The Indiana State Department of Health (ISDH) Maternal and Child Health’s (MCH) Genomics and Newborn Screening Program makes funds available for specific programs using this Grant Application Procedure (GAP). This GAP has been developed to support care services for Cystic Fibrosis in order to reduce infant morbidity and mortality within the State of Indiana.

APPLICATIONS MUST BE RECEIVED BY 4:00PM ON FRIDAY, AUGUST 18, 2017.

1. Submit application electronically to Maternal and Child Health to: MCHBusinessUnit@isdh.IN.gov
2. The application must be typed (12 pt font) and double-spaced. Each page must be numbered sequentially beginning with Form A, the Applicant Information page.
3. Appendices must include team CVs, financial spreadsheets, and drafted goals with measurable outcomes. The appendix may include other information as you see fit.
4. All sections of the application must be submitted at the same time. Applications missing any section will not be reviewed.

Questions regarding this grant application may be directed to the Maternal and Child Health Business Unit (MCHBusinessUnit@isdh.IN.gov) or Megan Griffie, Director of Genomics and Newborn Screening (MGriffie@isdh.IN.gov/317-233-1231).

Grant Application Packet Table of Contents:

I. Purpose of Grant and Description of Required Services
II. FY 2018 and FY 2019 Grant Application Guidance
III. Application Forms
   i. Form A
   ii. Form B-1
   iii. Form B-2
IV. Budget
   i. Budget Instructions
   ii. Account Codes
V. Resource Contact References
VI. Definitions
Eligibility Criteria
To be eligible for the Cystic Fibrosis (CF) funding opportunity, applicants must have a staff team including (at a minimum) a licensed/board-certified pulmonologist, genetic counselor(s), respiratory therapist and social worker/case manager. Additionally, applicants must provide financial ability to maintain basic business practices (outside of the tasks included with this service) without grant awarded funding.

Purpose of Grant
Grant funding is provided from the Newborn Screening program to provide early intervention and follow-up services for children residing in the state of Indiana who were born with Cystic Fibrosis (CF). Services include, but are not limited to, confirmatory testing and diagnosis, therapy services, education for patient and family regarding care and lifestyle needs, family planning services for future family growth, etc. Additionally, this funding is purposed to provide genetic evaluation and counseling services while educating at both the community and health care professionals levels. Note: this funding opportunity is not intended to support personnel fees.

Description of Required Services
Applicants must, at a minimum, provide the following services:

1) Provide early contact with primary care provider (PCP) and families of children with newborn screening results that are positive for Cystic Fibrosis and ensure that appropriate confirmatory testing is performed.

2) Provide services to patients in the State of Indiana, including the following:
   a) Treatment for disease management
   b) Genetic counseling, pre and post-diagnosis counseling, for prenatal patients (pregnant women) as appropriate;
   c) Evaluation and counseling to patients and families; and
   d) Other consultations as necessary.

3) Address access to care with patients and families (appropriateness of care/providers, transportation needs, funding and other resources available)

4) Refer families of children with special health care needs to appropriate resources, including Children’s Special Health Care Services and Women with Infants and Children (WIC) clinic.
   a) Inform families of children under age three about First Steps when appropriate.

5) When appropriate, provide education to patients and families regarding the positive effects of family planning and options for future family growth as a genetic carrier, as well as referral to MCH programs as needed.

6) Provide educational presentations to the general public, health care professionals and college or graduate-level students regarding the field of medical genetics and the conditions treated. Note: use of technology and social media is highly encouraged.

Reporting Requirements

1) For all children who receive direct (face-to-face) or indirect (telephone) services and consultations, the grantee shall be expected to maintain a log including but not limited to the following information. Note: The grantee shall be prepared to provide documentation for auditing purposes as needed to ensure compliance with requirements outlined in the grant proposal but reports do not need to be sent regularly to ISDH.
   • Child’s name
   • Child’s DOB
   • Parent’s name, address and zip code
   • PCP’s name and address
   • Date and time of phone conversations
   • Summary of phone conversation
   • Date packets were mailed
   • Name and address that packets were mailed to
   • List of any additional information included in the packet
   • Method of consultation
   • Date and time of consultation
   • Summary of consultation
   • List of information provided to the parents
   • Received completed evaluation

2) The grantee shall be required to participate in biannual meetings with the ISDH Director of Genomics and Newborn Screening and INSTEP Administrator.

3) The grantee will contact the Newborn Screening Follow-Up Coordinator regarding any open cases, quarterly.

4) The grantee shall be expected to utilize the ISDH Newborn Screening web application (INSTEP), in order to maintain complete records and track all children receiving services funded by this grant.

5) The grantee will create a waiver for parents wanting to opt out of these follow-up services and will keep a list of individuals opting out or lost to follow-up.
FY 2018 & FY 2019 Cystic Fibrosis Application Guidance

Please complete/create the following components:

1. Applicant Information Page (Form A) (provided)
   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.

2. Table of Contents (created by applicant)
   The table of contents must indicate the page where each section begins, including appendices.

3. Cystic Fibrosis Proposal Narrative
   A. Summary (created by applicant)
      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 proposal. The summary should:
      - Relate to Cystic Fibrosis Care Program services only;
      - Identify the problem(s) to be addressed;
      - Outline work plans to meet requirements of services provided
      - Succinctly state goals of your work plan;
      - Include a brief overview of evaluation/quality assurance methods
   
   B. Forms B-1 and B-2 (provided)
      All information on the Project Description Forms (Forms B-1 and B-2) must be completed. This summary form with its narrative will become part of the grant agreement and will also be used as a fact sheet on the project. Form B-2 requests specific information on each clinic site. The following information should be included:
      - **Form B-1:** The Project Description must include work plans for meeting requirements and a summary of the goals and brief needs assessment. 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.
      - **Form B-2:** The “Target population and estimated number to be served” is the number of clients to be served with NBS funds at each clinic site. The “NBS Budget for site” is the estimated NBS funds budgeted for each clinic site. The “Services Provided in NBS Budget Site” should include only those services provided with NBS funds. The “Other Services Provided at Site” section should include all services offered at clinic site(s) other than NBS funded services.

4. Applicant Agency Description (created by applicant)
   **NOTE:** Large organizations should write this description for the unit directly responsible for administration of the project. This description of the sponsoring agency should:
   - Include a history of the project- detailing, if applicable, past performance with providing these services;
   - Identify strengths and specific accomplishments pertinent to this proposal;
   - Include a discussion of the administrative structure of the organization within which the project will function, including an organization chart;
   - Include ability of agency to perform, at a minimum, basic business practices without NBS grant funding (include further financial record with budgeting documentation);
   - Identify project locations and discuss how they will be an asset to the project; and
   - Discuss the collaboration that will occur between the project and other organizations and healthcare providers.
   The discussion should identify the role of other collaborative partners, how the collaborations will benefit the project, and how each collaborates with your organization. You may attach MOUs, MOAs, and letters of support.

5. Statement of Need (created by applicant)
   Describe and document the specific problem(s) or need(s) to be addressed by the project. Documentation may include current data, research, local surveys, reports from professional local and national health organizations, and other reliable resources. Applicants should include a reference page for sources of documentation. The problems identified should:
   - 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 and how those barriers will be addressed; and
• Address disparities if the county has significant minority populations and how disparities will be addressed.

6. Performance Objectives, Goals and Activities (created by applicant)
Create a table which includes Performance Measures (PM) for each goal and associated activity included in the work plan. Each PM should include one or more Annual Outcome Objectives (specific goals) as well as additional Supporting Activities that must reflect a comprehensive plan to achieve the respective objectives. For each activity, the applicant must indicate: a 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.

Note: All grantees are required to collect data to monitor progress on each objective and activity. This data will be submitted in the Annual Performance Reports for FY 2018 and FY 2019 after each of these years is completed.

Grantee is expected to fulfill the requirements of Indiana’s Newborn Screening Law (Indiana Code 16-41-17, available at https://iga.in.gov/legislative/laws/2014/ic/) as outlined in the PMs for this funding opportunity.

7. Evaluation Plan (created by applicant)
NOTE: This should be a separate narrative section. Evaluation methods reflected on the Performance Measures Tables should be included in the overall Evaluation Plan. This section should have two parts:

1) An evaluation plan to determine whether the evidence-based interventions and activities are having an impact on objective goals. Please discuss the methodology for measuring achievement of activities, including 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, measurable, and related to improving health outcomes;
   • 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 explains 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.

2) A quality assurance evaluation plan to ensure that services are performed well. Please discuss:
   • Methods used to evaluate quality assurance (e.g. chart audits, patient surveys, presentation evaluations (including a copy of the presentation evaluation), observation); and
   • Methods used to address identified quality assurance problems.

8. Staff (created by applicant)
List all staff that will work on the project. Include name, job title, and primary duties. 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 (created by applicant)
Describe the facilities that will house project services. In this section you must address the following and demonstrate that:
   • Facilities are adequate to house the proposed program;
• Facilities are accessible for individuals with disabilities in accordance with the Americans with Disabilities Act of 1990;
• Facilities will be smoke-free at all times; and
• Hours of operation are 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.)

10. Infant Mortality
An Indiana key health initiative is collaborating with community partners to reduce infant mortality rates across the state. As part of this improvement collaboration the Genomics and Newborn Screening Program is looking for grantees that are able to help in the reduction of infant mortality within one or more core functions. These core functions include, (1) Quality Improvement Data Methods (2) Finance and Payment Mechanisms (3) Education and Marketing and (4) Disparities and Health Equity. In addition, the State of Indiana is looking to address disparities in infant mortality seen in 10 Indiana zip codes. Grantees are encouraged to discuss how, if any, they plan to address disparities in these areas and how their program will address the core functions of the improvement collaboration.

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>46312</td>
<td>Lake</td>
</tr>
<tr>
<td>46324</td>
<td>Grant</td>
</tr>
<tr>
<td>46806</td>
<td>Lake</td>
</tr>
<tr>
<td>46226</td>
<td>Marion</td>
</tr>
<tr>
<td>46208</td>
<td>Marion</td>
</tr>
<tr>
<td>46201</td>
<td>Marion</td>
</tr>
<tr>
<td>46218</td>
<td>Marion</td>
</tr>
<tr>
<td>47302</td>
<td>Delaware</td>
</tr>
<tr>
<td>46203</td>
<td>Marion</td>
</tr>
<tr>
<td>46229</td>
<td>Marion</td>
</tr>
</tbody>
</table>

11. Endorsements (created by applicant)
Each application must include at least three current letters of support from or memoranda of understanding (MOU) with relevant agencies. Letters of support and MOUs must demonstrate a commitment to collaboration between the applicant agency and other relevant community organizations. Letters of support and MOUs must be current and from organizations able to effectively coordinate programs and services with the applicant agency. MOUs must clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care. MOUs with other genetic services serving the same geographic area, including MCH-funded and MCH non-funded services, should clearly state how the services will work together.

12. Budget (created by applicant)
Budget forms are included as a separate Microsoft Excel workbook and are to be completed and submitted with this Grant Application Packet. See p.10 for more information on how to complete the budget forms.

13. Review Criteria
All proposals will be reviewed on the quality, clarity and completeness of the application. Applications will be decided upon according to the extent to which the proposal:
1) Contributes to the advancement and/or improvement of the health of citizens in Indiana;
2) Is responsive to program objectives for the activities for which grant dollars are being made available;
3) Is well executed and capable of attaining program objectives;
4) Describes SMART (Specific, Measurable, Attainable, Relevant, Time-based) objectives, activities, performance measures and outcomes with respect to timelines and resources;
5) Estimates reasonable cost to ISDH, considering the anticipated results;
6) Indicates that program personnel are well qualified for their roles in the program by training and/or experience, and the applicant organization has adequate facilities and personnel;
7) Provides an evaluation plan and/or data source(s) that will be used to determine the level of success for the project;
8) Is responsive to the special concerns and program priorities specified in this notice of availability of funds;
9) Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship;
10) Explicitly identifies specific groups in the service area who experience a disproportionate burden of the health condition and explains the root causes of disparities.
Title of Project: ________________________________________________________________

Federal ID Number: ________________________  Medicaid Provider Number: ________________________

Legal Agency/ Organization Name: ____________________________________________________________

Address: Street ______________________________________ City ______________________________________

          Zip Code

          Phone

          Fax

Project Director (Printed) ____________________________ Title ____________________________ Email ____________________________

Project Director Signature* ____________________________ Date ____________________________

Agency CEO or Official Custodian of Funds ____________________________ Title ____________________________ Email ____________________________

Agency CEO/Custodian of Funds Signature* ____________________________ Date ____________________________

Date registered with Secretary of State: ____________________________

(Applicants must be registered with the Secretary of State to be considered for funding)
<table>
<thead>
<tr>
<th>Project Name:</th>
<th>Project Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Fax Number:</td>
</tr>
<tr>
<td>Counties Served:</td>
<td></td>
</tr>
<tr>
<td>Type of Organization:</td>
<td>State □</td>
</tr>
<tr>
<td>Requested Funds: $______________</td>
<td>(Amount should reflect total for FY 2018 + total for FY 2019)</td>
</tr>
<tr>
<td>Sponsoring Agency:</td>
<td></td>
</tr>
<tr>
<td>Summarize project. Include plans to meet requirements, needs assessment, and goals.</td>
<td></td>
</tr>
</tbody>
</table>

Summarize evaluation tools. (Note: match evaluation tools with afore mentioned service requirements and goals)
<table>
<thead>
<tr>
<th>NBS Project Name:</th>
<th>Clinic Site Address:</th>
<th>Clinic Schedule (days &amp; times):</th>
<th>Counties Served:</th>
<th>Services Provided in NBS Budget for site:</th>
<th>Target Population and estimated number to be served with NBS funds:</th>
<th>Other services provided at site (non-NBS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Number:</td>
<td># Clinic Sites:</td>
<td></td>
<td></td>
<td></td>
<td>NBS Budget for Site:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NBS Project Name:</th>
<th>Clinic Site Address:</th>
<th>Clinic Schedule (days &amp; times):</th>
<th>Counties Served:</th>
<th>Services Provided in NBS Budget for site:</th>
<th>Target Population and estimated number to be served with NBS funds:</th>
<th>Other services provided at site (non-NBS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Number:</td>
<td># Clinic Sites:</td>
<td></td>
<td></td>
<td></td>
<td>NBS Budget for Site:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NBS Project Name:</th>
<th>Clinic Site Address:</th>
<th>Clinic Schedule (days &amp; times):</th>
<th>Counties Served:</th>
<th>Services Provided in NBS Budget for site:</th>
<th>Target Population and estimated number to be served with NBS funds:</th>
<th>Other services provided at site (non-NBS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Number:</td>
<td># Clinic Sites:</td>
<td></td>
<td></td>
<td></td>
<td>NBS Budget for Site:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NBS Project Name:</th>
<th>Clinic Site Address:</th>
<th>Clinic Schedule (days &amp; times):</th>
<th>Counties Served:</th>
<th>Services Provided in NBS Budget for site:</th>
<th>Target Population and estimated number to be served with NBS funds:</th>
<th>Other services provided at site (non-NBS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Number:</td>
<td># Clinic Sites:</td>
<td></td>
<td></td>
<td></td>
<td>NBS Budget for Site:</td>
<td></td>
</tr>
</tbody>
</table>
Budget Instructions
Review all materials and instructions before beginning to complete your budget

Creating the Budget Workbook
Budget forms are to be attached as a separate Microsoft Excel workbook. The budget is an estimate of what the project will cost. Create separate budgets for both fiscal year (FY) 2018 and 2019 using separate tabs for each worksheet. Include basic business costs and income from patient care or other funding sources depicting ability to maintain daily business practices outside the scope of NBS grant funding project. Be sure to demonstrate that all expenses are directly related to the project and the relationship between budget and project objectives are clear, provide budget narrative inside worksheet if necessary for clarification. Note: FY 2018 runs from July 1, 2017 through June 30, 2018; FY 2019 runs from July 1, 2018 through June 20, 2019.

Required Items to Include:
- Budgeted cost for patient visit expenses (avg. cost per patient and total for FY)
- Expenses related to confirmatory testing and treatment
- Cost of treatment/medications (estimated per patient and total for FY)
- Medical supplies for in-office treatment or home

**Note:** All patients, regardless of income, should receive necessary services. Though, it is expected that insurance and/or resources available are used to cover the costs associated with patient care prior to the use of NBS grant funds.

Allowable Expenditures
1. Medical food/metabolic formula
2. Patient visit fees
3. Patient transportation (only when resources unavailable)
4. Medical supplies/treatment supplies
5. In-state staff travel for patient care (when necessary)
6. **Note:** In-state travel information must include miles, mileage reimbursement rate, and reason for travel. Travel reimbursement must be calculated for each staff member who will be reimbursed and may not exceed state rates ($0.38 per mile, $26 per day per diem, and $89 plus tax per night of lodging).
7. Laboratory testing fees
8. Patient communication fees
9. Courier services for patient medication/food/formula/etc. delivery (only outside of reasonable travel distance)
10. Other costs associated with providing patient care

Non-Allowable Expenditures
The following examples may NOT be claimed as project costs and may NOT be paid for with NBS Funds:
1. Personnel salaries
2. Incentives, fringe benefits
3. Construction of buildings, building renovations;
4. Depreciation of existing buildings or equipment;
5. Contributions, gifts, donations;
6. Entertainment;
7. Automobile purchase/rental;
8. Business financial costs such as internet, electric, utilities, etc;
9. Fines and penalties;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Fundraising expenses;
14. Legal fees;
15. Legislative lobbying;
16. Out-of-state travel;
17. Dues to societies, organizations, or federations
<table>
<thead>
<tr>
<th>Account Codes</th>
<th>Physicians</th>
<th>Other Service Providers</th>
<th>Care Coordination</th>
<th>Nurses</th>
<th>Social Service Providers</th>
<th>Nutritionists/ Dietitians</th>
<th>Medical/ Dental Project Director</th>
<th>Other Administration</th>
<th>Fringe Benefits</th>
<th>Contractual Services</th>
<th>Other Expenditures</th>
<th>Consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>111.000</strong> Physicians</td>
<td>Clinical Geneticist</td>
<td>Medical Geneticist</td>
<td>Pediatrician</td>
<td>Family Practice Physician</td>
<td>OB/GYN</td>
<td>Resident/ Intern</td>
<td>General Family Physician</td>
<td>Other Physician</td>
<td>Neonatologist</td>
<td>Audiologist</td>
<td>Genetic Counselor (M.S.)</td>
<td>Psychologist</td>
</tr>
<tr>
<td></td>
<td>Community Educator</td>
<td>Outreach Worker</td>
<td>Speech Pathologist</td>
<td></td>
<td>Community Health Worker</td>
<td>Physical Therapist</td>
<td>Occupational Therapist</td>
<td>Family Planning Counselor</td>
<td>Physician Assistant</td>
<td>Respiratory Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Practice Physician</td>
<td>OB/GYN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pediatrician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OB/GYN</td>
<td>Resident/ Intern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neonatologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.200</strong> Other Service Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child Development Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Educator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Health Worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Planning Counselor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.350</strong> Care Coordination</td>
<td>Licensed Clinical Social Worker(L.C.S.W.)</td>
<td>Registered Dietician</td>
<td>Social Worker (M.S.W.)</td>
<td>Licensed Social Worker (L.S.W.)</td>
<td>Social Worker (B.S.W.)</td>
<td>Registered Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Licensed Social Worker (L.S.W.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.400</strong> Nurses</td>
<td>Clinic Coordinator</td>
<td>Licensed Midwife</td>
<td>Pediatric Nurse Practitioner</td>
<td>Community Health Nurse</td>
<td>Licensed Practical Nurse</td>
<td>Registered Nurse</td>
<td>Family Planning Nurse Practitioner</td>
<td>Other Nurse</td>
<td>School Nurse Practitioner</td>
<td>Family Practice Nurse Practitioner</td>
<td>Other Nurse Practitioner</td>
<td>OB/GYN Nurse Practitioner</td>
</tr>
<tr>
<td></td>
<td>Licensed Social Worker (L.C.S.W.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Licensed Social Worker (L.S.W.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.600</strong> Social Service Providers</td>
<td>Caseworker</td>
<td>Counselor (M.S.)</td>
<td>Social Worker (M.S.W.)</td>
<td>Licensed Clinical Social Worker(L.C.S.W.)</td>
<td>Social Worker (B.S.W.)</td>
<td>Counselor</td>
<td>Licensed Social Worker (L.S.W.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Licensed Social Worker (L.S.W.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.700</strong> Nutritionists/ Dietitians</td>
<td>Dietitian (R.D. Eligible)</td>
<td>Registered Dietitian</td>
<td>Nutritionist (Master’s Degree)</td>
<td>Nutrition Educator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.800</strong> Medical/ Dental Project Director</td>
<td>Dental Director</td>
<td>Medical Director</td>
<td>Project Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.825</strong> Project Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>111.850</strong> Other Administration</td>
<td>Accountant/ Finance/ Bookkeeper</td>
<td>Data Entry Clerk</td>
<td>Nurse Aid</td>
<td>Administrator/ General Manager</td>
<td>Evaluator</td>
<td>Other Administration</td>
<td>Clinic Aide</td>
<td>Laboratory Assistant</td>
<td>Programmer/ Systems Analyst</td>
<td>Clinic Coordinator (Administration)</td>
<td>Laboratory Technician</td>
<td>Secretary/ Clerk/ Medical Record</td>
</tr>
<tr>
<td><strong>115.000</strong> Fringe Benefits</td>
<td>Insurance and Bonding (insurance premiums for fire, theft, liability, fidelity bonds, etc.; malpractice insurance premiums cannot be paid with grant funds)</td>
<td>Equipment Leases</td>
<td>Licensing</td>
<td></td>
<td>Maintenance Agreements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>200.000</strong> Contractual Services</td>
<td>Conference Registrations</td>
<td>In-State Staff Travel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>200.800</strong> Rental and Utilities</td>
<td>Janitorial Services</td>
<td>Utilities</td>
<td>Rental of Space</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>200.850</strong> Communications</td>
<td>Postage (including UPS)</td>
<td>Publications</td>
<td>Subscriptions</td>
<td>Printing Costs</td>
<td>Reports</td>
<td>Telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>200.900</strong> Other Expenditures</td>
<td>Approved items not otherwise classified above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Consultants**

Individuals not directly employed by your organization, but with whom you want to contract to perform services under this grant. (If you are contracting with an organization for services, you should list the organization under 200.00 Contractual Services.)
### Resource Contact Information

*Note: This is *not* a comprehensive resource list, please feel free to utilize any additional resources for patient care*

<table>
<thead>
<tr>
<th>Site</th>
<th>Phone</th>
<th>Address</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby and Me Tobacco Free sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evansville Christian Life Center</td>
<td>(812) 492-0711</td>
<td>509 S. Kentucky Ave. Evansville, IN 47714</td>
<td></td>
</tr>
<tr>
<td>Clark County Health Department</td>
<td>(812) 283-2747</td>
<td>1301 Akers Ave. Jeffersonville, IN 47130</td>
<td></td>
</tr>
<tr>
<td>Family Medicine Center-Vigo Co. (Union Hospital, Inc.)</td>
<td>(812) 238-7631</td>
<td>1513 N. 6 ½ St. Terre Haute, IN 47807</td>
<td></td>
</tr>
<tr>
<td>Pregnancy Plus Anderson</td>
<td>(765) 298-2229</td>
<td>1210 A Medical Arts Building, Ste. 203, Anderson, IN 46011</td>
<td></td>
</tr>
<tr>
<td>Pregnancy Plus Muncie</td>
<td>(765) 216-6234</td>
<td>3025 North Oakwood Ave. Muncie, IN 47304</td>
<td></td>
</tr>
<tr>
<td>Family Connections</td>
<td>(812) 689-6363</td>
<td>202 N. Gaslight Dr. Versailles, IN 47042</td>
<td></td>
</tr>
<tr>
<td>Community Health and Wellness Center</td>
<td>(812) 279-6222</td>
<td>2415 Mitchell Road. Bedford, IN 47421</td>
<td></td>
</tr>
<tr>
<td>St. Vincent-Frankfort</td>
<td>(765) 659-3240</td>
<td>1300 South Jackson St. Frankfort, IN 46041</td>
<td></td>
</tr>
<tr>
<td>Health and Hospital Corporation</td>
<td>(317) 221-2126</td>
<td>4087 Millersville Rd. Indianapolis, IN 46205</td>
<td></td>
</tr>
<tr>
<td>Children’s Special Health Care Services (CSHCS)</td>
<td>(800) 475-1355</td>
<td>2 N Meridian St, 7B Indianapolis, IN 46204</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Option 1</strong> – Spanish Interpretation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Option 2</strong> – Application Status or Eligibility/Reevaluation Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Option 3</strong> – Prior Authorization, Care Coordination or Insurance Updates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Option 4</strong> – Travel Inquiries or Travel Reimbursement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Option 5</strong> – Payment of Claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Option 6</strong> – Provider Relations &amp; Provider Agreement</td>
</tr>
<tr>
<td>First Steps, First Steps State Administration Bureau of Child Development Services</td>
<td>(800) 545-7763</td>
<td>402 W Washington St., W435, MS-51. Indianapolis, IN 46204</td>
<td><a href="mailto:FirstStepsWeb@fssa.in.gov">FirstStepsWeb@fssa.in.gov</a></td>
</tr>
<tr>
<td>Hoosier Healthwise (Medicaid, SCHIP)</td>
<td>(800) 889-9949</td>
<td></td>
<td><a href="mailto:hoosierhealthwise@maximus.com">hoosierhealthwise@maximus.com</a></td>
</tr>
<tr>
<td>Indiana Family Helpline</td>
<td>(800) 433-0746</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana Tobacco Quitline</td>
<td>(800) QUIT-NOW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WIC</td>
<td></td>
<td><a href="http://www.in.gov/isdh/19691.htm">http://www.in.gov/isdh/19691.htm</a></td>
<td><a href="mailto:inwic@isdh.in.gov">inwic@isdh.in.gov</a></td>
</tr>
</tbody>
</table>
Definitions

- **Client/ patient**: A recipient of services that are supported by program expenses funded in whole or in part by ISDH Newborn Screening (NBS) dollars.
- **Clinical patient**: Any individual who had an appointment and was evaluated by or received services.
- **College or graduate level students**: Includes nursing and medical students.
- **Consultation**: A visit with a patient where the grantee is **not** the primary provider of services.
- **Counseling only**: A communication which deals with the human problems associated with the occurrence or risk of occurrence of a 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.
- **Cultural competence**: A defined set of values, principles, behaviors, attitudes, policies and structures that enable organizations to work effectively cross-culturally. To be culturally competent, an organization must 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. Organizations must incorporate this in all aspects of policy-making, administration, practice, and service delivery, and 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, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, volume 1*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.)
- **Designated inborn errors of metabolism**: Those conditions for which an interval and/or an initial reporting form has been created within the Indiana Newborn Screening Tracking and Education Program (INSTEP) application.
- **Evaluation/ counseling**: Some degree of assessment (e.g., a physical examination) is performed in addition to genetic counseling services.
- **INSTEP**: Indiana Newborn Screening Tracking and Education Program (INSTEP) is a web-based application developed by the Indiana State Department of Health Newborn Screening (NBS) Program in order to help ensure that all children in Indiana receive the best care related to newborn screening.
- **NBS 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.
- **Program expense**: Any expense included in the budget to be funded by NBS (supplies, space costs, etc.)
- **Return visit**: Clients who have been previously seen in your project clinic and are returning for follow-up care.
- **SMART goals**: SMART is an acronym for **Specific**, **Measurable**, **Attainable**, **Relevant**, and **Time-based**. SMART goals take each of these into account. This goal is:
  - **Specific**: Detailed  
  - **Measurable**: “at least 98%”  
  - **Attainable**: It is reasonable to hand out packets to almost all patients.  
  - **Relevant**: It has to do with the activities outlined in this grant application packet.  
  - **Time-based**: This is to occur during FY 2016, which has a specific start and end date.
- **System of care**: “A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.” (Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, D.C.: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.)
- **Telephone contact**: A phone conversation where a limited amount of counseling and/or a referral is discussed.
- **Types of clients**: Pregnant women, infants, children, adolescents, adult women and families