Nebraska

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/21/2026 1.33.36 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2027
End Year	2028

State SUPTRS BG Unique Entity Identification

Unique Entity ID	HKQDEXRXGKL1

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	Nebraska Department of Health and Human Services
Organizational Unit	Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Thomas
Last Name	Janousek
Agency Name	NE DHHS Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026
Telephone	(402) 875-3763
Fax	(402) 742-8314
Email Address	Thomas.Janousek@nebraska.gov

State CMHS Unique Entity Identification

Unique Entity ID	HKQDEXRXGKL1

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Nebraska Department of Health and Human Services
Organizational Unit	Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Thomas
Last Name	Janousek
Agency Name	NE DHHS Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026
Telephone	(402) 875-3763
Fax	(402) 742-8314
Email Address	Thomas.Janousek@nebraska.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date	8/19/2026 5:51:18 PM

VI. Contact Person Responsible for Application Submission

First Name	John
Last Name	Trouba
Telephone	(402) 471-7824
Fax	(402) 742-8314
Email Address	john.trouba@nebraska.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2027

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--

    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?

    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Nebraska

Name of Chief Executive Officer (CEO) or Designee: Thomas Janousek, PsyD

Signature of CEO or Designee[1]: _____

Title: Director Division of Behavioral Health Date Signed:

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas Janousek, PsyD

Signature of CEO or Designee[1]: _____

Title: Director Division of Behavioral Health

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Thomas Janousek, PsyD

Title

Director Division of Behavioral Health

Organization

NE Department of Health and Human Services - Division of Behavioral Health

Signature: Date:

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Footnotes:

The Nebraska DHHS Division of Behavioral Health affirms it has not undertaken any lobbying during the most recently completed (prior to the application) state fiscal year. No lobbying activities to disclose or report.

Planning Tables

Table 2: MHBG Planned State Agency Budget for SFY2027

States are asked to present their projected one-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027).

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2026 Planning Period End Date: 6/30/2027

Activity	Source of Funds						
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Use Disorder Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children (PWWDC)							
b. All Other							
2. Recovery Support Services							
3. Primary Prevention							
4. Early Intervention Services for HIV							
5. Tuberculosis Services							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[a]		$436,172.30					
7. State Hospital				$5,574,736.86	$105,639,268.90		
8. Other Psychiatric Inpatient Care			$2,120,006.77		$2,246,432.66		
9. Other 24-Hour Care (Residential Care)			$21,468,323.92		$1,626,968.60		
10. Ambulatory/Community Non-24 Hour Care		$3,271,292.25	$170,601,249.10	$315,299.00	$49,022,234.48		
11. Crisis Services (5 percent set-aside) Set Aside[b]		$436,172.30	$2,957,168.20		$15,625,163.80		
12. Other Capacity Building/Systems Development							
13. Administration[c]		$218,086.15					
14. Total		**$4,361,723.00**	**$197,146,747.99**	**$5,890,035.86**	**$174,160,068.44**	**$0.00**	**$0.00**

[a] Row 6 in Column B: per statute, states are required to set-aside 10 percent of the total MHBG award for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[b] Row 11 in Column B: per statute, states are required to set-aside 5 percent of the total MHBG award for Behavioral Health Crisis Services (BHCS) programs.

[c] Per statute, administrative expenditures for the MHBG cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned expenditures by State Fiscal Year (Table 2), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4 must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each Fiscal Year should match the SUPTRS BG Final Allotments for the state.

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Expenditure Category	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	**$4,746,934.00**	**$4,827,081.00**
2 . Recovery Support Services[b]	**$418,804.00**	**$317,544.00**
3 . Substance Use Primary Prevention[c]	**$1,923,612.00**	**$1,950,526.00**
4 . Early Intervention Services for HIV[d]		
5 . Tuberculosis Services		
6 . Other Capacity Building/Systems Development[e]	**$961,368.00**	**$961,368.00**
7 . Administration[f]	**$423,722.00**	**$424,027.00**
8. Total	**$8,474,440.00**	**$8,480,546.00**

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned SFY 2027 budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 12-month period (for most states, it is July 1, 2026 - June 30, 2027).

Planning Period Start Date: 7/1/2026 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	$425,665.00
1b. Crisis Services for Adults	$436,173.00
1c. CSC/ESMI program for Adults	$0.00
1d. Other outpatient/ambulatory services for Adults	$178,726.00
1e. *Other Direct Services for Adults	$0.00
2. Subtotal of Services for Adults	$$1,040,564.00
3. Services for Children	
3a. EBPs for Children	$1,737,128.00
3b. Crisis Services for Children	$0.00
3c. CSC/ESMI program for Children	$436,173.00
3d. Other outpatient/ambulatory services for Children	$0.00
3e. *Other Direct Services for Children	$0.00
4. Subtotal of Services for Children	$$2,173,301.00
5. Other Capacity Building/Systems Development	$929,772.00
6. Administrative Costs	$218,086.00
7. *Any Other Cost	$0.00
8. Total MHBG Allocation[c]	**$$4,361,723.00**

Please provide brief explanation for services with an asterisk* below:

NA

[a]This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6 for a 12 month period.

[b]Administrative Costs should not exceed 5 percent of total MHBG allocation.

[c]The total budget should be equal to your MHBG allocation for the FY2027 12 month period.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Information Dissemination	Universal	$115,955	$157,775
	Selective	$62	
	Indicated	$465	
	Unspecified	$0	
	Total	**$116,482**	**$157,775**
2. Education	Universal	$481,839	$526,009
	Selective	$113,564	
	Indicated	$30,785	$26,590
	Unspecified	$0	
	Total	**$626,188**	**$552,599**
3. Alternatives	Universal	$12,554	$21,237
	Selective	$0	$131,676
	Indicated	$16,047	$2,000
	Unspecified	$0	
	Total	**$28,601**	**$154,913**
4. Problem Identification and Referral	Universal	$9,000	$20,896
	Selective	$178,488	$145,439
	Indicated	$0	
	Unspecified	$0	
	Total	**$187,488**	**$166,335**
	Universal	$493,760	$444,224
	Selective	$0	

5. Community-Based Processes	Indicated	$0	
	Unspecified	$0	
	Total	**$493,760**	**$444,224**
6. Environmental	Universal	$431,711	$435,298
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$431,711**	**$435,298**
7. Section 1926 (Synar)-Tobacco	Universal	$39,382	$39,382
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$39,382**	**$39,382**
8. Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
Total Prevention Budget		**$1,923,612**	**$1,950,526**
Total Award [a]		**$8,474,440**	**$8,480,546**
Planned Primary Prevention Percentage		**22.70%**	**23.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

1. Table 5a reports planned FFY2027 SUPTRS BG allocation for Primary Prevention Expenditures by Strategy/IOM Categories which sum to a total amount of $1,950,526. This amount corresponds with the reported amount in Table 4 Row 3. Substance Use Primary Prevention $1,950,525.58 (as auto-rounded in WebBGAS). The total amount of the FFY2027 SUPTRS BG allocation supporting planned Primary Prevention activities includes Table 5a Strategies/IOM Categories and Table 6 SUPTRS BG Other Capacity Building/Systems Development Activities Row 6b and Row 7b, $1,950,526 + $298,584 + $65,000.00, respectively, for a total of $2,314,110.

Planning Tables

Table 5b SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Strategy	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Universal Direct	$800,118	$645,014
2. Universal Indirect	$784,083	$1,074,807
3. Selective	$292,114	$131,676
4. Indicated	$47,297	$99,029
5. Column Total	**$1,923,612**	**$1,950,526**
6. Total SUPTRS Award[a]	**$8,474,440**	**$8,480,546**
7. Primary Prevention Percentage	**22.70%**	**23.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

1. Table 5b reports planned FFY2027 SUPTRS BG allocation for Primary Prevention Expenditures by IOM Categories which sum to a total amount of $1,950,526. This amount corresponds with the reported amount in Table 4 Row 3. Substance Use Primary Prevention $1,950,525.58 (as auto-rounded in WebBGAS). The total amount of the FFY2027 SUPTRS BG allocation supporting planned Primary Prevention activities includes Table 5b IOM Categories and Table 6 SUPTRS BG Other Capacity Building/Systems Development Activities Row 6b and Row 7b, $1,950,526 + $298,584 + $65,000.00, respectively, for a total of $2,314,110.

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2027 SUPTRS BG award.

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Priority Substances	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
Alcohol	☑	☑
Tobacco/Nicotine-Containing Products	☑	☑
Cannabis/Cannabinoids	☑	☑
Prescription Medications	☑	☑
Cocaine	☐	☐
Heroin	☑	☑
Inhalants	☐	☐
Methamphetamine	☑	☑
Fentanyl or Other Synthetic Opioids	☐	☐
Other	☐	☐
Priority Populations		
Students in College	☑	☑
Military Families	☑	☑
American Indian/Alaska Native	☑	☑
African American	☐	☐
Hispanic	☐	☐
Persons Experiencing Homelessness	☐	☐
Native Hawaiian/Pacific Islander	☐	☐
Asian	☐	☐
Rural	☑	☑

Footnotes:

Planning Tables

Table 6 SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Activity	FFY 2026			FFY 2027		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00	$200,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$200,000.00	$0.00	$0.00	$200,000.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00	$50,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$50,000.00	$0.00	$0.00	$50,000.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$298,584.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$298,584.00	$0.00	$0.00	$298,584.00
7. Training and Education	$0.00	$0.00	$0.00	$347,784.00	$0.00	$65,000.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$347,784.00	$0.00	$65,000.00	$347,784.00	$0.00	$65,000.00
8. Total	**$597,784.00**	**$0.00**	**$363,584.00**	**$597,784.00**	**$0.00**	**$363,584.00**

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan Table 6 address MHBG funds to be expended on other capacity building /systems development activities during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027). Please use these columns to capture how much the state plans to expend over a 12-month period.

MHBG Planning Period Start Date: 07/01/2026 MHBG Planning Period End Date: 06/30/2027

Activity	FFY 2026 MHBG[1]	FFY 2026 BSCA Funds[2]	FFY 2027 MHBG[3]
1. Information Systems	$400,000.00		$200,000.00
2. Infrastructure Support	$1,009,544.00		$504,772.00
3. Partnerships, Community Outreach, and Needs Assessment	$100,000.00	$180,000.00	$50,000.00
4. Planning Council Activities			
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education	$350,000.00	$416,454.00	$175,000.00
8. Total	**$1,859,544.00**	**$596,454.00**	**$929,772.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

[3] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [**July 1, 2026 – June 30, 2027**, for most states].

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
NAVIGATE	2.00
	0.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
	436,172.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

The FEP service includes four components: individual therapy, medication management, family therapy/education, and supported employment services.
Medicaid can provide coverage for three of the four components but will not provide funding for supported employment services. This component of the model can be billed to the Division of Behavioral Health and paid for by MHBG FEP set-aside funds.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

The DHHS-Division of Behavioral Health (DBH) funds training on the NAVIGATE fidelity-based model to community providers who are currently providing the FEP service and those who have an interest in providing the service and fidelity model in the future. DBH also collaborated with national technical assistance organizations to provide this type of support and education to community providers.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

DBH has been collaborating with local and national behavioral health entities to increase the community's knowledge of the FEP program and the NAVIGATE fidelity model used in it. DBH has contracted with the University of Nebraska's Medical Center (UNMC) to gather, analyze, and interpret information on individuals with ESMI. UNMC's Prevalence Study focuses on understanding the needs of the ESMI population, including barriers to specialty services and ESMI-specific interventions and treatment options. This study also gathers information on FEP program outcomes, client satisfaction, and prevalence rates of individual seeking these services.
DBH collaborates with community partners and national trainers for provide ESMI education and training to FEP staff members and providers.

8. Please describe the planned activities in FY2027 for your state's ESMI programs.

DBH has partnered with the Public Policy Center at University of Nebraska-Lincoln (UNL) to create and produce educational videos on FEP among young adults. These videos will be provided to the Lincoln Public Schools district and other local educators to increase the community's awareness of ESMI and provide resources.
DBH is currently in the process of working with one of Nebraska's CCBHCs to expand FEP programs and increase access for individuals with ESMI

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

The Individual must meet all of the following admission guidelines:
• Age: 14 years of age through 35 years of age
• The Individual has a primary diagnosis, as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, that includes psychosis and may include individuals with co-occurring disorders.
Accepted diagnosis from this service include:
a. F20.0 Paranoid schizophrenia
b. F20.1 Disorganized schizophrenia
c. F20.2 Catatonic schizophrenia
d. F20.3 Undifferentiated schizophrenia
e. F20.5 Residual schizophrenia
f. F20.81 Schizophreniform disorder
g. F20.89 Other schizophrenia
h. F20.9 Schizophrenia, unspecified
i. F21 Schizotypal disorder
j. F22 Delusional disorders
k. F23 Brief psychotic disorder
l. F24 Shared psychotic disorder
m. F25.0 Schizoaffective disorder, bipolar type
n. F25.1 Schizoaffective disorder, depressive type

o. F25.8 Other schizoaffective disorders
p. F25.9 Schizoaffective disorder, unspecified
q. F28 Other psychosis disorder not due to a substance or known physical condition
r. F29 Unspecified psychosis not due to a substance or known physical condition
• Symptoms of a psychotic disorder for a period lasting more than 1 week and no more than 2 years
• Presence of functional deficits in 2 of 3 functional areas: Vocational/Education, Social Skills, and Activities of Daily Living
o Vocational/Education: Inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks
o Social Skills: Repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others
o Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning
• The Individual can reasonably be expected to benefit from the Coordinated Specialty Care model
• It is expected that the Individual will be able to benefit from this treatment
#

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

In SFY 2025, DBH explored the opportunity of releasing an RFA to determine the provider's interest in these services and/or in other regions of Nebraska. During this process, one provider reached out to DBH with interest in adding CSC/FEP to their array of services using the NAVIGATE model. The provider was also interested in facilitating a NAVIGATE training for the community and other potential service providers. This conversation overlapped with the implementation of Nebraska's 7 Certified Community Behavioral Health Clinics (CCBHCs) that opened in January of 2026. Upon further investigation, the provider reached out to DBH with interest in a direct contract with one of the CCBHCs to provide CSC/FEP with the NAVIGATE model to be implemented in SFY 2027.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

DBH is collaborating with the Public Policy Center at UNL to create educational videos and resources about individuals experiencing ESMI, including treatment interventions and available local resources.

12. Please indicate area of technical assistance needs related to this section.

• Individualized TA for state-specific needs
• Client recruitment and referrals
• Training on fidelity tool, what other ESMI service qualify for set aside
• Workforce development, evidence-based treatment interventions, early detection, psychoeducation materials to be used for outreach and treatment, and co-occurring ESMI and SUD conditions

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an Advisory: **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Nebraska has one statewide 988 Crisis Call Center, operated by Father Flanagan's Boys' Home (Boys Town) in Omaha, which serves the entire state. The Nebraska Division of Behavioral Health (DBH) contracts with the state's six Regional Behavioral Health Authorities (RBHAs), which in turn contract with Mobile Crisis Team providers to ensure crisis response coverage across all 93 counties.

Mobile Crisis Teams can be activated through Nebraska 988 or by contacting a Mobile Crisis provider or RBHA directly. While in-person mobile crisis services are available statewide, some rural communities utilize telehealth or telephone-based crisis response when an on-site response is

not immediately available.

In addition to Mobile Crisis Teams, various law enforcement agencies across Nebraska have implemented co-responder models to provide behavioral health support during emergency responses. Nebraska also has three Crisis Receiving and Stabilization Centers that offer short-term assessment, stabilization, and treatment as an alternative to emergency departments or inpatient psychiatric hospitalization.

On January 1, 2026, Nebraska launched seven Certified Community Behavioral Health Clinics (CCBHCs), each of which provides crisis services as part of the state's behavioral health crisis continuum.

In May 2026, through funding provided by the Rural Health Transformation initiative, Nebraska partnered with Avel eCare to provide 24/7 virtual access to physicians, nurses, behavioral health clinicians, and other specialists via secure video technology. This initiative enhances crisis response capacity, particularly in rural and frontier communities where immediate access to in-person behavioral health services is limited.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

1. Someone to contract:
There is 1 call center in Nebraska. The vendor had previous experience in providing services as part of the Suicide Lifeline prior to the implementation of 9-8-8. The 1 call center has protocols in place to follow-up with callers who meet certain criteria and consent to the follow up call. Crisis Response is provided throughout all 93 counties across Nebraska.

2. Someone to respond:
The number of communities that have mobile behavioral health crisis capacity includes 342 fire and rescue departments, 136 fire only departments, and 152 law enforcement agencies in Nebraska. There are 3 areas of Nebraska that have co-responder models. Crisis Response is provided throughout all 93 counties across Nebraska. Nebraska is currently partnering with Avel eCare, a telehealth crisis response service offered to law enforcement entities.

3. Safe Place to be:
Nebraska's behavioral health crisis continuum includes emergency departments, crisis receiving and stabilization services, and Certified Community Behavioral Health Clinics (CCBHCs) that provide individuals with safe locations to receive assessment, stabilization, and treatment during a behavioral health crisis. There are approximately 20 emergency departments across the state, four of which operate specialized behavioral health components to provide enhanced behavioral health assessment and treatment. In addition, Nebraska has three Crisis Receiving and Stabilization Centers (CRSCs) that provide short-term assessment, diagnosis, observation, and stabilization as an alternative to emergency departments or inpatient psychiatric hospitalization. Since the implementation of seven Certified Community Behavioral Health Clinics (CCBHCs) on January 1, 2026, crisis service capacity has expanded across the state, with each CCBHC providing crisis services as part of Nebraska's behavioral health crisis continuum. The Division of Behavioral Health continues to strengthen access to safe places for individuals experiencing a behavioral health crisis by expanding community-based crisis services and increasing access to timely stabilization and treatment, particularly in rural and underserved areas.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Nebraska continues to strengthen its behavioral health crisis continuum by expanding access to safe, community-based settings where individuals experiencing a behavioral health crisis can receive timely assessment, stabilization, and treatment. The Division of Behavioral Health (DBH) partners with the six Regional Behavioral Health Authorities (RBHAs) to ensure individuals have access to the least restrictive and most appropriate level of care based on their needs.

Currently, Nebraska has approximately 20 emergency departments, including four emergency departments with specialized behavioral health components, that provide emergency behavioral health assessment and treatment when medically necessary. To provide alternatives to emergency departments and inpatient psychiatric hospitalization, Nebraska has established three Crisis Receiving and Stabilization Centers (CRSCs) located in Regions 3, 5, and 6. These facilities provide short-term crisis assessment, observation, stabilization, and coordination with ongoing behavioral health services.

Nebraska continues to expand access to community-based crisis stabilization through the implementation of seven Certified Community Behavioral Health Clinics (CCBHCs), which became operational on January 1, 2026. Each CCBHC provides crisis intervention services and works collaboratively with the statewide 988 Crisis Call Center, Mobile Crisis Teams, hospitals, law enforcement, and community providers to ensure individuals are connected to appropriate care and follow-up services.

Recognizing the unique challenges of serving rural and frontier communities, Nebraska has also expanded the use of telehealth to improve access to crisis services. Through Rural Health Transformation funding, the state partnered with Avel eCare in 2026 to provide 24/7 virtual access to behavioral health clinicians and other healthcare professionals, increasing the availability of crisis assessment and clinical support in areas with limited local resources.

Moving forward, Nebraska will continue to develop its crisis system by expanding community-based crisis stabilization options, strengthening partnerships among crisis providers, hospitals, emergency departments, law enforcement, and CCBHCs, and improving access to timely, person-centered care throughout the state. These efforts support SAMHSA's vision of providing individuals in crisis with a safe place to receive assessment, stabilization, treatment, and connection to ongoing behavioral health services in the least restrictive setting possible.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 7

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 630

b. Integrated with public safety first responder structures (police, paramedic, fire): 3

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 20

b. Number of Emergency Departments that operate a specialized behavioral health component: 4

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 3

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Nebraska will utilize the Mental Health Block Grant 5% Crisis Set-Aside to continue strengthening an evidence-based behavioral health crisis continuum that aligns with SAMHSA's National Guidelines for Behavioral Health Crisis Care. Funding supports the continued development and enhancement of the three core crisis system components: someone to contact, someone to respond, and a safe place to go. Planned activities include maintaining and enhancing the statewide 988 Crisis Call Center, strengthening Mobile Crisis Team capacity across all six Regional Behavioral Health Authority (RBHA) service areas, expanding access to crisis stabilization services, and improving coordination among crisis providers, hospitals, emergency departments, law enforcement, and community behavioral health providers.

Nebraska also continues to expand access to crisis services in rural and frontier communities through innovative service delivery models. In 2026, the state partnered with Avel eCare through the Rural Health Transformation Program to provide 24/7 virtual access to behavioral health clinicians and other healthcare professionals, increasing crisis response capacity and supporting communities with limited access to in-person behavioral health resources. Additionally, Rural Health Transformation initiatives continue to support the expansion of crisis stabilization infrastructure and other community-based crisis services throughout Nebraska.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

Footnotes:

1. Footnote to Question 5. Other program implementation data that characterizes crisis services system development. > Someone to contact: Crisis Contact Capacity > c. Estimated percent of 911 calls that are coded out as BH related: Number is not available. 911 centers in Nebraska do not track the number of mental health related calls. Through a Joint Protocols workgroup with the Nebraska 911 Public Service Access Points (PSAPs), protocols to identify appropriate callers experiencing a crisis and to warm transfer those callers to 988. A pilot has been or is being implemented in each of the 6 RBHA's. This pilot began March 2024 and to date, there have been 27 calls warm transferred by 911 to 988. There are some PSAPs in the state that have mental health professionals available to consult when needed.

2. Footnote to Question 5. Other program implementation data that characterizes crisis services system development. > Someone to respond > c. . Number that utilizes peer recovery services as a core component of the model: Unknown count utilizing peer recovery services as a core component of the model employed by public safety first responder structures.

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

The Division of Behavioral Health administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role as the chief behavioral health authority for the State of Nebraska. This legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. The state advisory committee structure changed by legislative action that became effective in July 2026. The State Advisory Committee on Substance Abuse Services was terminated. The legislation amended the enacting statute for the State Advisory Committee on Mental Health Services to rename the committee as the State Advisory Committee on Mental Health and Substance Use Services and added the responsibilities of the former State Advisory Committee on Substance Abuse Services, without changing the composition of the newly renamed committee. The division is working to incorporate the voice and perspective of Consumers and Providers of substance use services and people in recovery from substance use services in order to maintain the committee's service as a behavioral health advisory council.

The committee will and does continue to have an active involvement in the state plan guiding the public health behavioral system by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local
levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application.

The DBH web page URL for State Advisory Committee on Mental Health and Substance Use Services meeting agenda and minutes is: https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx
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Recent activities include:
<> August 6, 2026 State Advisory Committee on Mental Health and Substance Use Services Meeting
Presentation of the SAMHSA Combined Mental Health and Substance Use Block Grant FFY2027 Mini-Application included review and discussion of the purposes of the block grants, Priority Areas, and budgets. The DBH Block Grant Priority Areas and preliminary data for the close of Year 1 of the FFY2026-2027 were presented. DBH submitted the Block Grant Application with identified annual performance indicators to SAMHSA on September 1, 2025, with targets later updated in November 2025.

Priority areas of the block grant are focused on identified critical areas for treatment and recovery success, including stable housing outcomes, employment, person-centered care, and access to treatment and support systems in one's community. The eight Block Grant Priority Areas are: #1-Prevention of binge drinking among youth and young adults; #2-Increase the use of Evidence-Based Strategies employed by prevention coalitions; #3-Consumers in Stable Living Arrangement at discharge from residential services; #4-Percentage of consumers in the labor market who are employed at discharge; #5-Access for Priority Populations to SUD services; #6-Increase utilization of treatment programs for first-episode psychosis; #7-Referral to services for persons with tuberculosis, and #8- Ensure timely access to Opioid Treatment Programs for women who have responsibilities of caring for vulnerable children. For SFY26, 22,763 persons have been served by DBH community-based services.

The block grant budget for Year Two of the Plan was presented. Figures were separated by Mental Health budget and Substance Use budget and reflected planned budget expenditures of Medicaid and other federal and state funds.
The committee did not take any action regarding recommendations or comments.

Deputy Director's Update – the DBH Deputy Director of Clinical Operations reviewed the status of the Rural Health Transformation Program (RHTP). These are federal funds made available with the intended purpose of expanding health care access in rural areas. Nebraska has received approximately $218 million per year, with DBH being allocated $11 million. DBH is aligning use of funds towards crisis level of care. The four prioritized activities for these funds are integrated primary care sites, telehealth crisis responders for law enforcement, modification of existing clinical facilities for mental health crisis stabilization centers, and a behavioral health nursing home pilot.

DBH Office of Consumer Affairs (OCA) Program Coordinator presented information on the 2026 Nebraska Recovery Month Celebration. This event will be held on Thursday, September 10th, 3:00-6:00 pm, at the Shildneck Bandshell in Antelope Park in Lincoln.

Director's Update – The DBH Deputy Director of Clinical Operations, spoke briefly on behalf of DBH Director Dr. Thomas Janousek, who was unable to attend. Medicaid service definitions are being updated, but this project has been delayed due to feedback that requires further review. The DBH Continuum of Care (CoC) manual's release date has been moved back from July 1, 2026 to January 2027.

Presentation by the Collaboration Manager with the Nebraska Investment Finance Authority (NIFA). NIFA is the designated State of Nebraska State Housing Agency. The NIFA presentation focused on "Investing in Stability: Integrating Housing, Services, and Innovation Across Nebraska." Discussion following the presentation included NIFA support for advancing the goals of Nebraska Olmstead Plan, the Nebraska's Strategic Housing Framework plan, NIFA collaborations with the Nebraska Department of Health and Human Services' divisions and other social services providers to make available information about safe, affordable and accessible housing to the most vulnerable people.

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<> June 22, 2026 Joint Advisory Committee Meeting – Special Meeting on Bylaws for the State Advisory Committee on Mental Health Services which will soon to be renamed the State Advisory Committee on Mental and Substance Use Services per enacted legislation.
Committee member representatives from both the Mental Health Services and Substance Abuse Services committees presented information about the draft Bylaws for the to-be-renamed Mental Health committee. These members worked as an ad hoc workgroup to further identify actions steps and recommendations on how to sustain an encompassing behavioral health perspective via amendments to the State Advisory Committee on Mental Health Services Bylaws for committee consideration. The draft Bylaws were presented, discussed, and officially adopted in order to have in place official Bylaws upon the legislative enacted termination of the State Advisory Committee on Substance Use Services whose official duties were, by statute change, assigned to the State Advisory Committee on Mental Health Services.

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<> April 9, 2026 Joint Advisory Committee Meeting
DBH presented a progress report on the Opioid Settlement Funds Request for Applications (Opioid Treatment Infrastructure Cash Fund-Construction) (RFA). Construction work has begun at all five entities awarded infrastructure grants. Purpose of these awards is enhancing Nebraska's Behavioral Health infrastructure through renovation, development, or expansion of their facilities to improve service delivery. Focus is on facilities providing crisis services. The construction period ends December 2027.

DBH provided an update on the delayed shared service definitions for DBH and the Division of Medicaid and Long-Term Care (MLTC), which oversees the Nebraska Medicaid program. Discussion about the purpose and status of the review of Standardized definitions allow for better integration of services to ensure a smooth transition between the respective programs, which helps connect beneficiaries with appropriate services. Providers in the DBH network must be dual enrolled as Medicaid providers to facilitate client transition between funders. While DBH and MLTC each serve specific target populations, life events may change a beneficiary's circumstances and thus their eligibility for either program.

DBH reported on RBHA activation to support people in areas affected by the unprecedented Nebraska Range Fires. Presentation on how DBH coordinates disaster response in the wake of the 2026 Nebraska wildfires. State funding supports activity. Work is guided by the Nebraska Behavioral Health All-Hazards Disaster Response & Recovery Plan, and focuses on readiness before, coordination during, and recovery after disasters. While each Behavioral Health Region maintains their own disaster response plans, DBH partners with the University of Nebraska Public Policy Center (UNL PPC) to provide preparedness workshops and meetings, and support statewide coordination and skill-building. Behavioral Health resources, such as helplines, provider information, and Mental Health First Aid training, are offered during the response process.

The committee chair persons led an activity called Community Behavioral Health Trending Matters where committee members share and discuss events and issues in their area, local community, and state. Topics centered on funding concerns and early services for youth, especially regarding the impact of unintended consequences of technology and social media on mental health.

Meeting agenda included the Director's Update. The DBH Director highlighted several current activities of the Division of

Behavioral Health. Key updates included: Crisis Stabilization services are being created in the rural Panhandle (Kimball) and northeast (South Sioux City). Three other agencies located in Lincoln and Omaha will be expanding substance use treatment services, too. The agencies are using a combination of funds, including funds awarded through the Opioid Treatment Infrastructure Cash Fund Request for Applications, to build, renovate, or expand facilities to assist with the expansion of services. Services will be expanded beyond opioid treatment services.

Certified Community Behavioral Health Clinics (CCBHCs) –Seven providers have been finalized as CCBHCs. All CCBHCs officially went live on January 1, 2026. Four of the new CCBHCs include providing an ACT Team as part of their services, increasing the statewide number of ACT Teams to seven. The CCBHCs are operating under on a new payment structure model and there is continual communication with the providers.

Rural Health Transformation Funds (RHT) – These are federal funds made available with the intended purpose to expand health care access in rural areas. Nebraska has submitted a proposal for $200 million per year of the five-year program. DBH is aligning use of funds towards crisis level of care. Examples of use of funds include filling a gap in telehealth by providing integrated mobile crisis platforms to serve the behavioral health needs of first responders, crisis center renovations to expand services, a pilot project involving incentivizing nursing homes to expand care to residents with behavioral health needs, and integrating Peers into crisis response services.

Lincoln Regional Center (LRC) –Outcomes of recent safety enhancements at LRC include decreased number of seclusion directives and decreased number of assaults on staff. An in-depth review of patient case files is being conducted of patients with longer lengths of stay to identify and remove barriers to discharge. LRC is successfully transitioning away from contracted employees. And LRC has added a new forensic navigator for the OCR team to liaison between the courts and OCR to increase diversion from impatient competency restoration, which is more expensive and overloads LRC flow.

State Legislative Change to JAC Committees – Mental Committee/Planning Council Chair reiterated the changes stemming from the legislation passed in 2025 and proposed in 2026. Legislative changes sunsets the State Advisory Committee on Substance Abuse Services on July 1, 2026. Discussion was entertained about how changes to the State Advisory Committee on Mental Health Services Bylaws can retain the voice and perspective of consumers, and their family members, and providers of substance use services, and appropriately represent these on the to be combined committee which is to be renamed the State Advisory Committee on Mental Health and Substance Use Services. Members volunteered to act as an ad hoc workgroup to further identify actions steps and recommendations on how to sustain an encompassing behavioral health perspective via amendments to the State Advisory Committee on Mental Health Services Bylaws for committee consideration by the Mental Health Committee and future legislation to improve representation.

Planning for the 2027 SAMHSA Combined Block Grant Mini-Application – Planning activity for the Nebraska Block Grant Priority Areas for FFY2026-2027. Note: DBH submitted the annual Implementation Reports for Year 2 of the 2024-2025 Block Grant Awards in December 2025. Discussion of the priority areas of the block grant identified critical areas for treatment and recovery success, including stable housing outcomes, employment, person-centered care, and access to treatment and support systems in one's community. Discussed the current eight Block Grant Priority Areas. The committees did not take any action regarding recommendations or comments.

Presentation on the Recovery Friendly Workplace initiative, which is to create work environments that further mental and physical well-being of employees in order to support the success of businesses in both the short-term and long-term. Other states that have implemented the initiative report both private and nonprofit businesses identify short-term success of higher engagement and productivity gains and long-term success of sustained business growth and lower turnover. Five companies/organizations are currently certified. (As of August 2026, 10 companies/organizations have been certified, with three additional workplaces in process of completing certification and four additional workplaces in the planning phase to begin working towards completing certification.)

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<> November 13, 2025 Joint Advisory Committee Meeting

Meeting topics included: DBH Director's Update – The DBH Director provided an update on the seven Certified Community Behavioral Health Clinics (CCBHCs) that have been finalized as CCBHCs and are implementing strategies to meet technical aspects of the designation. There will be at least one CCBHC is each of RBHA service area across the state. Next, share information about the success of Opioid Settlement Funds Request for Applications (RFA); DBH received 24 applications, with five being approved for activities to renovate, develop, or expand facilities to implement treatment programs and services (a $10.5 million one-time investment). Next, discussed efforts to expand Crisis Stabilization services to the panhandle and in northeast Nebraska. South Sioux City, while three other areas of the state will be expanding their current services. Next, reported DBH and Medicaid are working to complete the Service Definition Project to provide consistent service delivery for consumers transitioning between the two systems. Next, shared information about two DBH 2026 Initiatives which are to improve data sharing between Medicaid and DBH and review the use of Outpatient Competency Restoration (OCR) and Emergency Protective Custody (EPC) for individuals with misdemeanor charges.

The Director discussed opportunities funded using the new Rural Health Transformation Funds which are intended to expand health care access in rural areas. Nebraska submitted a proposal for $200 million per year. Public Health funds could cover such things as healthy foods, weight loss programs and medications, health education, and technologies. Mental Health funds could cover integrated clinics, crisis center renovations to expand services, integrated mobile crisis platforms, and a pilot program for

nursing homes to expand care to behavioral health patients with higher needs (DBH branded as PATHWAYS Home).

Presentation by the DBH Serious Mental Illness (SMI) Waiver Administrator who reviewed the planned 1915(i) Waiver: Pathways Home program. (This program was scheduled to go live on January 1, 2026, pending approval from the Centers for Medicare & Medicaid Services (CMS) but was delayed and then reconfigured to be a DBH-only program after the state made the decision to not pursue the 1915(i) Waiver). (The Pathways Home Program is providing Targeted Case Management for those individuals with a Serious Mental Illness who are experiencing 10 or more ER visits in a year and identify and facilitate supportive wrap around services where the individual feels supported, and all providers are aware of what is happening, allowing them to be aware of all goals and issues that might arise.)

Presentation by Oxford House Nebraska to share information about the organization's work in supporting and advocating for Nebraska citizens working through substance abuse issues.

DBH presented the draft 2025 SAMHSA Block Grant Implementation Reports, including financials, SYNAR Report, and Priority Areas Close Out Review for SFY2024-SFY2025 Awards. The presentation concluded with an update on the 2026-2027 Block Grant Application Year-1 revisions to the Priority Areas originally submitted on September 1, 2025. The committees did not take any action regarding recommendations or comments.

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<> August 7, 2025 Joint Advisory Committee Meeting

Meeting presentations included: DBH Director Update; Presentation by DBH on the Substance Use Recovery Month activities. Presentation and review by the committee of the FFY2026- 2027 SAMHSA Combined Mental Health and Substance Use Prevention, Treatment, and Recovery Services Block Grant Application (including the two-year budgets, assessment, and Planning Table 1 - Priority Areas and Annual Performance Indicators). The committees did not take any action regarding recommendations or comments.

Next, the committees engaged with Disability Rights Nebraska following their presentation. Disability Rights of Nebraska is Nebraska's designated Protection & Advocacy for Individuals with Mental Illness organization. A presentation by DBH acting as the designated Secretary of the Opioid Settlement Remediation Advisory Committee for the state. A DBH presentation on the DBH-led Opioid Treatment Infrastructure Cash Fund Request for Applications (RFA) project; the RFA awards will fund provider projects to renovate, develop, or expand facilities to implement treatment programs and services for opioid use disorder (OUD) and/or substance use disorder (SUD).

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On August 21, 2026, the DBH posted an email notice on the DBH Listserv to invite DBH audiences to inspect and comment on the draft Combined FFY2026-2027 MH/SUPTRS Block Grant Mini Application. The DBH Listserv distributes to 1,200 individuals and 140 organizations included members of the State Advisory Committee on Mental Health and Substance Use Services, state Prevention Advisory Council, Family Organizations, Certified Peer Specialists, Regional Behavioral Health Authorities, DBH NBHS Network Providers, the four federally recognized tribes in Nebraska and partner state, regional, and local agencies.

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-Start Notice-

Notice of Opportunity for Public Comment on the FFY 2027 Mini Application for the Combined FFY2026-2027 Mental Health/Substance Use Prevention, Treatment, and Recovery Services (MH/SUPTRS) Block Grant Application

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Comments are invited on the Nebraska DRAFT FFY 2027 Mini Application for the Combined FFY2026-2027 MH/SUPTRS Block Grant Application.

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Nebraska has been invited to submit an application to the federal Substance Abuse Mental Health Services Administration (SAMHSA) for the federal fiscal year (FFY) 2026-2027 Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBG).

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To review the draft Nebraska Application for the SAMHSA Uniform FFY 2026-2027 Mini Application of the Combined Block Grant Application for Community Mental Health Services Block Grant and the Substance Use Prevention, Treatment, and Recovery Services Block Grant please visit the Division of Behavioral Health Public Participation web page https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

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To provide comment on the FFY 2027 Mini Application for the Combine FFY 2026-2027 Community Mental Health Services Block Grant and Substance Use Prevention, Treatment, and Recovery Services Block Grant – Draft Application public comment can be submitted via U.S. Postal Service or email to:

John Trouba – Federal Aid Administrator
John.Trouba@nebraska.gov
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, 4th Floor
PO Box 95026
Lincoln, NE 68509-5026

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Written comments will be accepted between August 21, 2026 and 4:00 p.m. August 28, 2026.
-30-
END

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

The Division of Behavioral Health administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role as the chief behavioral health authority for the State of Nebraska. This legislation also established the State Advisory Committee on Mental Health Services which serves as the Mental Health Planning Council for the Community Mental Health Services Block Grant. Legislation that became effective in July 2026 change the name of this committee to the State Advisory Committee on Mental Health and Substance Use Services, maintain the responsibilities and role as the Mental Health Planning Council, and broadened its role to be inclusive of both mental health and substance use concerns upon the termination in legislation authorizing the State Advisory Committee on Substance Abuse Services.

The committee will continue its active involvement in the state plan guiding the public health behavioral system by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Nebraska Revised Statute 71-814 (1) creates and authorizes the State Advisory Committee on Mental Health and Substance Use Services. Section 2 of the chapter sets out the responsibilities of the committee : "The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services and, beginning July 1, 2026, substance use disorder services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division."

Committee meetings include two opportunities (near the beginning and the end of meetings) for public comment regarding discussions and issues that are before the committees. Throughout the day, committee members are engaged in discussion of agenda items and following each topic committee members are asked for recommendations to the DBH regarding actions or next steps for the DBH to consider when moving forward in each respective area. All committee members have equal voice/vote in committee recommendations. Administrative staff from the Community-Based Services Section of DBH, including staff from the Office of Consumer Affairs, attend meetings to listen to committee discussion as well as public comment for a better understanding of the committee perspective.

Each meeting may include individuals with lived experience or advocates, sharing successes, barriers and challenges along their individual roads to recovery, or presenters of current topical issues and/or behavioral health projects. Presentations by individuals with lived experience and advocates keep the consumer perspective in front of the committee as well as DBH staff, and allows successes and challenges to have a "face" to support the reality of challenges for those served.

The DBH web page URL for advisory committee meeting agenda and minutes is: https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2027 End Year: 2028

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Heather Bird	Advocates/representatives who are not state employees or providers			
Verdell Bohling	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Mary Ann Borgeson	Advocates/representatives who are not state employees or providers			
Micki Charf	State Employees			
Margaret Damme	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Roger Donovick	State Employees			
Lindy Foley	State Employees			
Ingrid Gansebom	Providers			
Victor Gehrig	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Jill Gregg	Providers			
Timothy Heller	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Susan Jensen	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Kristen Larsen	State Employees			
Kyle Long	Parents of children with SED			
Kelli Means	Providers			

Angela Miles	State Employees			
Jennifer Reyna	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Danielle Smith	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Gage Stermensky II	Persons in Recovery from or providing treatment for or advocating for SUD services			

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2027 End Year: 2028

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	4	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	1	
4. Vacancies (individuals and family members)	4	
5. Total individuals in recovery, family members, and parents of children with SED	**12**	**46.15%**
6. State Employees	5	
7. Providers	3	
8. Vacancies (state employees and providers)	3	
9. Total State Employees & Providers	**11**	**42.31%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	1	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	2	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**3**	**11.54%**
16. Total membership (all members of the council)	**26**	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

State law gives the public the opportunity to advise the Division in service planning. The URL of the plan posted for comment is:
https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

The previous plan year final version was posted and is posted on the same web page, URL:
https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

Nebraska - FFY 2027 Combined MHBG/SUPTRS BG Application

Environmental Factors and Plan - Section 16. Syringe Services Program (SSP)

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The Nebraska Department of Health and Human Services Division of Behavioral Health does not use SUPTRS BG or state funds to support elements of any Syringe Services Program nor has it developed or submitted a plan to the State Project Officer to repurpose SUPTRS BG funds for an SSP.