Memorandum
Department of Community Health
Lansing, Michigan 48913

February 16, 2006

To: Directors and Program Staff of Community Mental Health Services Program (CMHSP), Aging Network organizations, Public Health or other community service organizations

From: Irene Kazieczko, Director, Bureau of Community Mental Health Services

Re: Request for Proposals: Alzheimer's Disease Demonstration Grants to States (ADDGS) Wraparound Initiative: Application Deadline: April 14, 2006
Project Period: May 15, 2006 through September 30, 2008

Attached for your careful review and response is the Michigan ADDGS Wraparound Initiative Request for Proposals (RFP). The Michigan Department of Community Health (MDCH) will award two grants to pilot the development of Wraparound Model Initiatives. The two pilot lead agencies will each identify a facilitator, develop a wraparound community team, and implement an integrated system array of wraparound protocols, services, and supports for individuals with dementia who exhibit acute behavioral symptoms of distress and their families. Eligible applicants are community mental health services programs, aging network organizations, public health or other community-based service organizations as lead agency for the project.

The Administration on Aging (AoA) awarded funding for ADDGS in July 2005 to further the development of innovative approaches to provide care for people with Alzheimer's disease and support for their family caregivers. The AoA is strengthening the ADDGS Program by continuing to incorporate a greater focus on using the ADDGS Program as a vehicle for advancing changes to a state's overall system of home and community-based care, including state programs to streamline consumer access to services and family caregiver support programs. The Michigan ADDGS grant is administered by the Mental Health & Substance Abuse Administration.

The Wraparound Initiative (one of three Michigan ADDGS initiatives) will fund implementation of a wraparound model in two communities in the second half of ADDGS Year 1 through Year 3. Each awarded lead agency will be granted up to $75,000 per year for a project period of approximately 29 months. Non-federal matching funds provided through the lead agency are also required. Grant awards will be provided for budget periods of May 15, 2006 through September 30, 2006 (Year 1), October 1, 2006 through September 30, 2007 (Year 2), and October 1, 2007 through September 30, 2008 (Year 3).

An informational meeting for organization personnel interested in responding to this RFP is scheduled for March 6, 2006, from 1:30 to 4:30 p.m., in the Lake Ontario Room at Michigan Library and Historical Center in Lansing. A summary of questions and answers from the meeting will be compiled and made available following the meeting.

Please direct questions regarding this RFP to Marci Cameron (see Section XII). Please share this RFP with program staff and community partner organizations.

cc: Patrick Barrie, Mark Kielhorn, Patrician Degnan, Marci Cameron, Alyson Rush

Alzheimer's Disease Demonstration Grants to States Program
Administration on Aging, U.S. Department of Health and Human Services
State of Michigan: 2005-2008
Administered by the Mental Health and Substance Abuse Administration
of the Michigan Department of Community Health

FUNDING OPPORTUNITY TITLE: **Alzheimer's Disease Demonstration Grants to States (ADDGS): Wraparound Initiative**

The Michigan Department of Community Health (MDCH), through a competitive Request for Proposals (RFP) process, will award two grants to pilot the development of Wraparound Model Initiatives. The two pilot lead agencies will each identify a facilitator, develop a wraparound community team, and implement an integrated system array of wraparound protocols, services, and supports for individuals with dementia who exhibit acute behavioral symptoms of distress and their families.

Catalog of Federal Domestic Assistance (CFDA) Number: 93-051

KEY DATES:

1. **The deadline date for submission of proposals is April 14, 2006.**
2. **An informational meeting for agency personnel interested in responding to this RFP is scheduled for March 6, 2006. A presentation on the Wraparound Model will be included.**
3. **The project period will begin May 15, 2006 and end September 30, 2008.**

ELIGIBLE APPLICANTS:
Community Mental Health Services Programs, aging network organizations, public health or other community-based service organizations as lead agency for the project.

AVAILABLE FUNDS:
The ADDGS Wraparound Initiative will fund two community agencies in the state of Michigan. Each agency will be funded a maximum of $75,000 per year for a project period of approximately 29 months. The initial two months (May and June, 2006) will focus on contract processing, start-up collaborative efforts, and team member training. The ADDGS grant funding from the Administration on Aging to MDCH extends from July 1, 2005 through September 30, 2008. Contracts awarded to successful bidders are renewable annually, dependent on performance and availability of funds. MDCH grant awards will be provided for budget periods of May 15, 2006 through September 30, 2006 (Year 1), October 1, 2006 through September 30, 2007 (Year 2), and October 1, 2007 through September 30, 2008 (Year 3).

The full project money (ADDGS grant funds and matching, non-federal funds) will be used to develop and coordinate a Community Team of individuals and organizations that can respond to and support family teams. Funds may also be used for training, facilitating, and to provide services that enable individuals with dementia who exhibit acute behavioral symptoms of distress to continue to be engaged in the community. All formal and informal supports and services in the community are identified, utilized, and maximized to respond to the needs (as identified in the wraparound process by family teams) of individuals with dementia and their family caregivers.

Match Requirement

The statutory authority for grant awards for the ADDGS program is contained in Section 398 of the Public Health Service Act (42 U.S.C. 398 et seq.), as amended by Public Law 101-157 and by 105-379, the Health Professions Education Partnerships Act of 1998. Section 398 requires that ADDGS grantees provide a 25% match (cash or in-kind) during the first year (FY '06), 35% during the second year (FY '07), and 45% during the third year (FY '08) of the grant period. MDCH is extending this match requirement to the two Wraparound Initiative-funded lead agencies.

In the first grant year, each lead agency must cover at least 25% of the project's total cost (up to $100,000) with non-federal resources ($25,000) (cash or in-kind). In other words, for every three (3) dollars received in grant funding, the applicant must contribute at least one (1) dollar in non-federal resources toward the project's total cost. A common error is to match 25% of the funds awarded, rather than 25% of the project's total cost. The formula for calculating the required first year match is:

$$\frac{\text{Funds Awarded (i.e., \$75,000)} \times \text{Applicant Match Rate (i.e., 25\%)}}{\text{Funds Awarded Match Rate (i.e., 75\%)}} = \text{Project Match Minimum Requirement}$$

Therefore, Year 2 Match (cash or in-kind) is $40,385 and Year 3 Match is $61,364, if maximum of funded $75,000 is applied for.
Providing more than the 25% (Year 1), 35% (Year 2), and 45% (Year 3) match is allowable.

Direct Service Requirement

In addition, a minimum of $60,400 must be allocated to direct services each year, which can include facilitation of family support as outlined in *Attachment D*, Communiques No. 9, p. 3, Wraparound Facilitator. Under this contract, other direct services expenditures can include home health care, personal care, adult day care, companion services, mental health counseling, short-term care in health facilities, and other respite care. Funds beyond the $60,400 direct services requirement may be used to purchase additional services.

Alzheimer's Disease Demonstration Grants to States Program
Administration on Aging, U.S. Department of Health and Human Services
State of Michigan: 2005-2008
Administered by the Mental Health and Substance Abuse Administration
of the Michigan Department of Community Health

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I. PROJECT SUMMARY AND PURPOSE

The Administration on Aging (AoA) awarded funding for Alzheimer's Disease Demonstration Grants to States (ADDGS) in July 2005 to further the development of innovative approaches to provide care for people with Alzheimer's disease and support for their family caregivers. The AoA is strengthening the ADDGS Program by continuing to incorporate a greater focus on using the ADDGS Program as a vehicle for advancing changes to a state's overall system of home and community-based care, including state programs to streamline consumer access to services and family caregiver support programs.

Michigan's ADDGS Grant Program:
"Integrated Systems Approaches to Implement Community Models of Support"
GOAL: To improve the responsiveness of Michigan's system of home and community-based care to the needs of people with dementia and coordinate these efforts with other current systems change initiatives.

First Initiative of the Michigan ADDGS Grant Program:
An Integrated Systems Model of Wraparound Services and Supports Initiative:
The ADDGS Wraparound Initiative (one of three Michigan ADDGS initiatives) will fund implementation of a Wraparound Model in two communities in the second half of ADDGS Year 1 through Year 3. The two pilot lead agencies will identify a facilitator, develop a wraparound community team, and implement an integrated system array of wraparound protocols, services, and supports for individuals with dementia who exhibit acute behavioral symptoms of distress and their families. A Wraparound Model that is currently successfully used for children and families will be modified to provide a strategy to help adults with dementia who exhibit acute behavioral symptoms of distress to remain in the community and prevent premature institutionalization.

The Michigan Department of Community Health (MDCH) will promote a collaborative approach among mental health, public health, and aging services systems in developing a community model of support for people with dementia and family members involved in their care. It is designed to ensure the needs of individuals with dementia and their caregivers are incorporated into the emerging infrastructure of Michigan's long-term care system. In alliance with MDCH's systems transformation process and vision of recovery, the Wraparound Initiative promotes person-centered planning, strength-based problem-solving, meaningful relationships with family and friends, engagement in daily activities that are meaningful, and inclusion in community life and activities.

Excerpt from AoA ADDGS Program Announcement: "Alzheimer's disease (AD) is a progressive, degenerative disease of the brain, and the most common form of dementia. Discovered and described in 1906 by Dr. Alois Alzheimer, AD now affects approximately 4 million Americans. Unless a cure or prevention is found, it is estimated that the number of Americans with Alzheimer's will climb to 14 million by the middle of [this] century. Although AD is not a normal part of aging, one in 10 persons over the age of 65 and nearly half of those over 85 may have Alzheimer's disease. Although AD eventually results in death, the disease can progress for years. A person with AD lives an average of eight years but can live as many as 20 years or more from the onset of symptoms.

"To focus attention on this need, to encourage states to develop models of assistance for persons with Alzheimer's disease, and to encourage close coordination and incorporation of those services into the broader home and community based care system, Congress funded the Alzheimer's Disease Demonstration Grants to States (ADDGS) program in 1991. Congress transferred the administration of the program to the AoA in 1998 in an effort to ensure coordination with other programs for older Americans. To date, the ADDGS program has proven successful in targeting service and system development to traditionally underserved populations, including ethnic minorities, low-income and rural families coping with Alzheimer's disease." Michigan is one of only a handful of states that have participated in the grant program since its inception.

II. TARGET POPULATION

The Wraparound Initiative targets adults with possible or probable Alzheimer's disease or related disorders who exhibit acute behavioral symptoms of distress and their caregivers. Individuals in this target population live in the community and are at risk for premature nursing home or other restrictive living arrangement. Family issues are multiple and cross service systems. Priority will be given to lead agencies that are located in ethnically diverse urban centers and/or rural communities.

III. PROBLEM STATEMENT

Often individuals with dementia who exhibit acute behavioral symptoms of distress "fall through the cracks" of community services, and those who care for these individuals may be frustrated by systems barriers. The symptoms of behavioral distress may preclude individuals from access to services or discharge them from services, and present difficulties in many aspects of daily life, e.g., home, work, church, and community. These symptoms may create increased risk of injury to selves or others. The health and functioning of family caregivers may be compromised.

Michigan is among many states currently engaged in systems change efforts to create a more balanced long-term care system that will expand the capacity of long-term support services in home and community settings. The road map has been guided in part by recommendations of the Michigan Long-Term Care Work Group Report (June 2000); Governor Granholm's priority initiatives and policy statements pertaining to long-term care reform; ongoing advocacy, consumer, provider and government collaboration; and lessons derived from grant initiatives funded by the Centers for Medicare and Medicaid Services (CMS) and Robert Wood Johnson Foundation. Michigan has received national recognition for its contributions to improving community and provider understanding about good dementia care. However, these service elements and practices have not been uniformly integrated within its system for home and community-based care. The ADDGS Initiative provides an opportunity to address these gaps and ensure that needs of individuals with dementia and their caregivers are incorporated in Michigan's long-term care system.

People with dementia who exhibit acute behavioral symptoms of distress may be described by others as resistant to care, challenging, agitated, disruptive, or aggressive [Cohen-Mansfield, *Alzheimer's Care Quarterly*, 2000, 1(4)]. Behavioral symptoms are common, upsetting to others, and may result in injury, discharge from services, and institutionalization. The American Association for Geriatric Psychiatry indicates the "clinical significance of agitation, aggression and psychosis in dementia cannot be stressed too strongly. The high prevalence of these

disorders is striking: up to 90% of all dementia patients will experience one or more behavioral or psychological disturbances during the course of their illness." In addition, "they are the primary cause of physical restraint, specialist referral and even institutionalization" [American Association for Geriatric Psychiatry, *Behavioral Disturbances in Dementia: What the Clinician Needs to Know*, 1998]. Talerico and Evans report the prevalence of aggressive/protective behavior (i.e., hitting, kicking, biting, slapping) exhibited by people living in the community ranges from 55-65%. The authors indicate there is a high prevalence of aggressive behaviors that occur during activities that require touch, such as providing assistance with personal care. These may occur in the context of a perceived threat and be rooted in the need for self-protection [Talerico and Evans, *Alzheimer's Care Quarterly*, 2000,1(4)]. Bartels and Colenda report that *severe* behavioral or psychiatric symptoms affect 20-40% of people with Alzheimer's disease, pose significant burden to families, and are strongly related to use of health care services and institutional care. The authors further describe a 'non-system' of care that results in service gaps and little coordination among providers of primary care, home health, long-term care, specialty mental health providers, public health and the aging network (Bartels and Colenda, *American Journal of Geriatric Psychiatry*, 1998, 6(2), Supplement 1]. This subset of individuals and their families requires significant long-term care support for the individual to remain in the community.

IV. PROPOSED INTERVENTION

A multi-system approach is required to develop and coordinate an integrated array of responsive, appropriate services and supports that can help sustain individuals with dementia who exhibit acute behavioral symptoms of distress in the community. The ADDGS project will use a process recommended by both the Governor's Medicaid Long-Term Care Task Force and Mental Health Commission to design and pilot the implementation of an integrated model of improved system coordination, shared protocols, wraparound services and supports. The wraparound team process provides a structural approach to pull professional and natural supports together to support individuals and families more effectively. Outcomes are identified, roles are clearly delineated to ensure less duplication, appropriate funding sources are identified and coordinated, and more efficient help is provided.

Wraparound is a term that describes an approach to building constructive relationships and networks of support with individuals and families whose needs fall outside the scope of traditional service systems and require integrated coordination among organizations and the individual's natural supports to reduce the use of institutional care settings. It has been widely used in the last decade in the public mental health system with families of children who have serious emotional disturbance and incorporated into other systems such as child welfare, juvenile justice, addiction services, and education [Burns and Goldman. *Promising Practices in Wraparound for Children with Serious Emotional Disturbances and Their Families: Systems of Care,* 1999] and [Pringle, et al, *Addictive Disorders and Their Treatment, 2002,* 1(4)]. Research studies on individual programs consistently report positive outcomes in terms of reduction in the use of residential placement, improvement in the functioning of participating youth and family caregivers, and improvement in relationships among participating systems [Community Living Exchange/Rutgers Center for State Health Policy. *Issue Brief: Wraparound Services*, November 2004].

As cited in the 2005 "Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities" by the U.S. Department of Health and Human

Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, "Rather than making an individual fit into a range of different service programs, some providers and communities wrap the necessary services around the individual. The wraparound model, effectively developed for child populations (Burns et al., 1999; U.S. Department of Health and Human Services, 1999; Goldman & Faw, 1999), is particularly well suited to an older adult population.

"Some older adult wraparound programs emphasize the integration of primary and secondary medical and social services, prevention, rehabilitation, medication, technical aids, and long-term care (Bergman et al., 1997). Others use a gatekeeper model…to identify older adults who may be at risk (Raschko, 1985)….A Community Mental Health Center in New Hampshire operates an Elders Wrap Around Team, which includes 12 regular member agencies, with an additional 40 agencies participating as individuals' needs warrant. The program has reduced client hospital admissions (from 24 to 6 within just one quarter), and reduced length of hospital stays for clients served (from 18 to 12 days) as well as significantly increased referrals to other community services (Duford, 1999)."

Wraparound is a process, not a service, which places individuals and families at the center in identifying the person's strengths. The process coordinates mental health and other community-based resources to enable the person to continue living safely in the community. Wraparound program models vary in terms of the target group served, proposed interventions, levels of funding and the type of lead agency, as well as the range of other collaborative agencies involved in developing an integrated community model of support that crosses the individual's life domains (i.e., residence, emotional, behavioral, relationships, spiritual, cultural). However, each wraparound process shares the following essential functions: a) Engage families and communities in a culturally responsive manner to be full partners in every level of the process of identifying strengths of the person at-risk for institutional placement and types of supports needed; b) Include a balance of formal and informal supports; c) Ensure the availability of a supports coordinator or facilitator and flexibility of funding, location, time, service response and setting; d) Establish an unconditional commitment to serving the individual and his/her family regardless of difficulty or change in needs; e) Develop service plans through a collaborative team process that have professional and natural supports; f) Identify and measure specific outcomes for each goal [Community Living Exchange/Rutgers Center for State Health Policy. *Issue Brief: Wraparound Services*, November 2004]. Unconditional care, also described as 'no reject, no eject,' is an inherent principle. Wraparound services and supports also include provisions for crisis and safety plans.

The MDCH Division of Mental Health Services for Children and Families has supported the implementation of wraparound services and supports for children with emotional disturbances and their families with funding from the Substance Abuse & Mental Health Services Administration (SAMHSA) Mental Health Services Block Grant Program. It provides training and technical assistance to local community collaborative bodies, wraparound supports facilitators, and community teams. The Michigan experience indicates wraparound initiatives are more successful when implemented in communities where there is a well established community collaborative body to assist with planning, implementation and garnering multiple funding sources for sustainability. There are currently seventy-six local community collaborative bodies endorsed by the State of Michigan (*see Attachment E*) that use community needs assessments and workgroups or committees to guide county-level planning and decision-making on funding support for services and to communicate with elected officials. Membership includes agency

directors of mental health, public health, family and older adult service organizations; representatives of school districts, hospitals, community businesses, and faith-based agencies; family court judges or administrators; and consumers and family members. Consumer participation (individuals and family members) is essential. Collaborative bodies use committees to implement a specific plan of action or system of care to meet identified needs of a target group. The MDCH Division of Mental Health Services for Children and Families provides technical assistance and training to support collaborative body coordinators.

The funded lead agency will serve as fiscal agent and coordinator for the project, and provides the ADDGS Wraparound Facilitator position (proposed typical functions are included in "Communiques No. 9" *Attachment D*). The Facilitator is a key figure to the success of the project, requiring someone who is committed to the Wraparound approach and its values, and who is capable of developing and facilitating collaborative efforts. The lead agency will be responsible for pulling together a new community team for the target population. This agency will also develop a work plan for sustainability.

V. ANTICIPATED INITIATIVE ACCOMPLISHMENTS

Two lead agencies will implement a community model of training and support which: 1) incorporates Michigan's Wraparound Best Practice Values (listed in *Attachment D*) and required components of a community team and supervisor, coordination of the wraparound process, a consumer/family team, individualized budgets for participating families, commitment to unconditional care and a graduation plan; 2) assures access to education, care consultation and management, respite, crisis intervention, back-up and aftercare support services as needed, delivered by people trained and knowledgeable in cognitive assessment and intervention; 3) prevents unnecessary hospitalizations, emergency room visits and placement in 24-hour care facilities; and 4) promotes the health and functional status of affected individuals and their caregivers. Community teams will have up to 29 months to implement a Wraparound Model of support.

The Wraparound Model produced will identify specific roles and responsibilities among community team members within multi-service systems and organizations, including: mental health, aging network, Department of Human Services' adult protective services, law enforcement, Alzheimer's Association chapters, and health care (such as primary care physicians, hospital emergency rooms and inpatient psychiatric units). Expertise on current financing strategies and benefits needs to be included in the Community Team in order to maximize all benefits available to the target population. Partnerships may also include a wide array of local supports, depending on the community and on consumer needs. Examples of partnerships may include clergy, visiting nurses, hospice, local fire personnel, senior center staff and organizational volunteers.

Family teams include both professional and natural supports of each family. It is anticipated that each community team will provide assistance to fifty families over the course of the total project (approximately 29 months).

"Wraparound programs face unique challenges in implementing individualized care in a collaborative, interagency and family-centered approach" because it requires that multiple levels of service delivery systems embrace the process [Community Living Exchange/Rutgers Center for State Health Policy. *Issue Brief: Wraparound Services*, November 2004]. Research literature

and experience of other wraparound initiatives indicate potential obstacles to implementation may include failure by participating agencies to consider and adopt a new philosophy and way of doing business, hidden/set agendas, competing philosophies and turf issues that may arise among agencies that haven't worked closely together before, staff turnover, and inadequate investment in putting families at the center of the assessment and planning process and not facing and dealing directly with conflicting perspectives. These hurdles can be overcome by periodically revisiting the mission of the initiative and value statements; being alert to policies under which each participating system/partner organization had to operate until now; providing adequate training and support of the team facilitator; retraining when staff turnover occurs; and gathering consumer/family satisfaction data. More importantly, when outcomes are achieved one family at a time, stakeholders tend to 'buy-in' because it works more effectively and families can remain together or in a less restrictive community-based alternative.

Levels of Initiative Goals

1. Individual and family consumers:
    a. Participating individuals with dementia will have fewer episodes of distress, continue to live at home, have improved quality of life, and not be discharged prematurely from community support services.
    b. The health and functional status of individuals with dementia and family members will be maintained.
    c. Families will improve their knowledge and capacity to assist people with dementia who are in distress and reduce future occurrences.
    d. The individual with dementia and the family's outcomes will be achieved.
    e. All available benefits will be identified, coordinated, and maximized for each person receiving wraparound services.

2. Community service providers:
    a. Staff will have enhanced knowledge and training about Alzheimer's disease, behavior issues, services and supports needs of consumers, and appropriate interventions to reduce consumer distress.
    b. Community resources will be maximized through increased sharing among community service providers and through awareness of and use of available finances, services and supports available. Collaboration will be developed for increased efficiency and effectiveness in service delivery.
    c. Types of coordination, supports and services needed for wraparound will be identified.
    d. Demonstration that it is in everyone's best interest (all funding parties, service providers, and informal community supports) to work together will be realized.
3. Service system:
    a. Model of best practices for replication will be developed.
    b. A new model will be developed that documents:
    *systems coordination barriers and strategies
    *promising practices
    *types of data, partnerships, services, and supports to help communities intervene
    *materials including survey and evaluation forms helpful in securing useful information
    *types of behavioral symptoms of distress that are most difficult for family members and providers of home and community services to understand, equipped

to address, and likely to result in a crisis response, interruption or termination of current service and living arrangements, and thus behavioral symptoms of individuals most in need of wraparound protocols, services and supports.
*identification of similarities and differences in wraparound model for children and families, and for individuals with dementia and their families.

c. Strategy for sustained practice that attends to programmatic and fiscal needs.
d. Opportunity to gather data to measure change and systems enhancements, as well as program cost comparisons.
e. Identification of the types of coordination, partnerships, supports and services required among multiple systems to help a high-risk group of people with dementia remain in the community, preserve health of family caregivers, and develop a unified strategy across systems that incorporates the most efficient use of resources and mechanisms for coordination.

Learning derived from implementing this model of organizing services and supports with people with dementia and their families will help MDCH identify universal elements of wraparound that can be applied to other vulnerable groups and incorporated into our service system. Whereas wraparound places individuals and families at the center of assessment and planning, this project component will also provide further understanding about key elements of consumer direction and family support that can be reviewed in relation to other current systems change initiatives such as the Independence Plus and Cash and Counseling Projects and National Family Caregiver Support Program.

VI. PROJECT MANAGEMENT

The MDCH is the state department responsible for the planning, financing and administration of public health, mental health, substance abuse services and the Medicaid-supported medical services program. MDCH's Mental Health & Substance Abuse (MH&SA) Administration will direct the new ADDGS Wraparound Initiative. MH&SA staff will manage contracts with the two funded lead agencies, provide training and technical support to local teams that implement wraparound services and supports, conduct periodic site visits for the purpose of support and consultation, and will analyze and report on data collected by local implementation teams to evaluate the quality of wraparound services and supports. Lead agencies will engage in activities that result in products outlined in Sections V: Expected Outcomes and Benefits, and will comply with Section VIII: Grantee Requirements. MH&SA staff will provide progress reports to the AoA and the Michigan Dementia Coalition, and will coordinate dissemination of Initiative results.

MDCH Division of Mental Health Services to Children and Families Wraparound consultants will provide technical assistance and training. A Wraparound Project Team is providing assistance in RFP development, proposal review, data collection development and review, progress review, and technical assistance to pilot teams. Project Team members represent administrations of Public Health, Mental Health, Department of Human Services, Medical Services Administration, and the Office of Services to the Aging (OSA). Michigan Dementia Coalition representatives participated in developing the AoA grant application and will serve as the state level advisory body for the overall project.

VII. EVALUATION

The MDCH Division of Mental Health Services for Children and Families has developed an evaluation protocol and quality assurance tools for wraparound initiatives that will be reviewed by a Wraparound Project Team subcommittee and MH&SA staff for further adaptation and use by agencies involved in the ADDGS project. Baseline and follow-up evaluations will be conducted for each family. Lead agencies are also required to maintain records sufficient to identify activities and supports provided to families and specific outcomes attained by each consumer.

VIII. GRANTEE REQUIREMENTS

1. Delivery of signed agreement with MDCH following funding award, within time frame designated by MDCH.
2. Development of wraparound model structure and collaborative partnerships for the target population, in accordance with the outline of responsibilities listed in Communiques, *Attachment D.*
3. A Community Team is developed by the lead agency in collaboration with the Community Collaborative.
4. Subcontract for the delivery of services identified in the Wraparound process.
5. Timely collection of data as stipulated by MDCH staff. Specific data to be collected and survey and evaluation forms will be included in the agreements between MDCH and grantee organizations.
6. Training and Consultation: Members of the two developed community teams will be required to participate in an MDCH-sponsored Wraparound Orientation Program as well as training and clinical case consultation on disease attributes, behavioral triggers, and interventions. Wraparound Supports facilitators will be required to attend a three-day training program. Lead agencies will identify areas of training needed to implement and sustain the wraparound process.
7. Submission of quarterly Financial Status Reports (FSRs) and narrative reports describing activities and accomplishments, problems and strategies, significant findings, and plans for the next report period.
8. Lead agencies must develop a plan for sustainability that maximizes resources and available funding from all existing and available sources (i.e., Medicare, Medicaid, insurances, private, etc.) for the target population. In addition, a set of recommendations and best practices (based on lessons learned, input from community team members, and consumer outcomes) will be summarized during the final project year for a community wraparound program for adults with dementia and their families. Recommendations must relate to financial, structure, and relationship aspects of the program.
9. Representatives of the two community teams will be expected to conduct presentations at statewide conferences sponsored by MDCH and OSA in Year 3 to disseminate information about findings and lessons learned from the ADDGS Initiative.

IX. PROPOSAL REQUIREMENTS

The proposal must be received at the Department of Community Health by **4:00 p.m. on Friday, April 14, 2006**. The proposals must be printed on eight and a half by eleven paper (i.e., no off-size paper, no inserts). Every page, including the face sheets and any attachments, must be numbered consecutively.

Submission may be electronic, mail-delivered, or hand-delivered.

The E-mail address is: cameronm@michigan.gov
Five (5) copies must be provided if mail or hand-delivered.

The mailing address is:
Michigan Department of Community Health
Bureau of Community Mental Health Services
Division of Program Development, Consultation & Contracts
Attention: Marci Cameron
Lewis Cass Building, 5th Floor
320 S. Walnut Street
Lansing, MI 48913

It is important that proposals are reviewed and edited for submission, including proposals drafted by subcontractors intending to perform services. MDCH staff will contact identified staff to resolve any questions regarding proposals. **Please make sure the face sheet contains the appropriate contact information.**

The lead agency must submit:

1. A proposal face sheet (face sheet included in this packet as *Attachment A*).

2. A narrative which addresses all the criteria by which the proposal will be reviewed (see Section XI: "Review Criteria for Proposals Submitted in Response to this Request"). The Project Narrative must provide a clear and concise description of the proposed project. The Project Narrative must include the following components:

   a. Brief Summary/Abstract
   b. Goals and objectives, as they relate to the ADDGS Wraparound Initiative goals.
   c. Proposed Intervention. Concise description of how you plan to address the project problem. Indicate what resources and relationships you plan to make use of and maximize.
   d. Target Populations and Organizations. This section should describe how you plan to involve both consumers and community-based organizations in a meaningful way in the planning and implementation of the proposal project. Identify any unique challenges underserved families may encounter in your community (i.e., low-income, rural/urban, minorities, non-English speaking) and planned means to address these challenges. Also include means of recruiting 50 families to enroll over the course of the project.
   e. Project Management. This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes.
   f. Organizational capability statement. Describe how the lead agency is organized, the nature and scope of its work, and the capabilities it possesses, including its relationship with the Community Collaborative. Include the same points for key partners. Include relevant experience in serving the target population and in collaboration and networking activities.
   g. A budget narrative that explains the budget summary and cost detail. Explain the work of subcontract agencies.

3. A work plan which addresses the full project period of May 15, 2006 through September 30, 2008. Specified goals, objectives and concrete activities that will be achieved. A work plan template is included in *Attachment B*.

4. A budget and a detailed budget description for the total project period (May 15, 2006 through September 30, 2008) and individual budgets for each fiscal year (Year 1: May 15, 2006 through September 30, 2006; Year 2: October 1, 2006 through September 30, 2007; Year 3: October 1, 2007 through September 30, 2008). Current DCH forms 385 and 386 are included in *Attachment C*. Budgets for Year 2 and Year 3 are estimates and provide plans for the duration of the project. Contracts awarded to successful bidders are renewable annually.
Note: Four pairs of Program Budget Summary and Program Budget-Cost Detail are required.

X. USE OF FUNDS

The full project money (ADDGS grant funds and matching, non-federal funds) will be used to develop and coordinate a Community Team of individuals and organizations that can respond to and support family teams. Funds may also be used for training, facilitating, and to provide services that enable individuals with dementia who exhibit acute behavioral symptoms of distress to continue to be engaged in the community. All formal and informal supports and services in the community are identified, utilized, and maximized to respond to the needs (as identified in the wraparound process by family teams) of individuals with dementia and their family caregivers.

This RFP promotes the grant's emphasis on service provision. A minimum of $60,400 must be allocated to direct services each year, which can include facilitation of family support as outlined in *Attachment D*, Communiques No. 9, p. 3, Wraparound Facilitator. Other direct service expenditures can include: home health care, personal care, adult day care, companion services, mental health counseling, short-term care in health facilities, and other respite care.

Funds may NOT be spent on:

a. vehicle purchases
b. construction and/or rehabilitation of buildings
c. basic research (e.g., scientific or medical experiments)

Please contact MDCH staff with questions about appropriate and allowed expenditures (see Section XII: MDCH contact).

XI. REVIEW CRITERIA FOR PROPOSALS SUBMITTED IN RESPONSE TO THIS REQUEST

1. Due Date:
The proposal must be received at the Department of Community Health by **4:00 p.m. on Friday, April 14, 2006.**
Submission may be electronic, mail-delivered, or hand-delivered.
Five (5) copies must be provided if mail or hand-delivered.

2. Organizational Eligibility:
   Community Mental Health Services Program, aging network organization, public health or other community-based service provider as lead agency for the project.

3. Project Narrative Structure:
   The Project Narrative must be double-spaced, on single-sided 8-1/2 x 11" plain white paper with 1" margins on both sides, and font size of not less than 11. The suggested length for the Project Narrative is six to ten pages. The Work Plan Grid and Vitae of key personnel are not counted as part of the Project Narrative. Every page, including the face sheets and any attachments, must be numbered consecutively.

Review Criteria

1. The proposal describes and includes evidence of consumer involvement, collaboration or support in developing, implementing and monitoring the project. Consumers include individuals with possible or probable dementia and family members. **(10 points)**

2. The proposal describes local partnerships that will be used to develop a collaborative, interagency array of wraparound supports and services. Evidence of established collaborations and existing networking structure and activities is shown, along with endorsement by the local Community Collaborative(s). Letters of support are insufficient. Explanation is needed to identify how partnering organizations (i.e., mental health, aging network, Department of Human Services' adult protective services, local law enforcement, Alzheimer's Association chapter, health care, and faith-based organizations) were involved in the development of the proposal and what they will specifically do to contribute to the wraparound process. Recommended is a memorandum of understanding which delineates roles, contributions, and responsibilities of partnering organizations for working with the target population in this project, plus letters of endorsement. Describe how the partners will meet the needs of all life domains (i.e., residence, emotional, behavioral, relationships, spiritual, cultural, recreational, health, safety, and financial). The geographical range of the project is specified. **(25 points)**

3. The proposal demonstrates organizational capacity to carry out the proposal. It includes evidence of project personnel who are knowledgeable about the target population and have prior experience in working with the target population. Position descriptions and/or resumes of key project personnel are included. Examples are provided of other successful projects the applicant agency has carried out to serve the target population and to enhance collaborative, community projects. The proposal and budget demonstrate that sufficient staff resources will be allocated to the project. The wraparound facilitator is identified. The proposal also demonstrates how the organization is positioned to continue the wraparound process once the ADDGS funding is completed. **(20 points)**

4. Identify community providers of adult day care, respite and aging services; health services; coalitions or collaborative groups addressing older adult issues; community collaborative teams for wraparound; and other resources available in the community. **(10 points)**

5. Describe how the lead agency and community team will solve the identified problem (see Sections II and III). Describe the steps that will be taken to identify and recruit families in need. **(10 points)**

6. The proposal identifies and exhibits awareness of service gaps and system barriers in the community. Possible strategies to overcome these are proposed. What are some of the unique challenges that underserved families may encounter in the community (e.g., low income, rural/urban, minorities, non-English speaking) and planned means to address these challenges. **(10 points)**

7. The proposal includes a Project Work Plan that provides clear goal statements, measurable objectives and tasks/action steps. It includes time lines by which specific objectives and activities will be achieved along with identification of the lead person and organization responsible for completing the task. It is consistent with the Project Narrative and Budget. It clearly demonstrates how the project will result in meeting the three levels of Initiative Goals (see Section V). **(10 points)**

8. The proposed budget and budget narrative demonstrate the level of funding requested is reasonable to achieve the proposed outcomes. Proposed costs are aligned with project objectives, personnel needs and other resources required to complete project activities. The budget narrative emphasizes the development of natural supports and existing funding supports or available benefits, as well as informal and community resources. Line item costs are specified and reasonable. Projected ability to provide each year's match is demonstrated. Any subcontract agencies are fully identified. A minimum of $60,400 must be allocated to direct services each year. Funding beyond the $60,400 direct service requirement may be designated to purchase additional services. **(5 points)**

Review and Selection Process

A subcommittee of the Wraparound Project Team will evaluate proposals. These reviewers represent and are experienced in varied administrative domains within the Michigan Department of Community Health. A family caregiver will also be included in the Review Subcommittee. Reviewers will review proposals and will make recommendations, focusing their comments on the criteria identified above. Award decisions will be made by the MDCH Mental Health and Substance Abuse Administration.

Successful applicants will receive a notification, followed by a Grant Agreement with MDCH. Unsuccessful applicants will be notified. Applicants may contact the MDCH contact if there are questions regarding review.

Assistance and clarifications in writing the proposals are available:

a. contact Marci Cameron (contact information below)
b. Information Meeting to be held on Monday, March 6, 1:30-4:30 pm in the Lake Ontario Room of the Michigan Library & Historical Center, 702 W. Kalamazoo Street, Lansing, Michigan 48915.
c. Questions and Answers from the Information Meeting will be posted on the MDCH website.

XII. MDCH CONTACT

Marci Cameron, ADDGS Grant Project Director
Division of Program Development, Consultation & Contracts
Bureau of Community Mental Health Services

Michigan Department of Community Health
Lewis Cass Building, 5th Floor
320 S. Walnut Street
Lansing, MI 48913
517-335-0226
cameronm@michigan.gov

XIII. RESOURCES

1. www.michigan.gov/mdch/0,1607,7-132-2942_15237---,00.html
2. www.dementiacoalition.org
3. www.alz.org

XIV. APPLICATION CHECK LIST

__ Proposal Face Sheet
__ Narrative
__ Project Work Plan for FY '06 – FY '08
__ Four (4) pairs of Budget Forms (MDCH 0385 and 0386)

XV. ATTACHMENTS

A. Proposal Face Sheet
B. DCH Budget Forms: Program Budget Summary (DCH-0385) and Program Budget Cost Detail (DCH-0386)
C. Project Work Plan Template
D. Communiques No. 9 (describing Wraparound Model)
E. Community Collaboratives in the state of Michigan

Alzheimer's Disease Demonstration Grants to States Program
Administration on Aging, U.S. Department of Health and Human Services
State of Michigan: 2005-2008
Administered by the Mental Health and Substance Abuse Administration
of the Michigan Department of Community Health

FUNDING OPPORTUNITY TITLE: **Alzheimer's Disease Demonstration Grants to States (ADDGS): Wraparound Initiative**

PROPOSAL FACE SHEET

1. Applying Agency Name:

2. Agency Address:

3. Specific counties to be served:

4. Name and contact information of the individual(s) at the lead agency to be contacted regarding this application in the event the review panel requests changes that will make the proposal appropriate to recommend for funding. The budget person must have the authority to modify the budget forms. The work plan person must have the authority to modify the work plan.

	NAME	TITLE	TELEPHONE NO.	EMAIL ADDRESS
Budget				
Work Plan				

Agency Director Printed Name: _____

Agency Director Signature: _____

Date: _____

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM			DATE PREPARED	Page	Of
CONTRACTOR NAME			BUDGET PERIOD From: To:		
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT ▶	AMENDMENT #	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER		

EXPENDITURE CATEGORY				TOTAL BUDGET (Use Whole Dollars)
1. SALARIES & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	$0	$0	$0	$0
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**

SOURCE OF FUNDS

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**$0**	**$0**	**$0**	**$0**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385(E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-110

ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page Of

PROGRAM	BUDGET PERIOD From:	To:	DATE PREPARED
CONTRACTOR	BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT		AMENDMENT #

1. SALARY & WAGES POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
			$0
			$0
			$0
			$0
			$0
			$0
			$0
	1. TOTAL SALARIES & WAGES:	0	$ 0

2. FRINGE BENEFITS (Specify)

☐FICA ☐LIFE INS. ☐DENTAL INS COMPOSITE RATE
☐UNEMPLOY INS. ☐VISION INS. ☐WORK COMP AMOUNT 0.00%
☐RETIREMENT ☐HEARING INS.
☐HOSPITAL INS. ☐OTHER (specify) _____ 2. TOTAL FRINGE BENEFITS: $0

3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $0

4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $0

5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Name Address Amount

5. TOTAL CONTRACTUAL: $0

6. EQUIPMENT (Specify items)

6. TOTAL EQUIPMENT: $0

7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

7. TOTAL OTHER: $0

8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)	8. TOTAL DIRECT EXPENDITURES:	$ 0
9. INDIRECT COST CALCULATIONS	**Rate #1: Base $0 X Rate 0.0000 % Total**	$ 0
	Rate #2: Base $0 X Rate 0.0000 % Total	$ 0
	9. TOTAL INDIRECT EXPENDITURES:	$ 0
10. TOTAL EXPENDITURES (Sum of lines 8-9)		$ 0

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0386 (E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-11 **Use Additional Sheets as Needed**

Project Work Plan

Attachment C

Goal:			
Measurable Outcome(s):			
Major Objectives	**Key Tasks**	**Lead Person**	**Timeframe (Start and End Date by Month) Year 1**
1.			
2.			

Project Work Plan

Major Objectives	Key Tasks	Lead Person	Timeframe (Start and End Date by Month)											
			1	2	3	4	5	6	7	8	9	10	11	12
3.														
4.														

Project Work Plan

Major Objectives	Key Tasks	Lead Person	Timeframe (Start and End Date by Month)											
			1	2	3	4	5	6	7	8	9	10	11	12
5.														
6.														

NOTE: Please do not infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.

Communiqués

Promoting Collaboration Across the Human Service System

Communiqués—No. 9 November 2005

THE COMMUNITY COLLABORATIVE, THE COMMUNITY TEAM AND WRAPAROUND

The wraparound process is an individualized, needs-driven, strengths based process for children and families with multiple needs. This process has resulted in significantly improved outcomes for children and their families. Because the wraparound process involves interagency collaboration, it should be overseen by the Community Collaborative and the Community Team.

Please Note: This Communiqué is an update of the Advisory #9 that was previously distributed (1997).

Wraparound Services are based on the following **best practice values**:

- Child Well-Being
- Family-Focused
- Safety
- Individualized
- Cultural Competency
- Direct Practice and System Persistence
- Community-Based
- Strength-Based
- Parent/Professional Partnerships
- Collaboration and Community Support
- Social Networks and Informal Supports
- Outcome Based
- Cost Effective and Cost Responsible

To facilitate wraparound services in the community, the **Community Collaborative** needs to:

1. Recognize that community agencies must share their resources in order to support children and families.
2. Sponsor the wraparound process.
3. Establish the Community Team.
4. Set goals, objectives and outcomes for the Community Team who manages the wraparound process.
5. Facilitate participation of agency staff in the wraparound process and prioritize their involvement on child and family teams.
6. Commit to the availability and management of funding and/or other resources to facilitate the Wraparound process in their community (i.e. staff participation on Child and Family Teams).
7. Receive reports from the Community Team and monitor progress and outcomes.
8. Promote training/education in the wraparound philosophy and approach, for all staff serving children and families

THE WRAPAROUND PROCESS

Fundamental Elements of the Wraparound Process discussed in this *Communiqué* include: 1) the philosophy of Unconditional Commitment; 2) an infrastructure which includes: a) the Community Team, b) the Wraparound Facilitator and c) Child and Family Teams; and 3) the processes of: a) Strengths Assessment, and b) Life Domains Needs Planning. These elements, outlined below, are the building blocks of the Wraparound Process. They are needed to insure inter-organizational collaboration in the provision of quality, family-centered, needs-driven, strength-based and individualized services/supports to children and their families.

1. PHILOSOPHY

A. UNCONDITIONAL COMMITMENT (Direct Practice and System Persistence)

Unconditional Commitment means, "Never give up". The Child and Family Team and the agency staff providing services must make a commitment to Unconditional Care. When things do not go well, or the needs of the child and family change, the child and family are not dropped from service. Rather, the services and supports are changed.

2. INFRASTRUCTURE

A. THE COMMUNITY TEAM (CT)

Membership of the Community Team:

- **Administrators and mid-managers** of public agencies providing services (Department of Human Services (DHS), Community Mental Health, Public Health, Schools, Probate/Family Court);
- **Parents/youth** who have experienced services; and
- **Community members** (may include private non-profit administrators, local business people, faith-based, family/friends of families and other community leaders with an interest in children and families).

Functions of the Community Team

- **Targeting and setting priorities**: The Community Team (CT) determines which population(s) of children/adolescents receives priority for services, taking into consideration resources and the needs of stakeholders. In most communities, children at high risk of out-of-home placement are targeted.
- **Gate-keeping**: The CT determines: 1) the information to be submitted by the referring party, and 2) the decision-making process and timetable for review/ approval. The CT accepts, reviews, and approves referrals.
- **Committing resources**: The CT identifies funding including flexible funds to serve the targeted populations to develop and provide individualized services. For each family, the CT determines who will provide resource coordination to facilitate wraparound services. The CT keeps track of the extent and use of resources and ensures that funds are expended according to the requirements of the fund source (i.e. Medicaid, various DHS funds, county/local funds, etc.). The CT reports to the Community Collaborative on the expenditures and outcomes. The CT members prioritize staff to participate on child and family teams.

- **Plan and budget review and approval**: For each family, the CT reviews a wraparound plan developed by the Child and Family Team. The CT reviews the plan for completeness (strengths, needs, strategies, funding, cost of services, outcomes) and the inclusion of crisis/safety plans. If the CT does not approve the plan, it is returned to the Child and Family Team for revision.
- **Performance monitoring**: The CT develops and implements a system to identify and measure outcomes that includes regularly scheduled data collection, analysis, review and utilization for informed decision making.
- **Training/Support**: The CT develops an on-going training plan for parents, agency staff and community members involved in the wraparound process. The training addresses the fundamental elements of the wraparound process and family-centered approaches/partnering with families. The training plan includes development of local coaches to mentor new facilitators, team members and service providers in the wraparound process. The CT supports the Wraparound Facilitators by troubleshooting barriers in the development and implementation of individualized plans.

B. WRAPAROUND FACILITATOR

The Wraparound Facilitator facilitates the wraparound process for children and their families. The Wraparound Facilitator is key in facilitating the planning and delivery of individualized services/supports.

Functions include, but are not limited to:

- Inspires a strong non-judgmental, family-centered approach
- Sets the stage for Unconditional Commitment
- Receives accepted referrals from the CT
- Contacts the family. Facilitates a Strengths Assessment process *(See #4 below)* at the initial meeting with the family or at the first meeting of the Child and Family Team
- Configures a Child and Family Team with each family
- Facilitates the meetings of the Child and Family Team. Makes adjustments for the culture and comfort level of the individual team members
- Assists the Child and Family Team in developing an individualized service and support wraparound plan, which is culturally relevant and includes crisis and safety plans.
- Submits wraparound plans to the CT for review and approval
- Identifies existing categorical services and makes recommendations regarding their usefulness, given the needs of the child and family
- Creates, and facilitates the implementation of, services/supports which do not presently exist
- Facilitates the development of transition strategies
- Advocates for the child and family
- Assesses training needs and arranges training of key individuals
- Manages individual wraparound budget plans and expenditures; works with fiscal staff
- Monitors the provision of services and supports
- Provides data so that the CT and the Community Collaborative can monitor outcomes of wraparound plans and expenditures

C. CHILD AND FAMILY TEAM

Membership: Includes those persons most familiar with the child/family plus service providers and community members. The majority of team members are the parents plus family members, friends and neighbors selected by the family.

Functions

- Participates in the Strengths and Culture Discovery
- Develops a wraparound plan that is family-centered
- Develops crisis and safety plans
- Works to support the implementation of the wraparound plan
- Accesses informal and formal support/resources
- Monitors services/supports for effectiveness
- Evaluates on a regular basis the individual/family outcomes identified by the wraparound plan
- Commits to Unconditional Commitment
- Revises plan based on changing needs, newly identified or developed strengths and/or on the result of an outcomes review
- Makes provisions for long term support of the family after formal services are completed

3. PROCESSES

A. STRENGTHS/CULTURE DISCOVERY

The Strengths/Culture Discovery process identifies the assets of the family, assists the members of the Child and Family Team to obtain a balanced picture of the family and of other Team members and begins the joining process between the family and the Team. The Strengths/Culture Discovery process is built on the identified strengths and culture of the child and family.

The Strengths/Culture Discovery

- ✓ Should consider cultural differences in approaching families
- ✓ Should identify the personal assets (values/attitudes, preferences, traditions/daily rituals, skills/abilities, interests, attributes/features), and resources of the individual, family and Team member
- ✓ Should focus on the child, other family members and family as a whole across all life domains
- ✓ Sets the stage for a holistic planning process

B. LIFE DOMAIN PLANNING

Each child and family team ensures that the plan is **family-driven, not agency driven** and that it:

- Includes **planning across all life domains** (emotional/psychological/behavioral, health, education/vocational, financial, crisis, safety, residence, social, recreational, and other life domains, as determined by the Child and Family Team)
- Is always a **blend of formal and informal resources**

- Has **strategies based on strengths, focused on need, and which is individualized, and community-based**
- Includes a **Crisis Plan** that is intended to help prevent a crisis and also to deal with the crisis when it occurs. "Crisis" is defined by the child, the family and/or the Child and Family Team. The Crisis Plan should include the availability of around-the-clock response (24 hours per day, 7 days per week)
- Has a **Safety Plan** that is intended to insure the safety of the children or family members in the home and should provide for round-the-clock response in the community (24 hours per day, 7 days per week)

IF YOU HAVE QUESTIONS REGARDING WRAPAROUND SERVICES or training available for Community Teams, Agency staff and Wraparound Facilitators, please contact Connie Conklin, Department of Community Health at (517) 241-5765 or conklinc@michigan.gov or Cheryl Henry, Department of Human Services at (517) 241-7358 or henryc@michigan.gov

IF YOU NEED GENERAL INFORMATION on Community Collaboratives, go to the Web site at: www.michigan.gov/mdch, click on Community Collaboratives on the right hand side of the page.

COMMUNITY COLLABORATIVES IN MICHIGAN

Community Collaborative	County Represented	Collaborative Coordinator/ Contact Person	Other Coordinator	Other Contact Person	Attachment E Chairperson
Alcona County Human Services Council	**Alcona**	Mary Kreft, Coordinator 1250 N. US-23 East Tawas, MI 48730-9440			Doug Ellinger, Sheriff Alcona County Sheriff 214 W. Main Street Harrisville, MI 48740
	PHONE (and PHONE EXTENSION)	(989) 362-2835			(989) 724-6271
	FAX				
	EMAIL	loscoSFSC@aol.com			Ellinger@alcona-county.net
Alger County Family Coordinating Council	**Alger**	Jayne Letts Strong Families/Safe Children 101 Pioneer Avenue Negaunee, MI 49866			Debra Fulcher 413 Elm St. Munising, MI 49862
	PHONE (and PHONE EXTENSION)	(906) 387-1711			(906) 387-5636
	FAX				
	EMAIL	jletts@chartermi.net			algerparksrecdept@yahoo.com
Allegan County Multi-Agency Collaborative Council	**Allegan**	Cathy Burton Snell (Contact Person) Allegan County ISD 310 Thomas Street Allegan, MI 49101	Sally Beyer SF/SC Coordinator Allegan County CMH 3285 – 122nd Avenue P. O. Drawer 130 Allegan, MI 49010		Jon Campbell 1639 Elm St. Otsego, MI 49078
	PHONE (and PHONE EXTENSION)	(269) 673-3121	(269) 673-6617 x4856		(269) 694-4632
	FAX	(269) 686-0327	(269) 686-9613		(269) 694-2404
	EMAIL	cburtonsnell@alleganisd.org	sbeyer@accmhs.org		Jcampbell@allegancounty.org
Alpena County Human Services Coordinating Council	**Alpena**	Pamela Lloyd-Gorski HSCC Coordinator 746 S. State Street Alpena, MI 49707		Doug McCombs Alpena County DHS 711 W. Chisholm Street Alpena, MI 49707	Carlene Przykucki Executive Director Northeast Michigan Community Partnership, Inc 3022 US 23 S Alpena, MI 49707
	PHONE (and PHONE EXTENSION)	(989) 354-9104		(989) 354-7227	(989) 356-2880
	FAX	(989) 354-3823		(989) 354-7242	(989) 354-6939
	EMAIL	pamlg@i2k.com		McCombs@michigan.gov	nemcpi@deepnet.net
Antrim County Human Services Director's Council	**Antrim**	Gary Knapp Mancelona Family Res. Ctr 205 Grove Street Mancelona, MI 49659			Bill Hefferan Antrim County Family Court PO Box 130 Bellaire, MI 49615
	PHONE (and PHONE EXTENSION)	(231) 587-5085			
	FAX	(231) 587-5313			

COMMUNITY COLLABORATIVES IN MICHIGAN

	EMAIL	garyknappcrd@hotmail.com			wmhh@voyager.net
Arenac County Resource Council	**Arenac**	Maureen Liden Arenac County MPCB/SFSC Coordinator 3709 Deep River Rd. Standish, MI 48658			Marc A. Lauria Cory Place Inc. 581 N. Scheurmann Bay City, MI 48706
	PHONE (and PHONE EXTENSION)	(989) 846-5512			(989) 895-5563
	FAX	(989) 846-4365			(989) 895-7312
	EMAIL	lidenm@michigan.gov			monkeebiz@hotmail.com
Barry Community Resource Network	**Barry**	Lyn Briel, Contact Person Thornapple Manor 2700 Nashville Hwy. Hastings, MI 49058		Jennifer Richards, Co-Chair Barry Community Foundation 629 W. State Street, Suite 201 Hastings, MI 49058	Lyn Briel, Co-Chair Thornapple Manor 2700 Nashville Hwy. Hastings, MI 49058
	PHONE (and PHONE EXTENSION)	(269) 838-8161 (cell) (269) 945-2407, x166		(269) 945-0526	(269) 838-8161 (cell) (269) 945-2407, x166
	FAX			(269) 945-0826	
	EMAIL	lynbriel@yahoo.com		jen@barrycf.org	lynbriel@yahoo.com
Bay Area Human Services Collaborative Council	**Bay**	Kari Gulvas HSCC Coordinator Bay Arenac Behavioral Health 306 Fifth Street, 3rd Floor Bay City, MI 48708	Ellen Albrecht Bay-Arenac Behavioral Health 201 Mulholland Bay City, MI 48708	Mike Dewey, Vice Chair Bay-Arenac ISD 4228 Two Mile Rd. Bay City, MI 48706	Scott Gilman, Chair Riverhaven Substance Abuse Coordinating Agency 306 Fifth St.- 3rd. Floor Bay City, MI 48708
	PHONE (and PHONE EXTENSION)	(989) 895-2246	(989) 895-2300	(989) 667-3273	(989) 895-2300
	FAX	(989) 895-2770	(989) 895-2390	(989)667-3286	(989) 895-2770
http://www.bahscc.org	**EMAIL**	kgulvas@babha.org	ealbrecht@babha.org	deweym@baisd.net	sgilman@babha.org
Benzie Human Services Collaborating Body	**Benzie**	Tad Peacock, Coordinator Benzie HSCB 6051 Frankfort Hwy Benzonia, MI 49616			Ray Kadlek, Chair Commission on Aging Board P.O. Box 8 Thompsonville, MI 49683
	PHONE (and PHONE EXTENSION)	(231) 882-2123			(231) 378-2619
	FAX	(231) 882-2204			(231) rayjean@coslink.net
	EMAIL	peacockf@msu.edu			
Berrien County Human Services Council	**Berrien**				Art Fenrick Southwest Michigan Community Action Agency 185 East Main, Suite 20 Benton Harbor, MI 49022
	PHONE (and PHONE EXTENSION)				

COMMUNITY COLLABORATIVES IN MICHIGAN

	FAX				
	EMAIL				afenrick@smcaa.com
Branch County Family Services Network	**Branch**	Jennifer Rodgers FSN Coordinator for Branch Co. 200 Orleans Boulevard Coldwater MI 49036			Tim Hart Q-1 Video 62 Division P. O. Box 620 Coldwater, MI 49036
	PHONE (and PHONE EXTENSION)	(517) 278-2129			(517) 279-8752
	FAX				
http://www.familyservicesnetwork.com	**EMAIL**	jrodgers@pinesbhs.org			tim@q1video.com
The Coordinating Council of Calhoun County	**Calhoun**	Anji Phillips TCC Director & SF/SC Coordinator 9 West Suttons Ridge Battle Creek, MI 49014	Christine Reed TCC Operations Manager TCC of Calhoun County 140 Michigan Avenue Battle Creek, MI 49017		A.J. Jones, N. D., Chair President/CEO Family Health Center 181 W. Emmett Street Battle Creek, MI 49017
	PHONE (and PHONE EXTENSION)	(269) 420-3215	(269) 441-5904		(269) 966-2600
	FAX	(269) 441-6015	(269) 441-6015		(269) 965-4773
http://www.tcccalhoun.org	**EMAIL**	AKP@summitpointe.org	cyr@summitpointe.org		ajjones@fhcbc.org
Cass County Human Services Coordinating Council	**Cass**	Ruth Andrews Prevention Coordinator Cass County Human Services Coordinating Council Woodlands BHN 960 M-60 East Cassopolis MI 49031		Robert Habicht Vice Chair Michigan Gateway Community Foundation P. O. Box 351 Buchanan, MI 49107	Lloyd Hamilton Child and Family Services Lewis Cass ISD 61682 Dailey Road Cassopolis, MI 49031
	PHONE (and PHONE EXTENSION)	(269) 445-5019		(269) 695-3521	(269) 445-6201
	FAX	(269) 445-3216		(269) 695-4250	
	EMAIL	ruthand@woodlandsbhn.org		rhabicht@mgcf.org	
Cheboygan County Human Services Coordinating Body	**Cheboygan**	Peter Amar, Prevention Coordinator Fox Farm Consulting Services P.O. Box 95 Johannesburg, MI 49751			Julie Sproul Cheboygan DHS 827 S. Huron Cheboygan, MI 49721
	PHONE (and PHONE EXTENSION)	(989) 731-5295			(231) 627-8511
	FAX	(989) 731-5295			(231) 627-8546
	EMAIL	peteamar@foxfarmconsulting.com			Sproulj@michigan.gov

COMMUNITY COLLABORATIVES IN MICHIGAN

Chippewa County	**Chippewa**	Geraldine Stelmaszek EUP Community Dispute Resolution Center P.O. Box 505 Sault Ste. Marie, MI 49783		Becky Davis EUP ISD P.O. Box 883 Sault Ste. Marie, MI 49783
	PHONE (and PHONE EXTENSION)	(906) 632-5467		(906) 632-3373
	FAX	(906) 632-5471		(906) 632-1125
	EMAIL	stelmaszekg@michigan.gov		bdavis@eup.k12.mi.us
Clare County Human Services Coordinating Body	**Clare**	Melissa DeRoche Strong Families/Safe Children Coordinator Central Michigan District Health Department 225 West Main P. O. Box 237 Harrison, MI 48625		Joe Phillips Clare County Juvenile Probation/ Family Court Clare County Building 225 West Main, P.O. Box 96 Harrison, MI 48625
	PHONE (and PHONE EXTENSION)	(989) 773-5921, x133		(989) 539-7887
	FAX	(989) 773-4319		(989) 539-7229
	EMAIL	mderoche@cmdhd.org		joe44phillips@hotmail.com
Clinton County Building Stronger Community Council	**Clinton**	Debby Kloosterman 13109 Schavey Road, Suite#4 DeWitt, MI 48820	Chris McDaniel Clinton Cty. Counseling 1000 E. Sturgis Suite 3 St. Johns, MI 48879	Jan Baszler Clinton/Gratiot DHS 201 W. Railroad Street St. Johns, MI 48879
	PHONE (and PHONE EXTENSION)	(517) 668-0185	(989) 224-5300	(989) 224-5502
	FAX	(517) 668-0446	(989) 224-2342	(989) 224-8717
	EMAIL	Klooster@edzone.net	mcdaniec@ceicmh.org	Baszlerj@michigan.gov
Copper Country Human Services Coordinating Body	**Baraga, Houghton, Keweenaw**	Dave Mayo-Kiely Copper Country HSCB 326 Shelden Ave., Suite 2 Houghton, MI 49931		Rebecca A. Malette UPCAP 1100 Century Way Houghton, MI 49931-2712
	PHONE (and PHONE EXTENSION)	(906) 483-4722		(906) 482-0982
	FAX	(906) 483-4972		(906) 482-1385
	EMAIL	hscbcoord@chartermi.net		maletter@chartermi.net
Crawford County Collaborative Body	**Crawford**	Cynthia Timmons, Collaborative and SF/SC Coordinator P. O. Box 834 Grayling, MI 49738	Linda Cronk, Vice Chair MSU Extension 200 Michigan Ave. Grayling, MI 49738	Cynthia Pushman, Director Otsego-Crawford DHS 800 Livingston Blvd., Suite 3A Gaylord, MI 49735
	PHONE (and PHONE EXTENSION)	(989) 344-9335		(989) 731-3108
	FAX	(989) 344-1815		
	EMAIL	cindy.timmons@hotmail.com	cronkl@msu.edu	pushmanc@michigan.gov

COMMUNITY COLLABORATIVES IN MICHIGAN

Delta County Family Community Collaborative	**Delta**	Deb Doyle Strong Families/Safe Children Coordinator C/O Six County Employment Alliance 2950 College Ave. Escanaba, MI 49829		Rich Miketinac Delta/ Menominee DHS 2940 College Ave. Escanaba, MI 49829	Barb Chenier, AODS Public Health Delta/Menominee 2920 College Avenue Escanaba, MI 49829
	PHONE (and PHONE EXTENSION)	(906) 789-0558 x 219		(906) 786-5394	(906) 786-9639
	FAX	(906) 789-9952			
	EMAIL	ddoyle@jobforce.org		Miketinacr@michigan.gov	BChenier@phdm.org
Dickinson County Collaborative Body	**Dickinson**	Bill Reid, Prevention Coordinator Northpointe Behavioral Healthcare Systems 715 Pyle Drive Kingsford, MI 49802		Bob Roberge, Director Dickinson/Iron Co DHS 1238 S Carpenter Ave Iron Mountain, MI 49801	Richard Thoune, Health Officer Dickinson-Iron District Health Dept. 818 Pyle Drive Kingsford, MI 49802
	PHONE (and PHONE EXTENSION)	(906) 779-0637		(906) 779-4150	(906) 779-7206
	FAX	(906) 779-0645		(906) 774-2775	(906) 774-9910
	EMAIL	breid@nbhs.org		roberger@michigan.gov	rthoune@hline.org
Eaton County Human Services Collaborative Council	**Eaton**	Joni L. Risner (Contact Person) Eaton County United Way P. O. Box 14 111 W. First Charlotte, MI 48813	Ronda Rucker Strong Families/Safe Children Coordinator 1050 Independence Blvd. Charlotte, MI 48813		Robert W. Johnson 1504 Millerburg Charlotte, MI 48813
	PHONE (and PHONE EXTENSION)	(517) 543-5402	(517) 543-2536		(517) 543-2453
	FAX	(517) 543-5651	(517) 543-2125		(517) 543-0857
	EMAIL	joni@ecuw.org	Ruckerr2@michigan.gov		
Emmet and Charlevoix Counties Human Services Coordinating Body	**Emmet, Charlevoix**	Lorraine Manary One MacDonald Drive, Ste. B Petosky, MI 49770			Terrance Newton Harbor Hall, Inc. 704 Emmet Street Petoskey, MI 49770
	PHONE (and PHONE EXTENSION)	(231) 347-6701, ext HSCB (4722) - V M-only (231) 582-9863 (Cell)			(231) 347-5511
	FAX	(231) 347-4370			(231) 347-5422
	EMAIL	lmanary@charter.net			tnewt@freeway.net
Genesee County Partnership for Families	**Genesee**	Ramona Mems, Coordinator Strong Families/Safe Children 801 Tuuri Place, Suite 232 Flint, MI 48503		Libby Richards Mott Children's Health Center 806 Tuuri Place Flint, MI 48503	Denise Chambers, Director Genesee County DHS 125 E. Union Flint, MI 48502
	PHONE (and PHONE EXTENSION)	(810) 341-6775; (810) 240-2744		(810) 767-5750	(810) 760-2645

	FAX	(810) 341-6779	(810) 768-7511	(810) 760-2984
	EMAIL	Ramona.Mems@earthlink.net	Richards@mottchc.org	chambersd@michigan.gov
Gladwin County Human Services Coordinating Body	**Gladwin**	Kara Pahl 655 East Cedar Gladwin, MI 48624		John Shaffer EMS 701 East Cedar Gladwin, MI 48624
	PHONE (and PHONE EXTENSION)	(989) 426-9295		(989) 426-9305
	FAX	(989) 426-2251		(866) 426-2241
http://www.gladwinonline.com	**EMAIL**	kmolski@cmhcm.org		shafferj@mindnet.org
Gogebic and Ontonagon Human Services Coordinating Body	**Gogebic and Ontonagon**	Betsy Wesselhoft Prevention Coordinator Gogebic County CMH 103 West US 2 Wakefield, MI 49968		David Hartberg Grand View Health System Grand View Lane Ironwood, MI 49938
	PHONE (and PHONE EXTENSION)	(906) 229-6104		(906) 932-2525
	FAX	(906) 229-6190		(906)
	EMAIL	wesselb@gccmh.org		dhartberg@gvhs.org
Grand Traverse Community Collaborative	**Grand Traverse**	Barbara Lemcool Grand Traverse Community Collaborative 701 S. Elmwood, Ste 19 Traverse City, MI 49684		Pam Ward Child Care Connections (formerly 4C) 720 S. Elmwood, Suite 4 Traverse City, MI 49684
	PHONE (and PHONE EXTENSION)	(231) 929-0174		(231) 941-7767
	FAX	(231) 941-0037		(231) 941-9412
	EMAIL	lemcoolb@michigan.gov		pamw@nwmi4c.org
Gratiot County Collaborative Council	**Gratiot**	Jen Arnold-Woodman, MSW Gratiot Collaborative Council Coordinator Gratiot-Isabella RESD 1131 E. Center Street Ithaca, MI 48847	Anne Lambrecht, Director Big Brothers Big Sisters of Gratiot and Montcalm Counties 227 East Superior Street Alma, MI 48801	Donna Kriss, Adoption Recruiter Department of Human Services 210 Commerce Dr. Ithaca, MI 48847
	PHONE (and PHONE EXTENSION)	(989) 875-5101 ext 246	(989) 463-3434	(989) 875-8232
	FAX		(989(463-5399	(989) 875-2811
http://www.geocities.com/gratiotcc	**EMAIL**	jwoodman@edzone.net	anne@bbbsgm.org	Krissd2@michigan.gov
Hillsdale County Human Services Network	**Hillsdale**	Christina Ludeker HCISD 310 West Bacon Street Hillsdale, MI 49242		Robert Henthorne, Supt. Hillsdale Co. ISD 310 West Bacon Street Hillsdale, MI 49242
	PHONE (and PHONE EXTENSION)	(517) 437-0990 x 139		(517) 437-0990 x 110
	FAX	(517) 439-4388		(517) 439-4388

		EMAIL	cludeker@hillsdale-isd.org		rhenthorne@hillsdale-isd.org
Huron County Human Services Coordinating Body	**Huron**		Kathie Harrison Huron Behavioral Health 1108 S. Van Dyke Bad Axe, MI 48413		Carl Osentoski HEDC 250 E. Huron Avenue Bad Axe, MI 48413
		PHONE (and PHONE EXTENSION)	(989) 269-9293		
		FAX	(989) 269-7544		
		EMAIL	kathie@huroncmh.org		carl@huroncounty.com
The Power of We Consortium	**Ingham**		Ron Uken Ingham County Health Department 5303 S. Cedar St., Lansing, MI 48911	Mike Brown, President Capital Area United Way 1111 Michigan Avenue--Suite 300 East Lansing, MI 48823	John Melcher, Co-Chair Associate Director, Community and Economic Development Program Michigan State University 1801 W. Main Street Lansing, MI 48915
		PHONE (and PHONE EXTENSION)	(517) 887-4558	517 203-5000	(517) 353-9555
		FAX	(517) 346-8011		(517) 484-0068
	http://www.cacvoices.org/hsac	**EMAIL**	ruken@ingham.org	m.brown@capitalareaunitedway.org	melcher@msu.edu
Ionia County Child, Family, and Community Council	**Ionia**		Krista Hausermann Project Coordinator ICCFCC 2191 Harwood Road Ionia, MI 48846	Lynette Seiler, Vice Chair Ionia County Comission on Aging 115 Hudson Street Ionia, MI 48846	Mark Howe Ionia Co. Administrator Ionia County Courthouse Ionia, MI 48836
		PHONE (and PHONE EXTENSION)	(616) 522-1408	(616) 527-5365	(616) 527-5300
		FAX	(616) 522-0830	(616) 527-5955	(616) 527-5380
		EMAIL	khauserm@ionia-isd.k12.mi.us	lseiler@ioniacounty.org	mhowe@ioniacounty.org
Iosco County Human Services Coordinating Council	**Iosco**		Mary Kreft, Coordinator 1250 N. US-23 East Tawas, MI 48730-9440		Mike Peach Volunteer Services Coordinator Iosco County DHS 2145 E. Huron Road East Tawas. MI 48730
		PHONE (and PHONE EXTENSION)	(989) 362-2835		(989) 362-0339
		FAX			(989) 362-0537
		EMAIL	loscoSFSC@aol.com		peachm@michigan.ogv
Iron County Collaborative Board	**Iron**		Bill Reid The same address, phone, fax, and email is used for Dickinson County.	Sandie Langdon Strong Families/Safe Children Coordinator	Tim Peruzzi, Superintendent West Iron Schools 601 Garfield Iron River, MI 49935
		PHONE (and PHONE EXTENSION)			(906) 265-9218
		FAX			(906) 265-9736

	EMAIL	slangdon@up.net		tperuzzi@up.net
Isabella County Community Collaborative	**Isabella**	Marilyn Thornton, Contact Person Program Director CMH for Central MI 301 S. Crapo Mt. Pleasant, MI 48858		Dee Obrecht Child and Family Enrichment Council 3333 South Lincoln Road Mt. Pleasant, MI 48858
	PHONE (and PHONE EXTENSION)	(989) 772-5930 x 1283		(989) 773-6444
	FAX			
http://www.mpce.org/IsabellaHHSCC	**EMAIL**	mthornton@cmhcm.org		cafedee@hotmail.com
Jackson County's Human Services Coordinating Alliance	**Jackson**	Valerie Herr HSCA Coordinator 1100 Clinton Rd., Suite 215 Jackson, MI 49202		Judith Jove, HSCA Chair 330 W. Michigan Avenue P.O. Box 6128 Jackson, MI 49204
	PHONE (and PHONE EXTENSION)	(517) 796-4750		(517) 787-7920
	FAX	(517) 796-5981		
	EMAIL	val@jacksonnonprofit.org		jove@strong-families.org
Kalamazoo County Multi-Purpose Collaborative Body (KCMPCB)	**Kalamazoo**	Janet M. Jones, Collaboration Coordinator Greater Kalamazoo United Way 709 South Westnedge Ave. Kalamazoo, MI 49007-5099	Sherry Thomas-Cloud, Director DHS 322 E. Stockbriege Kalamazoo, MI 49001	Janice M. Brown, Superintendent Kalamazoo Public Schools 1220 Howard Street Kalamazoo, MI 49008
	PHONE (and PHONE EXTENSION)	(269) 343-2524 x 221	(269) 337-5000	(269) 337-0100
	FAX	(269) 344-7250	(269) 337-5179	
	EMAIL	jjones@gkuw.org	Thomas-clouds@michigan.gov	brownjm@kalamazoo.k12.mi.us
Community Collaborative of Kalkaska County	**Kalkaska**	Ranae McCauley, Coordinator Community Collaborative of Kalkaska County MSU Extension 605 North Birch Street Kalkaska, MI 49646	49646 Phone FAX email	Sr. Augusta Stratz Health and Healing Ministry PO Box 113 Kalkaska, MI 49646
	PHONE (and PHONE EXTENSION)	(231) 258-3320		(231) 258-5228 Cell (231) 620-0375 213.258.5228
	FAX	(231) 258-4678		
	EMAIL	Mccaul12@msu.edu		astratz@torchlake.com

COMMUNITY COLLABORATIVES IN MICHIGAN

Kent County Family and Children's Coordinating Council	**Kent**	Matthew VanZetten, Office of the Administrator, Kent County Family and Children's Coordinating Council Coordinator, Kent County Administration Bldg 300 Monroe Avenue, N.W. Grand Rapids, MI 49503		Carol Paine-McGovern 2445 Hall St. SE Grand Rapids, MI 49506
	PHONE (and PHONE EXTENSION)	(616) 632-7566		(616) 285-0409
	FAX	(616) 632-7565		(616)
http://www.accesskent.com/kcfccc	**EMAIL**	kcfccc@kentcounty.org matthew.vanzetten@kentcounty.org		painemcgov@aol.com
Lapeer County MPCB	**Lapeer**	Michael J. Rexin Lapeer ISD 1996 West Oregon Lapeer, MI 48446		Jim Chybowski Executive Director of corporate Services—Lapeer Region Mott Community College 550 Lake Drive Lapeer, MI 48446
	PHONE (and PHONE EXTENSION)	(810) 245-3980		(810) 667-4166
	FAX	(810) 664-1011		
	EMAIL	m_rexin@yahoo.com		jchybows@mcc.edu
Leelanau County Family Coordinating Council	**Leelanau**	Bob MacEachran Leelanau County FCC 7401 East Duck Lake Road, Suite 300 Lake Leelanau, MI 49653		Jenifer Murray Benzie Leelanau Health Dept. 7401 East Duck Lake Road Suite 100 Lake Leelanau, MI 49653
	PHONE (and PHONE EXTENSION)	(231) 256-0222		(231) 256-0208
	FAX	(231) 256-0226		(231) 256-0226
	EMAIL	bmaceachran@co.leelanau.mi.us		jmurray@bldhd.org
Lenawee County Multi-Purpose Collaborative Body	**Lenawee**	Gratia L. Karmes Lenawee County CMHSP 1040 South Winter Street Suite 1022 Adrian, MI 49221	Jackie Johnson, Prevention Coordinator Lenawee County CMHSP 1040 South Winter Street, Suite 1022 Adrian, MI 49221	Joe Satterelli, Director Department of Human Services 1040 South Winter Adrian, MI 49221
	PHONE (and PHONE EXTENSION)	(517) 264-0189	(517) 264-0136	(517) 264-6402
	FAX	(517) 265-8237	(517) 265-8237	(517) 264-6357
	EMAIL	gkarmes@lcmha.org	jjohnson@lcmha.org	Satterellij@michigan.gov

COMMUNITY COLLABORATIVES IN MICHIGAN

Livingston County Human Services Collaborative Body	**Livingston**	Alissa Parks Livingston County CMH 2280 East Grand River. Howell, MI 48843	Marilyn Hysen 5115 Brady Road Howell, MI 48843
	PHONE (and PHONE EXTENSION)	(517) 546-4126	(734) 878-6792
	FAX	(517) 546-1300	(734) 878-6792
	EMAIL	aparks@cmhliv.org	Thysen@provide.net
Mackinac County Human Services Collaborative Body	**Mackinac**	Geraldine Stelmaszek EUP Community Dispute Resolution Center P.O. Box 505 Sault Ste. Marie, MI 49783	Terri Bush, Chairperson Mackinac County DHS 199 Ferry Lane St. Ignace, MI 49781
	PHONE (and PHONE EXTENSION)	(906) 632-5467	(906) 643-6109
	FAX	(906) 632-5471	(906) 643-7467
	EMAIL	stelmaszekg@michigan.gov	busht@michigan.gov
Macomb County Human Services Coordinating Body	**Macomb**	Madeline Nantais, Prevention Coordinator Macomb County CMH Services 10 North Main, 5th Floor Mt. Clemens, MI 48043	Donald I. Habkirk, Jr. Macomb County CMH 10 North Main, 5th Floor Mt. Clemens, MI 48043
	PHONE (and PHONE EXTENSION)	(586) 466-7903	(586) 469-5779
	FAX	(586) 469-7958	(586) 469-7674
	EMAIL	madeline.nantais@mccmh.net	don.habkirk@mccmh.net
Manistee Human Services Collaborating Body	**Manistee**	Deb Wright 6021 S. Pere Marquette Hwy. Ludington, MI 49431	Char Myers Manistee ISD Manistee, MI 49660
	PHONE (and PHONE EXTENSION)	(231) 845-6445	(231) 723-6205
	FAX	(231) 843-1083	(231) 723-1520
http://www.muskegonhealth.net/ccc	**EMAIL**	Debwright7@aol.com	cmyers@Manistee.org
Marquette County Family Coordinating Council	**Marquette**	Kelly Zambon Child and Family Services 706 Chippewa Square, Suite 203 Marquette, MI 49855	Jayne Letts Big Brothers/Big Sisters 101 Pioneer Avenue Negaunee, MI 49866
	PHONE (and PHONE EXTENSION)	(906) 228-4050, x113	(906) 387-1711
	FAX	(906) 228-2153	(906)
	EMAIL	kellyzambon@miuplink.com	jletts@chartermi.net
Mecosta County Human Services Coordinating Body	**Mecosta**	David Bair, Strong Families/Safe Children Coordinator 1310 Upton St. Mt. Pleasant, MI 48858	Thomas Hogenson Mecosta County General Hospital 405 Winter Big Rapids, MI 49037
	PHONE (and PHONE EXTENSION)	(989) 330-9644	(231)

COMMUNITY COLLABORATIVES IN MICHIGAN

	FAX				(231)
	EMAIL	dbair4948@hotmail.com			thogenson@mcghhospital.com
Menominee County Collaborative Board	**Menominee**	Bill Reid The same address, phone, fax, and email is used for Dickinson County.			Mary Bradley Menominee County F.I.A. 1301 7th Street Menominee, MI 49858
	PHONE (and PHONE EXTENSION)				(906) 863-7832
	FAX				(906)
	EMAIL				bradcrew@new.rr.com
Midland County Health and Human Services Council	**Midland**	Susan Asher Community Impact Director United Way of Midland County 220 West Main Street, #100 Midland, MI 48640			Mike Krecek, Director Midland County Health Department 220 W. Ellsworth Midland, MI 48640
	PHONE (and PHONE EXTENSION)	(989) 631-3670			(989)832-6673
	FAX	(989) 832-5524			(989) 832-6628
	EMAIL	sasher@unitedwaymidland.org			
Monroe County Human Services Collaborative Network	**Monroe**	Doug Redding Monroe ISD 1101 South Raisinville Road Monroe, MI 48161	Sandie Pierce Monroe County Human Services Collaborative Network 2901 Sharon Drive Monroe, MI 48162		Joe Grifka, Superintendent Fairview 3604 South Custer Road Monroe, MI 48161
	PHONE (and PHONE EXTENSION)	(734) 242-5799 x 1912	(734) 242-1331		(734) 240-3191
	FAX	(734) 242-5807	(734) 242-4378		(734) 240-3198
	EMAIL	redding@misd.k12.mi.us	piercesandie@hotmail.com		Joe_Grifka@monroemi.org
Montcalm Human Services Coalition	**Montcalm**	Lisa M. Lund, CSW Montcalm Human Services Coalition 621 New Street, P.O. Box 367 Stanton, MI 48888		Don Lehman, V. Chair MSUE 211 W. Main P.O. Box 308 Stanton, MI 48888	Phil Larson, Chair Ionia Montcalm DHS 609 N. State P O Box 278 Stanton, MI 48888
	PHONE (and PHONE EXTENSION)	(989) 831-5261 x 449		(989) 831-7500	(989) 831-8411
	FAX	(989) 831-8727		(989) 831-7515	(989) 831-8496
	EMAIL	llund@maisd.com		lehmand6@msu.edu	larsonp@michigan.gov
Montmorency County Family Coordinating Council	**Montmorency**	Carlene Przykucki, Northeast Michigan Community Partnership (NEMCP), Inc. 3022 US 23S, Suite C Alpena MI 49707			Jim Beach, Director Oscoda DHS P. O. Box 849 Mio, MI 48647
	PHONE (and PHONE EXTENSION)	989-356-2880			(989) 785-6013
	FAX	989-354-6939			
	EMAIL	nemcpi@deepnet.net			Beachj2@michigan.gov

COMMUNITY COLLABORATIVES IN MICHIGAN

Muskegon County Community Coordinating Council	**Muskegon**	Jane Drake, Coordinator Community Coordinating Council 425 W Western Ave Suite 200 Muskegon MI 49440		Linda Juarez Hackley Community Hospital 2700 Baker Street Muskegon Heights, MI 49444	Jane Johnson, Director Muskegon DHS 2700 Baker Street PO Box 4290 Muskegon Heights, MI 49444
	PHONE (and PHONE EXTENSION)	(231)-722-4538 ext. 108		(231) 733-6693	(231) 733-3870
	FAX	231-722-4616		(231) 737-0534	
	EMAIL	Jdrake@cffmc.org		ljuarez@hackley-health.org	Johnsonj13@michigan.gov
Newaygo County Human Services Coordinating Body	**Newaygo**	Sarah Bowman Newaygo CMH 1049 Newell, P. O. Box 867 White Cloud, MI 49349			Greg Snyder, Executive Director Newaygo Co Mental Health Cntr 1049 Newell, PO Box 867 White Cloud, Michigan 49349
	PHONE (and PHONE EXTENSION)				
	FAX				
	EMAIL	sbowman@newaygocmh.org			gsnyder@newaygocmh.org
Oakland County Human Services Coordinating Council	**Oakland**	Pam Barckholtz, Coordinator Strong Families/Safe Children 5555 Grass Lake Rd. White Lake, MI 48383		Jim Perlaki, VP of Community Intervention Services The Common Ground Sanctuary 1410 S. Telegraph Bloomfield Hills, MI 48302	Ron Borngesser, CEO Oakland Livingston Human Service Agency (OLHSA) 196 Cesar Chavez Drive Pontiac, MI 48343-0598
	PHONE (and PHONE EXTENSION)			(248) 456-8150	(248) 209-2605
	FAX			(248) 456-8147	(248) 209-2615
	EMAIL	barckholtzp@michigan.gov		jperlaki@commongroundsanctuary.org	ronb@olhsa.org
Ogemaw County Human Services Council	**Ogemaw**	Teresa Tokarczyk, Contact person School Success Supervisor AuSable CMH 511 Griffin West Branch, MI 48661	Laura Reynolds Strong Families/Safe Children Coordinator District Health Dept. #2 630 Progress Street West Branch, MI 48661	Teresa Tokarczyk, Vice Chairperson School Success Supervisor AuSable CMH 511 Griffin West Branch, MI 48661	Rhonda Schick, Chairperson 806 W. Houghton Ave. Room 203 West Branch, MI 48661
	PHONE (and PHONE EXTENSION)	(989) 345-5571	(989) 343-1807	(989) 345-5571	(989)
	FAX	(989) 345-4111		(989) 345-4111	
	EMAIL	Teresa.tokarczyk@avcmh.org	lchapman@dhd2.org	Teresa.tokarczyk@avcmh.org	rschnick@ogemawcourt.com

COMMUNITY COLLABORATIVES IN MICHIGAN

Osceola Human Services Coordinating Council	**Osceola**	Larry Emig, Strong Families/ Safe Children Coordinator 436 W. Osceola Ave. Reed City, MI 49677	Kay Frederick, Juvenile Officer Osceola Co. Family Court 410 W. Upton Ave Reed City, MI 49677	Trincie Stroven Custody/Parenting Time Specialist Osceola County Friend of the Court 301 W. Upton Ave Reed City, MI 49677
	PHONE (and PHONE EXTENSION)	(231) 342-9163 (cell)	(231) 832-6128	(231) 832-6131
	FAX	(231) 832-4880	(231) 832-6181	(231)
	EMAIL	leemig@charter.net	kayefrederick@juno.com	strovent@michigan.gov
Oscoda County Human Services Coordinating Council	**Oscoda**	Brandi Desmarteaux, Coordinator MSU Extension PO Box 849 Mio, MI 48647		Jim Beach, Director Oscoda DHS P. O. Box 849 Mio, MI 48647
	PHONE (and PHONE EXTENSION)	(989) 826-4026 (989) 345-0692		(989) 826-4000
	FAX	(989) 826-3961		(989) 826-3961
	EMAIL	DesmarteauxB@michigan.gov		Beachj2@michigan.gov
Otsego Human Services Network	**Otsego**	Peter Amar, Prevention Coordinator The same address/email is used for Cheboygan County.		Barbara Soffredine COP ESD 6065 Learning Lane Indian River, MI 49749
	PHONE (and PHONE EXTENSION)			(231) 238-9394
	FAX			(231) 238-8551
	EMAIL			soffredb@copesd.k12.mi.us
Ottawa County Human Services Coordinating Council	**Ottawa**	Pat VerDuin (Contact Person) Ottawa County Familly Court 12120 Fillmore West Olive, MI 49460		Pat VerDuin Ottawa County Familly Court 12120 Fillmore West Olive, MI 49460
	PHONE (and PHONE EXTENSION)			(616)786-4124
	FAX			
	EMAIL	pverduin@co.ottawa.mi.us		pverduin@co.ottawa.mi.us
Presque Isle Human Services Coordinating Council	**Presque Isle**	Mary Schalk, Coordinator 5067 Klee Road Rogers City, MI 49779		Amy Fullerton, Chair TAPESTRY Project 6201 M 33 Onaway, MI 49765
	PHONE (and PHONE EXTENSION)	(989) 734-2877		(989) 733-4112
	FAX	(989) 734-2877		(231) 238-8551
	EMAIL	maryschalk@direcway.com		rfullerton@net4kids.us

COMMUNITY COLLABORATIVES IN MICHIGAN

Roscommon Human Services Collaborative Body	**Roscommon**	Cynthia Timmons Collaborative Coordinator P.O. Box 834 Grayling, MI 49738	Dan Lowery SF/SC Coordinator CMDHD P.O. Box 739 Prudenville, MI 48651	Rhoda Hacker, Director River House Shelter P.O. Box 661 Grayling, MI 49734	Honorable Doug Dosson Probate Judge Roscommon County Probate and Family Court County Building Room 132 500 Lake Street Roscommon, MI 48653
	PHONE (and PHONE EXTENSION) **FAX** **EMAIL**	(989) 344-9335 (989) 344-1815 Cindy.Timmons@hotmail.com	(989) 366-9166, ext. 29 dlowery@cmdhd.org	(989) 348-3169 director@riverhouseshelter.org	(989) 275-7675 probatecourt@roscommoncounty.net
Saginaw County Human Services Collaborative Body	**Saginaw**	Marcy Mietz, SCHSCB Coordinator 1600 N. Michigan Saginaw MI 48602			Dr. Cheryl Plettenberg, Chair 1600 N. Michigan Ave. Saginaw, MI 48602
	PHONE (and PHONE EXTENSION) **FAX** **EMAIL**	(989) 758-3785 (989) 758-3746 mmietz@saginawcounty.com			(989) 758-3822 (989) 758-3746 cplettenberg@saginawcounty.com
Sanilac County Human Services Coordinating Body	**Sanilac**	Sharon Brittich Sanilac County HSCB 171 Dawson Sandusky, MI 48471			Marvin Pichla Michigan Works 3270 Wilson Street Marlette, MI 48453
	PHONE (and PHONE EXTENSION) **FAX** http://www.greatlakes.net/~packman/hscb **EMAIL**	(810) 648-0112 x 3 (810) 648-3699 packman@greatlakes.net			(989) 635-3561 (989) 635-2230 pichlam@thumbworks.org
Schoolcraft County Family Coordinating Council	**Schoolcraft**	Pat Duyck Family Resource Center 7065 W. Smith Lake Drive Manistique, MI 49854			Joan Ecclesine Early Head Start Services Coordinator 426 Chippewa Avenue Manistique, MI 49854
	PHONE (and PHONE EXTENSION) **FAX** **EMAIL**	(906) 341-0401 (906) rogersfan@hotmail.com			(906) 341-6423 (906) 341-5862 jecclesine@mdsecp.com
Shiawassee County Health and Human Services Council	**Shiawassee**	Rich Baldwin 5951 Buttonwood Drive Haslett, MI 48840			Cynthia Mayhew 1905 W. M-21 Owosso, MI 48867
	PHONE (and PHONE EXTENSION) **FAX** **EMAIL**	(517) 339-9871 (517) 339-5908 rlbald@aol.com			(989) 723-7377 (989) 725-6113 arcshia@michonline.net

COMMUNITY COLLABORATIVES IN MICHIGAN

St. Clair County Community Services Coordinating Body	**St. Clair**	Amy Smith Community Planning Office St. Clair County CMH 1011 Military Street Port Huron, MI 48060-5416			Michael McCartan St. Clair County CMH 1011 Military Street Port Huron, MI 48060
	PHONE (and PHONE EXTENSION)	(810) 985-8900			(810) 985-8900
	FAX	(810) 985-7620			(810) 985-7620
	EMAIL	asmith@scccmh.org			mccartan@scccmh.org
St. Joseph County Human Services Commission	**St. Joseph**	Elizabeth O'Dell St. Joseph County HSC 692 East Main Centreville, MI 49032		Matt Chambers TR Health Three Rivers, MI 49093	Duke Anderson 570 Marshall Road Coldwater, MI 49036-8262
	PHONE (and PHONE EXTENSION)	(269) 467-1298		(269)	(517) 279-4301
	FAX	(269) 467-4012		(269)	(517) 278-2923
http://www.stjosephhsc.org/	**EMAIL**	OdellE@michigan.gov			Danderson@countyofbranch.com
Tahquamenon Area Human Service Collaborative Body	**Luce**	Karen Pentland, Contact Person Success Oriented Directed Achievement 500 W. McMillan Newberry, MI 49868	Rose Ann Welty, SF/SC Coordinator 200 Hamilton P.O. Box 73 Newberry, MI 49868		Karen Pentland, Chair Success Oriented Directed Achievement 500 W. McMillan Newberry, MI 49868
	PHONE (and PHONE EXTENSION)	(906) 293-0123	(906) 293-8145		(906) 293-5144
	FAX		(906) 293-8199		
	EMAIL	Pentlandk2@michigan.gov	roseann@up.net		Pentlandk2@michigan.gov
Tuscola County Human Services Coordinating Council	**Tuscola**	Susan Andrus, Coordinator Tuscola County HSCC 1104 East Kinney Road Munger, MI 48747-9772		Carol Socha TISD 1385 Cleaver Caro, MI 48723	Gretchen Tenbusch, Director Tuscola County Health Department 1309 Cleaver Road Caro, MI 48723
	PHONE (and PHONE EXTENSION)	(989) 659-2805		(989) 673-2144, x 401	(989) 673-8114, x115
	FAX	(989) 659-2358		(989) 673-5366	(989) 673-7490
		TESEAndrus@speednetllc.com		csocha@tisd.k12.mi.us	gtenbusch@tchd.us
Van Buren County Human Services Collaborative Council	**VanBuren**	Claren Schweitzer VanBuren CMH P.O. Box 249 Paw Paw, MI 49079			Jeff Elliott VanBuren Public Health 57418 CR681 Hartford, MI 49057
	PHONE (and PHONE EXTENSION)	(269) 657-7702 x 3131			(269) 621-3143
	FAX	(269) 657-3474			(269) 621-2725
	EMAIL	cschweitzer@vbcmh.com			jeffe@vbcassdhd.org

COMMUNITY COLLABORATIVES IN MICHIGAN

Washtenaw Human Services Collaborative Council	**Washtenaw**	Mike Scholl Human Services Community Collaborative Washtenaw County Public Health Administration 555 Towner P. O. Box 915 Ypsilanti, MI 48197-0915	Frank Cambria, Deputy County Administration Washtenaw County Administration 220 North Main Ann Arbor, MI 48104
	PHONE (and PHONE EXTENSION)	(734) 544-6856	(734) 222-6850
	FAX	(734) 544-6704	(734)
http://www.ewashtenaw.org/government/departments/hscc/index_html	**EMAIL**	schollm@ewashtenaw.org	cambriaf@ewashtenaw.org
Wayne County Human Services Coordinating Body	**Wayne**	Billie Jean Edwards, SF/SC Manager Wayne County DHS Cadillac Place, Suite #5-600 3040 West Grand Blvd. Detroit, MI 48202	Jerome Rutland, Chair Wayne County DHS, Director Cadillac Place, Suite #5-650 3040 West Grand Blvd. Detroit, MI 48202
	PHONE (and PHONE EXTENSION)	(313) 456-1232	(313) 456-1025
	FAX	(313) 456-1239	(313) 456-1218
	EMAIL	edwardsb2@michigan.gov	rutlandj@michigan.gov
West Michigan Child and Family Leadership Council	**Lake, Mason, Oceana**	Kathy Kovalchik-Lacko West Michigan CFLC 5868 W. US 10 Ludington, MI 49431	Rich VandenHeuvel, Executive Director West Michigan CMH 920 Diana Ludington, MI 49431
	PHONE (and PHONE EXTENSION)	(231) 845-1723	(231) 843-5489
	FAX	(231)	(231) 845-7095
	EMAIL	leadership@uwmasoncounty.org	richv@wmcmhs.org
Wexford-Missaukee Human Services Leadership Council	**Wexford, Missaukee**	Shari Spoelman Northern Lakes CMH 527 Cobbs Street Cadillac, MI 49601	Dave VanHouten Department of Human Services P. O. Box 309 Cadillac, MI 49601
	PHONE (and PHONE EXTENSION)	(231) 876-3280	(231) 779-4501
	FAX	(231) 775-1692	(231) 779-4507
	EMAIL	Shari.spoelman@nlcmh.org	vanhoutend@michigan.gov

For additions/corrections, please contact Mary Ludtke at 517/241-5769 or email: ludtkem@michigan.gov