to collaborate with other northwest suburban agencies providing similar services, eliminating duplication of effort

Describe sustainability efforts of funding for this program

Please list all outside consultants including professional fundraiser, include their objective and total fees and expenses paid. If you used a professional fundraiser, include total amount raised by the fundraiser.

Objectives
State client based outcome objectives (Tell what the client will get out of these services, e.g., client will get and keep a job for at least 6 months):
Identify strategy to achieve objectives (e.g., client will attend job skill workshop and be appropriately placed in employment):
Identify method of measuring outcome objectives (e.g., caseworker and client report):
Provide outcome objective results for previous year:
Provide any changes that are being made in the program as a result of the previous outcomes:

Identify major staff positions responsible for this program & the number of employees directly responsible for clients & ratio of staff to clients	
Position	Qualifications (include applicable degree) and Staff:Client ratio

Describe recent implementation of cost reduction measures

Other pertinent information

Budget

A. Salaries-List each position by title (top 3 positions only)		
Position/Title	**Salary (Include bonuses, deferred comp, and all other allowances) <u>Please attach Organizational Chart</u>**	**Fringe Benefits**

B. Occupancy-Include only: Facility, rent, usage charges, utility charges, building and grounds services, supplies and property insurance	
Item	**2025-26 (3/1/25 - 2/28/26) Cost**
	$
	$
	$
	$

C. Program-direct client contact employees/consultants, supported/transitional living programs-include rent, client transportation, utilities for facility	
Item	**2025-26 (3/1/25 - 2/28/26) Cost**
	$
	$
	$

D. Percent (%) All administration costs are to total budget-include only non-client contact expenses	

AGENCY CERTIFICATION

Please mark "YES" or "NO" as appropriate next to each statement and initial each. Your initials certify the accuracy of each statement. Supporting documents may be requested at a future date and must be supplied upon request.

Initial	YES	NO	
_____	____	____	Agency maintains a personnel policy manual
_____	____	____	Agency has Audited Financial by independent CPA
_____	____	____	Agency has a non-discrimination policy
_____	____	____	Agency has a sexual harassment policy
_____	____	____	Agency has a grievance procedure
_____	____	____	Agency has an ethics policy
_____	____	____	Agency has a whistle blower policy
_____	____	____	Agency has a conflict of interest policy
_____	____	____	Agency has an effective fiscal management system in place
_____	____	____	Agency maintains liability insurance coverage
			If yes, amount of coverage_____
			Name of insuring agency_____
_____	____	____	Agency pays all federal and state required payroll taxes
_____	____	____	Agency maintains fidelity bond coverage for employees handling agency accounts
			If yes, amount of coverage_____
			Name of insuring agency_____
			If no, what would cost of coverage be_____
_____	____	____	Agency has by laws in place
			Date accepted_____
			Date last amended_____
_____	____	____	Agency has established policies for client admission and discharge procedures

_____
Print name of person initialing above

_____
Signature of person initialing above

_____
Title

_____
Signature date