**WYOMING COURT SUPERVISED TREATMENT PROGRAM**

STATE FISCAL YEAR 2024

GRANT APPLICATION

****

Behavioral Health Division

122 West 25th Street, Herschler Building West, Suite B

Cheyenne, WY 82002

**Application Sections**

[Application Instructions – Page 3](#gjdgxs)

1. [Program Type, Mission, Goals](#30j0zll)
2. [Funding Request](#3znysh7)
3. [Program Data to Support Request](#2et92p0)
4. [Funding Sources, Practices, Fiscal Agent](#tyjcwt)
5. [Projected Budget and Justification](#3dy6vkm)
6. [Magistrates](#1t3h5sf)
7. [Risks/Needs Assessment Practices](#4d34og8)
8. [Substance Abuse Treatment Services, Practices, Certifications](#2s8eyo1)
9. [Mental Health Services, Practices, Certifications](#17dp8vu)
10. [Training Summary](#3rdcrjn)
11. [Recidivism, Retention, Sobriety](#26in1rg)
12. [Community Outreach](#lnxbz9)
13. Surcharge
14. [Master Contact List](#35nkun2)
15. [Assurances](#1ksv4uv)
16. [List of Required Attachments](#44sinio)

# **SFY2024 Wyoming Court Supervised Treatment (CST) Program Application Instructions**

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

These instructions are for SFY 2024 applications. Please read carefully so the application is completed accurately. If you have questions, contact Alicia Johnson: 307-777-6885, or email cstprogram@wyo.gov.

The application contains three (3) documents. Please fill out every section completely.

1. Instructions
2. Application
3. Budget Justification Worksheet

This application and materials are not a guarantee of contract or funding. An incomplete application will result in no contract being awarded. Any program that has not met all contract deliverables from the current contract year will not be eligible for a contract in SFY24. **As a Court Supervised Treatment Program applying for State of Wyoming funds, you are required to adhere to requirements in the Court Supervised Treatment Programs Act (Wyo. Stat. § 7-13-1601 through Wyo. Stat. § 7-13-1616), all current State Rules and Regulations (Mental Health and Substance Use Disorder Services Rules Chapters 1-6), and any policies and procedures set by the Wyoming Department of Health, Behavioral Health Division.**

**Special Instructions:**

* If you are applying for funding for more than one (1) program, you must complete a separate application for each program.
* Do not put sections onto separate pages. Allow each section to utilize the same page if there is room in order to save space and printing costs. Use only the space provided.
* Budget and Budget Justification Spreadsheet: Fill in all projected dollar amounts by line item. Provide an explanation for each on the Justification spreadsheet, including surcharge. If you do not intend to utilize surcharge, please indicate that in the Justification spreadsheet next to the surcharge amount. Provide your best estimates and if an award is granted, we will collect a finalized budget by June 30, 2023. The total match must meet or exceed twenty-five (25) percent of the total amount awarded.
* Matching funds letters should be grouped together into one (1) scanned document rather than several separate documents.

**Application Deadline: February 1, 2023 - 5pm MDT**

 **Send all completed application documents via email** to cstprogram@wyo.gov. All information and attachments included in the application must be submitted in the order they appear in the application. Applications that do not follow the format will be deemed to be “incomplete” and returned to the applicant.

Save the completed application and budget attachment using the file name: court-name grant app (or budget) FY24. (e.g. **AlbanyCountyCSTProgram grant app FY24**). Documents that do not follow the file naming convention will be deemed “incomplete” and returned to the applicant.

**All applications should be sent electronically via email**. If you are experiencing technical difficulties, please contact Alicia. All documents must arrive no later than 5:00 pm on February 1, 2023.

**Section 1. Program Type, Mission, Goals**

Official Program Name:

1. Program Type:

[ ]  Adult Drug Court

[ ]  Juvenile Drug Court

[ ]  DUI Court

[ ]  Tribal Healing to Wellness Court

[ ]  Reentry Drug Court

[ ]  Veterans Treatment Court

[ ]  Federal District Drug Court

[ ]  Family Dependency Treatment Court

[ ]  Back on TRAC

[ ]  Other (Please specify):

1. Use the following space for Program Mission Statement and Goals (see W.S. §7-13-1603(b))

**Section 2. Funding Request**

Please list number of slots requesting state funds to support in FY24.

|  |  |  |  |
| --- | --- | --- | --- |
|   | No. of Slots | Cost per Slot | Total |
| Adult |       |  $ 9,354.66  | $       |
| Juvenile |        |  $ 14,716.84  | $       |
| Total State Funding Request | $       |

**Section 3. Program Data to Support Request**

The CST Program will provide the number of unique participants served for FY20-FY23 (Dec. 31, 2023), amount of unspent funds for FY22, recidivism rates for FY22 and FY23 through Dec. 31, 2023, and retention rates for FY22 through Dec. 31, 2023.

OPTIONAL: Use the following space to share any important information/circumstances regarding unique participant numbers, retention, and recidivism rates:

**Section 4. Funding Sources, Practices, Fiscal Agent**

Program Funding and Fees

1. Is the program currently receiving federal funds (for FY23)? [ ]  Yes [ ]  No
2. If yes, list the name of grant and amount received:

1. Will the program apply for other federal funds in FY24? [ ]  Yes [ ]  No
2. Does the program intend to request funding to aid in CARF accreditation? [ ]  Yes [ ]  No

*If the program contracts with a Community Mental Health Center who receives funding from the Behavioral Health Division, the program is not eligible to receive CARF funding.*

1. If the program will receive other supplemental funds (gifts, contributions, donations, or grants) outside of the state grant and city/county match funds, list the funding source(s) and dollar amount(s) here:

1. How much will program participants pay in CST Program fees (designate if per phase, per year, per month, other)?

1. What other expenses will participants be responsible for throughout the program (ex. SCRAM bracelets, drug testing, other)?

1. If participants are required to pay CST-related expenses directly to any organization holding a contract or MOU with the program (treatment providers, drug testing services, etc.) how are those payments tracked and reported back to the program?

1. Is the program’s fiscal/fiduciary agent on the program’s governing body or board?

[ ]  Yes [ ]  No

*If the fiscal/fiduciary agent is not on the governing body or board, email a signed copy of the resolution appointing the fiscal/fiduciary agent to* *cstprogram@wyo.gov* *for record keeping purposes.*

1. Upon application submission, please submit the letters from the agency or agencies that committed in-kind contributions and local match funds for the upcoming year of FY24. These documents should be scanned and submitted as one (1) document.

**Section 5. Projected Budget and Justification (Attachment A)**

*Fill out the Budget and Budget Justification Attachment A and submit with your application. (The Budget tab and Budget Justification tab are both on the same document.) Match funds must be at least 25% of your state funds request. Federal grants and any other state funds cannot be counted in your match funds.*

**Section 6. Magistrates**

1. Pursuant to W.S. 7-13-1606(d), “The application shall identify participating judges and contain a plan for the participation of judges. The plan shall be consistent with rules adopted by the department and the Supreme Court.” Use the following space to provide the plan for the participation of all judges/magistrates in the program:

1. To aid the Supreme Court in compiling data to build their projected CST magistrate budgets, what is the **average number of hours per week** that a magistrate is utilized in the program?

**Section 7. Risks/Needs Assessment Practices**

1. What participant risks/needs screening and assessment processes does the program currently use? Explain the process and list all tools used.

1. What is the job title of the individual(s) conducting the screening of participants?

1. Use the following space to explain if the program opts to serve individuals with risk/need levels different than the best practice population and summarize this policy including if and how the groups are separated.

**Section 8. Substance Use Treatment Services, Practices, Certifications**

1. Will the program hire in-house treatment providers? [ ]  Yes [ ]  No
2. Will the program contract for treatment? [ ]  Yes [ ]  No

If yes, provide the name of the provider here:

1. What is the expiration date of the in-house program or contracted treatment provider’s STATE CERTIFICATION?
2. What is the expiration date of the treatment provider’s NATIONAL ACCREDITATION?

**Section 9. Mental Health Services, Practices, Certifications**

* + - 1. Does the program have a contract (or MOU) for mental health services?

[ ]  Yes [ ]  No

* + - 1. Does the program refer participants to local Community Mental Health Center(s)?

[ ]  Yes [ ]  No

Use the following space to provide the name or names of the mental health treatment providers used by the program.

1. Does the mental health provider keep the program team fully informed of all matters relevant to the treatment and program progress of all participants? [ ]  Yes [ ]  No

How is this information communicated?

**Section 10. Training Summary**

List every program team member and every treatment provider, the training hours they have acquired in the last fiscal year (July 1, 2021 - June 30, 2022), and the title of the training. If training hours are not entered, please provide an explanation on why required hours were not obtained and the plan for completion of the hours in the next contract year. Add rows as needed.

*If the training was not from an organization listed in Rule or Guideline and was not preapproved, it will not be counted for completed hours.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Member Position | Member Name | Title of Training | Hours Received | Member Start Date |
| Participating Judge |       |       |       |       |
| Prosecuting Attorney |       |       |       |       |
| Defense Attorney or *Guardian ad litem* |       |       |       |       |
| Monitoring Officer/Probation Officer |       |       |       |       |
| Treatment Provider Representative |       |       |       |       |
| Program Coordinator |       |       |       |       |

**Section 11. Recidivism, Retention, Sobriety**

Court Supervised Treatment Programs contribute to the goals of reducing crime/reducing recidivism, retaining individuals for the full duration of the program, and increasing durations of sobriety prior to graduating a program. Goals for each of the three (3) target areas are set in annual contracts and in site visit reports, and the goals are based on the functionality of existing programs and averages reported in national or regional studies.

1. What method(s) does your program utilize to track recidivism?

2. What does your program do to retain participants in the program?

**Section 12. Community Outreach**

Discuss community outreach activities completed by the program in FY23 to date:

**Section 13. Surcharge**

If you are interested in receiving surcharge funding, please provide the amount desired and what you would like to use the funding for. Please note, this application is NOT a guarantee of funding and the amount may be subject to change. If your county serves more than one (1) program, please also include the surcharge amount desired for each program.

If granted, how will the surcharge funding be utilized?

**Section 14. Master Contact List**

|  |  |
| --- | --- |
| **Legal Name of CST Program (name used for the IRS):** |       |
| **Organization Governing the Contract:** |       |
| **Mailing Address** | **Physical Address for FedEx of Contract** |
|       |       |

CST Program Coordinator Information: Provide contact information for the Program Coordinator.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Title** | **Mailing Address** | **Telephone** | **E-mail** | **Specific requests** |
|       |       |       |       |       |       |

Contracting Agency and Contract Signatory Information: Provide information for the individual who will sign the state contract and the individual who will attest their signature, if applicable. Add rows as needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **Mailing Address** | **Telephone** | **E-mail** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

The Attorney General and Wyoming Department of Health Director would like to limit the number of contracts with two signature pages. If you are required legally to provide an original signature to a department or attorney, list below:

[ ]  Yes, I need an Original Signature for:

|  |  |
| --- | --- |
| **Name** | **Purpose** |
|       |       |
|       |       |

[ ]  No, I do not need an Original Signature; an email copy will be fine.

Fiscal or Fiduciary Agent Information: Provide information for the individual for the fiduciary agent for this program. Add rows as needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Title | Mailing Address | Telephone | E-mail |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

Governing Body: Provide information for the representatives of the governing body for this program. Add rows as needed.

|  |
| --- |
| **General Governing Body Information**  |
| **Governing Body Members** |
| **Name** | **Title** | **Telephone** | **E-mail** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

Program Team Member Contact Information (as required by W.S. 7-13-1609(a)): Provide the name and contact information for all Program Team Members. If their title is not what is described, add the title after their name. There must be someone for each position listed unless otherwise specified. If the program does not have all required team members, provide a plan for recruiting any missing members. Do not alter the member column titles. Add rows as needed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Member** | **Name & Title** | **Mailing Address** | **Telephone** | **E-mail** | **% Weekly Staffings attended SFY 22** |
| **Participating Judge \*** |       |       |       |       |       |
| **Substitute Judge \*****(who sits in for Participating Judge, not mandatory)** |       |       |       |       |       |
| **Prosecuting Attorney** |       |       |       |       |       |
| **Defense Attorney or *Guardian* *ad litem*** |       |       |       |       |       |
| **Monitoring Officer/Probation Officer** |       |       |       |       |       |
| **Treatment Provider Representative** |       |       |       |       |       |
| **Program Coordinator** |       |       |       |       |       |
| **Other (List Title, not mandatory)** |       |       |       |       |       |

**\***Can be only a District Court Judge, Circuit Court Judge or Magistrate, Municipal Court Judge or Tribal Court Judge (W.S. 7-13-1602(vii)).

Treatment Provider(s) Organization Information: Add rows as needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **Mailing Address** | **Telephone** | **E-mail** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

Ancillary and Community Services Information: List all ancillary and community service provider information including information on employment providers, subcontractors, and contractors. Add rows as needed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Provider(s) or Contractors** | **Address/Telephone**  | **Duration of current contract (start/end dates)** | **Description of services provided** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

Mental health provider contact information: Add rows as needed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Treatment Provider(s) or Contractors** | **Address** | **Duration of current contract (start/end dates)** | **Total $ Amount of Contract** | **Certification Expiration Date if Applicable** | **National Accreditation Expiration Date if Applicable** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |

**Section 15. Assurances**

Review all assurances and make sure the required attachments (Attachment A and match fund letters) are provided with this application. **Type initials in the boxes below.**

1. This application was reviewed and approved by the Program Team and the representative from the Governing Body:
2. All attachments (application, matching funds letters, Attachment A, Contracts or MOUs) were reviewed and approved by the Program Team and the representative from the Governing Body:
3. Indicate here if the program would like a 10 minute phone call with the funding panel that will be held in March 2023, between 9:00am and 1:00pm and who will be present for the call. Date to be determined and will be provided to programs via email. Specific times will be determined after all applications are submitted. This is optional and allows you an opportunity to highlight progress in your program or circumstances influencing your funding request.

**Section 15. List of Required Attachments**

1. Letters from the agency or agencies that committed in-kind contributions and local match funds for the application year of FY24.
2. Attachment A, Budget and Budget Justification.