FY 2012 and FY 2013 NS Application for Funding
Sickle Cell Care Coordination Services

ISDH Maternal and Child Health Division (MCH) makes funds available for specific programs using this Grant Application Procedure (GAP). This GAP has been specifically designed for the Sickle Cell program.

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
   - Promotion of 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.

Instructions

1. An application for Newborn Screening (NS) funds must be received by ISDH MCH by March 1, 2011.
2. Mail application to: Indiana State Department of Health
   ATTENTION: Vanessa Daniels
   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 point, 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 CV's, 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 Bob Bowman, Director of Genomics and Newborn Screening, at 317.233.1231 or BobBowman@isdh.IN.gov.

CRITERIA FOR ELIGIBILITY

Prerequisites
Eligible applicants must have a board-certified hematologist on staff.

Purpose of Grant

To improve care coordination between a tertiary care center and primary care providers in the community following both inpatient hospitalization and outpatient care.

NOTE: Documentation of services administered must be provided upon request by the ISDH.

Description of Required Services
Applicants must be able to provide the following services:

1) Serve as a link for families between inpatient admission and outpatient follow-up.
    a. Prior to inpatient discharge, ensure follow-up appointments are made as well as contacting families if patients happen to be discharged without a follow-up appointment
    b. Meeting with families to provide education about the importance of SCD preventive care
2) Contact families to improve rates of outpatient clinic follow-up.
3) Facilitate communication with primary care providers.
    a. Ensure a summary note is sent to each patient's primary care provider after each inpatient discharge.
    b. Ensure a dictation or summary note is sent to each patient's primary care provider regarding outpatient care at least annually.
4) Identify patients in need of specific health maintenance measures and facilitating the delivery of these measures.
5) Generate an individualized care letter for emergency care for all children at their first visit and updated at least yearly.
6) Generate an Individualized Pain Management plan for both home and emergency use for all children by one year of age, and updated at least yearly.
7) Help to maintain the SCD database such as recent testing (TCD) and preventive care measures (pneumococcal vaccination).
8) Participate in implementation of quality assurance initiatives including patient-specific pain management pathways for home and Emergency Department use.
9) Provide family counseling for SCD including discussion of inheritance and basic discussion of risk of a second child with SCD, and referring for formal genetic counseling when needed.
10) Coordinate annual meetings with families to discuss quality of care provided by the applying facility.

Size of Population Being Served
The grantee will be expected to provide services for a significant portion of children in IN with a confirmed diagnosis of a hemoglobinopathy.

Reporting Requirements

1) The grantee shall be expected to maintain a log of follow-up services provided for *all* children who receive services funded by this grant. This log shall be maintained for direct (face-to-face) or indirect (telephone) consultations to include but not be limited to:
    - Child's name,
    - Child's DOB,
    - Parent's name and address,
    - PCP's name and address,
    - Date and time of phone conversations,
    - Summary of phone conversation,
    - Date dictation or summary notes were mailed,
    - Name and address that dictation or summary notes were mailed to,
    - List of any additional information included in the packet.
    - Method of consultation,
    - Date and time of consultation,
    - Summary of consultation,

- A log of information provided to the parents.

2) The grantee shall be required to participate in quarterly meetings as warranted with the ISDH Director of Genomics and Newborn Screening and the Sickle Cell Program Director in order to clarify and resolve the status of any open cases.
3) The grantee shall be expected to utilize the ISDH Newborn Screening web application, when available, in order to maintain complete records and track all children receiving services funded by this grant.
4) The grantee shall be prepared to provide documentation for auditing purposes as needed to ensure compliance with requirements outlined in the grant proposal.

FORMS

Applicant Information (Form A)

NS 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 – Hemoglobinopathy Services Providers Annual Performance Report

Appendix B – Definitions (NS Services)

Appendix C – Grant Application Scoring Tool

Priority Health Needs for the MCH population, 2012 – 2013

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)

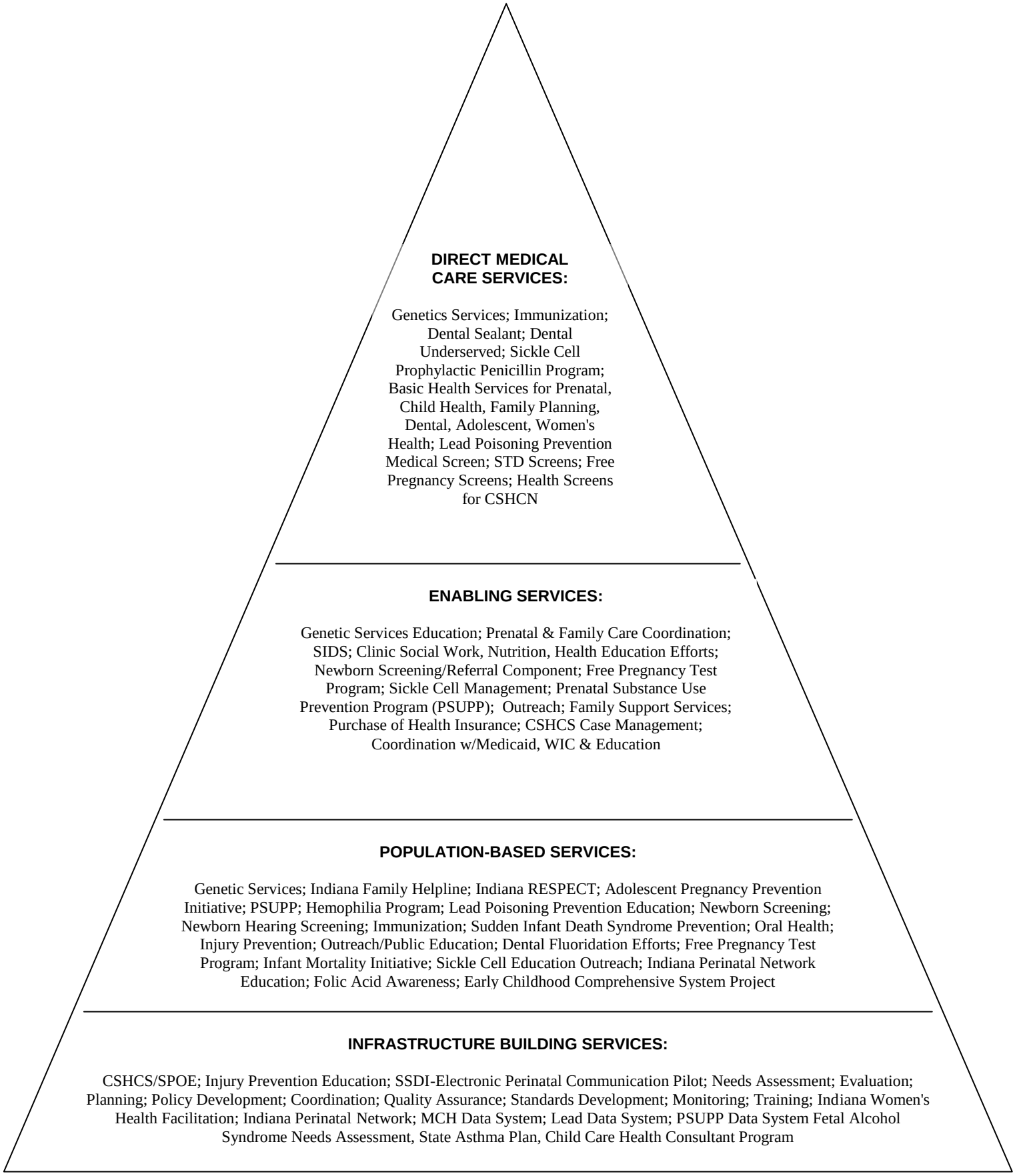
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity. (ISDH Priorities #1, #2, & #3)

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 2012 and FY 2013 Hemoglobinopathy Services Grant 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, the person authorized to make legal and contractual agreements for the applicant agency, must sign and date this document.

2. Table of Contents (created by applicant)

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

3. Hemoglobinopathy Services 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 Hemoglobinopathy program services only;
- Address applicant's capacity to add these services;
- Describe how the project will provide these services;
- Justify the need for the funds being provided by this grant;
- Emphasize accomplishments/progress made toward previously identified objectives and outcomes; and
- Indicate the percentage of the target population served by your project and the percentage of racial/ethnic minority clients among your clients served.

B. Forms B-1 and B-2

All information on the Project Description Forms (Forms B-1 and B-2) must be completed. Indicate how many clients will be served for FY 2012 and FY 2013. 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
Project Description (created by applicant)

- The Project Description 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

- The "Target population and estimated number to be served" on Form B-2 is for individual clinic site(s) and is the number to be served with Newborn Screening (NS) and NS matching funds.
- The "NS Budget for Site" is the estimated NS and NS matching funds budgeted for the individual clinic site.
- The "Services Provided in NS Budget Site" should include only those services provided with NS and NS matching funds.

- The "Other Services Provided at Site" section should include all services offered at clinic site(s) other than NS and NS matching 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:

- 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 **(NOTE: Applicants should attach an organization 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 collaborative partners and specify how each collaborates with your organization. You may attach MOUs, MOAs, and letters of support.

5. Outcome and Performance Objectives and Activities

Hemoglobinopathy Services projects have mandatory related Performance Measures (PM) (see pages 12 –20).

Pages 12 – 20 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 (Supporting 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.

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

Grantee is expected to fulfill the requirements of Indiana's Newborn Screening Law and the ISDH Priority Health Initiatives as outlined in the Performance Measures for this funding opportunity. For a list of the ISDH Priority Health Initiatives, see pages 4 – 5 of this application.

Applicants are to complete the Hemoglobinopathy Services Performance Measures on pages 12 – 20. 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 MCH consultants before submitting them with the grant application.**

Pages 12 – 20 are to be used by grantees to monitor progress on each activity and to submit in the Annual Performance Report for FY 2012 and FY 2013 after each year is completed. The columns on the Performance Measures forms labeled "Activity Status," "Documentation Used," "Staff Responsible," and "Comments/Adjustments" are only to be completed and submitted with the FY 2012

and FY 2013 Annual Performance Reports. MCH 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 2012 and FY 2013 Annual Performance Reports.

6. 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: 1) an evaluation plan to determine whether the evidence-based interventions/activities are working to impact both the specific objective goal and the priorities and 2) 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.

7. 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 total 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.

8. 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.

9. Budget and Budget Narrative

NOTE: Do not combine budget information for FY 2012 and FY2013. You must complete separate budget pages for each fiscal year.

In this section, you must demonstrate that:

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

Complete this entire section by providing budget information for FY 2012 and for FY 2013. The budget is an estimate of what the project will cost. Complete the provided standard budget forms (NS Budget pages 1, 2, and 3) according to directions. Do not substitute a different format. Projects do not need to include matching funds. However, any additional source(s) of funds that support services should be reported under non-matching funds.

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

The budget narrative must include a justification for every 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 Newborn Screening (NS) 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 $0.44 per mile.

Complete Form C – List all ISDH funding received by proposing organization in FY 2011.

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

10. 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/files/certification_list.xls.

11. 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.

Applicants are not required to obtain the signature(s) of or send a support letter(s) to the local health officer(s) in each county where services are proposed. Applicants may enter "N/A" for this line on Form A.

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.
- 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).

Questions regarding this grant application may be directed to Vanessa Daniels (VDaniels@isdh.IN.gov / 317-233-1241) or Bob Bowman (bobbowman@isdh.IN.gov / 317-233-1231).

REQUIRED FORMS FOR HEMOGLOBINOPATHY SERVICES PROVIDERS

1) Form A: Applicant Information

2) Form B-1 and B-2: Hemoglobinopathy 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
Hemoglobinopathy Services Providers

FY 2012 - 2013 OBJECTIVES and ACTIVITIES

Performance Measure 1: Ensure that children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy receive appropriate care coordination.

Directions for Completion

To complete these tables, please state your projected goals (of the percentage of children that will receive appropriate follow-up services) for FY 2012 and FY 2013.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting expectations in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: The ISDH Genomics and Newborn Screening Program expects that **95%** of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy receive appropriate follow-up services after discharge.

Performance Objective (PO) 1a:

Ensure that _____% **(estimated goal)** of children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy receive a follow-up appointment after discharge.

PO 1a: Follow-up services provided for children with Sickle Cell disease or another hemoglobinopathy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy		
(b) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy that had a follow-up appointment scheduled at the time of discharge		
(c) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy that were contacted after discharge in order to schedule a follow-up appointment		
Goal: Percentage of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy that had a follow-up appointment scheduled at the time of discharge		

***Percentage = [(b + c) / a] x 100**

Performance Objective 1b:

Ensure that ____% **(estimated goal)** of primary care providers of children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy receive documentation of the child's hospital stay within 2 weeks of discharge.

PO 1b: Follow-up services provided for children with Sickle Cell disease or another hemoglobinopathy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy		
(b) Total number of primary care providers of a child admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy that received a summary note within 2 weeks of discharge.		
Goal: Percentage of primary care providers of a child admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy that received a summary note within 2 weeks of discharge.		

***Percentage = (b / a) x 100**

Performance Objective 1c:

Ensure that ____% **(estimated goal)** of children of Sickle Cell disease are contacted.

PO 1c: To contact families to improve rates of outpatient clinic follow-up with a confirmed diagnosis of Sickle Cell Disease.

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of children diagnosis of Sickle Cell disease.		
(b) Total number of children diagnosis of Sickle Cell disease that have successfully been contacted prior to an appointment as a reminder.		
(c) Total number of children diagnosis of Sickle Cell disease that have been contacted after a missed appointment or who have not been seen within the prior 6-12 months.		
Goal: Percentage of children diagnosis of Sickle Cell disease that have been contacted by multiple means if necessary.		

***Percentage = [(b + c) / a] x 100**

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 1. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments shall be filled in on quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Ensure that all children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy have an identified PCP at the time of discharge			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Inform > 90% of families of children in the appropriate age range about First Steps, Children's Special Health Care Services, SCHIP, WIC, and Hoosier Healthwise (Medicaid).			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Ensure that families are educated on Medical Homes.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

FY 2012 – 2013 OBJECTIVES and ACTIVITIES

Performance Measure 2: Provide care coordination for children seen in an Outpatient clinic diagnosed with Sickle Cell disease).

Directions for Completion

To complete these tables, please state your projected goals (of the percentage of families of children diagnosed with a hemoglobinopathy that receive appropriate care coordination) for FY 2012 and FY 2013.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting or exceeding expectation in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: The ISDH Genomics and Newborn Screening Program expects at least **95%** of families of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) to receive appropriate care coordination.

Performance Objective 2a:

Ensure that at least ____% **(estimated goal)** of families of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) receive appropriate care coordination.

PO 2a: Care coordination for children diagnosed with a hemoglobinopathy (including Sickle Cell disease)

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease)		
(b) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where the parent received a follow-up phone call *only***		
(c) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where the parent received a follow-up letter *only***		
(d) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where the parent was contacted by multiple communication methods**		
(e) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where it was not possible to contact the parent (Child is lost to follow-up)**		
Goal: Percentage of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) where the parent received at least one follow-up contact		

Performance Objective 2b: Ensure that ____% **(estimated goal)** of primary care providers (PCPs) of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) and seen in outpatient clinic receive a summary note for every comprehensive visit.

PO 2b: Contact with PCPs of children diagnosed with a hemoglobinopathy (including Sickle Cell disease)

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease)		
(b) Total number of visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) whose PCPs received a summary note after the visit		
Goal: Percentage of visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) whose PCPs received a summary note after the visit		

***Percentage = (b / a) x 100**

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 2. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments shall be filled in on the quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments /Adjustments
Provide a reminder phone call to > 90% of patients/families of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) prior to visit			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Develop targeted interventions for patients at high risk for being lost to follow-up			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide assistance in utilizing local agencies and schools as referral sources for nutritional care, financial concerns, social services or educational assistance to > 90% of patients/families of children diagnosed with a hemoglobinopathy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide a hard copy of appropriate resource information to > 95% of families of children diagnosed with a hemoglobinopathy			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide referrals to families to sickle cell disease specific Family Support Groups.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Collaborate with the CYACC (Center For Youth and Adults with Conditions of Childhood) Transition Clinic to develop transition guidelines including timeline for transition to adult care.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

FY 2012 – 2013 OBJECTIVES and ACTIVITIES

Performance Measure 3: Develop Individualized Pain Management Plans for both home and emergency use.

Directions for Completion

To complete these tables, please state your projected goals (of the percentage of new families seen in the clinic that will receive education) for FY 2012 and FY 2013.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting and exceeding expectation in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Performance Objective 3:

Ensure that_____% **(estimated goal)** of new families seen in the clinic will receive an Individualized Pain Management Plan for both home and emergency use for all children by one year of age.

PO 3: New families will received an Individualized Pain Management Plan.

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families seen in the clinic with children born with Sickle Cell disease		
(b) Total number of new families seen in the clinic with children born with Sickle Cell disease who received an Individualized Pain Management Plan for home use for all children by one year of age.		
(c) Total number of new families seen in the clinic with children born with Sickle Cell disease who received an Individualized Pain Management Plan for emergency use for all children by one year of age.		
Goal: Percentage of new families seen in the clinic with children born with Sickle Cell disease who received an Individualized Pain Management Plan for both home and emergency use for all children by one year of age.		

***Percentage = [(b + c) / a] x 100**

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 3. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Referred > 95% of families of children Participated in implementation of quality assurance initiatives including patient-specific pain management pathways for home use.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Referred > 95% of families of children participated in implementation of quality assurance initiatives including patient-specific pain management pathways for Emergency Department use.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

FY 2012 – 2013 OBJECTIVES and ACTIVITIES

Performance Measure 4: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Directions for Completion

To complete these tables, please state your projected goals (of the percentage of new families seen in the clinic that will receive education) for FY 2012 and FY 2013.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting and exceeding expectation in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: The ISDH Genomics and Newborn Screening Program expects at least **90%** of new families seen in the clinic to be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

Performance Objective 4a:

Ensure that_____% **(estimated goal)** of new families seen in the clinic will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

PO 4a: New families seen in the clinic and educated to the *negative* effects of *smoking* during pregnancy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families with members who smoke and were seen in the clinic that received **smoking cessation education**		
(b) Total number of new families with members who reportedly smoke and were seen in the clinic		
Goal: Percentage of new families with members who smoke and were seen in clinic that received **smoking cessation education**		

***Percentage = (b / a) x 100**

Performance Objective 4b:

Ensure that _____% **(estimated goal)** of new families seen in the clinic that will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

PO 4b: New families who were seen in the clinic and educated to the *negative* effects of *alcohol consumption* during pregnancy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families who were seen in the clinic and received education on **alcohol-related birth defects**		
(b)Total number of new families who were seen in the clinic		
Goal: Percentage of new families who were seen in the clinic and received education on **alcohol-related birth defects**		

***Percentage = (b / a) x 100**

Performance Objective 4c:

Ensure that _____% of **(estimated goal)** of new families seen in the clinic that will be educated on the ***positive*** effects of taking ***folic acid***.

PO 4c: New families seen in the clinic and educated on the *positive* effects of taking *folic acid*

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families who were seen in the clinic and received **folic acid education**		
(b) Total number of new families who were seen in the clinic		
Goal: Percentage of new families who were seen in the clinic and received **folic acid education**		

***Percentage = (b / a) x 100**

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 3. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Develop and incorporate into your patient intake forms a protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol during pregnancy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Referred > 90% of patients who admit to smoking, drinking, or using drugs to appropriate community cessation programs (e.g. Prenatal Substance Use Prevention Program (PSUPP), Indiana Tobacco QuitLine, Alcoholics Anonymous).*			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

* Please see Hemoglobinopathy Services Definitions on page 67 for additional contact information available through ISDH family support resources.

FY 2012 – 2013 OBJECTIVES and ACTIVITIES

Performance Measure 5: Provide educational presentations to health care professionals and college or graduate level students.

Directions for Completion

To complete this table please state your projected goals (the total number of presentations) for FY 2012 and FY 2013.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting or exceeding expectation 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 **Hemoglobinopathies Services Definitions** on page 67 for more information concerning types of services.

Note: The ISDH Genomics and Newborn Screening Program expects a ***minimum* of four (4)** presentations are to be given to health care professionals, college students, and/or graduate students. Do **not** count one presentation under two different audiences; each presentation should be included in the column that corresponds to the majority of the audience. Feel free to use additional pages as necessary.

Performance Objective 5:

Project staff shall provide a **minimum of four (4)** presentations.

PO 5: Sickle Cell Presentations

Main Audience	FY 2012	FY 2013
Health care professionals and college or graduate level students		
Other presentations		
Goal: **Total Number of Presentations**		

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 4. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports. D**o not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Collect evaluation sheets for each presentation; use feedback from these evaluation sheets to modify and improve presentations.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Determine the size of each audience. (**Note**: Attendance or evaluation sheets may be used to determine these numbers.)			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Note: Application Evaluation Plan should include a sample evaluation sheet and a description of how scores will be compiled. Modifications to the presentations based on applicable feedback shall be documented.

Indiana State Department of Health
Hemoglobinopathy Services Providers

FY 2012 – 2013 OBJECTIVES and ACTIVITIES

Project Specific Performance Measure:

Project Specific Performance Objective:

Service Projections

	FY 2010 (Baseline)	FY 2011	FY 2012	FY 2013

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/Adjustments will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

BUDGET INSTRUCTIONS

Materials Provided: The following materials are included in this packet:

Instructions
Definitions – Revenue Accounts
Chart of Account Codes
Non-allowable Expenditures
Budget Narrative Form (NS Budgets for FY 2012 & FY 2013)
Section I - Sources of Anticipated Revenue (NS Budgets for FY 2012 & FY 2013)
Section II - Estimated Costs and Clients to be Served (NS Budgets for FY 2012 & FY 2013)
Anticipated Expenditures (NS Budgets for FY 2012 & FY 2013)

INSTRUCTIONS

Review all materials and instructions before beginning to complete your budget. If you have any questions relative to completing your project's budget, contact:

Vanessa Daniels **VDaniels@isdh.IN.gov** **317/233-1241**

In completing the packet, remember that all amounts should be rounded to the nearest dollar.

Completing the Budget Narrative Form

NOTE: Create a separate budget for Fiscal Year (FY) 2012 and for FY 2013.

- FY 2012 runs from July 1, 2011 through June 30, 2012.
- FY 2013 runs from July 1, 2012 through June 30, 2013.

The Budget Narrative Form does not provide a column for NS Matching Funds but does provide a column for Total NS + NS Matching.

Schedule A

For each individual staff member, provide the name of the staff member and a brief description of his/her role in the project. If multiple staff members are entered in one row (for instance, 111.400 Nurses), a single description may be provided, if applicable. Each staff member must be listed by name. Calculations must be provided for each staff member in the Calculations column. This calculation should be in the form salary ($) = $/hour x hours/week x weeks/year. Fringe may be calculated for all staff. If different fringe rates are used for different categories of staff, fringe may be calculated by category.

Schedule B

List each contract, each piece of equipment, general categories of supplies (office supplies, medical supplies, etc.), travel by staff members, and significant categories in Other Expenditures (such as Indirect) in the appropriate column. Provide calculations as appropriate. Calculations are optional for Contractual Services. Travel must be calculated for each staff member who will be reimbursed and may not exceed $0.44 per mile.

Completing Section I - Sources of Anticipated Revenue

List all anticipated revenue according to source. If the project was funded in previous years with Newborn Screening 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 do not need to include matching funds. However, any additional source(s) of funds that support services should be reported under non-matching funds. Non-matching funds are additional sources of support that are not included in the match. These funds are not subject to NS guidelines.

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

Estimate the NS Matching Funds allocated per service listed (e.g., how much of the NS 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 NS 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 NS and NS Matching Funds.

(The rest of this page left blank intentionally)

DEFINITIONS - REVENUE ACCOUNTS

Account	Account Title	Description
414	NS Grant Request	Funds requested as reimbursement from the Indiana State Department of Health for project activities.
Matching Funds*		*Cash used for project activities that meet the matching requirements and are designated by the project as matching funds.* *****
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 Heathwise and CHIP as reimbursement provided for services to eligible clients.
434	Private Insurance	Monies received from health insurers for covered services provided to participating clients.
436	Patient Fees	Monies collected from clients for services provided based on NS approved sliding fee schedule.
437	Other Matching	Other income directly benefiting the project and not classified above which meets matching requirements.
Nonmatching Funds		*Funds which do not meet matching requirements or are not designated as matching funds.*
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	Income directly benefiting the project and not classified above that does not meet matching requirements or that is in excess of the required/ designated match amount.
Estimated Cash on Hand as of June 30th of last FY		*Monies received by the project during the previous fiscal years and not yet used for project expenditures.*
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 NS project as allocated and the expenditure of these funds is reported to NS Services.
5. Funds are subject to the same expenditure guidelines as NS grant funds (i.e., no food, entertainment or legislative lobbying).

SCHEDULE A - CHART OF ACCOUNT CODES

111.000 PHYSICIANS

Clinical Geneticist
Family Practice Physician
General Family Physician
Genetic Fellow
Medical Geneticist
Neonatologist
OB/GYN
Other Physician
Pediatrician
Resident/Intern
Substitute/Temporary
Volunteer

111.150 DENTISTS/HYGIENISTS

Dental Assistant
Dental Hygienist
Dentist
Substitute/Temporary
Volunteer

111.200 OTHER SERVICE PROVIDERS

Audiologist
Child Development Specialist
Community Educator
Community Health Worker
Family Planning Counselor
Genetic Counselor (M.S.)
Health Educator/Teacher
Occupational Therapist
Outreach Worker
Physical Therapist
Physician Assistant
Psychologist
Psychometrist
Speech Pathologist
Substitute/Temporary
Volunteer

111.350 CARE COORDINATION

Licensed Clinical Social Worker (L.C.S.W.)
Licensed Social Worker (L.S.W.)
Physician
Registered Dietitian
Registered Nurse
Social Worker (B.S.W.)
Social Worker (M.S.W.)
Substitute/Temporary
Volunteer

111.400 NURSES

Clinic Coordinator
Community Health Nurse
Family Planning Nurse Practitioner
Family Practice Nurse Practitioner
Licensed Midwife
Licensed Practical Nurse
OB/GYN Nurse Practitioner
Other Nurse
Other Nurse Practitioner
Pediatric Nurse Practitioner
Registered Nurse
School Nurse Practitioner
Substitute/Temporary
Volunteer

111.600 SOCIAL SERVICE PROVIDERS

Caseworker
Licensed Clinical Social Worker (L.C.S.W.)
Licensed Social Worker (L.S.W.)
Counselor
Counselor (M.S.)
Social Worker (B.S.W.)
Social Worker (M.S.W.)
Substitute/Temporary
Volunteer

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitute/Temporary
Nutritionist (Master Degree)	Volunteer

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	Substitute/Temporary
Genetic Associate/Assistant	Volunteer
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 non-matching 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 cost for NS projects and may not be paid for with NS or NS Matching Funds:

1. Construction of buildings, 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 NS projects and may be paid for only with specific permission from the Director of Maternal and Children's Special Health Care Services, ISDH:

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 NS and/or NS 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 Manager, MCH, VDaniels@isdh.IN.gov or 317/233-1241

FY 2012 Budget Narrative

The budget narrative must include a justification for every NS 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 NS 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 ($0.44 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 NS	Total NS + NS MATCHING
	For each personnel entry, include name, title and brief description of his/her role in the project (i.e. provides direct services). List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to NS	Total cost charged to NS and NS 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 NS	Total NS + NS 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 = $0.44 X miles for each staff member being reimbursed for travel.	Total to be charged to NS	Total cost charged to NS and NS 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 2013 Budget Narrative

The budget narrative must include a justification for every NS 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 NS 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 ($0.44 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 NS	Total NS + NS MATCHING
	For each personnel entry, include name, title and brief description of his/her role in the project (i.e. provides direct services). List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to NS	Total cost charged to NS and NS 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 NS	Total NS + NS 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 = $0.44 X miles for each staff being reimbursed for travel.	Total to be charged to NS	Total cost charged to NS and NS 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 2012

Project Title: _____ **Project #** _____

Applicant Agency: _____

414 Newborn Screening 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 June 30, 2011

400.1	Matching	$_____
400.2	Non-matching	$_____

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 2013

Project Title: _____ **Project #** _____

Applicant Agency: _____

414 Newborn Screening 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 June 30, 2012 (may use estimate for 2011)

400.1	Matching	$_____
400.2	Non-matching	$_____

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
NS AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2012

Project Title:_____ **Project #**_____

Applicant Agency: _____

Service	NS Cost Per Service[1]	NS Matching Funds Allocated Per Service[3]	Total Unduplicated # Estimated To Be Served by NS & NS Matching Funds[5]
Hemoglobinopathy Coordination of Medical/ Community Services			
Other (please list)			
TOTAL	[2]	[4]	

1 Cells in this column should reflect the amount of the NS grant award that is estimated to be spent on specific services, e.g., prenatal care, family planning. Do not enter a per client cost.

2 This cell should reflect the total grant request (line A from NS Budget – 1).

3 Cells in this column should reflect the amount of NS matching funds estimated to be spent on specific services.

4 This cell should reflect total NS matching funds estimated to be spent on NS services (line B from NS Budget – 1).

5 Cells in this column should reflect the unduplicated number of clients you estimated to be served with NS and NS matching funds during the fiscal year.

SECTION II - BUDGET
NS AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2013

Project Title:_____ **Project #**_____

Applicant Agency: _____

Service	NS Cost Per Service[1]	NS Matching Funds Allocated Per Service[3]	Total Unduplicated # Estimated To Be Served by NS & NS Matching Funds[5]
Hemoglobinopathy Coordination of Medical/ Community Services			
Other (please list)			
TOTAL	[2]	[4]	

1 Cells in this column should reflect the amount of the NS grant award that is estimated to be spent on specific services, e.g., prenatal care, family planning. Do not enter a per client cost.

2 This cell should reflect the total grant request (line A from NS Budget – 1).

3 Cells in this column should reflect the amount of NS matching funds estimated to be spent on specific services.

4 This cell should reflect total NS matching funds estimated to be spent on NS services (line B from NS Budget – 1).

5 Cells in this column should reflect the unduplicated number of clients you estimated to be served with NS and NS matching funds during the fiscal year.

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2012

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]
			NS Funds 414	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 2013

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]
			NS Funds 414	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 111.40

FORM A

HEMOGLOBINOPATHY SERVICES PROVIDERS
GRANT APPLICATION
FY 2012 & FY 2013

Title of Project: _____ Federal I.D. #: _____

Medicaid Provider Number: _____ FY 2011 NS Contract Amount: $_____

FY 2012 NS Amount Requested: $_____ FY 2012 Matching Funds Contributed $_____

FY 2013 NS Amount Requested: $_____ FY 2013 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.

FORM B-1

FY 2012 & 2013
Project Description

Project Name:		Project Number:
Address:	City, State, Zip	
Telephone Number:	Fax Number:	E-Mail Address:
Counties Served:		
Type of Organization: State ☐	Local ☐	Private Non-Profit ☐
Requested Funds: $_____ Matching Funds: $_____ Non-matching Funds: $_____ (Amounts above should reflect total for FY 2012 + total for FY 2013)		
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.)		

FY 2012 & FY 2013

FORM B-2

NS Project Name:	Project Number:	# Clinic Sites

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

FORM C

FUNDING **CURRENTLY** RECEIVED BY YOUR AGENCY
FROM THE INDIANA STATE DEPARTMENT OF HEALTH

LIST ALL SOURCES OF ISDH FUNDING

SOURCE	FISCAL YEAR	AMOUNT

TOTAL $_____

COMMENTS:

_____

_____

_____

Appendix A

INDIANA STATE DEPARTMENT OF HEALTH
NEWBORN SCREENING PROGRAM
HEMOGLOBINOPATHY SERVICES PROVIDERS
ANNUAL PERFORMANCE REPORT FY 2012

PROJECT NAME: _____

PROJECT NUMBER: _____

APPLICANT AGENCY: _____

REPORTING PERIOD: FY 2012 (7/1/11 TO 6/30/112)

DATE SUBMITTED: _____ PREPARED BY: _____

I. Instructions…….(Page 44)

II. Narrative……(Page 44)

III. Quality Assurance……(Page 44)

IV. Demographic Data……(Pages 44 - 46)

V. Program Monitoring Data……(Pages 46 - 50)

VI. Project Data……(Pages 51 - 61)

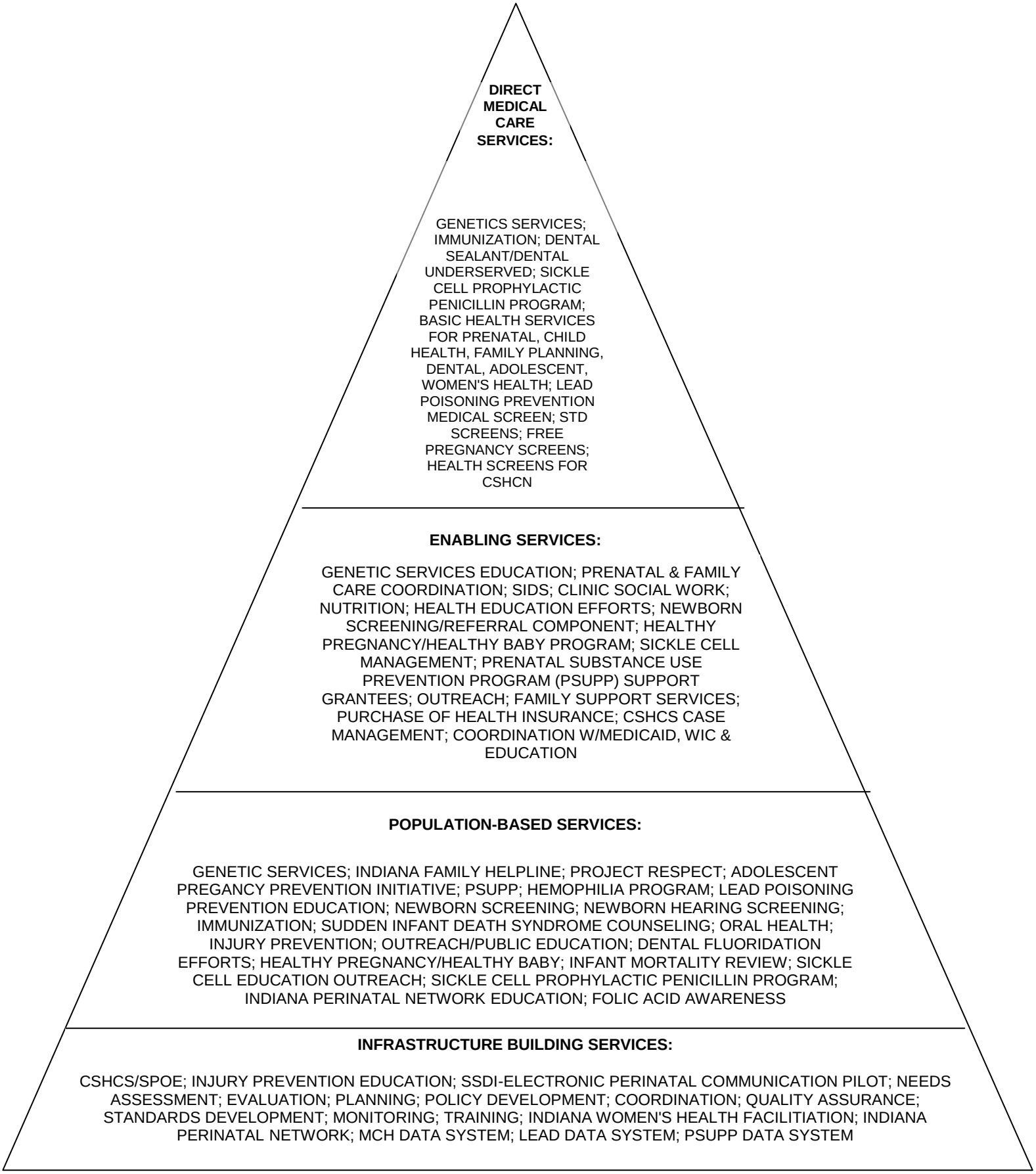
VII. Appendices……(Pages 62 - 65)

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 CSHCS 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 NS 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 NS funds. The Narrative should be supported by the statistical report and completed work plan. It should provide a complete picture of your NS 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.
- Complete the hours of services form. Indicate any changes from the original application.
- 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 # is less annually). 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 NS data reports. Summarize the data problems – incomplete collection or program challenges – indicating the specific areas. Review the charts to determine if 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 Services, Fiscal Year 2012, 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/ Unknown	Total Served (All Races)	Non-Hispanic/ Unknown	Hispanic	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
OTHER INDIVIDUALS > 22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2012/2013 proposal.
**If applicable

Totals Should Match

Table 2. Number of Return Visit Individuals Who Received Services, Fiscal Year 2012, 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/ Unknown	Total Served (All Races)	Non-Hispanic/ Unknown	Hispanic	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
OTHER INDIVIDUALS > 22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2012/2013 proposal.

Totals Should Match

Table 3. Number of New Individuals Who Received Services Provided or Paid for in Whole or in Part by NS or NS Matching Funds in Fiscal Year 2012, 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 NS or NS Matching Funds in Fiscal Year 2012, 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 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
Consultations					
Telephone Contacts					
Referrals To MCH Clinic					
Referrals To First Steps					
Referrals from NS					
Referrals To PSUPP					
Referrals To WIC Clinic					

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

Table 6: Educational Outreach Activities

	Number of Education Sessions Completed	Average Number of Participants per Session	Overall Score From Evaluation Sheets
Health care professionals and college or graduate level students			
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: 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 Services								
Clinical Services								
TOTAL								

Table 8: Primary Indication for Reason for Referral to Clinical Services

	FY 11	FY 12	FY 13
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 9: Final or Best Working Diagnosis for Clinical Patients

	FY 11	FY 12	FY 13
1. No Evidence of Abnormality or Specific Disorder	_____	_____	_____
2. Chromosomal and Single Gene Disorders	_____	_____	_____
3. Metabolic/Endocrine Disorder	_____	_____	_____
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.

Table 10: Unduplicated Patients Seen By County of Residence

COUNTY	PREGNANT WOMEN	CLINICAL PATIENTS	**TOTAL**

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 2013 objectives should be completed based upon the projections submitted in the FY 2012 – 2013 grant application.

The specific activities for each objective should be completed and the status of each indicated in the Comments/Adjustments 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).

Hemoglobinopathy Services Providers should complete the following pages addressing NS performance measures.

A. Hemoglobinopathy Services

Performance Measure 1: Ensure that children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy receive appropriate care coordination.

Directions for Completion

Please complete the tables below. Report the total number of newborn patients with Sickle Cell disease or another hemoglobinopathy that received services. The ISDH Genomics/NBS Program expects that **100%** of children diagnosis of Sickle Cell disease or other hemoglobinopathy will receive appropriate follow-up services before 4 weeks of age.

Performance Objective (PO) 1a:

Ensure that _____% **(estimated goal)** of children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy receive a follow-up appointment after discharge.

PO 1a: Follow-up services provided for children with Sickle Cell disease or another hemoglobinopathy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy		
(b) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy that had a follow-up appointment scheduled at the time of discharge		
(c) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy that were contacted after discharge in order to schedule a follow-up appointment		
Percentage of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy that had a follow-up appointment scheduled		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = [(b + c) / a] x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Performance Objective 1b:

Ensure that ____% **(estimated goal)** of primary care providers of children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy receive documentation of the child's hospital stay within 2 weeks of discharge.

PO 1b: Follow-up services provided for children with Sickle Cell disease or another hemoglobinopathy

Annual Outcome Objective	**FY 2012**	**FY 2013**
(a) Total number of children admitted to the hospital with Sickle Cell Disease or an other hemoglobinopathy		
(b) Total number of primary care providers of a child admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy that received a summary note within 2 weeks of discharge.		
Percentage of primary care providers of a child admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy that received a summary note within 2 weeks of discharge.		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = (b / a) x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Performance Objective 1c:

Ensure that ____% **(estimated goal)** of children of Sickle Cell disease are contacted.

PO 1c: To contact families to improve rates of outpatient clinic follow-up with a confirmed diagnosis of Sickle Cell Disease.

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of children diagnosis of Sickle Cell disease.		
(b) Total number of children diagnosis of Sickle Cell disease that have successfully been contacted prior to an appointment as a reminder.		
(c) Total number of children diagnosis of Sickle Cell disease that have been contacted after a missed appointment or who have not been seen within the prior 6-12 months.		
Percentage of children diagnosis of Sickle Cell disease that have been contacted by multiple means if necessary.		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = [(b + c) / a] x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

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

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Ensure that all children admitted to the hospital with Sickle Cell Disease or another hemoglobinopathy have an identified PCP at the time of discharge			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Inform > 90% of families of children in the appropriate age range about First Steps, Children's Special Health Care Services, SCHIP, WIC, and Hoosier Healthwise (Medicaid).			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Ensure that families are educated on Medical Homes.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Hemoglobinopathy Services

Performance Measure 2: Provide care coordination for children seen in an Outpatient clinic diagnosed with a hemoglobinopathy (including Sickle Cell disease).

Directions for Completion

Please complete the tables below. Report the total number of newborn patients with Sickle Cell disease or another hemoglobinopathy that received services. The ISDH Genomics/NBS Program expects that **95%** of children diagnosis of Sickle Cell disease or other hemoglobinopathy will receive appropriate educational and/or follow-up services.

Performance Objective 2a:

Ensure that at least ____% **(estimated goal)** of families of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) receive appropriate care coordination.

PO 2a: Care coordination for children diagnosed with a hemoglobinopathy (including Sickle Cell disease)

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease)		
(b) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where the parent received a follow-up phone call *only***		
(c) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where the parent received a follow-up letter *only***		
(d) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where the parent was contacted by multiple communication methods**		
(e) Total number of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) **where it was not possible to contact the parent (Child is lost to follow-up)**		
Percentage of missed visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) where the parent received at least one follow-up contact		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = [(b + c) / a] x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Performance Objective 2b: Ensure that ____% **(estimated goal)** of primary care providers (PCPs) of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) and seen in outpatient clinic receive a summary note for every comprehensive visit.

PO 2b: Contact with PCPs of children diagnosed with a hemoglobinopathy (including Sickle Cell disease)

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease)		
(b) Total number of visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) whose PCPs received a summary note after the visit		
Percentage of visits in outpatient clinic by a child diagnosed with a hemoglobinopathy (including Sickle Cell disease) whose PCPs received a summary note after the visit		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = (b / a) x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

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

Activity	Documentation Used	Staff Responsible	Activity Status	Comments /Adjustments
Provide a reminder phone call to > 90% of patients/families of children diagnosed with a hemoglobinopathy (including Sickle Cell disease) prior to visit			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Develop targeted interventions for patients at high risk for being lost to follow-up			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide assistance in utilizing local agencies and schools as referral sources for nutritional care, financial concerns, social services or educational assistance to > 90% of patients/families of children diagnosed with a hemoglobinopathy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide a hard copy of appropriate resource information to > 95% of families of children diagnosed with a hemoglobinopathy			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide referrals to families to sickle cell disease specific Family Support Groups.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Collaborate with the CYACC (Center For Youth and Adults with Conditions of Childhood) Transition Clinic to develop transition guidelines including timeline for transition to adult care.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Hemoglobinopathy Services

Performance Objective 3: Ensure that_____% **(estimated goal)** of new families seen in the clinic will receive an Individualized Pain Management Plan for both home and emergency use for all children by one year of age.

Directions for Completion

Please complete the table below. The ISDH Genomics/NBS Program expects that at least **90%** of new families seen in clinic will receive an Individualized Pain Management Plan.

PO 3: New families will received an Individualized Pain Management Plan.

Annual Outcome Objective	**FY 2012**	**FY 2013**
(a) Total number of new families seen in the clinic with children born with Sickle Cell disease		
(b) Total number of new families seen in the clinic with children born with Sickle Cell disease who received an Individualized Pain Management Plan for home use for all children by one year of age.		
(c) Total number of new families seen in the clinic with children born with Sickle Cell disease who received an Individualized Pain Management Plan for emergency use for all children by one year of age.		
Percentage of new families seen in the clinic with children born with Sickle Cell disease who received an Individualized Pain Management Plan for both home and emergency use for all children by one year of age.		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = [(b + c) / a] x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 3. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Referred > 95% of families of children Participated in implementation of quality assurance initiatives including patient-specific pain management pathways for home use.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Referred > 95% of families of children participated in implementation of quality assurance initiatives including patient-specific pain management pathways for Emergency Department use.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Performance Measure 4: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Directions for Completion

Please complete the tables below. The ISDH Genomics/NBS Program expects that at least **90%** of new families seen in clinic should be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

Performance Objective 4a:

Ensure that_____% **(estimated goal)** of new families seen in the clinic will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

PO 4a: New families seen in the clinic and educated to the *negative* effects of *smoking* during pregnancy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families with members who smoke and were seen in the clinic that received **smoking cessation education**		
(b) Total number of new families with members who reportedly smoke and were seen in the clinic		
Percentage of new families with members who smoke and were seen in clinic that received **smoking cessation education**		
Estimated Goal (percentage) stated in the Grant Application		

*** Percentage = (a / b) x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Performance Objective 4b:

Ensure that _____% **(estimated goal)** of new families seen in the clinic that will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

PO 4b: New families who were seen in the clinic and educated to the *negative* effects of *alcohol consumption* during pregnancy

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families who were seen in the clinic and received education on **alcohol-related birth defects**		
(b)Total number of new families who were seen in the clinic		
Percentage of new families who were seen in the clinic and received education on **alcohol-related birth defects**		
Estimated Goal (percentage) stated in the Grant Application		

*** Percentage = (a / b) x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Performance Objective 4c:

Ensure that _____% of **(estimated goal)** of new families seen in the clinic that will be educated on the ***positive*** effects of taking ***folic acid***.

PO 4c: New families seen in the clinic and educated on the *positive* effects of taking *folic acid*

Annual Outcome Objective	FY 2012	FY 2013
(a) Total number of new families who were seen in the clinic and received **folic acid education**		
(b) Total number of new families who were seen in the clinic		
Percentage of new families who were seen in the clinic and received **folic acid education**		
Estimated Goal (percentage) stated in the Grant Application		

*** Percentage = (a / b) x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

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

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Develop and incorporate an intake protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol or other drugs during pregnancy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Referred > 90% of patients who admit to smoking, drinking, or using drugs to appropriate community cessation programs (e.g. Prenatal Substance Use Prevention Program (PSUPP), Indiana Tobacco QuitLine, Alcoholics Anonymous).*			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

* Please see Hemoglobinopathy Services Definitions on page 67 for contact information for available ISDH family support resources.

A. Hemoglobinopathy Services

Performance Measure 5: Provide educational presentations to health care professionals and college or graduate level students.

Directions for Completion

Report the total number of presentations given by your project staff. A **minimum of 4** presentations are to be given to health care professionals, college students, and/or graduate students. 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; each presentation should be included in the column that corresponds to the majority of the audience.

Performance Objective 5: Project staff provided _____ presentations.

	# of Talks						
Main audience:	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2012 Estimated**	***FY 2012 % Completed***	**FY 2013 Actual**	**FY 2013 Estimated**	***FY 2013 % Completed***
Health care professionals and college or graduate level students							
Other presentations							
Total Number of Presentations Given							
Estimated Goal given in the Grant Application							

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

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

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

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Collect evaluation sheets for each presentation; use feedback from these evaluation sheets to modify and improve presentations.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Determine the size of each audience. (**Note**: Attendance or evaluation sheets may be used to determine these numbers.)			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Hemoglobinopathy Services

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2012	FY 2013	Percent change from previous year

Percent change = [(2013#s – 2012 #s) / 2012 #s] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

A. Hemoglobinopathy Services

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2012	FY 2013	Percent change from previous year

Percent change = [(2013 #s – 2012 #s) / 2012 #s] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

Appendix 1

Hemoglobinopathy Services Providers
Performance Objective Summary
FY 2012 & FY 2013

FY 2012

	MET	
PERFORMANCE OBJECTIVE 1a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 1b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 1c:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 3:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 4a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 4b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 4c:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 5:	☐ ***YES***	☐ ***NO***

Percent of NS Required Performance Objectives Met _____

Number of Project Chosen Objectives Met _____

Total Number of Project Chosen Objectives _____

Percent of Project Chosen Objectives Met _____

Appendix 2

Hemoglobinopathy Services
DEFINITIONS
FY 2012 & FY 2013

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

Clinical Patient – Any individual who had an appointment and was evaluated by or received services.

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.

Performance Measure 3 – Contact Information for ISDH Family Support Resources

- **Children's Special Health Care Services** (CSHCS)
  - 2 North Meridian Street, 7B, Indianapolis, IN 46204
  - (800) 475-1355 (phone)
    - Option 1 - Spanish Interpretation
    - Option 2 – Application Status or Eligibility/Reevaluation Information
    - Option 3 – Prior Authorization, Care Coordination or Insurance Updates
    - Option 4 – Travel Inquiries or Travel Reimbursement
    - Option 5 – Payment of Claims
    - Option 6 – Provider Relations & Provider Agreement
- **Indiana Family Helpline**
  - (800) 433-0746 (voice)
  - (866) 275-1274 (TTY / TDD)
- **Indiana Tobacco Quitline**
  - (800) QUIT-NOW
- **Prenatal Substance Use Prevention Program** (PSUPP)
  - PSUPP Director, Indiana State Department of Health
  - 2 North Meridian Street, Indianapolis, IN 46204
  - 317-233-1257 (phone)
  - 317-234-2995 (fax)
  - A list of PSUPP Program Clinics is available at http://www.in.gov/isdh/22245.htm.

Performance Measure 4

College or graduate level students – 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.)

NS DEFINITIONS
FY 2012 & FY 2013

Client/Patient – A recipient of services that are supported by program expenses funded in whole or in part by Children's Special Health Care Services (NS) or local (NS) matching dollars

Program Expenses – any expense included in the budget that the NS project proposes to be funded by NS or NS matching dollars (includes staff, supplies, space costs, etc.)

Matching Funds – At least 30% of the NS award. Whatever dollars the project assigns to support the NS funded service (includes Medicaid or other income generated by service provision).

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

NS 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 NS projects to include all clients seen that are funded by NS or NS match dollars in their client count. They will also allow projects to enroll all clients that are served by staff paid with NS or NS 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 involve systematically 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)

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

FY 2012 & FY 2013 NS 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 2011 NS contract amount
____ Funds requested, matching funds contributed FY 2012 & FY 2013
____ 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. Dr. McBurney has granted permission of use of this adaptation.**

3.0 NS Proposal Narrative (15 points)

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

____ Relates to NS services only
____ Addresses project's capacity to add these services
____ Describes how the project will provide these services
____ Justifies the need for funding

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

- NS 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
____ NS and Non-NS 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)

6.0 Tables

____ NS 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:_____
(30 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 Measures 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, who is 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 described

____ Methods used to address identified quality assurance problems

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)

0.0 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:_____
(18 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

____ 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
NS 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 2010 & FY 2011

The Regional Health Systems Development Consultant (primary reviewer) should describe below performance achievements and/or problems/concerns identified in review of the FY 2010 & FY 2011 Annual Performance Reports that are relevant to this proposal.

(The rest of this page left blank intentionally)