

FY 2009 & FY 2010 Application for Maternal and Child Health Grant Application Procedure (GAP)

The Indiana State Department of Health (ISDH) Maternal and Children's Special Health Care Services Division (MCSHC) is requesting applications from local and statewide service providers and planning organizations to provide services and planning for Maternal and Child Health and Children with Special Health Care Needs, to be funded by ISDH MCSHC through the Maternal and Child Health (MCH) Block Grant under Title V of the Social Security Act of 1934.

In spring 2005, MCSHC identified ten health priorities (listed in the GAP) through a data driven needs assessment process with statewide citizen input. The primary MCSHC health priority is to improve infant health outcomes. MCSHC is currently emphasizing initiatives to significantly decrease the percentage of Indiana women who smoke during pregnancy.

This grant application will be open to all projects proposing to address the four ISDH Public Health Initiatives and two or more of the ten identified Maternal and Child Health priorities. Applicants will be required to identify at least one measurable deliverable related to each of these priorities and initiatives.

This Grant Application Procedure is integrated with the mission of the Indiana State Department of Health (ISDH): "The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities."

ISDH has also developed the following Priority Health Initiatives:

1. Data-driven efforts for both health conditions and health systems initiatives
 - Effective, efficient, and timely data collection.
 - Evidence-based and results-oriented interventions based on best practices.
2. INShape Indiana
 - Promote prevention and individual responsibility, especially in the areas of obesity prevention through good nutrition and exercise and smoking cessation.
 - Participate in this effort with all components of communities – collaborative partners.
 - Integrate INShape opportunities in all programming and communications.
3. Integration of medical care with public health
 - Appropriately targeted access to care for underserved Hoosiers.
 - Opportunities for Medicaid demonstration projects to showcase successful public health-based interventions.
 - All direct and enabling services providers must be Medicaid providers.
4. Preparedness
 - Continual scanning for developing public health threats, regardless of cause of the threat (particularly direct medical care projects).
 - Planning and training for poised and effective response to threats that cannot be prevented.
 - Coordinate with the Local Public Health Coordinator.

REQUIREMENTS

All MCHSC applicants must address either MCSHC Priority #1 and one or more of Priorities #3 - #10 **or** MCSHC Priority #2 and one or more of Priorities #3 - # 10 (see page 4). All MCSHC applicants are also required to incorporate each of the four ISDH priority health initiatives (above) into their local project efforts. For example, applicants must submit evidence-based interventions for which data will be collected that can show results-oriented outcome improvements based on MCSHC Priority #1 or #2 and one or more of the other MCSHC priorities. Projects must participate in community collaborations to promote INShape Indiana and promote individual responsibility within their project clientele, particularly for smoking cessation and obesity prevention

and weight management efforts. Projects must work within their community in establishing preparedness responses to emergencies and determining their appropriate role in emergency response.

Benchmark Needs Assessment data were also used to determine focus counties (see Appendix E) in which to target resources. MCHSC will assign additional evaluation weight to projects providing services in focus counties that impact the MCSHC priorities that need to be addressed.

Instructions

1. An application for Maternal and Child Health Block Grant funds must be received by Maternal and Child Health Services by the close of business on **Friday, March 7, 2008**.
2. Mail application to: Indiana State Department of Health
Maternal and Child Health Services
ATTENTION: Randy Gardner
2 North Meridian Street, Section 8C
Indianapolis, IN 46204
3. Submit the original proposal and three copies. Do not bind or staple.
4. The application must be typed (no smaller than 12 pitch, printed on one side only) and double-spaced. Each page must be numbered sequentially beginning with Form A, the Applicant Information page.
5. The narrative sections of the application must not exceed 30 double-spaced typed pages. Applications exceeding this limit will not be reviewed.
6. Appendices, excluding CVs, must not exceed 20 pages. Appendices that serve only to extend the narrative portion of the application will not be accepted.
7. The application must follow the format and order presented in this guidance. Applications that do not follow this format and order will not be reviewed.
8. The application will not be reviewed if all sections are not submitted.

Note: Questions about this application should be directed to Vanessa Daniels, Grants Coordinator, at VDaniels@isdh.IN.gov or 317/233-1241, or Courtney Eddy, Genetics Specialist, at CEddy@isdh.IN.gov or 317/233-9260.

Informing Local Health Officers of Proposal Submission

Funded projects are expected to collaborate with local health departments. If you are unable to submit a letter of support from the local health officer, at a minimum, submit copies of letters sent to the local health officers, from all jurisdictions in the proposed service area, informing them of your application. These letters should include requests for support and collaboration and indicate that the proposal was included for review by the health officer(s).

FORMS

Applicant Information (Form A)

MCH Project Description (Forms B-1 and B-2) *NOTE: B-1 does not substitute for a project summary.*

Funding Currently Received by Your Agency from ISDH (Form C)

APPENDICES

Appendix A – Genetic Services Annual Performance Report

Appendix B –Definitions (MCH and Genetic Services)

Appendix C – Indiana MCSHC Consultant Assignments

Appendix D - MCSHC Consultant Assignments Map

Appendix E – Focus Counties

Appendix F – Health Professional Shortage Areas (HPSA)

Appendix G – Medically Underserved Areas (MUA)

Appendix H – At-Risk Lead Concentration Areas

Appendix I – ISDH and Public Health Partners Field Staff

Appendix J – Grant Application Scoring Tool

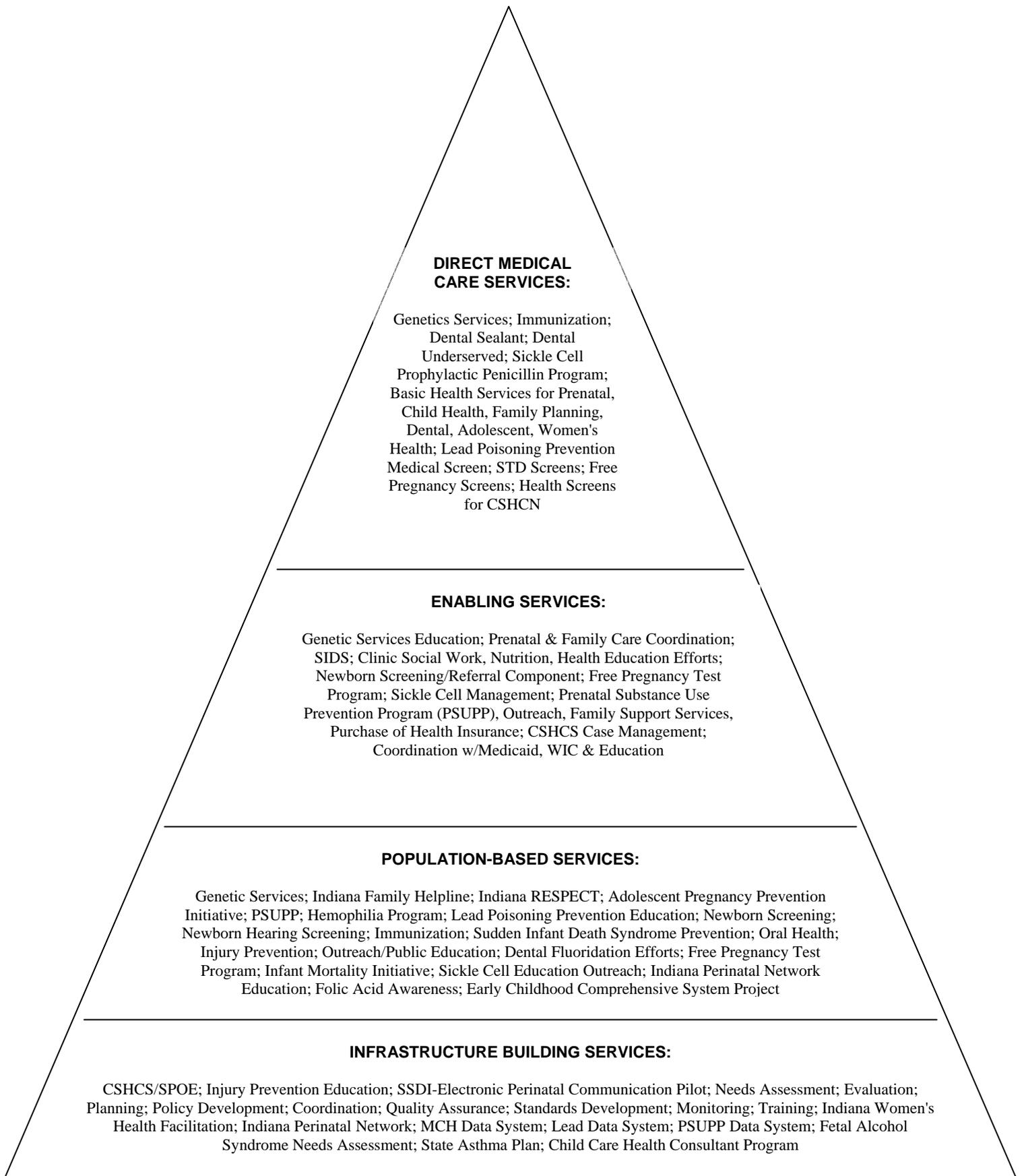
WEBSITES

- FY 2009 & FY 2010 MCH GAP:
<http://www.in.gov/isdh/programs/mch/grantopportunities/grantopportunities.htm>
- Application with linkages to data: <http://www.state.in.us/isdh/programs/mch/index.htm>
- Direct data sites for: MUA/HPSA data: <http://www.bphc.hrsa.gov/bphc/database.htm>
- Health data: http://www.in.gov/isdh/dataandstats/data_and_statistics.htm
- Poverty data: http://www.stats.indiana.edu/welfare_topic_page.html
- “Best Practice” guidelines for pregnant women: <http://www.indianaperinatal.org>
- County Fact Sheets with MCSHC Priority Counties:
<http://www.in.gov/isdh/programs/mch/countydatasheet.htm>
- Title V FY 2008 – 2010 Needs Assessment:
<http://www.in.gov/isdh/programs/mch/NAwithactivitiesattachmentfinal.pdf>
- National Center for Cultural Competence: <http://gucchd.georgetown.edu/nccc/index.html>
- Indiana Department of Administration list of Minority and Women’s Business Enterprises:
<http://www.in.gov/idoa/minority/Certifications.xls>

Priority Health Needs for the MCSHC population, 2006 - 2011

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality, and racial and ethnic disparities in pregnancy outcomes. (ISDH Priorities #1 & #3)
2. To reduce barriers to access to health care, mental health care, and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women, and families. (ISDH Priorities #1, #3, & #4)
3. To build and strengthen systems of family support, education, and involvement to empower families to improve health behaviors. (ISDH Priorities #1, #2, & #3)
4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning, and birth defects. (ISDH Priorities #1, #2, #3 & #4)
5. To decrease tobacco use in Indiana, particularly among pregnant women. (ISDH Priorities #1, #2, & #3)
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs. (ISDH Priorities #1 & #3)
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior (including teen pregnancy), unhealthy dietary behaviors, and physical inactivity. (ISDH Priorities #1, #2, & #3)
8. To reduce obesity in Indiana. (ISDH Priorities #1, #2, & #3)
9. To reduce the rates of domestic violence to women and children, child abuse, and childhood injury in Indiana. (ISDH Priorities #1 & #3)
10. To improve racial and ethnic disparities in women of childbearing age, mothers, and children's health outcomes. (ISDH Priorities #1 & #3)

FIGURE 2: CORE PUBLIC HEALTH SERVICES



FY 2009 & FY 2010 Genetic Services Application Guidance

1. Applicant Information Page (Form A)

This is the first page of the proposal. **Complete all items on the page provided (Form A).** The project director and the person authorized to make legal and contractual agreements for the applicant agency must sign and date this document. If the project will not require a medical and/or dental director, write “not applicable” on the appropriate line(s). All appropriate lines must be signed and dated. While the signature of the County Health Officer is not mandatory, if there is no signature, this space should be used to note the date that letters were sent to all affected County Health Officers.

2. Table of Contents

The table of contents must indicate the page where each section begins, including appendices.

3. Genetic Services Proposal Narrative

A. Project Summary

NOTE: This is a separate narrative section. The abstract on form B-1 will be taken from this summary.

Begin this page with the Title of Project as stated on the Applicant Information Page. The summary will provide the reviewer a succinct and clear overview of the MCH proposal. The summary will be the last section written and should:

- Relate to Title V program services only;
- Identify the problem(s) to be addressed;
- Succinctly state the objectives; and
- Include an overview of solutions (methods).
- Currently funded programs should also emphasize accomplishments/progress made toward previously identified MCH objectives and outcomes.
- Currently functioning services should indicate the percentage of the target population served by your project and the percentage of minority clients among your population.

B. Form Completion

All information on the Genetic Services Project Description (Form B) must be completed.

Indicate how many patients will be served for FY 2009 and for FY 2010. This summary form with its narrative will become part of the contract and will also be used as a fact sheet on the project. Page B-2 requests specific information on each clinic site. The following information should be included:

FORM B-1

- Project Description section must include, at a minimum, a history of the project, problems to be addressed, and a summary of the objectives and work plan. Any other information relevant to the project may also be included, but this should be an abstract of the Project Summary described in section A. *Hint: If it runs to more than one page, you've written too much.*
- May not be more than one page, but may be single-spaced.

FORM B-2

- Target population and estimated number to be served on page B-2 is for the individual clinic site(s) and is the number to be served with MCH and local matching funds.
- Total MCH budget for site is the estimated MCH and local matching funds budgeted for the individual clinic site.
- Services provided in MCH budget site should include only those services provided with MCH and local matching funds.
- Other services provided at site should include all services offered at clinic site other than MCH and local matching funded services.

4. Applicant Agency Description

This description of the sponsoring agency should:

- Include a statement of purpose (mission statement);
- Include a brief history;
- Identify strengths and specific accomplishments pertinent to this proposal;
- Include a discussion of the administrative structure within which the project will function within the total organization (attach an organizational chart);
- Identify project locations and discuss how they will be an asset to the project; and
- Include a discussion on the collaboration that will occur between the project and other organizations and healthcare providers. The discussion should identify the role of other local agencies and specify how each collaborates with your organization. Attach Memoranda of Understanding (MOU), Memoranda of Agreement (MOA) and Letters of Support (LOS).

Note: Large organizations should write this description for the unit directly responsible for administration of the project.

5. Statement of Need

Describe and document the specific problem(s) or need(s) to be addressed by the project. This section must address those MCSHC priorities that you intend to impact. Documentation may be provided by reference – do not include copies of source material. Documentation may include current data, research, local surveys, reports from the local Health Department or United Way, and must include data available from the ISDH website. Proposals to address problems that are not adequately supported with such data will not be considered.

The problems identified should:

- Clearly relate to ISDH MCSHC Priorities (see Page 4);
- At least one problem must relate to either MCSHC Priority #1 or Priority #2;
- Specifically address one or more of MCSHC priority needs #3 - #10;
- Clearly relate to the purpose of the applicant agency;
- Include only those problems that the applicant can impact;
- Be client/consumer focused;
- Be supported by data available on the ISDH website and/or from local sources (this evidence must show that the problem(s) or need(s) exist(s) in *your* community);
- Describe the target population(s) and numbers to be served and identify catchment areas;

- Describe the system of care and how successfully the project fits into the system (identify the public service providers and the number of private providers in the area serving the same population with the same services and indicate a need for the project);
- Describe barriers to access to care;
- Address disparities if the county has significant minority populations; and
- Indicate whether the program provides services in a focus county (Appendix E), Health Professional Shortage Area (HPSA – Appendix F), Medically Underserved Area (MUA – Appendix G), and/or an at-risk lead concentration area (Appendix H), or provides child health services in a county with inadequate child health providers (Appendix D).

6. Performance Objectives and Activities

MCSHC requires that grantees be accountable for some of the 18 MCHB and 8 State Negotiated Performance Measures that relate to their service category and some related Performance Measures that require direct or enabling services to make an impact. Genetic Services projects have mandatory related Performance Measures (see pages 14-21).

Pages 14-21 provide the format for applicants to indicate the goal (Annual Performance Objective) for each Performance Measure, the baseline from which the project will improve or maintain the Performance Measures, and the activities on which the project will focus to impact the performance measure (Work Plan Measurable Activities). Activities must reflect a comprehensive plan to achieve the objective. Some PM tables list required activities. Projects applying for these Performance Measures must list additional activities to accomplish the objective.

All applicants are required to incorporate each of the four ISDH priority health initiatives into their service delivery (see page 1 for a list). Issues such as data collection, emphasis on prevention and individual responsibility, integration of INShape Indiana, targeting access to care, and scanning for public health threats should be addressed in the activities on the Performance Measure tables. Emphasis should be on health outcomes (e.g. smoking cessation or weight control).

For each activity on the table, the applicant must indicate a clear and objective method to measure and document the activity, what documentation will be used, and what staff position is responsible for implementing, measuring, and documenting that activity.

Applicants are to complete the Genetic Services Performance Measures on pages 14-21. There is an additional blank table for optional project-specific performance measures, objectives and activities that an applicant may add based on local needs. This blank table should be copied for each additional objective and activities added by the project. Project-specific activities will be evaluated as part of the quality evaluation of the project. **Applicants are strongly encouraged to discuss development of project-specific performance measures with MCSHC consultants before submitting them with the grant application.**

Pages 14 – 21 are to be used by grantees to monitor progress on each activity and to submit in the Annual Performance Report for FY 2009 and FY 2010 after each year is completed. The columns on the Performance Measures forms for Quarterly Results, Adjustment in Work Plan, and Problems are also to be completed and submitted with the FY 2009 and FY 2010 Annual Performance Reports. MCSHC consultants will contact projects quarterly to monitor progress on the activities and provide

technical assistance. All applicants are required to collect data for monitoring purposes. See Appendix A (the Annual Performance Report) for required monitoring data elements. This information will be reported in the FY 2009 and FY 2010 Annual Performance Reports.

7. Evaluation Plan

NOTE: This should be a separate narrative section. Evaluation methods reflected on the Performance Measures Tables should be included in the overall Evaluation Plan.

A project evaluation plan should have two parts: an evaluation plan to determine whether the evidence-based interventions/activities are working to impact both the specific objective goal and the priority/ies and a quality assurance evaluation plan to ensure that services are performed well.

In the first part, discuss the methodology for measuring the achievement of activities. The plan should include intermediate (e.g. monthly, quarterly) measures of activities as well as assessment at the end of the funding period. An effective evaluation requires that:

- Project-specific activities to meet objectives are clear and measurable;
- Plan explains how evaluation methods reflected on the Performance Measure forms will be incorporated into the project evaluation;
- Staff member(s) responsible for the evaluation is/are identified;
- Plan includes explanation of what data will be collected and how it will be collected;
- Plan lists how and to whom data will be reported;
- Appropriate methods are used to determine whether measurable activities and objectives are on target for being met; and
- If activities and objectives are identified as off-target during an intermediate or year-end evaluation and improvement is necessary to meet goals, staff member(s) responsible for revisiting activities to make changes which may lead to improved outcomes is/are identified.

In the second part, discuss:

- Methods used to evaluate quality assurance (e.g. chart audits, patient surveys, presentation evaluations, observation); and
- Methods used to address identified quality assurance problems.

8. Staff

List all staff that will work on the project. Include name, job title, primary duties, and number of hours per week for each staff member. *Hint: Make sure the number of staff hours reflected in this list agrees with the staff hours totals listed on the Budget Summary page.*

Describe the relevant education, training, and work experience of the staff that will enable them to successfully develop, implement, and evaluate the project. Submit job descriptions and curriculum vitae of key staff as an appendix. Copies of current professional licenses and certifications must be on file at the organization. In this section you must show that:

- Staff is qualified to operate proposed program;
- Staffing is adequate; and
- Job descriptions and curriculum vitae (CVs) of key staff are included as an appendix.

9. Facilities

Describe the facilities that will house project services. Address the adequacy, accessibility for individuals with disabilities in accordance with the Americans with Disabilities Act of 1990, and assure that project facilities will be smoke-free at all times. Hours of operation must be posted and visible from outside the facility. (Include evening and weekend hours to increase service accessibility and indicate hours of operation at each site on Form B-2).

In this section you must demonstrate that:

- Facilities are adequate to house the proposed program;
- Facilities are accessible for individuals with disabilities;
- Facilities will be smoke-free at all times; and
- Hours of operation are posted and visible from outside the facility.

10. Budget and Budget Narrative

NOTE: Do not combine budget information for FY 2009 and 2010. You must complete separate budget pages for each fiscal year.

In this section, be sure to demonstrate that:

- All expenses are directly related to project;
- Relationship between budget and project objectives is clear; and
- Time commitment to project is identified for major staff categories and is adequate to accomplish project objectives.

Complete this entire section by providing budget information for FY 2009 and for FY 2010. The budget is an estimate of what the project will cost. Complete the standard budget forms (MCH Budget pages 1, 2, and 3) provided according to directions. Do not substitute a different format. Projects must include matching funds equaling a minimum of 30% of the MCH budget (see budget instructions for matching funds requirements).

NOTE: A Budget Narrative form is provided. Do not substitute a different format.

The budget narrative must include a justification for every MCH line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the MCH budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties.

In-state travel information must include miles, reimbursement, and reason for travel. Travel reimbursement may not exceed State rates. Currently, the in-state travel reimbursement is \$0.40 per mile.

Complete Form C – List all ISDH funding received by proposing organization in FY 2008.

Check for internal consistency among the budget forms:

- Budget pages 1, 2, and 3 are complete for each year
- Budget narratives include justification for each line item and are completed for each year
- Budget correlates with project duration
- Funding received for ISDH Form C is complete

- Information on each budget form is consistent with information on all other budget forms

11. Minority Participation

All applicants must include a statement regarding minority participation in the planning and operation of their MCH program. Minority individuals and/or organizations should be involved in planning and evaluating the project to ensure services are adequate for the minority community. Projects are also encouraged to seek to do business with Minority-Owned Business Enterprises to help provide services or operational support for the project. For a list of certified Minority-Owned Business Enterprises, see <http://www.in.gov/idoa/minority/Certifications.xls>

12. Endorsements

Submit letters of support and memoranda of understanding (MOU) that demonstrate a commitment to collaboration between the applicant agency and other relevant community organizations. Letters of support and MOUs must be current. Each application must include at least three letters of support from or MOUs with relevant agencies.

The local health department should be involved in planning the project. At a minimum, the local health officer in each county where services are proposed must be notified that the organization is proposing services. Signature of the local health officer on Form A is sufficient; if a signature cannot be obtained, include a copy of the organization's letter to the health officer in each service county advising of proposal submission to ISDH. If a signature is not feasible, be sure to indicate in the signature space on Form A the date that the letter was sent to all affected health officers.

Projects are also strongly encouraged to work with their Local Public Health Coordinators to enhance preparedness (ISDH Priority Health Initiative #4).

Checklist – Letters of Support and Memoranda of Understanding:

- Endorsements are from organizations able to effectively coordinate programs and services with applicant agency
- Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care
- Endorsements and/or MOUs are current
- Collaborate with Local Public Health Coordinator
- MOUs with other genetic services serving the same geographic area, including MCH funded and MCH non-funded services, clearly state how the services will work together
- Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has/have signed Form A)

13. Plan to Reduce or Eliminate Reliance on Title V funding (to be completed after funding is awarded)

Because Title V funding from the federal government has decreased, demand for services have increased, and many annual applicants for Title V funding have been receiving these funds for many

years, MCSHC staff wants to identify ways to assist grantees in reducing reliance on Title V funding while maintaining the quality and quantity of the currently funded services.

To that end, MCSHC will require each grantee for FY 2009 & 2010 to develop a plan to decrease or eliminate the need for Title V funding without eliminating the services that Title V funds (unless that service is no longer needed) to be included in the FY 2008 Annual Report for current grantees.

MCSHC wants to understand what barriers prevent projects from becoming self-supporting and what other funding sources or reimbursement opportunities are available. MCSHC staff can then assist in eliminating infrastructure barriers so that grantees can reduce reliance on Title V.

The plan should include the following:

- A list of the funding sources, amounts, and percentages for the organization or (in the case of large organizations) department in which the MCSHC grant is housed.
- A list of the total costs of the MCSHC project as a stand-alone or within a larger entity with a chart of funding sources for the MCSHC service.
- Barriers experienced in insurance reimbursements, community support, and any other issue that makes it difficult for the service provided by the grant to be self-supporting.
- Opportunities available to the project for continuous support.
- A timeline indicating what barriers need to be eliminated and when to effect a reduction or elimination of reliance on Title V funds while maintaining the currently funded services.

Questions regarding the plan to reduce or eliminate reliance on Title V funding may be directed to your HSD consultant (see pages 54 & 55), Vanessa Daniels (VDaniels@isdh.IN.gov / 317-233-1241) or Nancy B. Meade (nmeade@isdh.in.gov / 317-233-7827).

GENETIC SERVICES REQUIRED FORMS

- 1) Form A: Applicant Information**
- 2) Form B-1 and B-2: MCH Project Description**
- 3) Form C: Funding Currently Received by Your Agency from ISDH**
- 4) Performance Measures 1 - 4**

Note: Providers serving counties with significant numbers of minority populations must identify activities for Performance Measures 1 and 3 related to outreach and marketing to the minority populations to provide culturally competent services to those populations.

Indiana State Department of Health
Genetic Services

FY 2009 – 2010 OBJECTIVES and ACTIVITIES

Performance Measure 1: Provide genetic evaluation and counseling services in designated area(s).

Performance Objective 1:

- Increase** the number of patients receiving genetic services by _____%.
- Maintain** the number of patients receiving genetic services.

Service Projections

Directions: Give estimates for current and upcoming years for the total number of patients. For FY 2007, state the number of patients seen for each of the types of services listed below. **FY 2007 & 2008 numbers should be the same as your FY 2007 – 2008 application. FY 2009 and FY 2010 should be numbers that reflect the percentage increase that you have set as a goal in the Performance Objective.** Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in the annual report. Gray areas will be filled in on the quarterly and annual reports, **do not** fill them in at this time. Please see **Genetic Services Definitions** on page 68 for more information concerning types of services.

Prenatal Genetics Patients

Type of Service	# of Pregnant Women			
	FY 2007	FY 2008	FY 2009	FY 2010
Pre-Diagnosis Counseling				
Post-Diagnosis Counseling				
Genetic Counseling Only (no prenatal procedures)				
Consultations				
Telephone Contacts				
Teratogens Call Line ¹				
Total				

¹Only if applicable

Clinical Genetics Patients

Type of Service	# of Patients			
	FY 2007	FY 2008	FY 2009	FY 2010
Evaluation/Counseling: Patient is an infant < 1 year of age				
Evaluation/Counseling: Patient is a child > 1 year of age, but < 22 years of age				
Evaluation/Counseling: Patient is ≥ 22 years of age				
Genetic Counseling Only				
Consultations				
Telephone Contacts				
Total				

Supporting Activities Table

Directions: State the planned activities to increase the number of patients receiving genetic services and which staff members will be responsible for those activities. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Greater than 90% of families of children under 3 years of age are informed about First Steps.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Greater than 90% of patients/families are informed about Children's Special Health Care Services (CSHCS)		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Greater than 90% of patients/families with children < 5 years of age are informed about Women, Infants, and Children (WIC) clinic		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Indiana State Department of Health
Genetic Services

FY 2009 – 2010 OBJECTIVES and ACTIVITIES

Performance Measure 2: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

(Please report the following percentages in the subsequent tables.)

Performance Objective 2a: _____% women of childbearing age seen in clinic will be educated to the **negative** effects of **smoking** during pregnancy.

Performance Objective 2b: _____% women of childbearing age seen in clinic will be educated to the **negative** effects of **consuming alcohol** during pregnancy.

Performance Objective 2c: _____% women of childbearing age seen in clinic will be educated to the **positive** effects of taking **folic acid**.

Service Projections

Directions: We expect that at least **90%** of women of childbearing age seen in clinic will be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid. Give estimates for current and upcoming years for each of the types of services listed below. Please give actual numbers and percentages for 2007 & 2008. Only complete for patients in your project population. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

PO 2a: Women of childbearing age seen in clinic and educated to the *negative* effects of *smoking* during pregnancy

	FY 2007	FY 2008	FY 2009	FY 2010
Number of women of childbearing age who smoke and were seen in clinic that received smoking cessation education				
Number of women of childbearing age who reportedly smoke and were seen in clinic				
Percentage of women of childbearing age who smoke and were seen in clinic that received smoking cessation education				

PO 2b: Women of childbearing age who were seen in clinic and educated to the *negative* effects of alcohol consumption during pregnancy

	FY 2007	FY 2008	FY 2009	FY 2010
Number of women of childbearing age who were seen in clinic and received education on alcohol-related birth defects				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received education on alcohol-related birth defects				

PO 2c: Women of childbearing age seen in clinic and educated to the *positive* effects of taking folic acid

	FY 2007	FY 2008	FY 2009	FY 2010
Number of women of childbearing age who were seen in clinic and received folic acid education				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received folic acid education				

Directions: State which staff members will be responsible for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Develop and incorporate into your patient intake a protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol during pregnancy.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Greater than 90% of patients who admit to smoking, drinking, or using drugs, and live in an area in which a Prenatal Substance Use Prevention Program (PSUPP) exist, are informed about PSUPP.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Indiana State Department of Health
Genetic Services

FY 2009 – 2010 OBJECTIVES and ACTIVITIES

Performance Measure 3: Provide educational genetics presentations to the general public and health professionals **not** in the field of genetics.

Performance Objective 3: *(Please report the following numbers in the subsequent table.)*

Project staff will provide _____ presentations, with at least _____ presentations being given to the general public and at least _____ presentations being given to health care providers **not** in the field of genetics.

Service Projections

Directions: A **minimum of 4** presentations are to be given, with at least 2 given to the general public and 2 being given to health care professionals **not** in the field of genetics. Give estimates for current and upcoming years for each of the types of presentations listed below. Please give actual numbers for 2007. While a **minimum** of 4 talks is required, please try to give accurate estimates based on the 2007 - 2008 application. For upcoming years, please honestly project how many talks you might be providing. When the audience is mixed, count individuals under the group that makes up the majority of the audience. Do **not** count one talk under two different audiences. Please see **Genetic Services Definitions** on page 68 for more information concerning types of audiences.

Genetics Presentations

	# of Talks			
	FY 2007	FY 2008	FY 2009	FY 2010
Main audience:				
General public <i>(e.g. high school students, support groups, etc.)</i>				
Health care professionals and college or graduate-level students not in the field of genetics				
Other presentations				
Total				

Supporting Activities Table

Directions: State which staff members will be responsible for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Evaluation sheets will be collected for each talk.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Audience size will be counted at each talk. (Note: attendance or evaluation sheets may be used to determine these numbers)		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Note: Evaluation narrative should include a sample evaluation sheet and a description of how scores will be compiled.

Indiana State Department of Health
Genetic Services

FY 2009 – 2010 OBJECTIVES and ACTIVITIES

Performance Measure 4: Provide confirmation of birth defects to the Indiana Birth Defects and Problems Registry (IBDPR).

Performance Objective 4: 100% of children in the appropriate age group with a confirmed diagnosis are reported to the IBDPR.

Service Projections

Directions: For current and upcoming years, estimate the **total** number of children < 3 years old with a reportable birth defect that you will see in your clinic. **If you have not already submitted a report for these children, please do so in the near future.** Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time. A list of reportable conditions and PDF version of the reporting form can be found at <http://www.in.gov/isdh/programs/ibdpr/reporting.htm>.

Reporting to the IBDPR

	# of Patients			
	FY 2007 (Baseline)	FY 2008	FY 2009	FY 2010
Number of children < 3 years of age* with at least 1 reportable birth defect that were reported to the IBDPR				
Total number of children < 3 years of age* with at least 1 reportable birth defect				
Percentage of observed birth defects reported to IBDPR				

*up to 5 years of age for autism or FAS

Supporting Activities Table

Directions: State which staff members will be responsible for the following activities, the current status of each activity, and provide a brief comment on how this activity is to be completed. Additional activities can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Complete a reporting form for each patient < 3 years of age (5 years for autism or FAS) that is born with a reportable condition and then fax the form to ISDH.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Indiana State Department of Health
Genetic Services

FY 2009 OBJECTIVES and ACTIVITIES

Project Specific Performance Measure:

Project Specific Performance Objective :

Service Projections

	FY 2007 (Baseline)	FY 2008	FY 2009	FY 2010

Supporting Activities Table

Directions: State which staff members will be responsible for the following activities, the current status of each activity, and provide a brief comment on how this activity is to be completed. Additional activities can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Completing Section I - Sources of Anticipated Revenue

List all anticipated revenue according to source. If the project was funded in previous years with Maternal and Child Health funds, estimate the cash you expect to have available from the previous year. This estimated cash-on-hand should be indicated by 400.1 and/or 400.2, respectively. If the estimated cash balance is negative, please list the estimate as \$0. All revenue used to support the project operations must be budgeted.

Projects must include matching funds equaling a minimum of 30% of the MCH budget. **“In-kind” contributions are not to be included in the budget. Projects that cannot meet these requirements must provide written justification in the budget narrative.** Matching funds are subject to the same guidelines as MCH funds (i.e., no equipment, food, entertainment or legislative lobbying). Costs of a modem line for each of your MCH computers and costs of Internet access are allowable.

Non-matching funds are additional sources of support that are not included in the match. These funds are not subject to MCH guidelines. *Hint: Do not overmatch. Funds supporting the program that are above the minimum 30% match requirement may be listed as “Other Non-Matching.”*

In the space at the bottom of Section I, please be sure to indicate how many hours are worked in a “normal” work week. This is usually determined by the applicant agency's policies.

Completing Section II - Estimated Cost and Clients to be Served

It is essential that this form be completed accurately because the information will be used in your contract. Your project will be accountable for the services that are listed and the number estimated to be served.

Estimate the MCH Cost per Service listed, e.g. how much of your MCH grant you propose to expend in each service. Figures for this are listed by service category in the column entitled **“MCH COST PER SERVICE.”** The total at the bottom of this column should equal the MCH grant award request.

Estimate the MCH Matching Funds allocated per service listed, e.g. how much of the MCH match you propose to expend in each service. The total at the bottom of this column should equal the total match you are adding to the MCH award to fund this program.

Estimate the number of unduplicated clients by service category who will receive each service in the column titled **“TOTAL UNDUPLICATED # ESTIMATED TO BE SERVICED”** by both MCH and MCH Matching Funds.

(The rest of this page left blank intentionally)

DEFINITIONS - REVENUE ACCOUNTS

Account	Account Title	Description
413	MCH Grant Request	Funds requested as reimbursement from the Indiana State Department of Health for project activities.
Matching Funds*		<i>Cash used for project activities that meet the matching requirements.*</i>
417	Local Appropriations	Monies appropriated from the local government to support project activities, e.g. local health maintenance fund.
419	First Steps	Monies received from First Steps for developmental disabilities services.
421	Donations – Cash	Monies received from donors to support project activities.
424	United Way/March of Dimes	Monies received from a United Way/March of Dimes agency to support project activities.
432	Title XIX – Hoosier Heathwise and Title XXI, CHIP	Monies received from Hoosier Healthwise and CHIP as reimbursement provided for services to eligible clients.
434	Private Insurance	Monies received from public health insurers for covered services provided to participating clients.
436	Patient Fees	Monies collected from clients for services provided based on the Maternal and Child Health Services-approved sliding fee schedule, including walk-ins.
437	Other Matching	Other income directly benefiting the project and not classified above which meets matching requirements.
Nonmatching Funds		<i>Funds that do not meet matching requirements.</i>
433	Title XX	Monies received from State Title XX agency (Family and Social Services Administration) for reimbursement provided for family planning services to eligible clients.
439	Other Nonmatching	Other income directly benefiting the project and not classified above which does not meet matching requirements.
Estimated Cash on Hand as of June 30 th of last FY		<i>Monies received by the project during the previous fiscal years and not yet used for project expenditures.</i>
400.1	Matching Cash on Hand	Those monies received during previous years from sources classified as matching.
400.2	Nonmatching Cash on Hand	Those monies received during previous years from sources classified as nonmatching.

* Matching requirements include:

1. Amounts are verifiable from grantee's records.
2. Funds are not included as a matching source for any other federally assisted programs.
3. Funds are allocated in the approved current budget.
4. Funds are spent for the Maternal and Child Health project as allocated and the expenditure of these funds is reported to Maternal and Child Health Services.
5. Funds are subject to the same guidelines as MCH grant funds (i.e., no equipment, food, entertainment, or legislative lobbying).

SCHEDULE A - CHART OF ACCOUNT CODES

111.000	<u>PHYSICIANS</u>	
	Clinical Geneticist	OB/GYN
	Family Practice Physician	Other Physician
	General Family Physician	Pediatrician
	Genetic Fellow	Resident/Intern
	Medical Geneticist	Substitutes/Temporaries
	Neonatologist	Volunteers
111.150	<u>DENTISTS/HYGIENISTS</u>	
	Dental Assistant	Substitutes/Temporaries
	Dental Hygienist	Volunteers
	Dentist	
111.200	<u>OTHER SERVICE PROVIDERS</u>	
	Audiologist	Outreach Worker
	Child Development Specialist	Physical Therapist
	Community Educator	Physician Assistant
	Community Health Worker	Psychologist
	Family Planning Counselor	Psychometrist
	Genetic Counselor (M.S.)	Speech Pathologist
	Health Educator/Teacher	Substitutes/Temporaries
	Occupational Therapist	Volunteers
111.350	<u>CARE COORDINATION</u>	
	Licensed Clinical Social Worker (L.C.S.W.)	Social Worker (B.S.W.)
	Licensed Social Worker (L.S.W.)	Social Worker (M.S.W.)
	Physician	Substitutes/Temporaries
	Registered Dietitian	Volunteers
	Registered Nurse	
111.400	<u>NURSES</u>	
	Clinic Coordinator	Other Nurse
	Community Health Nurse	Other Nurse Practitioner
	Family Planning Nurse Practitioner	Pediatric Nurse Practitioner
	Family Practice Nurse Practitioner	Registered Nurse
	Licensed Midwife	School Nurse Practitioner
	Licensed Practical Nurse	Substitutes/Temporaries
	OB/GYN Nurse Practitioner	Volunteers
111.600	<u>SOCIAL SERVICE PROVIDERS</u>	
	Caseworker	Social Worker (B.S.W.)
	Licensed Clinical Social Worker (L.C.S.W.)	Social Worker (M.S.W.)
	Licensed Social Worker (L.S.W.)	Substitutes/Temporaries
	Counselor	Volunteers
	Counselor (M.S.)	

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitutes/Temporaries
Nutritionist (Master Degree)	Volunteers

111.800 MEDICAL/DENTAL/PROJECT DIRECTOR

Dental Director	Project Director
Medical Director	

111.825 PROJECT COORDINATOR

111.850 OTHER ADMINISTRATION

Accountant/Finance/Bookkeeper	Laboratory Technician
Administrator/General Manager	Maintenance/Housekeeping
Clinic Aide	Nurse Aide
Clinic Coordinator (Administration)	Other Administration
Communications Coordinator	Programmer/Systems Analyst
Data Entry Clerk	Secretary/Clerk/Medical Record
Evaluator	Substitutes/Temporaries
Genetic Associate/Assistant	Volunteers
Laboratory Assistant	

115.000 FRINGE BENEFITS

200.700 TRAVEL

Conference Registrations	Out-of-State Staff Travel (only available with non-matching funds)
In-State Staff Travel	

200.800 RENTAL AND UTILITIES

Janitorial Services	Rental of Space
Other Rentals	Utilities
Rental of Equipment and Furniture	

200.850 COMMUNICATIONS

Postage (including UPS)	Reports
Printing Costs	Subscriptions
Publications	Telephone

200.900 OTHER EXPENDITURES

Insurance and Bonding	Insurance premiums for fire, theft, liability, fidelity bonds, etc. Malpractice insurance premiums cannot be paid with grant funds. However, matching and nonmatching funds can be used.
Maintenance and Repair	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
--	
Other	Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project costs for Maternal and Child Health projects and may not be paid for with MCH or MCH Matching Funds:

1. Construction of buildings or building renovations;
2. Depreciation of existing buildings or equipment;
3. Contributions, gifts, donations;
4. Entertainment, food;
5. Automobile purchase / rental;
6. Interest and other financial costs;
7. Costs for in-hospital patient care;
8. Fines and penalties;
9. Fees for health services;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Executive expenses (car rental, car phone, entertainment);
14. Client travel; and/or
15. Legislative lobbying.

The following may be claimed as project costs for Maternal and Child Health projects and may only be paid for with specific permission from the Director of Maternal and Children's Special Health Care:

1. Equipment;
2. Out-of-state travel; and
3. Dues to societies, organizations, or federations.

All equipment costing \$1,000 or more that is purchased with MCH and/or MCH Matching Funds shall remain the property of the State and shall not be sold or disposed of without written consent from the State.

For further clarification on allowable expenditures, please contact:

Vanessa Daniels, Grants Coordinator, MCSHC, VDaniels@isdh.IN.gov or 317/233-1241

FY 2009 Budget Narrative

The budget narrative must include a justification for every MCH line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the MCH budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement (\$.40 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total MCH	Total MCH + MCH MATCHING
	<p>For each personnel entry, include name, title, and brief description of his/her role in the project (i.e. Provides direct services)</p> <p>List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.</p>	<p>Personnel = \$/hr X hrs per week X weeks per year</p> <p>Fringe = salary X fringe rate</p>	Total to be charged to MCH	Total cost charged to MCH and MCH Matching funds
Schedule A				
111.000 Physicians				
111.150 Dentists / Hygienists				
111.200 Other Service Providers				
111.350 Care Coordination				
111.400 Nurses				
111.600 Social Service Providers				
111.700 Nutritionists / Dietitians				
111.800 Medical/Dental / Project Director				
111.825 Project Coordinator				
111.850 Other Administration				
115.000 Fringe Benefits				

Account Number and Item	Description and Justification	Calculations	Total MCH	Total MCH + MCH MATCHING
	List each contract and explain its purpose. List each piece of equipment separately along with price for one. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.	Equipment = price for 1 X number required. Travel = \$0.40 X miles for each staff member being reimbursed for travel.	Total to be charged to MCH	Total cost charged to MCH and MCH Matching funds
Schedule B				
200.000 Contractual Services				
200.500 Equipment				
200.600 Consumable Supplies				
200.700 Travel				
200.800 Rental and Utilities				
200.850 Communications				
200.900 Other Expenditures				
		SUBTOTAL SCHEDULE A		
		SUBTOTAL SCHEDULE B		
		TOTAL SCHEDULES A&B		

FY 2010 Budget Narrative

The budget narrative must include a justification for every MCH line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the MCH budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement (\$.40 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total MCH	Total MCH + MCH MATCHING
	<p>For each personnel entry, include name, title and brief description of their role in the project (i.e. Provides direct services)</p> <p>List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.</p>	<p>Personnel = \$/hr X hrs per week X weeks per year</p> <p>Fringe = salary X fringe rate</p>	Total to be charged to MCH	Total cost charged to MCH and MCH Matching funds
Schedule A				
111.000 Physicians				
111.150 Dentists / Hygienists				
111.200 Other Service Providers				
111.350 Care Coordination				
111.400 Nurses				
111.600 Social Service Providers				
111.700 Nutritionists / Dietitians				
111.800 Medical/Dental / Project Director				
111.825 Project Coordinator				
111.850 Other Administration				
115.000 Fringe Benefits				

Account Number and Item	Description and Justification	Calculations	Total MCH	Total MCH + MCH MATCHING
	List each contract and explain its purpose. List each piece of equipment separately along with price for one. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.	Equipment = price for 1 X number required. Travel = \$0.40 X miles for each staff being reimbursed for travel.	Total to be charged to MCH	Total cost charged to MCH and MCH Matching funds
Schedule B				
200.000 Contractual Services				
200.500 Equipment				
200.600 Consumable Supplies				
200.700 Travel				
200.800 Rental and Utilities				
200.850 Communications				
200.900 Other Expenditures				
		SUBTOTAL SCHEDULE A		
		SUBTOTAL SCHEDULE B		
		TOTAL SCHEDULES A&B		

SECTION I - BUDGET
SOURCES OF ANTICIPATED REVENUE FOR FISCAL YEAR 2009

Project Title: _____ Project # _____

Applicant Agency: _____

413 Maternal and Child Health Grant Request (A) \$ _____

MATCHING FUNDS - CASH

417 Local Appropriations \$ _____

419 First Steps \$ _____

421 Cash Donations \$ _____

424 United Way/March of Dimes \$ _____

432 Hoosier Heathwise/CHIP (Titles XIX / XXI) \$ _____

434 Private Insurance \$ _____

436 Patient Fees \$ _____

437 Other Matching \$ _____

TOTAL MATCHING FUNDS (Cash) (B) \$ _____

NONMATCHING FUNDS - CASH

433 Title XX \$ _____

439 Other \$ _____

TOTAL NONMATCHING FUNDS (C) \$ _____

ESTIMATED CASH ON HAND AS OF SEPTEMBER 30, 2008

400.1 Matching \$ _____

400.2 Nonmatching \$ _____

TOTAL ESTIMATE (400.1 + 400.2) (D) \$ _____

TOTAL PROJECT REVENUE (A)+(B)+(C)+(D) (E) \$ _____

A Full-Time Employee Works _____ Hours Per Week.

SECTION I - BUDGET
SOURCES OF ANTICIPATED REVENUE FOR FISCAL YEAR 2010

Project Title: _____ Project # _____

Applicant Agency: _____

413 Maternal and Child Health Grant Request (A) \$ _____

MATCHING FUNDS - CASH

417 Local Appropriations \$ _____

419 First Steps \$ _____

421 Cash Donations \$ _____

424 United Way/March of Dimes \$ _____

432 Hoosier Heathwise/CHIP (Titles XIX / XXI) \$ _____

434 Private Insurance \$ _____

436 Patient Fees \$ _____

437 Other Matching \$ _____

TOTAL MATCHING FUNDS (Cash) (B) \$ _____

NONMATCHING FUNDS - CASH

433 Title XX \$ _____

439 Other \$ _____

TOTAL NONMATCHING FUNDS (C) \$ _____

ESTIMATED CASH ON HAND AS OF SEPTEMBER 30, 2009 (may use estimate for 2008)

400.1 Matching \$ _____

400.2 Nonmatching \$ _____

TOTAL ESTIMATE (400.1 + 400.2) (D) \$ _____

TOTAL PROJECT REVENUE (A)+(B)+(C)+(D) (E) \$ _____

A Full-Time Employee Works _____ Hours Per Week.

SECTION II - BUDGET
MCH AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2009

Project Title: _____ Project # _____

Applicant Agency: _____

Service	MCH Cost Per Service ¹	MCH Matching Funds Allocated Per Service ³	Total Unduplicated # Estimated To Be Served by MCH & MCH Matching Funds ⁵
Genetic – Clinical			
Genetic – Prenatal			
Other (please list)			
Teratogen Call Center ⁶			
TOTAL	2	4	

- ¹ Cells in this column should reflect the amount of the MCH grant award that is estimated to be spent on specific services, e.g. prenatal care or family planning. Do not enter a per client cost.
- ² This cell should reflect the total grant request (line A from MCH Budget – 1).
- ³ Cells in this column should reflect the amount of MCH matching funds estimated to be spent on specific services.
- ⁴ This cell should reflect total MCH matching funds estimated to be spent on MCH services (line B from MCH Budget –1).
- ⁵ Cells in this column should reflect the unduplicated number of clients you estimated to be served with MCH and MCH matching funds during the fiscal year.
- ⁶ If applicable

SECTION II - BUDGET
MCH AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2010

Project Title: _____ Project # _____

Applicant Agency: _____

Service	MCH Cost Per Service ¹	MCH Matching Funds Allocated Per Service ³	Total Unduplicated # Estimated To Be Served by MCH & MCH Matching Funds ⁵
Genetic – Clinical			
Genetic – Prenatal			
Other (please list)			
Teratogen Call Center ⁶			
TOTAL	2	4	

- ¹ Cells in this column should reflect the amount of the MCH grant award that is estimated to be spent on specific services, e.g. prenatal care or family planning. Do not enter a per client cost.
- ² This cell should reflect the total grant request (line A from MCH Budget – 1).
- ³ Cells in this column should reflect the amount of MCH matching funds estimated to be spent on specific services.
- ⁴ This cell should reflect total MCH matching funds estimated to be spent on MCH services (line B from MCH Budget –1).
- ⁵ Cells in this column should reflect the unduplicated number of clients you estimated to be served with MCH and MCH matching funds during the fiscal year.
- ⁶ If applicable

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2009

Project Title: _____ Project # _____ Applicant Agency: _____

Acct. Number	Description Number	Total Funds	GRANT FUNDS	MATCHING FUNDS									NON-MATCHING FUNDS			Normal Work Wk. Hours Budgeted on Project ¹
			MCH Funds 413	Local Approp. 417	First Steps 419	Cash Donations 421	United Way/ March of Dimes 424	Hoosier Heathwise & CHIP XIX & XXI 432	Private Insurance 434	Patient Fees 436	Other Matching 437	Cash on Hand 400.1	Title XX 433	Other 439	Cash on Hand 400.2	
Schedule A																
111.000	Physicians															
111.150	Dentists/Hygienists															
111.200	Other Service Providers															
111.350	Care Coordination															
111.400	Nurses															
111.600	Social Service Providers															
111.700	Nutritionists/Dietitians															
111.800	Medical/Dental/ Project Director															
111.825	Project Coordinator															
111.850	Other Administration															
115.000	Fringe Benefits															
Schedule B																
200.000	Contractual Services															
200.500	Equipment															
200.600	Consumable Supplies															
200.700	Travel															
200.800	Rental and Utilities															
200.850	Communications															
200.900	Other Expenditures															
SUBTOTAL SCHEDULE A																
SUBTOTAL SCHEDULE B																
TOTAL																

¹ Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2010

Project Title: _____ Project # _____ Applicant Agency: _____

Acct. Number	Description Number	Total Funds	GRANT FUNDS	MATCHING FUNDS									NON-MATCHING FUNDS			Normal Work Wk. Hours Budgeted on Project ¹
			MCH Funds 413	Local Approp. 417	First Steps 419	Cash Donations 421	United Way/ March of Dimes 424	Hoosier Heathwise & CHIP XIX & XXI 432	Private Insurance 434	Patient Fees 436	Other Matching 437	Cash on Hand 400.1	Title XX 433	Other 439	Cash on Hand 400.2	
Schedule A																
111.000	Physicians															
111.150	Dentists/Hygienists															
111.200	Other Service Providers															
111.350	Care Coordination															
111.400	Nurses															
111.600	Social Service Providers															
111.700	Nutritionists/Dietitians															
111.800	Medical/Dental/ Project Director															
111.825	Project Coordinator															
111.850	Other Administration															
115.000	Fringe Benefits															
Schedule B																
200.000	Contractual Services															
200.500	Equipment															
200.600	Consumable Supplies															
200.700	Travel															
200.800	Rental and Utilities															
200.850	Communications															
200.900	Other Expenditures															
SUBTOTAL SCHEDULE A																
SUBTOTAL SCHEDULE B																
TOTAL																

¹ Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400

TITLE V MATERNAL AND CHILD HEALTH
APPLICATION
FY 2009 & FY 2010

Title of Project _____ Federal I.D. # _____

Medicaid Provider Number: _____ FY 2007 - 2008 MCH Contract Amount \$ _____

FY 2009 MCH Amount Requested: \$ _____ FY 2009 Matching Funds Contributed \$ _____

FY 2010 MCH Amount Requested: \$ _____ FY 2010 Matching Funds Contributed \$ _____

Legal Agency /Organization Name: _____

Street _____ City _____ Zip Code _____

Phone _____ FAX _____ E-Mail Address _____

Project Director (type name) _____ Phone _____ E-Mail Address _____

Board President/Chairperson (type name) _____ Phone _____

Project Medical Director (type name) _____ Phone _____

Agency CEO or Official Custodian of Funds
(type name) _____ Title _____ Phone _____

Signature of Project Director _____ Date _____

Signature of person authorized to make legal
And contractual agreement for the applicant agency _____ Title _____ Date _____

Signature of County Health Officer
(or date letter sent to County Health Officers) _____ County _____ Date _____

Are you registered with the Secretary of State? Yes No

Note: All arms of local and State government are registered with the Secretary of State. Applicants must be registered with the Secretary of State to be considered for funding.

FY 2009 & FY 2010
Project Description

Project Name:		Project Number:
Address:	City, State, Zip	
Telephone Number:	Fax Number:	E-Mail Address:
Counties Served:		
Type of Organization:	State <input type="checkbox"/>	Local <input type="checkbox"/> Private Non-Profit <input type="checkbox"/>
Requested Funds: \$_____ Matching Funds: \$_____ Non-matching Funds: \$_____		
(Amounts above should reflect total for FY 2009 + total for FY 2010)		
Sponsoring Agency:		
Summarize identified needs from the needs assessment section. Include only those needs the Project will address.		
Summarize Performance Measures from Performance Measures Tables (Hint: Each identified need above should be addressed with a Performance Measure.)		

MCH Project Name:		Project Number:	# Clinic Sites
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site (include matching funds):	
Counties Served:	Services Provided in MCH Budget for site (include matching funds):		
Target Population and estimated number to be served with MCH and matching funds:	Other services provided at site (non-MCH or non-Match):		
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site (include matching funds):	
Counties Served:	Services Provided in MCH Budget for site (include matching funds):		
Target Population and estimated number to be served with MCH and matching funds:	Other services provided at site (non-MCH or non-Match):		
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site (include matching funds):	
Counties Served:	Services Provided in MCH Budget for site (include matching funds):		
Target Population and estimated number to be served with MCH and matching funds:	Other services provided at site (non-MCH or non-Match):		
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site (include matching funds):	
Counties Served:	Services Provided in MCH Budget for site (include matching funds):		
Target Population and estimated number to be served with MCH and matching funds:	Other services provided at site (non-MCH or non-Match):		
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site (include matching funds):	
Counties Served:	Services Provided in MCH Budget for site (include matching funds):		
Target Population and estimated number to be served with MCH and matching funds:	Other services provided at site (non-MCH or non-Match):		
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site (include matching funds):	
Counties Served:	Services Provided in MCH Budget for site (include matching funds):		
Target Population and estimated number to be served with MCH and matching funds:	Other services provided at site (non-MCH or non-Match):		

Appendix A

INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
GENETIC SERVICES
ANNUAL PERFORMANCE REPORT FY 2009

PROJECT NAME: _____

PROJECT NUMBER: _____

APPLICANT AGENCY: _____

REPORTING PERIOD: FY 2009 (10/1/08 TO 9/30/09)

DATE SUBMITTED: _____ PREPARED BY: _____

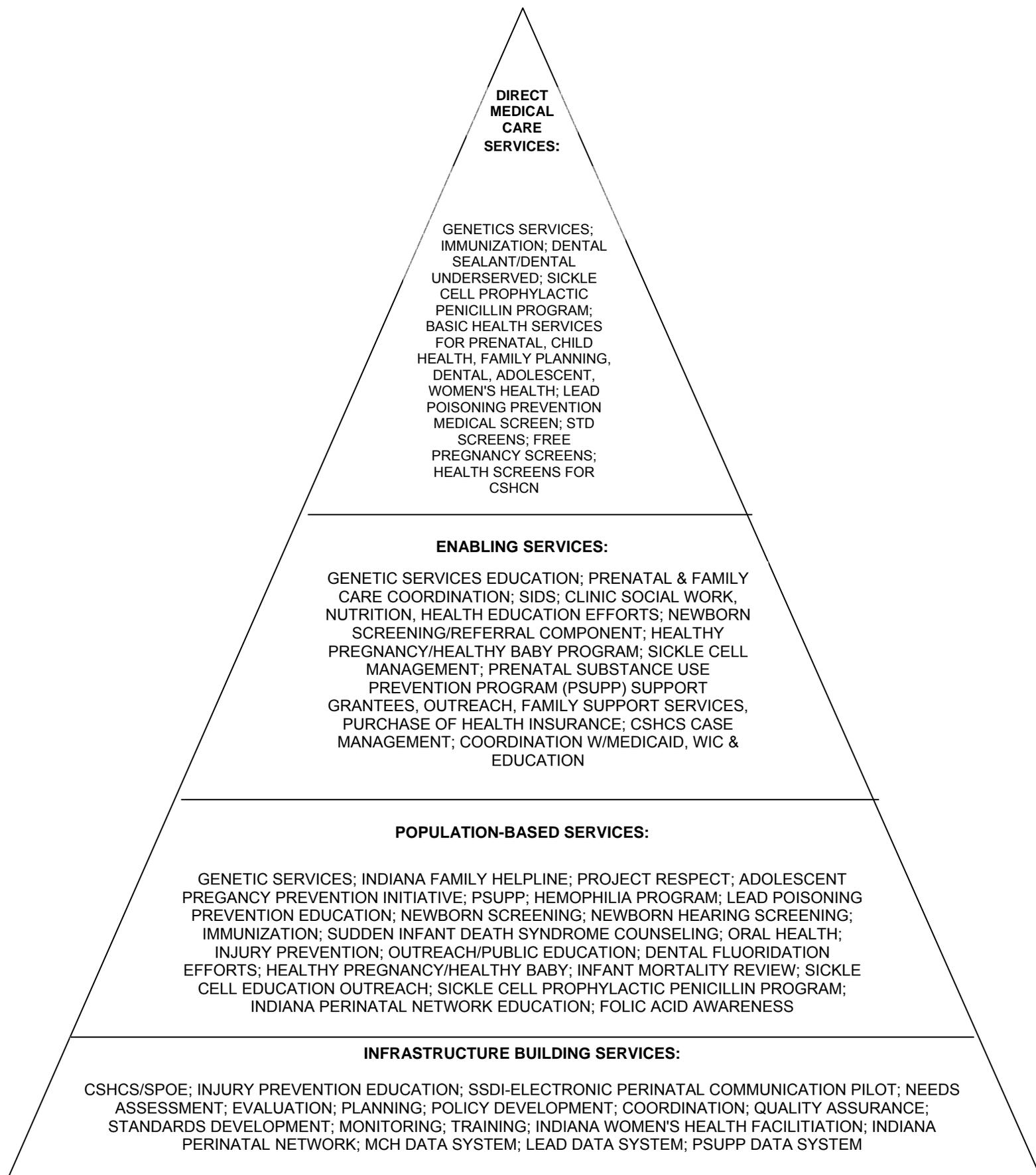
- I. Instructions.....(Page 44)
- II. Narrative.....(Page 44)
- III. Quality Assurance.....(Page 44)
- IV. Demographic Data.....(Pages 45 - 46)
- V. Program Monitoring Data.....(Pages 46 - 52)
- VI. Project Data.....(Pages 53 - 61)
- VII. Appendices.....(Pages 62 - 65)

Appendix 1 Performance Objective Summary

Appendix 2 Definitions

Appendix 3 Descriptions for Final or Best Working Diagnosis Table

**FIGURE1: CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES**



I. Instructions

Instructions are included by section in the report form.

II. Narrative

Using the categories below, describe through narrative and statistics the services provided by Title V funding to women and/or children in your project during the last fiscal year. Keep the discussion brief and address only the services and activities in which your project is engaged and which are funded by Title V funds. The Narrative should be supported by the statistical report and completed work plan. It should provide a complete picture of your MCH program, including where your services fit into the Core Public Health Services Pyramid. As part of the description of services provided, the discussion should include the following information for each service category:

- Explain the strengths and weaknesses of the project and project accomplishments during the funding year.
- Explain any significant discrepancies between projected number served and actual number served. Significant discrepancies exist if the number served fell below or exceeded projected service levels by more than 10%.
- Explain any change in clinical or administrative procedure, including staffing changes.
- Document activities to improve communications with, outreach to, and services for racial and ethnic minorities. Include plans to reduce disparities in access to services and health outcomes.
- List which agencies and organizations are cooperating with the project and explain their role. **All** indicated agencies and organizations should have current MOUs with the project.
- Elaborate on special events and initiatives undertaken by the project in the Work Plan Activities listed on the Performance Measure Tables Work Plans.

III. Quality Assurance

1. Chart audit. If the Project served less than 200 clients, review 50 charts or all charts of clients served (whichever annual # is lower). If the Project served 200 or more clients, review 100 charts. **Summarize the findings and indicate changes or improvements to be made.** The project should conduct 25% of the annual chart reviews during each quarter during the funding year and describe the reviews in the quarterly reports, along with adaptations, changes, or adjustments made in the work plan or policies and procedures as a result of the chart review findings.
2. Review the MCH data reports. Summarize the data problems – incomplete collection or program challenges – indicating the specific areas. Review the charts to determine whether staff completion or errors are contributing to the problem.
3. Report appropriate individuals to the IBDPR. Document every child with a birth defect that was seen in the Project clinic and verify that the child is reported to the Indiana Birth Defects and Problems Registry, provided the patient is within the appropriate age range.
4. Send a copy of the chart audit tool format used for each service type.

IV. Demographic Data

Complete Tables 1-4. This information is essential for Maternal and Child Health Services to meet federal reporting requirements.

Table 1. Number of New Individuals Who Received Genetic Services in Fiscal Year 2009, by Race

Class of individual and type of service	# Est. to be Served*	Race						Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/Unknwn	Total Served (All Races)	Non-Hispanic/Unknown	Hispanic
PREGNANT WOMEN										
INFANTS UNDER ONE YEAR OF AGE										
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)										
OTHER INDIVIDUALS										
TERATOGEN CALL CENTER**										
OTHER INDIVIDUALS > 22 years										
OTHER SERVICES (SPECIFY):										
TOTAL (All Services):										

*As indicated in FY 2009/2010 proposal.

**If applicable

Totals Should Match

Table 2. Number of Return Visit Individuals Who Received Genetic Services in Fiscal Year 2009, by Race

Class of individual and type of service	# Est. to be Served*	Race						Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/Unknwn	Total Served (All Races)	Non-Hispanic/Unknown	Hispanic
PREGNANT WOMEN										
INFANTS UNDER ONE YEAR OF AGE										
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)										
OTHER INDIVIDUALS										
TERATOGEN CALL CENTER										
OTHER INDIVIDUALS > 22 years										
OTHER SERVICES (SPECIFY):										
TOTAL (All Services):										

*As indicated in FY 2009/2010 proposal.

Totals Should Match

Table 3. Number of New Individuals Who Received Services Provided or Paid for in Whole or in Part by Title V or Title V Matching Funds in Fiscal Year 2009, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMEN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

Table 4. Number of Return Visit Individuals Who Received Services Provided or Paid for in Whole or in Part by Title V or Title V Matching Funds in Fiscal Year 2009, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMEN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

V. Program Monitoring Data

Tables 5 - 12 request program monitoring data.

Table 5: Types of Genetic Service Provided

Type of Service	Pregnant Women	Infants < 1 Year of Age	Children Under 22 (Excluding Those < 1 yr)	Patients ≥ 22 years of age	Total
Pre-Diagnosis Counseling					
Post-Diagnosis Counseling					
Evaluation/Counseling for a known diagnosis					
Evaluation/Counseling for an unknown diagnosis					
Genetic Counseling Only					
Consultations					
Telephone Contacts					
Teratogens Call Line*					
Referrals To MCH Clinic					
Referrals To First Steps					
Referrals To CSHCS					
Referrals To PSUPP					
Referrals To WIC Clinic					

*only if applicable.

See **Definitions** in Appendix 2 for clarification of the types of services.

Table 6: Educational Genetic Outreach Activities

	Number of Education Sessions Completed	Average Number of Participants per Session	Overall Score From Evaluation Sheets
General public (e.g. high school students, support groups, etc.)			
Health care professionals and college or graduate level students not in the field of genetics			
Other presentations			
TOTAL			

NOTE: The number of educational sessions should match the number given in the grant application. Additional information required in the Performance Measures section.

Table 7: Genetics Patient Satisfaction Surveys

	Number of Surveys Given to Clients	Number of Surveys Completed and Returned	Survey Return Rate	Score for Scheduling and Location	Score for Interaction with Clinic Staff	Score for Expectations and Understanding	Score for Benefits of Genetics Clinic	Score for Overall Satisfaction
Prenatal Genetic Services								
Clinical Genetic Services								
TOTAL								

Table 8: Primary Indication For Prenatal Genetic Services

	<u>FY 08</u>	<u>FY 09</u>	<u>FY 10</u>
1. Advanced Maternal Age	_____	_____	_____
2. Personal or Family History of Chromosomal Abnormality	_____	_____	_____
3. Personal or Family History of Metabolic Disorder	_____	_____	_____
4. Personal or Family History of Neural Tube Defect	_____	_____	_____
5. Personal or Family History of Other Heritable Disorder or Birth Defect	_____	_____	_____
6. Personal or Family History for Hemoglobinopathy	_____	_____	_____
7. Maternal Serum Screen indicates an increased risk for a Neural Tube Defect	_____	_____	_____
8. Maternal Serum Screen indicates an increased risk for a chromosomal abnormality	_____	_____	_____
9. Previous Spontaneous Abortions/Stillbirths	_____	_____	_____
10. Teratogen Exposure	_____	_____	_____
11. Abnormal Ultrasound (without other indication)	_____	_____	_____
12. Parental Concern/Anxiety (without other indication)	_____	_____	_____
13. Other	_____	_____	_____
14. Primary Indication Not Recorded or Unknown	_____	_____	_____
TOTAL	_____	_____	_____

Table 9: Results of Prenatal Genetic Patient Evaluations

I. Outcome of Prenatal Evaluations Performed	FY 08	FY 09	FY 10
1. No fetal abnormality found	_____	_____	_____
2. Fetal abnormality found	_____	_____	_____
3. Findings of uncertain significance	_____	_____	_____
4. Results impossible to interpret or not obtained due to unsatisfactory evaluation	_____	_____	_____
5. Evaluation performed, but results unreported	_____	_____	_____
SUBTOTAL OF PRENATAL EVALUATIONS COMPLETED	_____	_____	_____
II. No Prenatal Evaluations Done or Recommended; Prenatal Evaluations Not Completed by Reporting Unit			
1. Testing not indicated in opinion of staff	_____	_____	_____
2. Testing declined or not completed by patient	_____	_____	_____
3. Spontaneous pregnancy loss before procedure	_____	_____	_____
4. No prenatal evaluations done; reason Unknown	_____	_____	_____
SUBTOTAL OF PRENATAL EVALUATIONS NOT COMPLETED	_____	_____	_____
III. Evaluation Status Unknown	_____	_____	_____
TOTAL	_____	_____	_____

Table 10: Primary Indication for Reason for Referral to Clinical Genetic Services

	<u>FY 08</u>	<u>FY 09</u>	<u>FY 10</u>
1. Rule Out/Confirm or Make Specific Diagnosis	_____	_____	_____
2. Return Visit (returning to same project group)	_____	_____	_____
3. Follow-up Appointment for Diagnosis made by an Unaffiliated Provider	_____	_____	_____
4. Unknown Reason for Referral	_____	_____	_____
TOTAL	_____	_____	_____

Table 11: Final or Best Working Diagnosis for Clinical Genetic Patients

	<u>FY 08</u>	<u>FY 09</u>	<u>FY 10</u>
1. No Evidence of Abnormality or Specific Disorder	_____	_____	_____
2. Chromosomal and Single Gene Disorders	_____	_____	_____
3. Metabolic/Endocrine	_____	_____	_____
4. Neuromuscular	_____	_____	_____
5. Skeletal/Connective Tissue/Neural Ectodermal (Excluding Chromosomal)	_____	_____	_____
6. Hematologic	_____	_____	_____
7. Functional Disorders	_____	_____	_____
8. Single Malformation	_____	_____	_____
9. Reproductive Risks (Use only when none of the above apply)	_____	_____	_____
10. Multiple Congenital Anomalies/Multiple Malformation Syndrome	_____	_____	_____
11. Unknown	_____	_____	_____
TOTAL	_____	_____	_____

Note: See Appendix 3 for examples of *Final or Best Working Diagnosis* for each option.

VI. Project Data

Specific directions are stated for each Performance Measure. Indicate if the Performance Objective was met by checking Yes or No. A Performance Objective Summary of all services is provided in Appendix 1. Please complete the summary for all services provided by the project.

FY 2009 Objectives should be completed based upon the projections submitted in the FY 2009 grant application.

The specific activities for each objective should be completed and the status of each indicated in the Comments/TA Plans section. If objectives were not met, indicate in this column why they were not met and what action will be taken to meet them this year. Your consultant will use this section to monitor project activities and provide technical assistance. Some forms have specific activities already listed. The status of each should be indicated as well as any additional comments. Any additional activities for your project should be listed. (See Appendix 2 for additional instructions and definitions).

Genetic Service Providers should complete the following pages addressing MCH performance measures.

A. GENETICS

Performance Measure 1: Provide genetic evaluation and counseling services in designated area(s).

Performance Objective 1:

- Increase** the number of patients receiving genetic services by _____%.
- Maintain** the number of patients receiving genetic services.

Directions: Report the total number of patients seen in your project population. The estimated number of patients is the number submitted on the grant application. Gray areas do not need to be completed.

Prenatal Genetics Patients

# of Pregnant Women	FY 2007	FY 2008	FY 2009	FY 2010
Total Number of Patients Seen				
Estimated Number of Patients Seen				
Percent of Estimate Achieved				

Total Number of Teratogens Call Line ¹				
Estimated Number of Teratogens Call Line ¹				
Percent of Estimate Achieved				

¹Only if applicable

Clinical Genetics Patients

# of Patients	FY 2007	FY 2008	FY 2009	FY 2010
Total Number of Patients Seen				
Estimated Number of Patients Seen				
Percent of Estimate Achieved				

Percent of Estimate Achieved = [Number of Patients Seen / Estimated Number of Patients Seen] x 100

PERFORMANCE OBJECTIVE MET: YES NO

Directions: State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that aided in meeting this objective can be added at the bottom of this table.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Greater than 90% of families of children < 3 years of age were informed about First Steps		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Greater than 90% of patients/families were informed about Children's Special Health Care Services (CSHCS)		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Greater than 90% of patients/families with children < 5 years of age were informed about Women, Infants, and Children (WIC) clinic		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

A. GENETICS

Performance Measure 2: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Performance Objective 2a: _____% women of childbearing age seen in clinic will be educated to the *negative* effects of **smoking** during pregnancy.

Performance Objective 2b: _____% women of childbearing age seen in clinic will be educated to the *negative* effects of **consuming alcohol** during pregnancy.

Performance Objective 2c: _____% women of childbearing age seen in clinic will be educated to the *positive* effects of taking **folic acid**.

Service Projections

Directions: Report the number of patients seen in your project population and from these numbers calculate the corresponding percentages. We expect that at least **90%** of women of childbearing age, seen in clinic, will be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

PO 2a: Women of childbearing age who were seen in clinic and educated to the *negative* effects of **smoking during pregnancy**

	FY 2007	FY 2008	FY 2009	FY 2010
Number of women of childbearing age who smoke and were seen in clinic that received smoking cessation education				
Number of women of childbearing age who reportedly smoke and were seen in clinic				
Percentage of women of childbearing age who smoke and were seen in clinic that received smoking cessation education				

PO 2b: Women of childbearing age who were seen in clinic and educated to the *negative* effects of alcohol consumption during pregnancy

	FY 2007	FY 2008	FY 2009	FY 2010
Number of women of childbearing age who were seen in clinic and received education on alcohol related birth defects				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received education on alcohol related birth defects				

PO 2c: Women of childbearing age seen in clinic and educated to the *positive* effects of taking folic acid

	FY 2007	FY 2008	FY 2009	FY 2010
Number of women of childbearing age who were seen in clinic and received folic acid education				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received folic acid education				

PERFORMANCE OBJECTIVE MET: YES NO

Directions: State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Develop and incorporate into your patient intake a protocol asking patients if they took folic acid or had smoked and/or consumed alcohol during pregnancy.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Greater than 90% of patients who admit to smoking, drinking or using drugs and live in an area in which a Prenatal Substance Use Prevention Program (PSUPP) exist were informed about PSUPP.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

A. GENETICS

Performance Measure 3: Provide educational genetics presentations to health professionals **not** in the field of genetics and the general public.

Performance Objective 3:

Project staff will provide _____ presentations, with at least _____ presentations being given to the general public and at least _____ presentations being given to health care providers **not** in the field of genetics.

Directions: Report the total number of presentations given by your project staff. A **minimum of 4** presentations are to be given, with at least 2 given to the general public and 2 being given to health care professionals not in the field of genetics. **Calculate the Percent Completed only for the current year.** In terms of estimating audience size, when the audience is mixed, count individuals under the group that makes up the majority of the audience. Do **not** count one talk under two different audiences. Please see **Definitions** on page 64 for more information concerning types of audiences.

Main audience:	# of Talks						
	FY 2008 Actual	FY 2009 Actual	FY 2009 Estimated	FY 2009 % Completed	FY 2010 Actual	FY 2010 Estimated	FY 2010 % Completed
General Public (e.g. high school students, support groups, etc.)							
Health care professionals and college or graduate level students not in the field of genetics							
Other Presentations							
Total							

Percent completed = [Number of talks given / Estimated number of talks] x 100

PERFORMANCE OBJECTIVE MET: YES NO

Directions: State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Evaluation sheets will be collected for each talk.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Audience size will be counted at each talk. (Note: attendance or evaluation sheets may be used to determine these numbers)		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

A. GENETICS

Performance Measure 4: Provide confirmation of birth defects to the Indiana Birth Defects and Problems Registry (IBDPR).

Performance Objective 4: 100% of children in the appropriate age group with a confirmed diagnosis are reported to the IBDPR.

Directions: Report the **total** number of children < 3 years old with a reportable birth defect that you will see in your clinic. **If you have not already submitted a report for these children, please do so in the near future.** A list of reportable conditions and PDF version of the reporting form can be found at <http://www.in.gov/isdh/programs/ibdpr/reporting.htm>.

Reporting to the IBDPR

	# of Patients			
	FY 2007 (Baseline)	FY 2008	FY 2009	FY 2010
Number of children < 3 years of age* with at least 1 reportable birth defect that were reported to the IBDPR				
Total number of children < 3 years of age* with at least 1 reportable birth defect				
Percentage of observed birth defects reported to IBDPR				

*up to 5 years of age for autism or FAS

PERFORMANCE OBJECTIVE MET: YES NO

Directions: State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
Report form for each patients < 3 years of age (5 years for FAS and autism) that are born with a reportable condition is completed and faxed to ISDH.		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	

A. GENETICS**PROJECT SPECIFIC PERFORMANCE MEASURE:****PERFORMANCE OBJECTIVE:****GOAL:**

	FY 2008	FY 2009	Percent Change from previous year

Percent change = $[(2009 \text{ \#s} - 2008 \text{ \#s}) / 2008 \text{ \#s}] \times 100$

PERFORMANCE OBJECTIVE MET: YES NO

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	

A. GENETICS

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2008	FY 2009	FY 2010
	%	%	%
	%	%	%
	%	%	%

PERFORMANCE OBJECTIVE MET: YES NO

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
		<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	

Appendix 1

**Genetic Services
Performance Objective Summary
FY 2009 & FY 2010**

FY 2009

MET

- | | | |
|----------------------------------|-------------------------------------|------------------------------------|
| <i>PERFORMANCE OBJECTIVE 1:</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>PERFORMANCE OBJECTIVE 2a:</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>PERFORMANCE OBJECTIVE 2b:</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>PERFORMANCE OBJECTIVE 2c:</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>PERFORMANCE OBJECTIVE 3:</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>PERFORMANCE OBJECTIVE 4:</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Percent of MCH Required Performance Objectives Met _____

Number of Project Chosen Objectives Met _____

Total Number of Project Chosen Objectives _____

Percent of Project Chosen Objectives Met _____

Appendix 2

**Genetic Services
DEFINITIONS
FY 2009 & FY 2010**

Definitions are listed according to appearance in the application.

Tables 2 and 4

Return Visit Individuals – Individuals that have been previously seen in your project clinic and are returning for follow-up care.

Table 5

Prenatal Genetics Patient – All pregnant women seen by the project who request or receive services relating to the outcome of the pregnancy, e.g. focused on the fetus.

Clinical Genetics Patient – Any individual who had an appointment and was evaluated by or received counseling from the project.

Genetic Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of recurrence of a genetic disorder in a family. For reporting purposes, this **only** includes face-to-face interactions. No physical exam or prenatal procedure is performed during this type of encounter.

Pre-diagnosis counseling – Counseling performed in the absence of any screening or diagnostic test results.

Post-diagnosis counseling – Counseling performed after a diagnosis is suggested/made by a screening or diagnostic test.

Consultation – A visit with a patient where the grantee is **not** the primary provider of services.

Telephone contact – A phone conversation where a limited amount of counseling and/or a referral is discussed.

Evaluation/Counseling – Some degree of assessment (e.g. a physical examination) is performed in addition to genetic counseling services.

Table 8

Advanced Maternal Age – Age 35 or older at EDC, although it is recognized that some programs may use a different age cutoff. This is a count of all women with AMA chosen as their primary indication.

Personal or Family History of Chromosome Abnormality – A known or suspected chromosomal abnormality in a relative where either of the patient's parents are known to have normal chromosomes or the parental chromosome status is unknown. This includes a family with a previous child with trisomy 21 or a deceased sibling with clinically diagnosed Down Syndrome with no known chromosome analysis completed. This also includes a family history where one of the parents is known to have a confirmed balanced or unbalanced translocation or is at risk for a translocation, but has not been tested.

Personal or Family History of Metabolic Disorder – A known or presumed metabolic defect which is inherited as an autosomal or polygenic trait in either the pregnant women herself (ex. diabetes mellitus or PKU) or in a previous child.

Personal or Family History of Neural Tube Defect – An open or skin-covered defect (anencephaly, spina bifida with or without hydrocephalus, or encephalocele) without other unrelated defects.

Personal or Family History of Other Heritable Disorder – Includes any other type of heritable mental retardation or genetic disorder which does not fit into any of the above categories.

Personal or Family History of Birth Defects – Includes any other type of heritable birth defect which does not fit into any of the above categories.

Personal or Family History of Hemoglobinopathy – Based on carrier testing and/or racial or ethnic risks, as well as family history.

Maternal Serum Screen Positive for NTD – Based on initial results at the local usage upper cutoff after adjustment for gestational age, maternal weight, race, and diabetes. This cutoff may be higher or lower in different locales.

Maternal Serum Screen Positive for Chromosomal Abnormality – Based on initial results at the local usage lower cutoff, which is usually correlated with maternal age for women under institutional cutoff for advanced maternal age.

Previous Spontaneous Abortions/Stillbirths – Based on local definitions (usually referring to two or more events of this nature).

Teratogen Exposure – Exposure to any exogenous substance or agent in the home, at the worksite, or in the outside environment which may predispose one to an increased risk of birth defects, mental retardation, fetal death, or other adverse perinatal outcome. This also includes medications with known teratogenic effects. This does not include endogenous maternal disorders, such as diabetes or PKU.

Abnormal Ultrasound – A fetal abnormality is seen or suspected after ultrasound examination, in absence of any other listed indication.

Parental Concern/Anxiety – A desire for prenatal diagnosis and/or testing which cannot be appropriately entered in any of the above categories.

Other – Any indication which does not fit the above entries as defined.

Performance Measure 3

Health professionals *not* in the field of genetics - Any individual who has received a degree, is currently employed, or is seeking employment in a healthcare field. This includes residents and fellows not specializing in genetics.

College or graduate level students *not* in the field of genetics – Includes nursing and medical students.

Appendix 3

Descriptions for Final or Best Working Diagnosis Table

(Five examples for each are listed.)

Chromosomal / Single gene

(includes cytogenetic and mutation analysis)

- 1) Trisomies
- 2) 45,X
- 3) 47,XXY
- 4) Fragile X
- 5) 22q11.2 deletion

Metabolic / Endocrine

- 1) PKU
- 2) Galactosemia
- 3) Hypothyroidism
- 4) Cystic Fibrosis
- 5) Tay-Sachs disease

Neuromuscular

- 1) Huntington disease
- 2) Muscular dystrophy
- 3) Mitochondrial disorders
- 4) Myasthenia gravis
- 5) Glycogen storage diseases

Skeletal / Connective Tissue

- 1) Marfan syndrome
- 2) Ehlers-Danlos syndrome
- 3) Tuberous sclerosis
- 4) Neurofibromatosis
- 5) Dysplasias

Hematologic

- 1) Hemophilia A
- 2) Other hemophilias
- 3) Alpha-thalassemia
- 4) Beta-thalassemia
- 5) Sickle cell anemia

Functional Disorders

- 1) Autism
- 2) Epilepsy
- 3) Cerebral palsy
- 4) Mental retardation
- 5) Failure to thrive / growth retardation

Single Malformation

- 1) Limb abnormalities
- 2) Anencephaly
- 3) Myelomeningocele
- 4) Cleft lip and/or palate
- 5) Heart defects

Reproductive Risk

- 1) Infertility
- 2) Consanguinity
- 3) Exposures
- 4) Known carrier
- 5) Increased empiric risk

Multiple Congenital Anomalies

- 1) CHARGE
- 2) VATER / VACTERL
- 3) MURCS
- 4) Pierre-Robin sequence
- 5) Potter sequence

Multiple Malformation

(More than one malformation is present and the overall gestalt does not match any known association or syndrome or sequence.)

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MCH DEFINITIONS FY 2009 & FY 2010

Client/Patient – A recipient of services that are supported by program expenses funded in whole or in part by the Title V (MCH Block Grant) or local Title V (MCH) matching dollars

Program Expenses – Any expense included in the budget that the MCH project proposes for funding by MCH or MCH matching dollars (includes staff, supplies, space costs, etc.)

Matching Funds – Must be a minimum of 30% of the Title V award; includes whatever dollars the project assigns to support the MCH-funded service (includes Medicaid or other income generated by service provision)

Types of Clients – Pregnant women, infants, children, adolescents, adult women and families

MCH Supported Services –

- Direct medical and dental care: Family Planning, Prenatal Care, Child Health (infant, child adolescent), Women's Health
- Enabling services: Prenatal Care Coordination, Family Care Coordination

These definitions will allow MCH projects to include all clients seen that are funded by Title V or Title V match dollars in their client count. They will also allow projects to enroll all clients that are served by staff paid with Title V or Title V matching funds.

Cultural Competence -

Cultural competence requires that organizations:

- Have a defined set of values and principles and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve;
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and systematically involve consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum. (adapted from Cross *et al*, 1989)

Genetic Services Definitions FY 2009 & FY 2010

Definitions are listed according to appearance in the application.

Pages 14 and 15

Prenatal Genetics Patient – All pregnant women seen by the project who request or receive services relating to the outcome of the pregnancy, e.g. focused on the fetus.

Clinical Genetics Patient – Any individual who had an appointment and was evaluated by or received counseling from the project.

Genetic Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of occurrence of a genetic disorder in a family. For reporting purposes, this **only** includes face-to-face interactions. No physical exam or prenatal procedure is performed during this type of encounter.

Pre-Diagnosis Counseling – Counseling performed in the absence of any screening or diagnostic test results.

Post-Diagnosis Counseling – Counseling performed after a diagnosis is suggested/made by a screening or diagnostic test.

Inpatient Consultation – A visit with a patient where the grantee is **not** the primary provider of services.

Telephone Contact – A phone conversation where a limited amount of counseling and/or a referral is discussed.

Evaluation/Counseling – Some degree of assessment (e.g. a physical examination) is performed in addition to genetic counseling services.

Page 18

Health professionals *not* in the field of genetics - Any individual who has received a degree, is currently employed, or is seeking employment in a healthcare field. This includes residents and fellows not specializing in genetics.

College or graduate level students *not* in the field of genetics – Includes nursing and medical students.

INDIANA MCSHC SYSTEMS DEVELOPMENT CONSULTANT ASSIGNMENTS

Carolyn Waller, Ph.D., Team Leader
317/233-1257, cwaller@isdh.in.gov

Larry Nelson, Team Leader
317/233-1356, lnelson@isdh.in.gov

Andrea L. Wilkes Team Leader
317/233-1246, awilkes@isdh.in.gov

Maternal & Child Health Division

<u>CONSULTANT NAMES</u>	<u>COUNTIES COVERED</u>
LARRY NELSON, Team Leader 317/233-1256 lnelson@isdh.in.gov	Benton, Carroll, Cass, Clay, Clinton, Fountain, Greene, Montgomery, Parke, Putnam, Owen, Sullivan, Tippecanoe, Vermillion, Vigo, Warren and White Counties
ANDREA L. WILKES, Team Leader 317/233-1246 awilkes@isdh.in.gov	Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby Counties
CAROLYN WALLER, Ph.D., Team Leader 317/233-1257 cwaller@isdh.in.gov	Prenatal Substance Use Prevention Program Grantees in Allen, Clark, Delaware, Dubois, Elkhart, Lake, LaPorte, Madison, Marion, Putnam, Ripley, St. Joseph, Tippecanoe, and Vigo Counties
BETH JOHNSON, R.N., M.S.N. 317/233-1344 bmjohnson@isdh.in.gov	Elkhart, Fulton, Jasper, Kosciusko, Lake, LaPorte, Marshall, Newton, Porter, Pulaski, St. Joseph, and Starke Counties
DONNA MYERS, R.N., M.S. 317/233-5596 (ISDH Office) dmyers@isdh.in.gov	Bartholomew, Brown, Clark, Crawford, Daviess, Dearborn, Decatur, Dubois, Floyd, Franklin, Gibson, Harrison, Jackson, Jefferson, Jennings, Knox, Lawrence, Martin, Monroe, Ohio, Orange, Perry, Pike, Posey, Ripley, Scott, Spencer, Switzerland, Vanderburgh, Warrick, and Washington
GERSHON GAMOR, M.S.W., L.C.S.W 317/233-1239 ggamor@isdh.in.gov	Statewide Social Worker and Statewide Free Pregnancy Test Program Adams, Allen, Blackford, Delaware, DeKalb, Fayette, Grant, Henry, Howard Huntington, Jay, LaGrange, Madison, Miami Noble, Randolph, Rush, Steuben, Tipton, Union, Wabash, Wayne, Wells, and Whitely Counties
Stephanie Woodcox 317/233-1374 swoodcox@isdh.in.gov	Statewide Adolescent Coordinator Grantees in Allen, Dubois, Lake, Marion, and St. Joseph Counties
COURTNEY EDDY Genetics Specialist 317/233-9620 CEddy@isdh.in.gov	Statewide Genetics Program Grantees in Allen, Clark, Delaware, Jefferson, Harrison, Lake, LaPorte, Marion, Monroe, St. Joseph, Tippecanoe, Vanderburgh and Vigo Counties

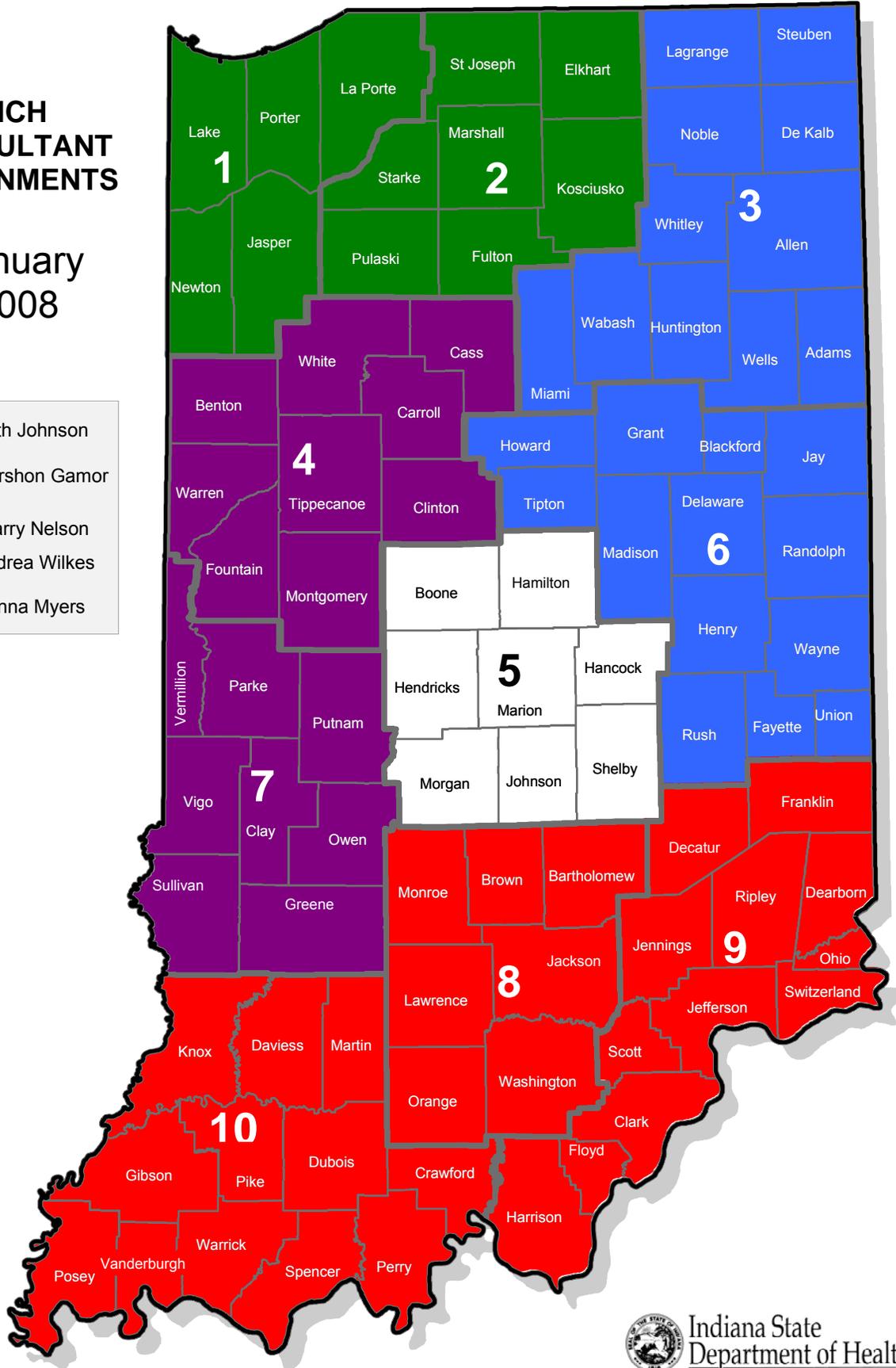
DISCIPLINE SPECIFIC KEY

Upon request, each county consultant will provide programmatic discipline-specific consultation to grantees and other agencies in their assigned counties in the discipline for which they are trained.

**MCH
CONSULTANT
ASSIGNMENTS**

January
2008

- Beth Johnson
- Gershon Gamor
- Larry Nelson
- Andrea Wilkes
- Donna Myers



1. FY 2006 Focus Counties

Appendix E

Allen
Clark
Daviess
DeKalb
Delaware
Elkhart
Fayette
Grant
Howard
Jackson
Knox
Lake
LaPorte
Madison
Marion
Monroe
Montgomery
Noble
Putnam
Scott
St. Joseph
Tippecanoe
Vanderburgh
Vigo
Wayne

2. Indiana Counties with highest rates of percentage of mothers who smoked during pregnancy (2005):

Crawford
Scott
Switzerland
Blackford
Fulton

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INDIANA PRIMARY CARE HEALTH SHORTAGE AREAS AND POPULATIONS

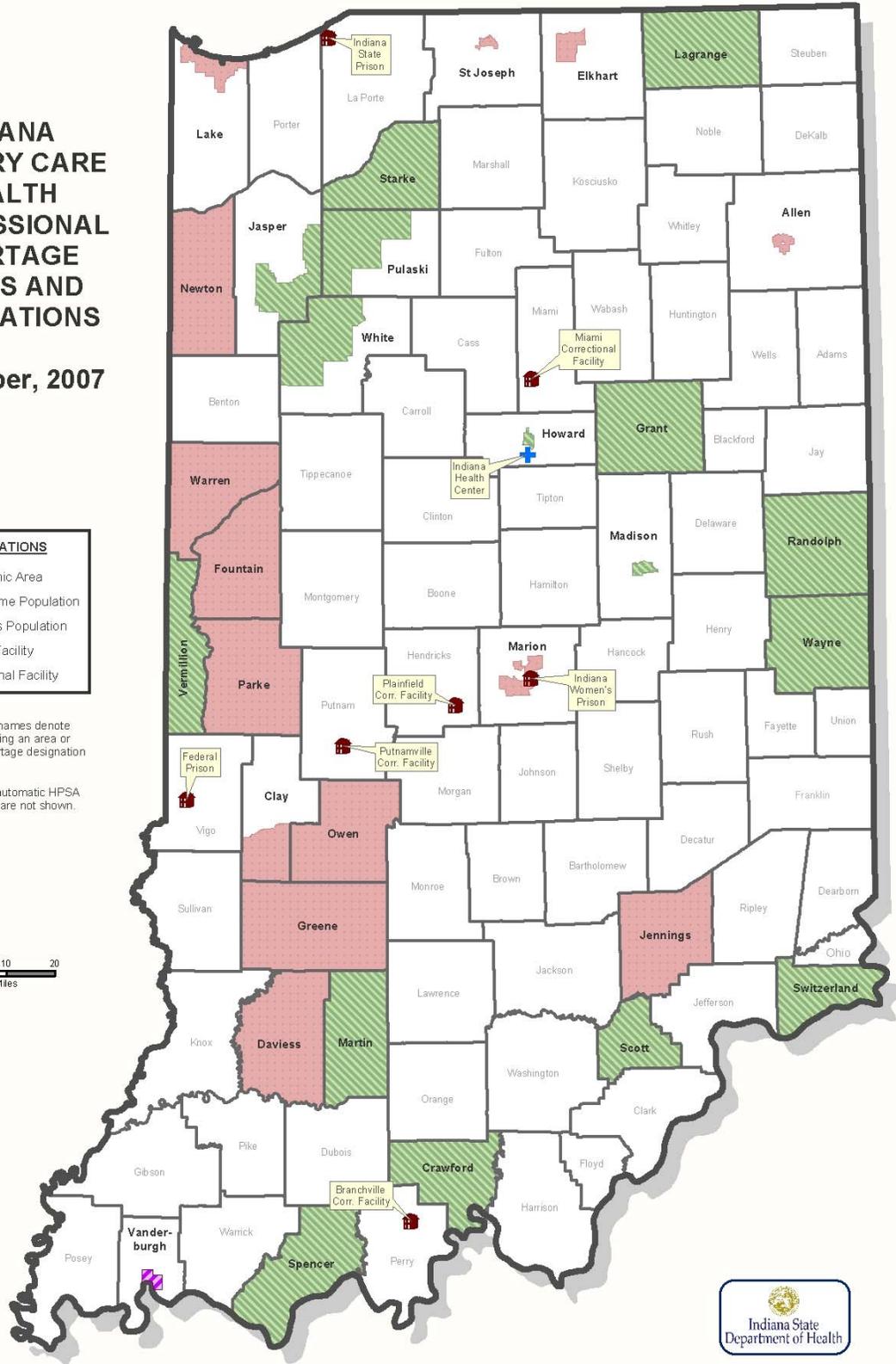
December, 2007

DESIGNATIONS

-  Geographic Area
-  Low-Income Population
-  Homeless Population
-  Medical Facility
-  Correctional Facility

Bold county names denote counties having an area or population shortage designation

Facilities with automatic HPSA designations are not shown.



Source: Shortage Designation Branch, HRSA, U.S. Department of Health and Human Services

INDIANA MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS

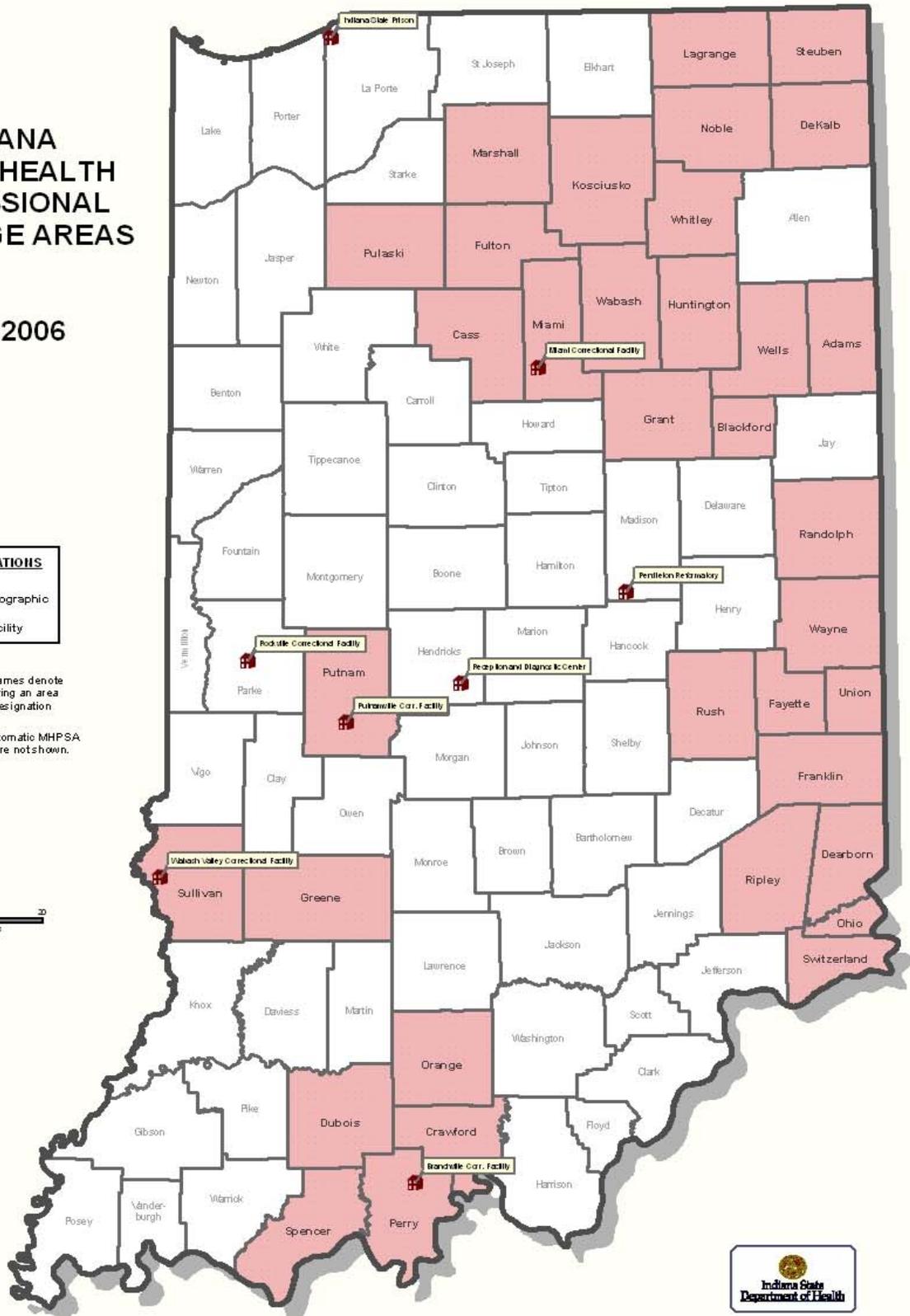
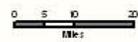
May, 2006

DESIGNATIONS

- Geographic
- Facility

Bold county names denote counties having an area shortage designation.

Facilities with automatic MHPSA designations are not shown.



Source: Shortage Designation Branch, HRSA, U.S. Department of Health and Human Services

INDIANA DENTAL HEALTH PROFESSIONAL SHORTAGE AREAS AND POPULATIONS

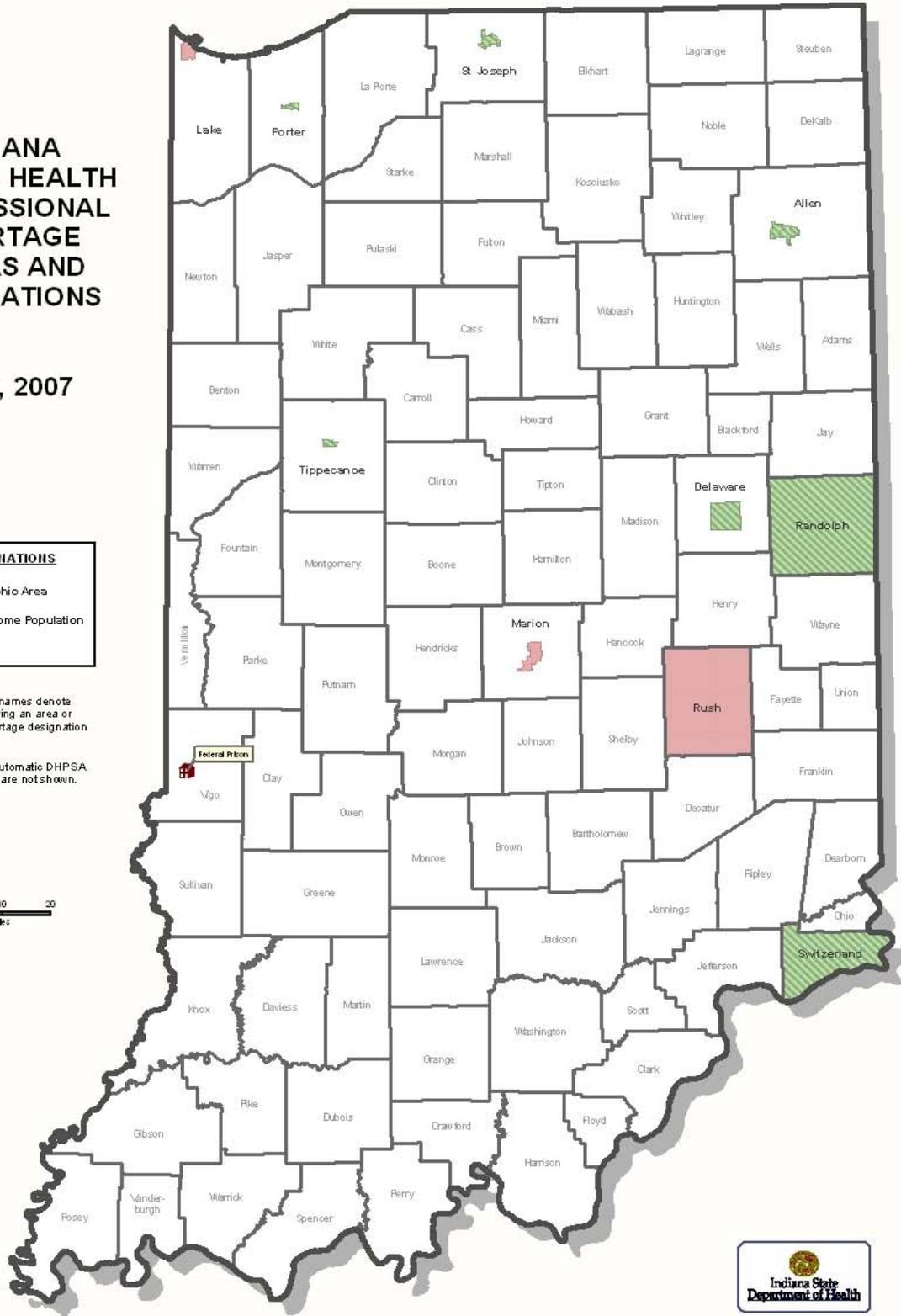
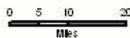
April, 2007

DESIGNATIONS

-  Geographic Area
-  Low Income Population
-  Facility

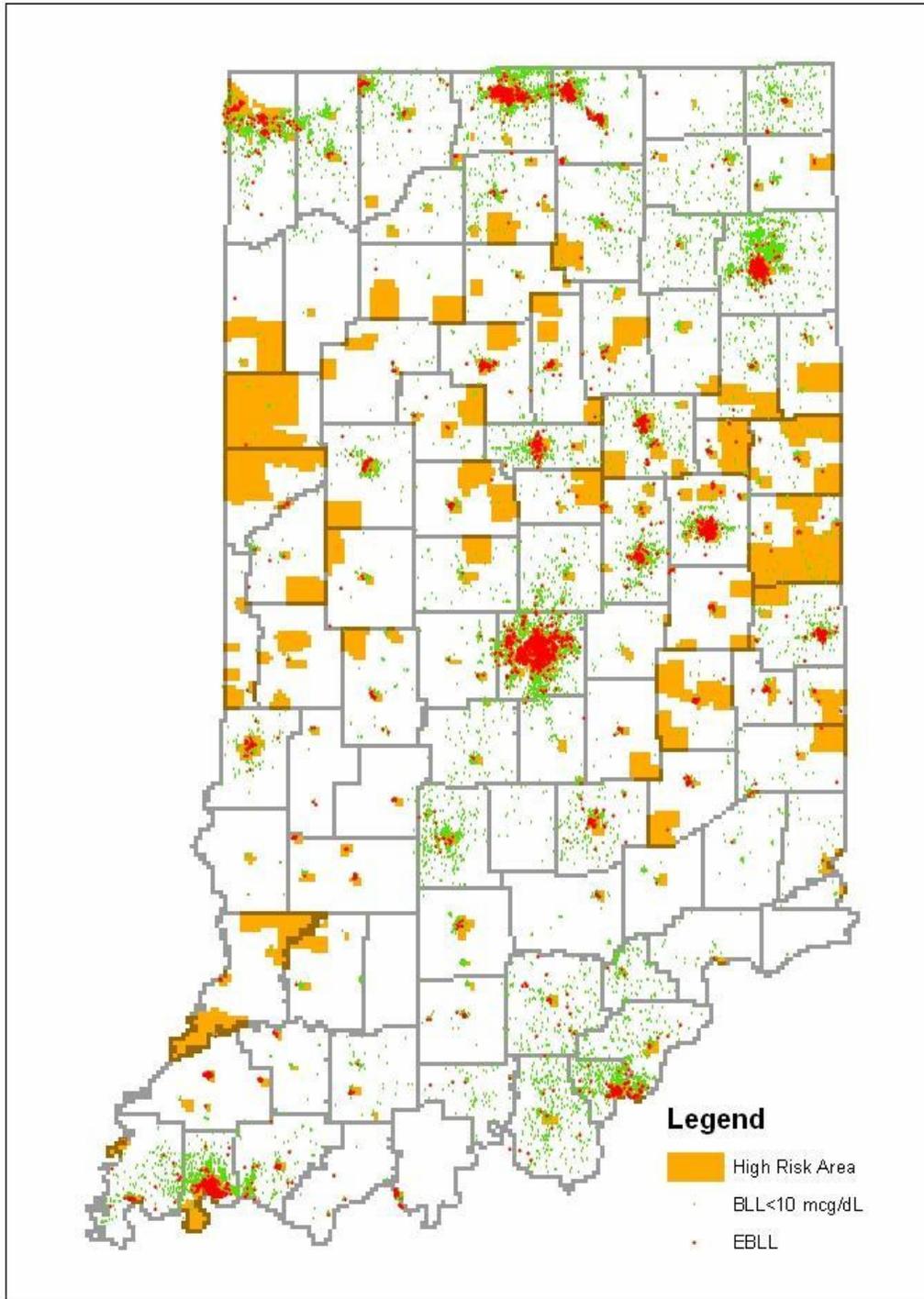
Bold county names denote counties having an area or population shortage designation

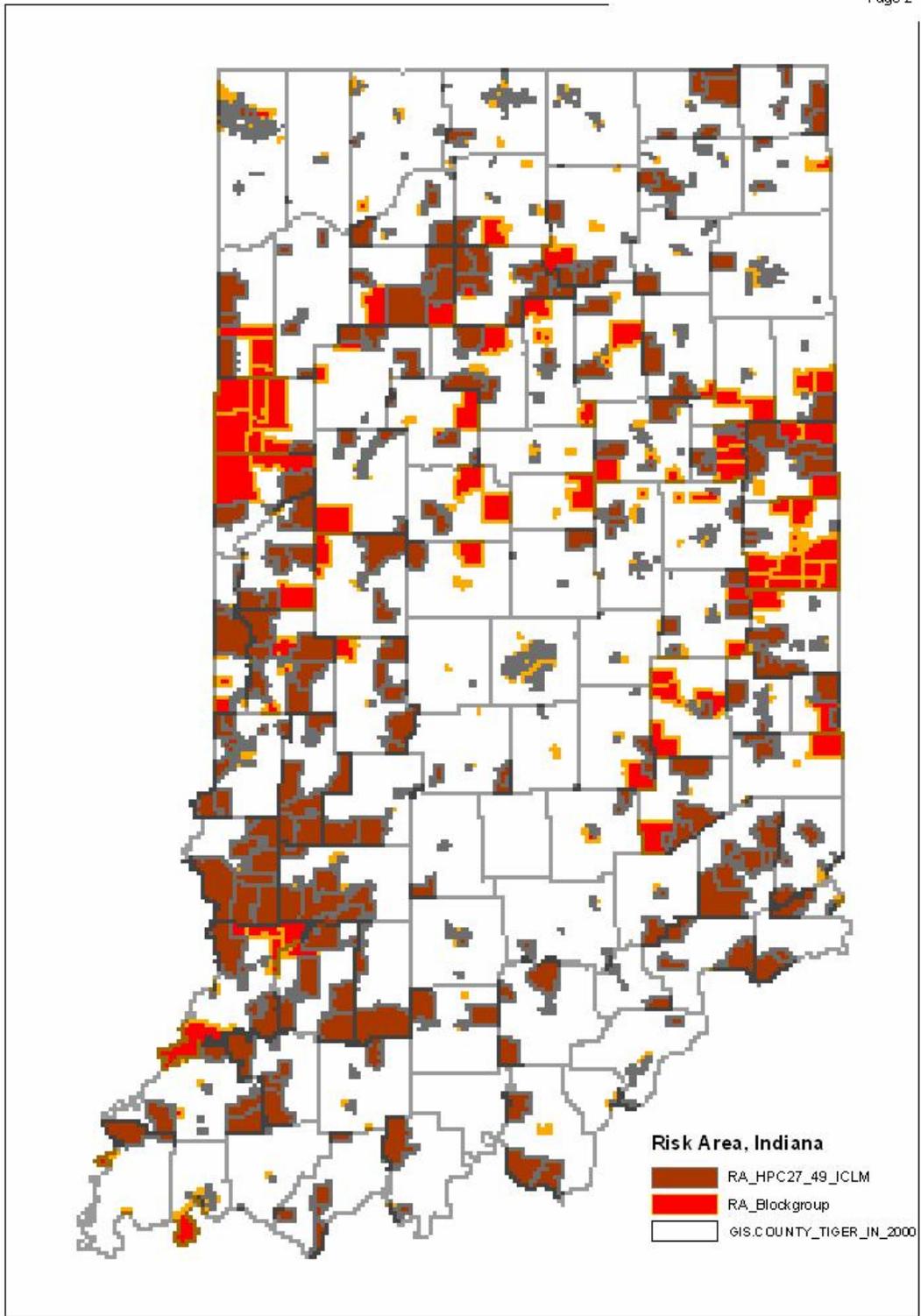
Facilities with automatic DHPHA designations are not shown.



Source: Shortage Designation Branch, HRSA, U.S. Department of Health and Human Services

Blood Lead Tests in Children aged 9 to 35 months, IN, 1997-2002





ISDH and Public Health Partners Field Staff

District 1

Dist. Coord., Shawn George, 219-738-1976
EPI, Donna Allen, 317-430-3844
Hosp. Area Coord., Murray Lawry, 317-439-9631;
PIO, Kevin Thompkins, 317-508-6497
Education Coord., Lynette Tucker, 219-613-7331
Mental Health:
 Swanson Ctr., 219-879-4621
 Tri-City MH Ctr., 219-398-7050
 Edgewater Systems, 219-885-4264
 Southlake Ctr. for MH, 219-736-7169
 Porter-Starke Svcs., 219-531-3500
 Wabash Valley Hosp., 765-463-2555

District 2 Dist. Coord., Deb Fulk, 574-293-9393

EPI, vacant
Hosp. Area Coord., Murray Lawry, 317-439-9631
PIO, Kristen Garcia, 317-416-8904;
Education Coord., Lynette Tucker, 219-613-7331
Mental Health: Madison Ctr. & Hosp., 574-234-0061; Oaklawn Psychiatric Ctr., 574-533-1234; Bowen Ctr. for Human Svcs., 574-267-7169; Four County Counseling Center, 574-722-5151

District 3

Dist. Coord., Joe Hilt, 317-439-9650
EPI, Brad Beard, 317-430-3845
Hosp. Area Coord., Murray Lawry, 317-439-9631
PIO, Kristen Garcia, 317-416-8904
Education Coord., Lynette Tucker, 219-613-7331
Mental Health: Northeastern Ctr., 260-347-2453; Bowen Ctr. for Human Svcs., 574-267-7169; Park Center, 260-481-2700; Four Cnty. Counseling Ctr., 574-722-5151

District 4

Dist. Coord., Catherine Went, 765-742-6255; **EPI**, Jennifer Wyatt, 765-742-6244; **Hosp. Area Coord.**, Joe Shelton, 317-508-8159; **PIO**, Kevin Thompkins, 317-508-6497; **Education Coord.**, Lynette Tucker, 219-613-7331
Mental Health:
 Wabash Valley Hosp., 765-463-2555; Four County Counseling Ctr., 574-722-5151; Behavioral Health Svcs., 765-453-8555

District 6 Dist. Coord., Deb Hopseker, 317-508-5746;

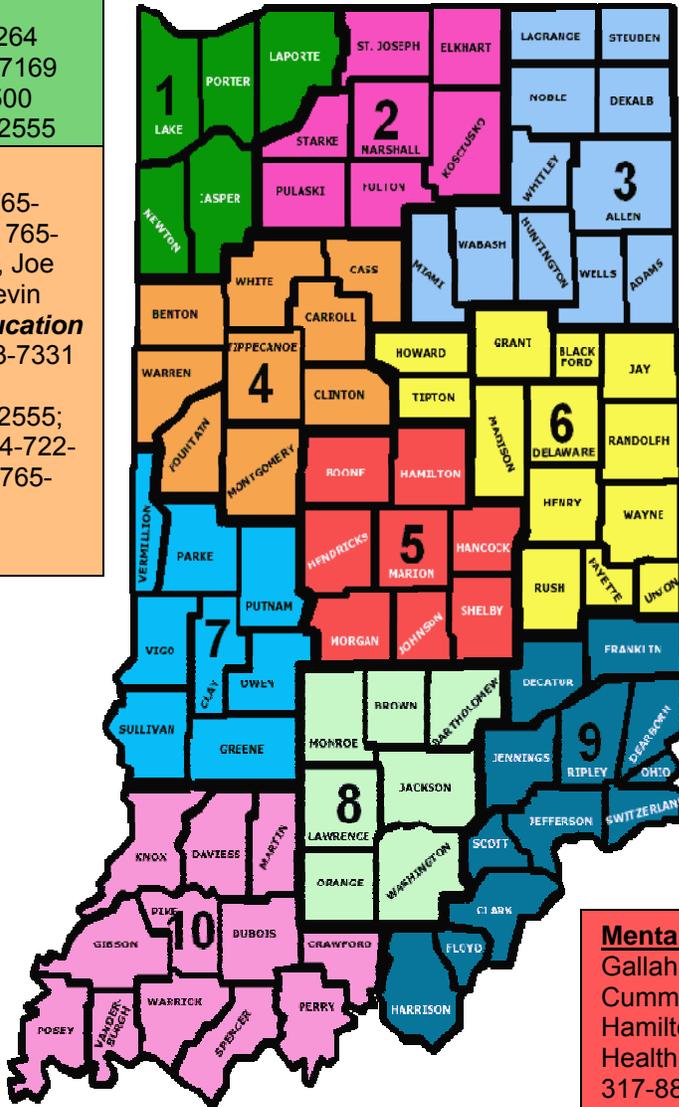
EPI, Stephanie Jackson, 317-430-3850; **Hosp. Area Coord.**, Joe Shelton, 317-508-8159; **PIO**, Keylee Wright, 317-439-9643; **Education Coord.**, Larry Long, 317-221-3138; Chief Nurse Conslnt., Janet Archer 317-234-3915
Mental Health: Behavioral Health Svcs., 765-453-8555; Grant-Blackford MH, 765-662-3971; Ctr. for MH, 765-649-8161; Comprehensive MH Svcs., 765-741-1928; Dunn MH Ctr., 765-983-8006

District 7

Dist. Coord., Stephen Cradick, 812-829-3476; **EPI**, Robert Allen, 317-430-3851; **Hosp. Area Coord.**, Dan Gettelfinger, 317-416-8905; **PIO**, Kimberly Wilkerson, 317-439-9679; **Education Coord.**, Larry Long, 317-221-3138; Chief Nurse Conslnt., Janet Archer 317-234-3915
Mental Health: Ctr. for Behavioral Health, 812-339-1691; Southern Hills Counseling Ctr., 812-482-3020; Hamilton Ctr., 812-231-8323; Cummins Behavioral HC, 317-272-3333;

District 5 Dist. Coord., Lloyd Flowers, 317-234-2816;

EPI, Sandy Gorsuch, 317-430-3848; **Hosp. Area Coord.**, Joe Shelton, 317-508-8159; **PIO**, Keylee Wright, 317-439-9643; **Education Coord.**, Larry Long, 317-221-3138; Chief Nurse Conslnt., Janet Archer 317-234-3915
Mental Health: BehaviorCorp, 317-587-0502; Gallahue Mental Health Svcs., 317-621-7600; Cummins Behavioral HC, 317-272-3333; Hamilton Ctr., 812-231-8323; Ctr. for Behavioral Health, 812-339-1691; Adult & Child MH Ctr., 317-882-5122; Midtown MHC, 317-554-2704



District 10

Dist. Coord., Stephanie Terry, 812-897-8605
EPI, Karen Gordon, 317-430-3852
Hospital Area Coord., Dan Gettelfinger, 317-416-8905
PIO, Kimberly Wilkerson, 317-439-9679
Education Coord., Dana Stidham, 812-343-2030
Mental Health: Samaritan Ctr., 812-886-6800; Southern Hills Counseling Ctr., 812-482-3020; Southwestern Ind. MH Ctr., 812-423-7791

District 8

Dist. Coord., Judith Gilliland, 812-472-3714; **EPI**, Robert Allen, 317-430-3851; **Hospital Area Coord.**, Dan Gettelfinger, 317-416-8905; **PIO**, John Sodrel, 317-416-8946; **Education Coord.**, Dana Stidham, 812-343-2030
Mental Health: Quinco Behavioral Health Sys., 812-348-7449; Lifespring MH Svcs., 812-280-2080; Southern Hills Counseling Ctr., 812-482-3020; Ctr. for Behavioral Health, 812-339-1691

District 9

Dist. Coord., Rebecca Lair, 317-431-9105; **EPI**, Steve Allen, 317-430-3853; **Hosp. Area Coord.**, Dan Gettelfinger, 317-416-8905; **PIO**, John Sodrel, 317-416-8946; **Education Coord.**, Dana Stidham, 812-343-2030
Mental Health: Lifespring MH Svcs., 812-283-4491; Quinco Behavioral Health Sys., 812-348-7449; Community MH Center 812-537-1302

Appendix J
INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
GRANT APPLICATION SCORING TOOL

FY 2009 & FY 2010 MCH Application Review Score: _____

Applicant Agency: _____

Project Title: _____

Reviewer: _____

Date of Review _____

Content Assessment

1.0 Applicant Information – Form A is complete (3 points)

Includes *all* of the following elements

- _____ Title of Project
- _____ Federal I.D. #
- _____ Medicaid Provider #
- _____ FY 2007 - 2008 MCH contract amount
- _____ Funds requested, matching funds contributed FY 2009 & FY 2010
- _____ Complete sponsoring agency data
- _____ Project Director signature
- _____ Authorized legal signature
- _____ County Health Officer signature
- _____ Secretary of State registration

NOTE: Primary and Secondary Reviewers do not need to evaluate section 1.0. Business Management staff will evaluate this section.

1.0 Score: _____
(3 points maximum)

2.0 Table of Contents

Table indicates the pages where each section begins, including appendices. Yes No

NOTE: Primary and Secondary Reviewers do not need to evaluate section 2.0. Business Management staff will evaluate this section.

*This document is an adaptation of an instrument by Dr. Wendell F. McBurney, Dean, Research and Sponsored Programs, Indiana University-Purdue University at Indianapolis. Doctor McBurney has granted permission of use of this adaptation.

3.0 MCH Proposal Narrative (15 points)

3.1 Project Summary includes *all* of the following elements (3.1 = 10 points max.)

- Relates to Title V services only
- Identifies problem(s) to be addressed
- Objectives are stated
- Overview of solutions (methods) is provided

3.2 Form B (**5 points**) (3.2 = 5 points maximum)

- MCH Project Description (B-1)

- Brief history is included
- Problems to be addressed are identified
- Objectives and workplan are summarized

- Clinic Site information (B-2)

- Project locations are identified
- Target population and numbers to be served by site are identified
- MCH and Non-MCH budget information per site is included

Comments:

3.0 Score: _____
(15 points maximum)

4.0 Applicant Agency Description

Flows from general to specific and includes *all* of the following elements:

4.1 Description of sponsoring agency

- Mission statement
- Brief history
- Description of administrative structure (organization chart is included)
- Project locations

4.2 Discussion of proposer's role in community and local collaboration (MOUs and MOAs attached, if not previously submitted)

Comments:

4.0 Score: _____
(5 points maximum)

5.0 Statement of Need

Must address MCSHC priorities for which applicant agency is requesting funding:

- _____ Clearly relates to ISDH MCSHC priorities
- _____ At least one problem statement addresses either MCSHC Priority #1 or Priority #2
- _____ Specifically address one or more of MCSHC priority needs #3 - #10
- _____ Relates to purpose of applicant agency
- _____ Problem(s)/need(s) identified are ones that applicant can impact
- _____ Client/consumer focused
- _____ Supported by statistical data, available on ISDH website and local sources. Data indicates the problem(s) or need(s) exist in the community.
- _____ Target populations/catchment areas are identified
- _____ Describes systems of care
- _____ Barriers to care are described
- _____ Disparities are addressed if county has significant numbers of minority population(s)

Comments:

5.0 Score: _____
(18 points maximum)

5.1 Statement of Need – Clinic or Service Provision Locations

- _____ Services located in a focus county (See Attachment E)
- _____ Services located in a HPSA (See Attachment F)
- _____ Services located in a MUA (See Attachment G)
- _____ Services located in an at-risk lead concentration area (See Attachment H)
- _____ Child health clinic(s) located in a county with inadequate child health providers as identified by OMPP (See Attachment D)
- _____ Services located in a former focus county and is a previously funded clinic location or in-home services project

NOTE: Primary and Secondary Reviewers do not need to evaluate section 5.1. ISDH GIS/ERC staff will evaluate this section.

5.0 Score: _____
(7 points maximum)

6.0 Tables

- _____ MCH service forms and tables are completed for one or more of the proposed services.
- _____ Pregnant women
 - _____ Child health
 - _____ Family planning
 - _____ School-based adolescent health
 - _____ Family care coordination
 - _____ Women's health
- _____ Performance objectives are included
- _____ Appropriate activities are included
- _____ Appropriate measures, documentation, and staff responsible for measuring activities are included
- _____ Project identifies how ISDH priority health initiatives will be incorporated into service delivery (activities on PM tables)

NOTE: Projects do not need to apply for every service (or even more than one) to receive full points for this section. Evaluators should verify that the application contains all required Performance Measure Tables for each service proposed and evaluate the quality of those tables.

Comments:

6.0 Score: _____
(15 points maximum)

7.0 Evaluation Plan Narrative

- _____ Project-specific objectives are measurable and related to improving health outcomes
- _____ Plan explains how evaluation methods reflected on the Performance Measure tables will be incorporated into the project evaluation
- _____ Staff responsible for the evaluation is identified
- _____ What data will be collected and how it will be collected are identified
- _____ How and to whom data will be reported are identified
- _____ Appropriate methods are used to determine whether measurable activities and objectives are on target for being met
- _____ If activities and objectives are identified as not on target during an intermediate or year-end evaluation, and improvement is necessary to meet goals, identify/ies staff member(s) responsible for revisiting activities to make changes which may lead to improved outcomes
- _____ Methods used to evaluate quality assurance (e.g. chart audits, client surveys, presentation evaluations, observation) are identified
- _____ Methods used to address identified quality assurance problems are identified

Comments:

7.0 Score: _____
(10 points maximum)

8.0 Staff

- _____ Staff is qualified to operate proposed program
- _____ Staffing is adequate
- _____ Job description and curriculum vitae of key staff are included as an appendix

Comments:

8.0 Score: _____
(4 points maximum)

9.0 Facilities

- _____ Facilities are adequate to house the proposed program
- _____ Facilities are accessible for individuals with disabilities
- _____ Facilities will be smoke-free at all times
- _____ Hours of operation are posted and visible from outside the facility

Comments:

9.0 Score: _____
(4 points maximum)

10.0 Budget and Budget Narrative

- _____ Relationship between budget and project objectives is clear
- _____ All expenses are directly related to project
- _____ Time commitment to project is identified for major staff categories and is adequate to accomplish project objectives

Comments:

10.0 Score: _____
(8 points maximum)

10.1 Budget and Budget Narrative Forms

- _____ Budget pages 1, 2, and 3 are complete for each year
- _____ Budget narratives include justification for each line item and are completed for each year
- _____ Budget correlates with project duration
- _____ Funding received from ISDH (Form C) is complete
- _____ Information on each budget form is consistent with information on all other budget forms

NOTE: Primary and Secondary Reviewers do not need to evaluate section 10.1. Business Management staff will evaluate this section.

10.1 Score: _____
(4 points maximum)

11.0 Minority Participation

- _____ Statement regarding minority participation in program design and evaluation

Comments:

11.0 Score: _____
(2 points maximum)

12.0 Endorsements

- _____ Endorsements are from organizations able to effectively coordinate programs and services with applicant agency
- _____ Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care
- _____ Endorsements and/or MOUs are current
- _____ Endorsement or MOU with Local Public Health Coordinator is included and current
- _____ Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has signed Form A)

Comments:

11.0 Score: _____
(5 points maximum)

TOTAL SCORE (To be calculated by Business Management staff):_____
(100 points maximum)

CHECKLIST To be completed by Business Management Staff

The following forms are completed:

Application Information – **Form A** Yes No

MCH Project Description – **Form B, (B-1, B-2)** Yes No

Funding Received thru ISDH – **Form C** Yes No

Informing Local Health Officers of Proposed Submission

- Includes letters to all health officers in jurisdictions included in proposed service area(s) or signature(s) of health officer(s) on Form A Yes No

Project Performance During FY 2007 & FY 2008

The Regional Health Systems Development Consultant (primary reviewer) should describe below performance achievements and/or problems/concerns identified in review of the FY 2007 & FY 2008 Annual Performance Reports that are relevant to this proposal.

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