Southside Early Learning Network

Coordinated Intake Policies and Procedures

DRAFT

Mission

The Southside Early Learning Network (SELN) is a collaborative that supports and improves outcomes for expectant moms and children birth to five in the Englewood, West Englewood and Greater Grand Crossing communities.

Outreach to Families:

In order to build a pathway for children to succeed, diverse stakeholders must be coordinated and responsive to the development of children and the needs of families. SELN brings together parent leaders, agencies and community partners to advocate for issues and policies that ensure children are entering school healthy and ready to learn.

We capitalize on the strengths of families and hope to reach all children as early as possible with evidence-based resources that help them thrive. By providing a single point of entry to home visiting and other high quality early childhood programs, SELN brings parents and community partners together to build an integrated community of care on the south side of Chicago.

Community awareness has been beneficial through the promotion of the following activities. Grass Roots activity of door to door knocking, attending community networking meetings / events, continuing the building of relationships with community agencies, medical providers, and high schools.

SELN Network and committee meetings actively seek to involve participants in the meetings and ensure all voices are heard.

We focus on the following goals to achieve a positive outcome for the families that we serve.

- Families will have positive and elevated minds that can be seen through physical community changes.
- All families will have equal access to quality health care.
- Families will be lifelong learners
- Families will have access to quality early childhood education programs. Families understand the importance of early childhood education and take advantage of available options.

We have an extensive referral process in how we conduct our outreach to families.

INTAKE POLICIES AND PROCEDURES

Program Recruitment and Referrals to Home Visiting

The SELN CI uses a three tiered recruitment strategy to ensure we reach as many families as possible. At the foundation is South Side Early Leaning network of interested partners which helps identify recruitment sources through its goal of community coordinated intake.

- Tier 1: Grass roots or Street level: This level of recruitment includes door to door outreach, some events and is focused on reaching especially hard to reach families who may not be connected with any organization or agency. COFI works closely with us in these outreach efforts through street teams, and parent driven and consumer outreach.

- Tier 2: Community Agencies, Government Entities, Hospitals and Clinics, ECE provider community: This level includes the development of relationships with agencies and individuals serving potential clients and developing a referral relationship that usually is specified in an MOU. This tier also includes physician offices, WIC, CPS and local schools, ECE home providers, Early Learning Programs, physicians, hospitals etc.

- Tier 3: Public Awareness: CAN TV, Community Events, Block Club, Alderman Offices, etc. The is a high level outreach that increases public awareness and increase "foot traffic" and self referrals to the programs. SELN utilizes the statewide IGROW materials to market Home Visiting programs and demonstrate a statewide focus for home visiting.

- SELN also has a partner list which can be accessed here.

SELN Partner List.xlsx

Initiating Referrals

The Southside Early Learning Network (MIECHV) Family Engagement Coordinator is part of the Coordinated Intake process and is responsible for marketing the program to generate new referrals and partnerships for the Home Visiting Program, as well as completing the initial intake. The Family Engagement Coordinator (FEC) has specific recruiting and outreach responsibilities in Tier 2 recruitment efforts to gain a larger margin of clients. The FEC will seek out and meet with medical providers, for example; Hospitals, independent medical clinics, dentists, independent physician's offices and those that are connected to hospitals.

Completing Partnership and the MOU

While the goal of the informational meeting is a written Partnership Agreement, that Agreement doesn't have to be in place for the referral source to make referrals, however it is preferred and a program goal. The interested party will sign a partnership agreement which will result in an MOU. The referring agency is trained on the completion of the Referral Form, which must accompany each referral.

Consents and Releases

CI and the partnering agency will obtain consent for the client to participate in services.

The parent's signature must be on the consent for before it is sent to SELN Coordinated Intake (CI). Once the referral has been completed, it should be faxed to CI at 773-776-8986 or emailed to miechvcoordinator@childrenshomeandaid.org

Community Collaborations

Our MIECHV funded partners are Family Focus, Henry Booth House, Child Serv and Women's Treatment Center. They are a critical part of the outreach effort all levels. SELN also has partnerships with many agencies in the surrounding communities. In collaboration with DHS, and IGROW, our effort is to reach as many clients as we can to serve them in their need. Each agency brings their own community history and recruitment sources to the Network and play a key role in the outreach efforts. These agencies use a variety of research based Home Visiting Models including Healthy Families, Parents as Teachers and Nurse -Family Partnerships.

SELN also does outreach to community partners through the network meetings whose members include agencies, CPS, State agencies, parents and members of the local child care community. These connections also provide referral sources.

Referral Process

The following are basic steps to the referral process:

The initial contact will be made by the MIECHV coordinated intake staff within the 24 hours upon receiving referral .The CI, the CI Intake Coordinator staff will screen the referral to verify client eligibility for program services. The following criterion is verified:

- The referral date and age of the mother
- Weeks pregnant and/or age of baby
- Address, secondary contact number
- Any presenting factors that might impact the referral decision
- CI staff refer client to agency which best fits the needs of the client based on the initial screening.
- The receiving agency is expected to assign the client and initiate contact with the family within 2 business days of receipt of the referral. At that point, the primary relationship for the family is with the receiving agency. The receiving agency will inform CI of the outcome of the client and if they were able to service them within 2 business days of receipt of the referral.
- In the event the CI Intake Coordinator has not heard from the designated agency within the specified time staff will contact both the family and receiving agency contact to ensure there is still interest in service and contact is being made. Families may be reassigned to other agencies if agencies are non-responsive, not able to assign home visitors or begin the outreach efforts in the specified time.

The CI or CI Coordinator will complete the CIAT, (Coordinated Intake Assessment Tool) prior to the home visitor meeting with the client unless requested by the servicing agency.

Referrals and Emergency Referrals Cont:

If we do not provide the services the participants need, Coordinated Intake and Home Visitors will refer participants to other agencies and Non MIECHV programs by utilizing the resource guide. Services requested can include any of the following:

- Day Care, Head Start ,Kindergarten, Education/Training, Individual and Family Counseling, Parent/Interaction/Support Groups, Food Pantries, Shelters and other social services.

- If participant is in need of food, clothes, shelter, we will refer participant to community resources, i.e. 911 and etc.

- CSD will have an annually updated resource guide that will be made available if needed.
- CSD will keep an updated copy of the resource list.

As emergencies rise within our families, we will refer and link our families to resources, to assess their needs.

CI Staff maintain a database of all referrals both made and received. Records will indicate if services were received or not. CI will notify the Referring Agency of the client placement outcome, within 7 business days.

Referral Closing Forms- in the event the receiving agency is unable to reach the client or the client drops the program or gets assigned to MIHOPE control group, a referral closing form is completed.

MIHOPE

U.S. Department of Health and Human Services (HHS) launched a national evaluation called the Mother and Infant Home Visiting Evaluation Project (MIHOPE). This evaluation, mandated by the Affordable Care Act, will inform the federal government about the effectiveness of the newly established MIECHV program in its first few years of operation, and provide information to help states develop and strengthen home visiting programs in the future. SELN Coordinated Intake is not the CI for MIHOPE in the Englewood Community. Each partner agency has their own designated Intake for MIHOPE. Clients are forwarded to the partner agency and the partner agency attempts to contact the client with 48 hours. The randomization is explained to the client. If the client is still interested in participating, the agency MIHOPE Intake enters them into the MIHOPE randomization. The partner agency will notify SELN Coordinated intake if the client is randomize in or out of receiving home visiting services, which usually takes about 7 business days.

FORMS

The Following Forms are used / Received by CI;

- SELN Screening Tool
- CIAT
- Partnership Agreement
- Memorandum of Understanding
- Client Profile
- Referral Closing Summary

Supervision and Training

- CI and CSD meet on at least monthly with the VP for ECS Jan Stepto-Millett for supervision.
- We also attend MIECHV Learning Community Meeting on a consistent basis
- The MIECHV funded partners serve as the SELN Advisory. The group meets once a month.
- We attend local council meeting with various organization as well attend development training.

Monitoring and Problem Solving

The SELN partners and Community System Development Staff are given monthly data reports which are discussed at the Advisory Council Meeting and during supervision. The reports consist of their client numbers, active and closed cases. They are also given a quarterly provider report which includes the contacts by the Family Engagement Coordinator.

Partners also send ongoing closed case information to CI.

Information on upcoming training is also shared with the partners and CSD.