Form 2: Program Application Sheet
Mental Health Treatment Services
Youth Continuum of Care

Instructions: Complete **one (1) Form 2** for **each program or service category** included in your proposal.

Each Form 2 should describe **only one program or service**, including the service category, program description, target population, capacity, service delivery model, and program-specific details.

If your organization is proposing multiple programs or service categories, submit a separate Form 2 for each one.

Agency Legal Name: _____

Location of Services Address/City/Zip: _____

SERVICE CATEGORIES

Using the checkboxes below, please identify which service categories you are applying to provide. Details of services found in Attachment A: Service Categories & Program Information:

1. Outpatient Services
    - ☐ 1.1. Outpatient Moderate Intensity (Non-FSP)
    - ☐ 1.2. Outpatient High Intensity
        - ☐ 1.2.1. Outpatient High Intensity (FSP Level Support)
        - ☐ 1.2.2. Therapeutic Behavioral Services (TBS)
        - ☐ 1.2.3. Intensive Care Coordination (ICC)
        - ☐ 1.2.4. In-Home Behavioral Supports
        - ☐ 1.2.5. Child & Family Team (CFT) Facilitation
    - ☐ 1.3. Supported Housing Program Level (field or embedded)
2. Evidence-Based Intensive Outpatient Services
    - ☐ 2.1. High Fidelity Wrap Around
    - ☐ 2.2. Functional Family Therapy (FFT)
    - ☐ 2.3 Multi-Systemic Therapy (MST)
    - ☐ 2.4 Parent-Child Interaction Therapy (PCIT)

3. Day Treatment Services

- ☐ 3.1. Day Treatment Rehabilitative Program Level
- ☐ 3.2. Day Treatment Intensive Program Level

4. Foster Care and Residential Services

- ☐ 4.1. Therapeutic Foster Care (TFC)

5. Early Intervention Services

- ☐ 5.1. Coordinated Specialty Care (CSC) For First Episode Psychosis (FEP)
- ☐ 5.2. 0-5 Screening, Assessment and Referral Services

6. Specialty Programs

- ☐ 6.1. Transcranial Magnetic Stimulation (TMS) Programs
- ☐ 6.2. Eating Disorder Treatment – Intensive Outpatient Level (EDO-IOP)
- ☐ 6.3. Eating Disorder Treatment – Partial Hospitalization Program Level (EDO PHP)
- ☐ 6.4. Eating Disorder Treatment – Residential Level (EDO RES)

PROGRAM DESCRIPTION

Please briefly describe your program(s). You may attach program brochures or other information material as applicable.

Is your program currently part of the Youth Mental Health Treatment Continuum of Care?

☐ Yes ☐ No

What does your program add to the continuum to improve the network of providers?

What is your current/proposed program capacity? (e.g., target monthly census, caseload size per FTE, target number served annually)

Does your program serve any unique populations? (e.g., gender, age, gender identity, dual-diagnosis, trauma, LatinX/Spanish Speaking or clients of specialized programs such as Intensive Services Foster Care (ISFC) or Transitional Housing Program (THP) for Foster Youth)

Does your program provide field-based services? ☐ Yes ☐ No

What region(s) does your program serve? (check all that apply)

☐ Central County
☐ South County
☐ North County
☐ West County
☐ East County
☐ Out of County

SERVICE PROVISION DETAILS

Please fill details below for all programs or services covered by this application.

Service Category	Evidence Based Practices or Specialties	Population Served	Hours of Operation	Frequency and Duration of Services	Address of Facility
e.g. *3.1 Day Treatment Rehabilitative Program*	***e.g.*** *DBT, CBT, Dual-diagnosis, eating disorders, trauma*	***e.g.*** *Men, Women, TAY Ages 12-18, veterans, etc.*	***e.g.*** *24 Hours, M-F 8AM – 5PM*	***e.g.*** *Daily 3-5 hours, monthly case management, weekly therapy*	***e.g.*** *2227 Capricorn Way, Santa Rosa, CA 95407*

ATTESTATION

To the best of my knowledge and belief, all information in this application is true and correct. The Respondent and/or Cosigner will comply with all of the requirements of the application process and the subsequent contract with the County.

Signature:_____Date:_____

Printed Name: _____