Amendment Number

Subcontract No. 2018      

**FY18 Program Abstract**

**SERVICE AGENCY SUBCONTRACTOR**

**Agency Name:**

**Street:**

**City:**       **County:**       Z**ip:**

**Phone:**       **Fax:**

**E-mail:**

**PRIMARY SERVICE SITE**

**Program Name:**

**Street:**

**City:**       **County:**       Z**ip:**

**Phone:**       **Fax:**

**E-mail:**

**Onsite Program Supervisor:**

**PROGRAM MODEL**

Healthy Families Illinois  Parents as Teachers  Nurse Family Partnership

**HFI PROGRAMS**

Credentialing Status:

Date of HFA Accreditation/PAT Endorsement:

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**FY18 Program Abstract**

**DESCRIBE COMMUNITY SERVED, COMMUNITY NAMES, COUNTIES, AND POPULATION DEMOGRAPHICS:** Include the racial, linguistic, ethnic, and cultural characteristics in your description. Also, include the zip codes of participants eligible for services in the program. Describe target population; include number of births in that population. Describe mechanism for tracking births within the target population and projected number of assessments, if applicable. Please list the names of the high schools in your catchment area.

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**FY18 Program Abstract**

**SUBCONTRACTOR CONTACT LIST**

Designate individuals from your organization who will fulfill specified roles for interface with Ounce staff in the following categories. You may assign site staff to be the contact in one or more of these roles. The Ounce uses the designated site contact information to create targeted mailing and e-mail lists, and we assume that the site contact will handle the responsibilities associated with their designated role. Assign organizational contacts based on the descriptions of the required tasks and expectations of your agency, and of the staff members to fulfill these roles in relationship to ongoing management of the Ounce Subcontract.

Changes to Contact or Contact Information: To change any of the designated contacts during the fiscal year, notify your IBTI Program Manager in writing and submit all changes in contact information or designation via the Program Narrative Quarterly Report or an Amendment.

**SERVICE AGENCY SUBCONTRACTOR NAME:**

**EXECUTIVE CONTACT:** This contact has executive level authority to sign legal contracts on behalf of the Subcontracting agency. The Ounce will contact this person in the event of any funding issues or any substantive program or fiscal concerns regarding the administration of the Subcontract.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**FY18 Program Abstract**

**PROGRAM MANAGEMENT CONTACT:** This is the primary person responsible for overall management of program and fiscal matters related to the Ounce Subcontract. This includes adherence to the IBTI Best Practice Standards. The IBTI Program Manager works directly with this contact to develop the design of service and annual Program Abstract, and to negotiate the use of IBTI funds. This contract is primarily responsible for the content and timely completion of required reports. This contact supervises direct service staff or supervisors.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**STAFF DEVELOPMENT/TRAINING CONTACT:** This contact is responsible for the supervision of direct service staff, the creation of staff development plans, and the oversight of registration for and staff attendance at Ounce Institute training events. This contact is point for all staff communications related to the Ounce Institute and is responsible for day-to-day interface with site staff in all matters related to training registration, attendance, cancellations, and travel.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**FY18 Program Abstract**

**FISCAL MANAGEMENT CONTACT:** This contact is the primary person responsible for the overall financial management of the Subcontract, including compliance with the Ounce Subcontract administrative requirements and the internal allocation, oversight, and tracking of Subcontract expenditures.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**FISCAL REPORT CONTACT:** This contact is responsible for the actual preparation, submission, and correction of Quarterly Cost Reports, forecasts, and Amendments. The IBTI Fiscal Advisor works directly with this contact to provide technical assistance and training, if necessary, to ensure submission of accurate financial reports that meet Ounce requirements.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**OUNCENET/MIS CONTACT:** This contact is the primary liaison with the OunceNet team or other Ounce contacts regarding data reporting issues, initial orientation of new site staff, providing written notification to OunceNet team regarding new user or follow-up training, and distribution of OunceNet or MIS-related correspondence to OunceNet users in the Ounce funded program.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**FY18 Program Abstract**

**AGENCY TECHNOLOGY CONTACT:** This is the person responsible for ensuring ongoing compliance with the technical specifications associated with the use of OunceNet. This person works directly with the OunceNet team or other specified Ounce contact to address and resolve technical issues related to OunceNet.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**FY18 Program Abstract**

**PROGRAM STAFFING**

List all staff members that provide direct services and program supervision that appear on page two (2) in the Personnel section of the Budget. For each staff member listed by name and job title, show the distribution of % FTE in Program in the Direct Services and % Supervision columns (i.e., adding the numbers in the Direct Services and % Supervision columns will equal the number in the % FTE in Program).

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name/Title** | **% FTE Agency** | **% FTE**  **Program** | **Direct Services** | | | | | **% Supervision** | **Supervised By** | **Freq. of Individual Supervision** |
| **% HV** | **% Doula** | **% PGS** | **% FAW** | **% IMH** |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |

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**FY18 Program Abstract**

**PROGRAM STAFFING, continued**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name/Title** | **% FTE**  **Agency** | **% FTE**  **Program** | **Direct Services** | | | | | **% Supervision** | **Supervised By** | **Freq. of Individual Supervision** |
| **% HV** | **% Doula** | **% PGS** | **% FAW** | **% IMH** |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |

**INTERNAL PROGRAM MANAGEMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staffing (review of participant or group of participant cases)** | Weekly or more frequently | Twice a month | Monthly | Quarterly |
| **Team Meetings** | Weekly or more frequently | Twice a month | Monthly | Quarterly |
| **Doula Clinical Support: Meetings with Doulas** | Weekly or more frequently | Twice a month | Monthly | Quarterly |
| **Doula Clinical Support: Meetings with Doula Supervisor** | Weekly or more frequently | Twice a month | Monthly | Quarterly |

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**FY18 Program Abstract**

**HOME VISITING SERVICES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Title** | **% HV Supervision** | **% HV Direct Services** | **Point Capacity of Caseload**  **(% HV Direct Services x 26)** |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
| Program Capacity: Total Point Value | | |  |
| Total Point Value to maintain at any one time (Total Point Value x 85%) | | |  |

|  |
| --- |
| **Please indicate the name(s) of the core curricula used in the home visiting program:** |
| 1. |
| 2. |
| 3. |

***Reference Note:***

**WEIGHTED CASELOAD SYSTEM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Level 1P** | **Level 1** | **Level 2** | **Level 3** | **Level 4** | **DHVM** | **Creative Outreach** |
| 2 pts | 2 pts | 1 pt | .5 pts | .25 pts | 2 pt | .5 pts |

**Full caseload = 26 points (HFA full caseload = 30 points)**

**WEIGHTED CASELOAD SYSTEM**

***When the participant is active in both the home visiting and Doula components, the Doula Home Visiting Model is used.***

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**FY18 Program Abstract**

**DOULA SERVICES**

If not applicable to this program, please check here

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Title** | **% FTE in Doula Home Visiting** | **% FTE in Prenatal Group Services** | **Caseload Size at any Time\*\*** |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |

**Total # of Participants Receiving Doula Home Visiting Services in FY18**

|  |  |
| --- | --- |
| **# Enrolled** |  |
| **# Short-term\*** |  |
| **Total\*\*** |  |

\*Participants targeted for short-term or a single service component and not expected to be involved in long-term home visiting within the IBTI program.

\*\*1 FTE Doula is expected to serve a minimum of 23 participants per year; caseload size at any time is expected to be a minimum of nine

**Perinatal Clinical Support Provider in FY18**

**Name:**

**Agency:**

**Credentials:**

|  |
| --- |
| **Please indicate the name(s) of the core curricula used for prenatal home visiting:** |
| 1. |
| 2. |
| 3. |

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**FY18 Program Abstract**

**DOULA HOME VISITING MODEL**

Indicate the number of visits each month in the staff columns to illustrate the program model of Doula Services.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ENROLLED PARTICIPANT** | **# Doula Visits** | **# Combined Visits\*** | **Total suggested Doula visits** | **# HV Visits** | **Total # of Visits** | **Total # suggested visits** |
| **Prenatal Month 7\*\*** |  |  | **2-4** |  |  | **3-5** |
| **Prenatal Month 8** |  |  | **3-5** |  |  | **4-6** |
| **Prenatal Month 9** |  |  | **3-5** |  |  | **4-6** |
| **Total Prenatal Visits** |  |  | **8-14** |  |  | **11-17** |
| **Postnatal Month 1** |  |  | **4-5** |  |  | **4-6** |
| **Postnatal Month 2\*\*** |  |  | **2-3** |  |  | **3-5** |
| **Total Postnatal Visits** |  |  | **6-8** |  |  | **7-11** |
| **Total Visits to Participant** |  |  | **14-22** |  |  | **18-28** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SHORT-TERM PARTICIPANT** | **# Doula Visits** | **# Combined Visits\*** | **Total suggested Doula visits** | **# HV Visits** | **Total # of Visits** | **Total # suggested visits** |
| **Prenatal Month 7\*\*** |  |  | **2-4** |  |  | **3-5** |
| **Prenatal Month 8** |  |  | **3-5** |  |  | **4-6** |
| **Prenatal Month 9** |  |  | **3-5** |  |  | **4-6** |
| **Total Prenatal Visits** |  |  | **8-14** |  |  | **11-17** |
| **Postnatal Month 1** |  |  | **4-5** |  |  | **4-6** |
| **Postnatal Month 2\*\*** |  |  | **2-3** |  |  | **3-5** |
| **Total Postnatal Visits** |  |  | **6-8** |  |  | **7-11** |
| **Total Visits to Participant** |  |  | **14-22** |  |  | **18-28** |

\*Combined Visit refers to a single home visit where both a Doula and home visitor (for an enrolled participant) or Doula and a community partner (for a short-term participant) are present.

\*\*Programs may choose to have Doulas visit prior to the third trimester of pregnancy or after the baby turns three months old, but there are no contractual expectations for these visits.

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**FY18 Program Abstract**

**PARENT GROUP SERVICES – ONGOING PARENT GROUPS**

If not applicable to this program, please check here

Enter information for each ongoing group for which a Group Profile will be created in OunceNet. Note: “Cycle” refers to the number of times the same group is held for the same returning core of group members.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Group Name and Staff (includes volunteers)** | **# of Sessions** | | | | **Total Group Sessions** | **# in Groups Enrolled** | **# in Groups Short-term** | **Meeting Day/Time** | **Location\*** | **Meals** | **Child Care** | **Trans.** |
| **Q1** | **Q2** | **Q3** | **Q4** |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
| **Total # of Sessions** | | | | |  |  | | | | | | |
| **Total # of Participants to be Served** | | | | | |  |  |  | | | | |

|  |
| --- |
| **\*\*\* LOCATION CODES**  S= School-based  C= Center-based  O= Other facility, i.e., church, other agency |

|  |
| --- |
| **Please list the name(s) of the core group curricula used:** |
| 1. |
| 2. |
| 3. |

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**FY18 Program Abstract**

**PARENT GROUP SERVICES – PRENATAL GROUPS**

If not applicable to this program, please check here

Enter information for each ongoing group for which a Group Profile will be created in OunceNet.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Group Name and Staff (includes volunteers)** | **# of Sessions** | | | | **Total Group Sessions** | **# in Groups Enrolled** | **# in Groups Short-term** | **Meeting Day/Time** | **Location\*** | **Meals** | **Child Care** | **Trans.** |
| **Q1** | **Q2** | **Q3** | **Q4** |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
| **Total # of Sessions** | | | | |  |  | | | | | | |
| **Total # of Participants to be Served** | | | | | |  |  |  | | | | |

|  |  |
| --- | --- |
| **\*\* FREQUENCY OF SESSION CODES**  EOM= Every two months/every other month  M= Monthly  2M= Twice a month  W= Weekly or more frequently | **\*\*\* LOCATION CODES**  S= School-based  C= Center-based  O= Other facility, i.e., church, other agency |

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**FY18 Program Abstract**

**PTS/HFI SITES – FAMILY ASSESSMENT SERVICES**

If not applicable to this program, please check here

Please indicate which model you are using to determine program eligibility:

Kempe Family Stress Checklist

One Step Eligibility Screening

Programs using the Kempe Family Stress Checklist, please complete the following table:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Title** | **% FTE in Agency** | **% FTE FAW** | **# Completed Assessments per Year** |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
| **Total (minimum of 192 assessments per year per 100% FTE)** | | |  |

Programs using the One Step Eligibility Screening, please provide the number of screenings to be completed during the fiscal year:

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**FY18 Program Abstract**

**CLINICAL/INFANT MENTAL HEALTH SERVICES**

If not applicable to this program, please check here

|  |  |  |
| --- | --- | --- |
| **Name/Title** | **% FTE in Agency** | **% FTE IMH** |
|  | % | % |
|  | % | % |

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Consultation** | | | |
| **Modality**  **(case staffing, individual staff consultation, training)** | | **Frequency** | |
|  | |  | |
|  | |  | |
|  | |  | |
| **Clinical Work with Families** | | | |
| **Estimated number served at any one time:** |  | **Estimated average # of sessions per family:** |  |
| **Estimated number served annually:** |  |
| **Group Facilitation** | | | |
| **Name of Group** | | **Frequency** | **Est. # Served** |
|  | |  |  |
|  | |  |  |
|  | |  |  |
| **Other (briefly describe other planned work and estimate numbers of participants served)** | | | |
|  | |  | |
|  | |  | |

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**FY18 Program Abstract**

**COMMUNITY EDUCATION**

If not applicable to this program, please check here

|  |  |  |
| --- | --- | --- |
| **Event Name/Staff** | **Frequency** | **# Attendees Expected** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total** | |  |

**FREQUENCY CODES**

|  |  |  |
| --- | --- | --- |
| A = Annually | 3Y = Three times per year | 2Y = Twice per year |
| Q = Quarterly | M = Monthly | 2M = Twice per month |
| W = Weekly or more frequently | AN = As Needed | NA = Not applicable |

Community education events are events utilized to promote your program or to keep the community informed about program activities. Examples include, but are not limited to, presentations to high schools, maternity fairs, health fairs, agency open houses, etc. If you have any questions about whether or not an event is considered community education, please contact your Program Manager or Program Advisor.

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**FY18 Program Abstract**

**LIST OF REQUIRED SUPPORTING DOCUMENTATION**

The following documentation is to be maintained on-site and made available to Ounce staff for inspection upon request:

**Consent to Participate** (see pages 171-174): *All participant files will contain the IBTI Program Consent to Participate form (rev. 4/1/14)*. This signed form indicates participant's consent to receive services, rights to confidentiality, and consent to share information (intake, services usage, and life events) with the Ounce, DHS, ISBE, CPS, and the Governor’s Office of Early Childhood. The consent form is available on the Ounce/IBTI Web site (www.opfibti.org) or through your Program Advisor.

**Child Abuse & Neglect Reporting Protocol**

Date last revised:

**Screening & Assessment**:

If not applicable to this program, please check here

If funded for HFI, list written agreements with the agencies providing screening and referral sources for the program.

|  |  |  |
| --- | --- | --- |
| **Agency** | **Nature of Agreement** | **Date signed by collaborating agency** |
|  |  |  |
|  |  |  |
|  |  |  |

**Doula Services**:

If not applicable to this program, please check here

If funded for Doula Services, written agreements with the hospitals specified below, stating that hospitals will allow Doulas to have access to labor and delivery.

|  |  |  |
| --- | --- | --- |
| **Hospital** | **Nature of Agreement** | **Date signed by hospital** |
|  |  |  |
|  |  |  |
|  |  |  |

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**FY18 Program Abstract**

**HEART TO HEART SITE SUPPORT AND INTERVENTION PLAN**

If not applicable to this program, please check here

Complete the following chart about your agency’s plans for Heart to Heart staff and implementation.

**Staff and Resource Information**

|  |  |
| --- | --- |
| **Staff Positions** | **Name of Staff Member** |
| **Program Director** |  |
| **Heart to Heart Program Contact: name, e-mail address, and phone number** |  |
| **Clinical Consultant** |  |
| **Community Resources** | **Agency Name** |
| **Sexual Assault Counseling** |  |
| **Domestic Violence Counseling** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Facilitators (2 facilitators per group required)** | **Projected # of Participants (specify language)** | **Projected Start Date** | **Projected Graduation Date** |
| **Heart to Heart**  **Group 1** |  | **# English –** |  |  |
| **# Spanish –** |
| **Heart to Heart**  **Group 2**  **(requires Ounce approval)** |  | **# English –** |  |  |
| **# Spanish -** |
| **Heart to Heart**  **Group 3**  **(requires Ounce approval)** |  | **# English –** |  |  |
| **# Spanish -** |