Amendment Number

Subcontract No. 2025

**FY25 Program Abstract**

**SERVICE AGENCY SUBCONTRACTOR**

**Agency Name:**

**Street:**

**City:**       **County:**       Z**ip:**

**Phone:**       **Fax:**

**E-mail:**

**PRIMARY SERVICE SITE**

**Program Name:**

**Street:**

**City:**       **County:**       Z**ip:**

**Phone:**       **Fax:**

**E-mail:**

**Onsite Program Supervisor:**

**Working Hours per Week**:

**PROGRAM MODEL**

Healthy Families Illinois  Parents as Teachers

HFA Credentialing/PAT Endorsement Status:

Date of HFA Accreditation/PAT Endorsement:

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**Program Abstract**

**DESCRIBE COMMUNITY SERVED, COMMUNITY NAMES, COUNTIES, AND POPULATION DEMOGRAPHICS:** Include the racial, ethnic, linguistic, and cultural characteristics in your description. Also, include the zip codes of participants eligible for services in the program. Describe target population and include number of births in that population. Describe mechanism for tracking births within the target population. Please list the program’s incoming referral sources and the number of anticipated referrals per month per referral partner.

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**Program Abstract**

**SUBCONTRACTOR CONTACT LIST**

Designate individuals from your organization who will fulfill specified roles for interface with Start Early staff in the following categories. Staff may be assigned as a contact in one or more of these roles. Start Early uses this information to create targeted distributions lists, and we assume that the site contact will handle the responsibilities associated with their designated role. Assign organizational contacts based on the descriptions of the required tasks and expectations of your agency, and of the staff members to fulfill these roles in relationship to ongoing management of the Start Early subcontract.

**Changes to Contact Information: To change any of the designated contacts during the fiscal year, notify your Start Early Program Advisor in writing and submit all changes in contact information or designation via the Program Narrative Quarterly Report or an amendment.**

**SERVICE AGENCY SUBCONTRACTOR NAME:**

**EXECUTIVE CONTACT:** This contact has executive level authority to sign legal contracts on behalf of the subcontracting agency. Start Early will contact this person in the event of any funding issues or any substantive program or fiscal concerns regarding the administration of the subcontract.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**Program Abstract**

**PROGRAM MANAGEMENT CONTACT:** This is the primary person responsible for overall management of program and fiscal matters related to the Start Early subcontract. This includes adherence to the Start Early Best Practice Standards. The Start Early Program Advisor works directly with this contact to develop the service design and annual Program Abstract, and to negotiate the use of Start Early funds. This contact is primarily responsible for the content and timely completion of required programmatic reports and supervises direct service staff or supervisors.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**DIRECT SERVICE SUPERVISOR:** This contact is responsible for supervision of direct service staff, creation of staff development plans, and oversight of registration for and staff attendance at Professional Learning Network (PLN) training events. This contact is point for all staff communications related to PLN and is responsible for day-to-day interface with site staff in all matters related to training registration, attendance, cancellations, and travel.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**Program Abstract**

**FISCAL CONTACTS:** These individuals are responsible for the overall financial management of the subcontract, including compliance with the Start Early administrative requirements and the internal allocation, oversight, and tracking of expenditures, as well as the actual preparation, submission, and correction of Quarterly Financial Cost Reports, forecasts, and amendments. The Start Early Fiscal Advisor works directly with this contact and provides technical assistance and training, if necessary, to ensure submission of accurate financial reports.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

**DATAPOINTS/MIS CONTACT:** This contact is the primary liaison with the DataPoints team or other Start Early contacts regarding data reporting issues, initial orientation of new site staff, providing written notification to the DataPoints team regarding new user or follow-up training, and distribution of MIS-related correspondence to DataPoints users in the Start Early funded program.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**Program Abstract**

**PROGRAM STAFFING**

List all staff members that provide direct services and program supervision that appear on page two (2) in the Personnel section of the budget. For each staff member listed by name and job title, show the distribution of % FTE in Program in the Direct Services and % Supervision columns (i.e., adding the numbers in the Direct Services and % Supervision columns will equal the number in the % FTE in Program). Please number positions so that they match numbering used in the budget. Only individuals with supervisory responsibilities should have FTE designated in the % Supervision column.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name/Title** | **% FTE Agency** | **% FTE**  **Program** | **Direct Services** | | | | | **% Supervision** | **Supervised By** | **Freq. of Individual Supervision** |
| **% HV** | **% Doula** | **% PGS** | **% FAW** | **% IMH** |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |

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**Program Abstract**

**PROGRAM STAFFING, continued**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name/Title** | **% FTE**  **Agency** | **% FTE**  **Program** | **Direct Services** | | | | | **% Supervision** | **Supervised By** | **Freq. of Individual Supervision** |
| **% HV** | **% Doula** | **% PGS** | **% FAW** | **% IMH** |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |
|  | % | % | % | % | % | % | % | % |  |  |

**INTERNAL PROGRAM MANAGEMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staffing (review of participant or group of participant cases)** | Weekly or more frequently | Twice a month | Monthly | Quarterly |
| **Team Meetings** | Weekly or more frequently | Twice a month | Monthly | Quarterly |
| **Doula Clinical Support: Meetings with Doulas** | Weekly or more frequently | Twice a month | Monthly | Quarterly |
| **Doula Clinical Support: Meetings with Doula Supervisor** | Weekly or more frequently | Twice a month | Monthly | Quarterly |

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**Program Abstract**

**HOME VISITING SERVICES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Title** | **% HV Supervision** | **% HV Direct Services** | **Point Capacity of Caseload**  **(% HV Direct Services x 22)** |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
| Program Capacity: Total Point Value | | |  |
| Total Point Value to maintain at any one time (Total Point Value x 85%) | | |  |

|  |
| --- |
| **Please indicate the name(s) of the core curricula used in the home visiting program:** |
| 1. |
| 2. |
| 3. |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WEIGHTED CASELOAD SYSTEM** | | | | | | | | |
| Level 1P | Level 1 | Level 2 | Level 3 | Level 4 | DHVM\* | CO | CO-TO | CO-TR |
| 2 | 2 | 1 | .5 | .25 | 2 | .25-2 | .25-2 | .5 |

*\*when a participant is enrolled in both the home visiting and Doula components, the Doula Home Visiting Model (DHVM) level is used*

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**Program Abstract**

**DOULA SERVICES**

If not applicable to this program, please check here

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Title** | **% FTE in Doula Home Visiting** | **% FTE in Prenatal Group Services** | **Caseload Size at any Time\*\*** |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |
|  | % | % |  |

**Total # of Participants Receiving Doula Home Visiting Services in FY25**

|  |  |
| --- | --- |
| **# Enrolled** |  |
| **# Short-term\*** |  |
| **Total\*\*** |  |

\*Participants targeted for short-term or a single service component and not expected to be involved in long-term home visiting within the HV&DN program.

\*\*1 FTE Doula is expected to serve a minimum of 23 participants per year; caseload size at any time is expected to be a minimum of nine

**Perinatal Clinical Support Provider in FY25**

**Name:**

**Agency:**

**Credentials:**

|  |
| --- |
| **Please indicate the name(s) of the core curricula used for prenatal home visiting:** |
| 1. |
| 2. |
| 3. |

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**Program Abstract**

**DOULA HOME VISITING MODEL**

Indicate the number of visits each month in the staff columns.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ENROLLED PARTICIPANT** | **# Doula Visits** | **# Combined Visits\*** | **Total suggested Doula visits** | **# HV Visits** | **Total # of Visits** | **Total # suggested visits** |
| **Prenatal Month 7\*\*** |  |  | **2-4** |  |  | **3-5** |
| **Prenatal Month 8** |  |  | **3-5** |  |  | **4-6** |
| **Prenatal Month 9** |  |  | **3-5** |  |  | **4-6** |
| **Total Prenatal Visits** |  |  | **8-14** |  |  | **11-17** |
| **Postnatal Month 1** |  |  | **4-5** |  |  | **4-6** |
| **Postnatal Month 2\*\*** |  |  | **2-3** |  |  | **3-5** |
| **Total Postnatal Visits** |  |  | **6-8** |  |  | **7-11** |
| **Total Visits to Participant** |  |  | **14-22** |  |  | **18-28** |

|  |  |  |  |
| --- | --- | --- | --- |
| **SHORT-TERM PARTICIPANT** | **# Doula Visits** | **Total # of Visits** | **Total # suggested visits** |
| **Prenatal Month 7\*\*** |  |  | **2-4** |
| **Prenatal Month 8** |  |  | **3-5** |
| **Prenatal Month 9** |  |  | **3-5** |
| **Total Prenatal Visits** |  |  | **8-14** |
| **Postnatal Month 1** |  |  | **4-5** |
| **Postnatal Month 2\*\*** |  |  | **2-3** |
| **Total Postnatal Visits** |  |  | **6-8** |
| **Total Visits to Participant** |  |  | **14-22** |

\*Combined Visit refers to a single home visit where both a Doula and home visitor (for an enrolled participant) or Doula and a community partner (for a short-term participant) are present.

\*\*Programs may choose to have Doulas visit prior to the third trimester of pregnancy or after the baby turns three months old, but there are no contractual expectations for these visits.

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**Program Abstract**

**PARENT GROUP SERVICES – ONGOING PARENT GROUPS**

If not applicable to this program, please check here

Enter information for each ongoing group for which a Group Profile will be created in DataPoints.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Group Name and Staff (includes volunteers)** | **# of Sessions** | | | | **Total Group Sessions** | **# in Groups Enrolled** | **# in Groups Short-term** | **Meeting Day/Time** | **Location\*** | **Meals** | **Child Care** | **Trans.** |
| **Q1** | **Q2** | **Q3** | **Q4** |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
| **Total # of Sessions** | | | | |  |  | | | | | | |
| **Total # of Participants to be Served** | | | | | |  |  |  | | | | |

|  |
| --- |
| **\*\*\* LOCATION CODES**  S= School-based  C= Center-based  O= Other facility, i.e., church, other agency  **V= Virtual** |

|  |
| --- |
| **Please list the name(s) of the core group curricula used:** |
| 1. |
| 2. |
| 3. |

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**Program Abstract**

**PARENT GROUP SERVICES – PRENATAL GROUPS**

If not applicable to this program, please check here

Enter information for each ongoing group for which a Group Profile will be created in DataPoints. List each group on one line, even if the group meets multiple times per year, then indicate the number of times per quarter that group meets. For # in Groups Enrolled and # in Groups Short-term, indicate the minimum number of participants you expect to have in group in any given cycle (the number of times the same group is held for the same returning core of group members). For Total # of Participants Served, indicate the total number of participants you expect to serve in groups for the fiscal year.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Group Name and Staff (includes volunteers)** | **# of Sessions** | | | | **Total Group Sessions** | **# in Groups Enrolled** | **# in Groups Short-term** | **Meeting Day/Time** | **Location\*** | **Meals** | **Child Care** | **Trans.** |
| **Q1** | **Q2** | **Q3** | **Q4** |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
|  |  |  |  |  |  |  |  |  |  | Y  N | Y  N | Y  N |
| **Total # of Sessions** | | | | |  |  | | | | | | |
| **Total # of Participants to be Served** | | | | | |  |  |  | | | | |

|  |  |
| --- | --- |
| **\*\*\* LOCATION CODES**  S= School-based  C= Center-based  O= Other facility, i.e., church, other agency  **V= Virtual** |  |

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**Program Abstract**

**CLINICAL/INFANT MENTAL HEALTH SERVICES**

If not applicable to this program, please check here

|  |  |  |
| --- | --- | --- |
| **Name/Title** | **% FTE in Agency** | **% FTE IMH** |
|  | % | % |
|  | % | % |

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Consultation** | | | |
| **Modality**  **(case staffing, individual staff consultation, training)** | | **Frequency** | |
|  | |  | |
|  | |  | |
|  | |  | |
| **Clinical Work with Families** | | | |
| **Estimated number served at any one time:** |  | **Estimated average # of sessions per family:** |  |
| **Estimated number served annually:** |  |
| **Group Facilitation** | | | |
| **Name of Group** | | **Frequency** | **Est. # Served** |
|  | |  |  |
|  | |  |  |
|  | |  |  |
| **Other (briefly describe other planned work and estimate numbers of participants served)** | | | |
|  | |  | |
|  | |  | |

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**Program Abstract**

**LIST OF REQUIRED SUPPORTING DOCUMENTATION**

The following documentation is to be maintained on-site and made available to Start Early staff for inspection upon request:

**Consent to Participate**: *All participant files will contain the Start Early Program Consent to Participate form (rev. 7/1/22)*. This signed form indicates participant's consent to receive services, rights to confidentiality, and consent to share information (intake, services usage, and life events) with Start Early, DHS, and ISBE. The consent form is available on the Start Early/Home Visiting & Doula Network Web site (www.opfibti.org) or through your Program Advisor.

**Child Abuse & Neglect Reporting Protocol**

Date last revised:

**Screening & Assessment**:

If not applicable to this program, please check here

If funded for HFA, list written agreements with the agencies providing screening and referral sources for the program.

|  |  |  |
| --- | --- | --- |
| **Agency** | **Nature of Agreement** | **Date signed by collaborating agency** |
|  |  |  |
|  |  |  |
|  |  |  |

**Doula Services**:

If not applicable to this program, please check here

If funded for Doula Services, written agreements with the hospitals specified below, stating that hospitals will allow Doulas to have access to labor and delivery. Please list **all** hospitals where your Doulas deliver, even if there is currently no written agreement.

|  |  |  |
| --- | --- | --- |
| **Hospital** | **Nature of Agreement** | **Date signed by hospital** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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**Program Abstract**

**HEART TO HEART SITE SUPPORT AND INTERVENTION PLAN**

If not applicable to this program, please check here

Complete the following chart about your agency’s Heart to Heart staffing and implementation plan.

**Staff and Resource Information**

|  |  |
| --- | --- |
| **Staff Positions** | **Name of Staff Member** |
| **Program Director** |  |
| **Heart to Heart Program Contact: name, e-mail address, and phone number** |  |
| **Clinical Consultant** |  |
| **Community Resources** | **Agency Name** |
| **Sexual Assault Counseling** |  |
| **Domestic Violence Counseling** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Facilitators (2 facilitators per group required)** | **Projected # of Participants (specify language)** | **Projected Start Date** | **Projected Graduation Date** |
| **Heart to Heart**  **Group 1** |  | **# English –** |  |  |
| **# Spanish –** |
| **Heart to Heart**  **Group 2**  **(requires Start Early approval)** |  | **# English –** |  |  |
| **# Spanish -** |
| **Heart to Heart**  **Group 3**  **(requires Start Early approval)** |  | **# English –** |  |  |
| **# Spanish -** |