

Illinois MIECHV Program Plan for State Fiscal Year (SFY) 2015

PROVIDER CONTACT INFORMATION

Provider Agency Name: Street Address: City, ZIP: Phone: Fax: E-Mail:	
Administrative Contact Name: Administrative Contact Title: Street Address: City, ZIP: Phone: Fax: E-Mail:	
Fiscal Contact Name: Fiscal Contact Title: Street Address: City, ZIP: Phone: Fax: E-Mail:	
Program Contact Name: Program Contact Title: Street Address: City, ZIP: Phone: Fax: E-Mail:	

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FOR ALL AGENCIES

<p>1. Target Population</p> <p>(include factors such as age, Medicaid eligibility, geographical boundaries and parenting status, e.g. first time or all parents)</p>	
<p>2. Geographic Area</p> <p>Describe the geographic area to be served; please indicate any changes from SFY14. For Chicago sites, please include ZIP codes.</p>	
<p>3. Race/ Ethnicity/ Languages</p> <p>Most recent ethnic, racial, and linguistic characteristics of the <u>community served</u>.</p>	
<p>4. Supporting Data</p> <p>Most recent statistical data regarding the target population. (e.g., how many families meet all of the descriptors of the target population – for example, how many 1st time births to mothers receive Medicaid in Pulaski County)</p>	
<p>5. Staffing</p> <p>How many FTEs and which positions do your MIECHV funds support? Are any MIECHV positions currently vacant? If so, please explain.</p>	

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FOR HOME VISITING AGENCIES ONLY

<p>1. Home Visiting Model</p> <p>Is this a change from SFY14? If yes, explain.</p>	
<p>2. Program Enhancements</p> <p>Is your program implementing any program enhancements (such as Doula, Infant Mental Health, Mothers and Babies, or others)? If yes, please list.</p>	
<p>3. Caseload Capacity</p> <p>a. Total FTE of MIECHV Home Visitors:</p> <p>b. Maximum number of families served per 1.0 FTE MIECHV home visitor:</p> <p>c. Maximum MIECHV caseload capacity:</p>	<p>3a: _____</p> <p>3b: _____</p> <p>3c: _____ (multiply 3a x 3b to get this number)</p>
<p>4. Acceptance Rate</p> <p>For the most recent quarter completed, please provide the percentage of the total number of eligible families referred, who successfully enrolled in HV (as defined by your HV model).</p>	
<p>5. Activities</p> <p>Parental support activities, recruitment, community awareness events, other than home visits, provided by MIECHV staff (e.g. Parent Support groups, Happiest Baby training, health fair).</p>	
<p>6. Referral Partners</p> <p>List the main community partners who will refer families from the target population. If you are receiving 100% of your referrals from CI, please note this. Please indicate if this is a change from SFY14.</p>	
<p>7. Data Quality</p> <p>Please briefly describe your program's process to ensure accurate and timely data reporting.</p>	

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FOR COORDINATED INTAKE AGENCIES ONLY

<p>1. Families Screened in SFY 14</p> <p>Number of CIATs completed for your collaborative during SFY14.</p>	
<p>2. Families Screened in SFY 15</p> <p>Proposed number of CIATs to be completed for your collaborative in SFY15.</p>	
<p>3. SFY15 Outreach Activities</p> <p>As defined by HRSA, the MIECHV priority populations are families that:</p> <ul style="list-style-type: none">• have low-income;• include pregnant women who have not attained age 21;• have a history of child abuse or neglect , or those who have had interactions with child welfare services;• have a history of substance abuse, or need substance abuse treatment;• have users of tobacco products in the home;• have a history of, or have children with low student achievement;• have children with developmental delays or disabilities; and• include members of the military. <p>Please describe your planned outreach and recruitment activities, community awareness events, etc. to reach these priority populations.</p>	

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FOR COMMUNITY SYSTEMS DEVELOPMENT AGENCIES ONLY

1. Current Community Partners

Please provide a current list of the community partners for which your MIECHV collaborative has a specific contact name for the purpose of making referrals. Please also include which of these agencies have a current MOU related to MIECHV. Please attach a sheet that uses the following format.

Agency Name	Specific Contact Person for Referral Network?	MOU?
<i>ABC Childcare</i>	<i>1</i>	<i>0</i>
<i>DEF Social Services</i>	<i>1</i>	<i>1</i>
<i>GHI Children's Clinic</i>	<i>1</i>	<i>1</i>
TOTALS:	3	2

<p>2. "Big Four" Partners*</p> <p>Do your current partners* include domestic violence, mental health, developmental delay, and substance abuse service providers? If not, please describe plans to reach these agencies.</p>	
<p>3. New Community Partners*</p> <p>Proposed number of additions to your referral network in SFY15.</p>	
<p>4. New MOUs</p> <p>Proposed number of additional MOUs in SFY15.</p>	
<p>5. Collaborative Meetings*</p> <p>How many times did the collaborative* meet during SFY14? How many times will it meet during SFY15?</p>	
<p>6. Strategic Planning*</p> <p>Does the collaborative* have a strategic plan? If not, what activities will take place in SFY15 to support a strategic planning process?</p>	
<p>7. System- Building Connections*</p> <p>Is the collaborative* working with local networks such as the Local Interagency Council, AOK Network, Child Care Resource & Referral, etc.? If not, what efforts will be made during SFY15?</p>	

*** Please note that these questions pertain to the larger early childhood collaborative in your community (not just the MIECHV-funded partners.)**