

# Connecticut Department of Mental Health and Addiction Services COVID-19 Behavioral Health Response and Assistance Program

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## EMPLOYEE ASSISTANCE PROGRAM MINI-GRANT (EAPMG)

### APPLICATION AND PROPOSAL

To ensure timely processing of your application, please return the following items as one complete packet (please check boxes accordingly):

- Completed Program Application and Proposal signed by authorized official (original signature required)
- Completed W-9 form signed by authorized official (original signature required)
- Documentation for existing or proposed Employee Assistance Program (EAP)
- Documentation / Proposal to enhance new or existing EAP

Please return all material via mail to:

**Advanced Behavioral Health\***  
**Attn: Paul Zakarian, Assistant VP of Programs**  
**213 Court Street, 8<sup>th</sup> floor**  
**Middletown, CT 06457**

\*Advanced Behavioral Health is contracted by the Department of Mental Health and Addiction Services to assist with the administration of the COVID-19 Behavioral Health Assistance Program

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## EMPLOYEE ASSISTANCE SERVICES MINI-GRANT (EAPMG)

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### APPLICATION AND PROPOSAL

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Mini-grants may be awarded to private, non-profit DMHAS-funded healthcare providers in need of funds to develop or enhance their employee assistance program (EAP) and/or individual EAP services as result of the COVID-19 Pandemic

EAP services eligible for mini-grants include the following;

1. Consultation services to enhance or develop an EAP. A reputable and/or certified EAP professional or consulting firm must provide consultation.
2. Enhancing existing EAP services. This may include extending the amount of sessions available, adding new providers, and/or increasing the types of services (i.e. groups, classes) that are available.
3. Adding new eligible EAP services, including Employee Well-Being workshops, Wellness workshops or Employee Health Assessment surveys.

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## Section 1. Application - Identifying Information

Please Type or Print Clearly      Federal Tax ID (TIN): \_\_\_\_\_

Legal Name of Organization  
(As Registered with the IRS): \_\_\_\_\_

Mailing Address for primary EAPMG Contact			
Contact Person:		Title:	
Street Address:			
City:	State:	Zip:	
Phone: ( )	Fax:	( )	
Email Address:			

Billing Contact and Address (if different from above)			
Contact Person:		Title:	
Street Address:			
City:	State:	Zip:	
Phone: ( )	Fax :	( )	
Email Address:			

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## Section 2: Application - General Business Information

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### A. General Information

Does the Organization presently receive DMHAS Grant Funds?  Yes  No

Is the Organization a private non-profit?  Yes  No

**B. Does the Organization currently have an Employee Assistance Program (EAP)?**  Yes  No

If yes, please provide a written description of the organization's existing program/services.

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## Section 3. Proposal

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- A. Attach a written proposal detailing EAP service needs and how the EAP Mini-Grant would be used to meet these needs, including a breakout of all anticipated costs and expected timelines. Written proposals should address at least one of the eligibility criteria above, and should not exceed two pages, double-spaced.**

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## **Certification and Authorization**

DMHAS has contracted with Advanced Behavioral Health, Inc., as the Administrative Service Organization for the COVID-19 Behavioral Health Response and Assistance Program Employee Assistance Program Mini-Grant (EAPMG). ABH, Inc., will assist DMHAS in facilitating the provider contracting process. For the purposes of submitting this proposal for EAPMG, the Applicant certifies that all information provided to Advanced Behavioral Health is true and correct to the best of the Applicant's knowledge and belief. The Applicant agrees to notify Advanced Behavioral Health promptly if there are any material changes in the information provided, whether prior to or after acceptance of a Mini-Grant. The Applicant understands and agrees that if DMHAS or Advanced Behavioral Health determines that this application contains any significant misstatements, misrepresentations, or omissions, the Application may be voidable at the sole discretion of either ABH or DMHAS.

The Applicant hereby authorizes the release to DMHAS or Advanced Behavioral Health of any information held by any person, entity, or governmental agency which DMHAS or Advanced Behavioral Health determines may have relevant information for purposes of evaluating this original application and proposal. The Applicant agrees to hold any such person, entity or governmental agency providing information to DMHAS or Advanced Behavioral Health harmless from any liability for providing such information.

The Applicant hereby further authorizes DMHAS or Advanced Behavioral Health to release any and all information related in any way to the Applicant's professional practice to any person, entity or governmental agency which: (a) provides DMHAS or Advanced Behavioral Health with an authorization signed by the Organization; or (b) has a legal right to know under any state or federal law. The Applicant agrees to hold DMHAS and Advanced Behavioral Health harmless from any liability for providing such information as specified herein.

The Applicant understands and agrees that the certifications, authorizations, and other provisions contained herein shall remain in force for as long as this application is pending and, if accepted for participation, for as long as the Applicant's provider agreement with DMHAS remains in force.

The Applicant further understands and agrees that (a) the Applicant has the burden of producing all information required or requested by DMHAS or Advanced Behavioral Health in connection with this application; and (b) DMHAS or Advanced Behavioral Health is under no obligation to complete the processing of this application until such information is provided by the Organization.

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*Name of Applicant Organization (Please type or print)*

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*Authorized Signature*

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*Date*

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*Name (Please type or print)*

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*Title (Please type or print)*

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