Agency name & Subcontract No. 2025-

 **Home Visiting & Doula Network**

 **Quarterly Narrative Report**

Abbreviated Version

Directions: Submit this version of the Program Narrative in Quarters 1 and 3.

**FY25 Quarter #: [ ] 1 [ ] 3**

**SECTION I. SUBCONTRACT COMPLIANCE**

1. **Staff Changes:** If there were any new hires, terminations, leaves of absence, or ongoing vacancies in the program during the last quarter, please complete the chart below.

[ ]  N/A

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Position** | **Person Replacing** | **Start Date** |
| **New Hires** |       |       |       |
|       |       |       |
|  | **Name/Position** | **Last Date of Employment** |
| **Terminations** |       |       |
|       |       |
|  | **Position** | **Person who last held position** | **Date position became vacant** |
| **Ongoing Vacancies** |       |       |       |
|       |       |       |
|  | **Name/Position** | **Date leave began** | **Anticipated end date** | **Type of leave\*** |
| **Leaves** |       |       |       |       |
|       |       |       |       |

\*P-paid out of contract funds, I-paid by disability or other non-contract funds, U-unpaid

Subcontract No. 2025-

**FY25 Quarterly Narrative Report**

1. **Program Contact Updates:** Please use the tables below to update any contact information for your program.

[ ]  No changes

**SERVICE AGENCY PRIMARY SERVICE SITE**

**Agency Name:**       **Program Name:**

**Street:**       **Street:**

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

**Phone:**       **Fax:**       **Phone:**       **Fax:**

**E-mail:**       **E-mail:**

**Executive Contact Program Management Contact**

**Name/Title:**       **Name/Title:**

**Street:**       **Street:**

**City:**       **Zip:**       **City:**       **Zip:**

**Phone:**       **Fax:**       **Phone:**       **Fax:**

**E-mail:**       **E-mail:**

[ ]  Add contact [ ]  Replace existing [ ]  Add contact [ ]  Replace existing

**Effective date:**

**Direct Service Supervisor**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

[ ]  Add contact [ ]  Replace existing contact

**Effective date:**

**Fiscal Report Contact**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

[ ]  Add contact [ ]  Replace existing contact

**Effective date:**

**Effective date:**

**Fiscal Contact**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

[ ]  Add contact [ ]  Replace existing contact

**Effective date:**

**DataPoints/MIS Contact**

**Name/Title:**

**Street:**

**City:**       **Zip:**

**Phone:**       **Fax:**

**E-mail:**

[ ]  Add contact [ ]  Replace existing contact

**Effective date:**

Subcontract No. 2025-

**FY25 Quarterly Narrative Report**

1. **Factors Affecting Program Services:** List anything (besides staffing) that has impacted the program’s effectiveness to meet contractual obligations this quarter (e.g., changes in community services available, linkage agreements, etc.).

[ ]  No change

1. Describe any deaths to Doula participants (child or adult) this quarter.

[ ]  N/A

1. If you are you still working with the family or processing the death with staff, please describe the work being done.

1. Do you need any additional support or resources in this area?

1. Describe any DCFS reports that program staff became aware of in the quarter (even if the alleged incident occurred prior to this quarter) **where the alleged victim of abuse or neglect was a child of a family served in your program**. State whether the person who reported the abuse or neglect was program staff or another source. If known, state the outcome of the investigation (indicated, unfounded, or pending). Describe the nature of the alleged abuse or neglect. If the program was not the source of the report, describe how the report came to the attention of the program staff.

[ ]  N/A

1. Do you need any additional support or resources in this area?