Amendment No.

Subcontract No. 2025-

**FY25 Family Connects Illinois 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**

[x]  Family Connects Illinois

Family Connects International Credentialing Status (Certified or Not Certified):

If Certified, Family Connects International Program Certification Period:

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**DESCRIBE THE COMMUNITY SERVED, CITIES OR TOWNS, COUNTIES, AND POPULATION DEMOGRAPHICS:** Include the racial, linguistic, ethnic, and cultural characteristics in your description. Also, include the zip codes of participants eligible for services in the program, as well as the participating delivery hospital(s) that determine eligibility. Describe target population; include number of county births in that population. Describe mechanism for tracking births within the target population and projected number of integrated home visits.

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**Subcontractor Contact List**

Designate individuals from your organization who will fulfill specified roles for interface with Start Early staff in the following categories. You may assign site staff to be the contact in one or more of these roles. Start Early uses the designated site contact information to create targeted mailing and e-mail 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 or Contact Information: To change any of the designated contacts during the fiscal year, notify your HV&DN Family Connects Illinois Program contact 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. The 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 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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**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:**

**Family Connects International Data System Contact:** This contact is the primary liaison with the Family Connects International data system team regarding data reporting issues, initial orientation of new site staff, and distribution of the FC International correspondence to Family Connects Illinois data system users in the Start Early funded program.

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

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**Family Connects Illinois 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 Agency, FC IL Program, 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 FC IL). For nurses, list the date each nurse received individual credentialing by the nurse supervisor or Family Connects International to provide home visits independently.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name/Title** | **% FTE Agency** | **% FTE****FC IL** | **% Direct Services****FC IL** | **% Supervision** | **Supervised By** | **Freq. of Group Case Conference** | **Date of****RN FC IL****Certification\*** |
|       |      % |      % |      % |      % |       |       |       |
|       |      % |      % |      % |      % |       |       |       |
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\* Please note any new RN FC IL Certification dates in quarterly report narratives

**Medical Director:** A Medical Director (minimum .1fte) is required to oversee the clinical protocol and provide clinical decision-making support for the FC IL nurses and Nursing Supervisor. Provides continuing education or educational resources for clinical team.

Name:       FTE:

Agency/Affiliation (if any):       Credential:

**Internal Program Management**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staffings (Family Connects Illinois case conference meetings)** | [ ]  Weekly or more frequently | [ ]  Twice a month | [ ]  Monthly | [ ]  Quarterly |
| **Team Meetings – includes FC IL and additional programs****Clinical Director: Meetings with Nursing Supervisor/Nurses** | [ ]  Weekly or more frequently[ ]  Weekly or more frequently  | [ ]  Twice a month[ ]  Twice a month | [ ]  Monthly[ ]  Monthly | [ ]  Quarterly[ ]  Quarterly |

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**Program Capacity**

It is estimated that 80 percent of eligible families will accept the program and 80 percent will complete the home visit or supportive call. Please complete the information below, based on the national service model estimates. If the actual program data reflects a different acceptance and completion rate, please share that information in your reply to item eleven.

|  |  |  |
| --- | --- | --- |
| 1 | Estimated number of annual births to county residents at the participating hospital(s) |       |
| 2 | Estimated number of families who will accept the program (Answer to number 1, multiplied by .8) |       |
| 3 | Estimated number of completed Integrated Home Visits and Supportive Calls (Answer to number 2, multiplied by .8) |       |
| 4 | Estimated weekly IHV and Supportive Calls completion rate (Answer to number 3, divided by 46, rounded up to nearest number)? 46 weeks are used to account for holidays, vacation, sick and training days when nurses are unavailable to provide IHVs. |       |
| 5 | Weekly nurse home visitor IHV capacity (Answer to number 4, divided by # of FTE nurse home visitors, rounded up to nearest number) |       |
| 6 | Estimated number of IHVs that will need to be rescheduled weekly, due to missed/failed appointments per nurse |       |
| 7 | Total nurse IHV and Supportive Call capacity (Add lines 5 and 6) |       |
| 8 | Estimated number of pre-IHV visits that will need to be completed weekly, per nurse |       |
| 9 | Estimated number of post-IHV visits that will need to be completed weekly, per nurse |       |
| 10 | Total Weekly Nurse Capacity (Add lines 7, 8 and 9) |       |
| 11 | Is current staffing sufficient to meet the needs of the program? Capacity should not exceed Total Weekly Nurse Capacity of 9 (in # 10 above). Please explain. |       |
| 12 | Estimated number of Post Visit Calls (PVC) that will need to be scheduled weekly |       |
| 13 | Any comments or concerns about the above information |       |

Please indicate the name(s) of the core curricula used in the Family Connects Illinois program. (use a comma or semi-colon to separate names of curricula)

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**Describe the Community Alignment Within Your Designated Family Connects Illinois Service Area:** Include any current agency affiliations with local collaborative networks that will be attended specifically by the Family Connects Illinois program personnel. Also, include any cooperative agreements or coordination of services already in place with local hospitals, Coordinated Intake services, Department of Human Services local Family and Community Resource Centers (Public Aid offices), community home visiting programs, Doula services, health departments, mental health providers, medical providers, and others. Please describe the activities that assist in building relationships that expand and/or strengthen community alignment.

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**COMMUNITY and HOSPITAL EDUCATION**

|  |  |  |
| --- | --- | --- |
| **Event Name/Staff** | **Frequency** | **# Attendees Expected** |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |
| **Total** |       |

**FREQUENCY CODES**

|  |  |  |
| --- | --- | --- |
| A = Annually | 3Y = Three times per year | 2Y = Twice per year |
| Q = Quarterly | M = Monthly | 2M = Twice per month |
| W = Weekly or more frequently | AN = As Needed | NA = Not applicable |

Community and hospital education events are events utilized to promote your program or to keep the community and/or participating hospital informed about program activities. Examples include, but are not limited to, presentations to agencies, maternity fairs, health fairs, agency open houses, hospital labor and delivery staff, hospital medical staff, etc. If you have any questions about whether or not an event is considered community education, please contact your Program Advisor.

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**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. 7/1/2022)*. 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** |
|       |       |       |
|       |       |       |
|       |       |       |

**Family Connects Illinois/Hospital Agreements**:

If not applicable to this program, please check here [ ]

Please provide information on any agreements (verbal and/or written) that the program has with the participating hospital(s), stating that the Family Connects Illinois service agency subcontractor is allowed to have access to labor and delivery patients.

|  |  |  |
| --- | --- | --- |
| **Hospital** | **Nature of Agreement** | **Date signed/agreed to by hospital** |
|       |       |       |
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