U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Maternal and Child Health Bureau
Division of Home Visiting and Early Childhood Systems

Affordable Care Act –
Maternal, Infant and Early Childhood Home Visiting Program: Grants to Nonprofit Organizations

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FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013

Application Due Date: February 15, 2013

Modified 1/30/13 to extend Application Due Date

Modified 12/18/12 to amend the period of support, periods of availability of funds for expenditure, and to provide pre-application technical assistance call information.

Ensure your Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration may take up to one month to complete.

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Authority: Social Security Act, Title V, § 511(h)(2)(B) (42 U.S.C. §711(h)(2)(B)), as amended by the Patient Protection and Affordable Care Act, § 2951 (P.L. 111-148).

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I. Funding Opportunity Description

1. Purpose

This competition is open to nonprofit organizations proposing to provide services under the Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant program in the **State of Florida** or the **State of Wyoming.** Both the State of Florida and the State of Wyoming have relinquished MIECHV funds and are not participating in the MIECHV grant program under Section 511(c) of the Social Security Act (42U.S.C. § 711(c))**.** Accordingly, grant funding is being made available to qualified nonprofit organizations for the purposes described in this funding opportunity announcement (FOA).

Applicant nonprofit organizations must demonstrate that they will provide home visiting services as defined in this FOA to families in communities identified as being at risk **either within the State of Florida *or* within the State of Wyoming** and will meet further legal and program requirements. Applicants must identify the state in which they are applying to provide services. If an eligible entity wishes to apply to provide services in more than one state, a separate application must be filed for each state in which services are proposed to be provided.

Eligible applicants for this competitive grant opportunity are **nonprofit organizations** with an established record of providing early childhood home visiting programs or initiatives in a state or several states.

Subsection 511(h)(2)(B) of the authorizing legislation specifically requires that program requirements for MIECHV grants to nonprofit organizations be, to the greatest extent practicable, consistent with the requirements applicable to eligible entities that are states; require each nonprofit organization grantee to carry out the program funded under this announcement based on the needs assessment that was previously conducted by the relevant state in which it is now proposing to provide services (i.e., either Florida or Wyoming) under subsection (b); and require the organization to establish quantifiable, measurable 3- and 5-year benchmarks consistent with the requirements for eligible entities that are states, as set forth in subsection (d)(1)(A).

2. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) (P.L. 111-148). The Affordable Care Act MIECHV program responds to the diverse needs of children and families in communities at risk and provides an opportunity for strong collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The funds are intended to assure, on a voluntary basis, effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to children and families through home visiting programs. This new program plays a crucial role in the national effort to build high-quality, comprehensive early childhood systems for pregnant women, parents and caregivers, and children from birth to eight years of age – and, ultimately, to improve health and development outcomes.

The Affordable Care Act MIECHV program is designed to: (1) strengthen and improve the programs and activities carried out under Title V; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. Consistent with the applicable legislation**,** at least 75 percent of the grant funding for a fiscal year must be used for the purposes of conducting a program using one or more evidence-based home visiting models. **No more than 25 percent of grant funding for a fiscal year can support promising approaches that do not yet qualify as evidence-based models.**

HRSA and the Administration for Children and Families (ACF), the agency with which HRSA is collaborating on this initiative, believe that home visiting is one of several strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development. Together, HRSA and ACF envision high- quality, evidence-based home visiting programs as part of an early childhood system for promoting health and well-being for pregnant women, children through age eight and their families. Other programs that contribute to this goal include child care, Head Start, pre-kindergarten, early intervention, special education, and the early elementary grades.

HRSA and ACF are working in close collaboration with other federal agencies and are partnering with states and other stakeholders to foster high-quality, well-coordinated home visiting programs for families in at-risk communities. HRSA and ACF realize that coordination of services with other agencies has been an essential characteristic of state and local programs for many years and will continue to encourage, support, and promote these activities, as close collaboration at all levels will be essential to effective, comprehensive home visiting and early childhood systems.

Additionally, HRSA and ACF believe that this law provides an opportunity for federal, state, and local agencies, through their collaborative efforts, to affect changes that will improve the health and well-being of vulnerable populations by addressing child development within the framework of life course development and a socio-ecological perspective. Life course development points to broad social, economic, and environmental factors as contributors to poor and favorable health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families. The socio-ecological framework emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

In FY 2010, $91 million in grant funding was awarded by formula to states and eligible jurisdictions under the MIECHV program. In FY 2011, $124 million in grant funding was allocated to these entities by formula, with the base allocation increased to $1 million and no entity receiving less than 120% of the FY 2010 allocation. In addition, in FY 2011, $100 million was awarded competitively to nine states for Expansion Grants and 13 states for Development Grants. In FY12, HRSA awarded $71.9 million in competitive funding to grantees of the MIECHV program in new Expansion Grants. The $71.9 million was awarded for ten four-year grants. Expansion Grants to support states and jurisdictions that have already made significant progress towards implementing high-quality home visiting programs as part of a comprehensive, high-quality early childhood system and are ready and able to take effective programs to scale, with grantees using funds to (1) expand the scale and/or scope of evidence-based home visiting programs and/or (2) enhance or improve existing home visiting programs. Development Grants are intended to support states and jurisdictions with modest home visiting programs to build on

existing efforts. In FY 2012, approximately $125,000,000 was allocated to be distributed to eligible entities that are states, as further set forth in the authorizing legislation, using the same formula as in FY 2011.

For the two eligible entities that have elected not to participate in the MIECHV program, the State of Florida and the State of Wyoming, the funds previously awarded to, but unexpended by, those states, as well as the funds that would have been made available to those states by formula grant in FY 2012, had they continued their participation, are now being made available for award to nonprofit organizations to provide services in those states, respectively.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during federal fiscal years 2013 and 2014. The project and budget period is three (3) years and six months, April 1, 2013 through September 30, 2016. Funding beyond the first year is dependent on the continued availability of appropriated funds for the MIECHV program in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

- Up to $16,205,648 will be available in FY 2013 to fund one (1) grantee to provide MIECHV services in the **State of Florida**. The period of availability for expenditure will be April 1, 2013 through September 30, 2015. Per statute, funds that have not been obligated for expenditure by the grantee during this period will be deobligated and no longer available. During FY 2014, an additional $5,975,876 is anticipated to be available to continue to fund MIECHV services in Florida. The period of availability for expenditure will be April 1, 2014 through September 30, 2016. Per statute, funds that have not been obligated for expenditure by the grantee during this period will be deobligated and no longer available. Applicants to provide services in Florida may apply for the ceiling amount of up to $16,205,648 for FY 2013 and up to $5,975,876 for FY2014.

- Up to $3,567,800 will be available in FY 2013 to fund one (1) grantee to provide MIECHV services in the **State of Wyoming**. The period of availability for expenditure will be April 1, 2013 through September 30, 2015. Per statute, funds that have not been obligated for expenditure by the grantee during this period will be deobligated and no longer available. During FY 2014, an additional $1,000,000 is anticipated to be available to continue to fund these services in Wyoming. The period of availability for expenditure will be April 1, 2014 through September 30, 2016. Per statute, funds that have not been obligated for expenditure by the grantee during this period will be deobligated and no longer available. Applicants to provide services in Wyoming may apply for the ceiling amount of up to $3,567,800 for FY 2013 and up to $1,000,000 for FY2014.

Per statute, funds made available to a grantee for a fiscal year shall remain available for expenditure by the grantee through the end of the second succeeding fiscal year after award.

Funds that have not been obligated for expenditure by the grantee during the period of availability will be deobligated. They may not be carried over into a subsequent fiscal year.

III. Eligibility Information

1. Eligible Applicants

This competition is open to nonprofit organizations proposing to provide services under the Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant program in the **State of Florida** and/or the **State of Wyoming.** Eligible applicants for this competitive grant opportunity are nonprofit organizations with an established record of providing early childhood home visiting programs or initiatives in a state or several states. Applications from entities that fail to meet these criteria will not be considered.

Nonprofit organizations wishing to apply for funding under this grant program must demonstrate that they will provide home visiting services as defined in this funding opportunity announcement (FOA) to families in communities identified as being at risk within the State of Florida or within the State of Wyoming. Applicants must identify the state in which they are applying to provide services. If an eligible entity wishes to apply to provide services in more than one state, a separate application must be filed for each state in which services are proposed to be provided.

2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

3. Other

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

<u>Maintenance of Effort/Non-Supplantation</u>
Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visiting programs or initiatives (per the Social Security Act, Title V, §511(f)). The grantee must agree to maintain non-federal funding for grant activities at a level which is not less than expenditures for such activities as of the most recently completed fiscal year (Attachment 9).

NOTE: Multiple applications from an organization are allowable. If an eligible entity wishes to apply to provide services in more than one state, a separate application must be filed for each state in which services are proposed to be provided.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information
HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. The registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting your application. All applicants ***must*** submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from **DGPWaivers@hrsa.gov**, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the following in the e-mail request: the HRSA announcement number for which the organization is seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to the submission along with a copy of the "Rejected with Errors" notification as received from Grants.gov. HRSA's Division of Grants Policy is the only office authorized to grant waivers. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.

IMPORTANT NOTICE: CCR moved to SAM
Effective July 30, 2012

The Central Contractor Registration (CCR) transitioned to the System for Award Management (SAM) on July 30, 2012. For any registrations in process during the transition period, the data that has been submitted to CCR will be migrated to SAM.

If a record was scheduled to expire between July 16, 2012 and October 15, 2012, CCR is extending the expiration date by 90 days. The registrant received an e-mail notification from CCR when the expiration date was extended. The registrant then will receive standard e-mail reminders to update their record based on the new expiration date. Those future e-mail notifications will come from SAM.

SAM will reduce the burden on those seeking to do business with the government. Vendors will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

Active SAM registration is a pre-requisite to the successful submission of grant applications!

Items to consider are:

- When does the account expire?
- Does the organization need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about SAM, please visit https://www.sam.gov.

Note: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). Grants.gov will reject submissions from applicants with expired registrations. Do not wait until the last minute to register in SAM. According to: the SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days. Therefore, ***check for active registration well before the application deadline.***

Applicants that fail to allow ample time to complete registration with SAM and/or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide,* available online at http://www.hrsa.gov/grants/apply/userguide.pdf. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at http://www.grants.gov/assets/ApplicantUserGuide.pdf. This Guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

1) Downloading from http://www.grants.gov, or

2) Contacting the HRSA Digital Services Operation (DSO) at: HRSADSO@hrsa.gov

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the "Application Format Requirements" section below.

2. Content and Form of Application Submission

Application Format Requirements
The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **HRSA strongly urges applicants to print their application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the *Electronic Submission User Guide* referenced above.**

Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.

Application Format
Applications for funding must consist of the following documents in the following order:

SF-424 Non-Construction – Table of Contents

- It is mandatory to follow the instructions provided in this section to ensure that the application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make the application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
- For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. The abstract must indicate the state in which services are being proposed to be provided.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; Counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Pages 1–2 to support structured budget for the request of Non-construction related funds.	Not counted in the page limit.
Budget Narrative Attachment Form	Form	Supports the upload of Project Narrative document.	Not counted in the page limit.
Budget Narrative	Attachment	Can be uploaded in Budget Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Project/Performance Site	Form	Supports primary and 29 additional sites in	Not counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Location(s)		structured form.	
Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with all additional site location(s)	Counted in the page limit.
Grants.gov Lobbying Form	Form	Supports required lobbying assurances.	Required. Not counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Optional, as applicable. Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for **specific** sequence. Counted in the page limit.

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that a table of contents cover page is included specific to the attachment. The Table of Contents page will not be counted in the page limit.
- Please use only the following characters when naming your attachments: A-Z, a-z, 0-9, underscore (_), hyphen (-), space, period, and limit the file name to 50 or fewer characters. Attachments that do not follow this rule may cause the entire application to be rejected or cause issues during processing.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Project Logic Model
Attachment 2	Project Timeline
Attachment 3	Project Organizational Chart
Attachment 4	Staffing Plan and Job Descriptions/ Resume for Key Personnel
Attachment 5	Biographical Sketches
Attachment 6	Description(s) of Proposed/Existing Contract (subcontracts)
Attachment 7	References and Citations
Attachment 8	Model Developer Approval Letter(s)

Attachment 9	Maintenance of Effort Chart
Attachment 10	Documentation of Nonprofit Status
Attachment 11	Letters of Support
Attachments 12-15	Other Relevant Documents

Application Format

i. Application Face Page

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. "Name and contact information of person to be contacted on matters involving this application." If, for any reason, the Project Director will be out of the office, please ensure the email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is **No. 93.505.**

DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at http://fedgov.dnb.com/webform or call 1-866-705-5711. Please include the DUNS number in item 8c on the application face page. Applications ***will not*** be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being "Rejected for Errors" by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the System for Award Management (SAM) in order to conduct electronic business with the Federal Government. SAM registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that the applicant organization SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with SAM can be found at https://www.sam.gov. Please see Section IV of this funding opportunity announcement for SAM registration requirements.

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Budget

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package.

Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A use rows 1 - 4 to provide the budget amounts for each year of the project. Please enter the amounts in the "New or Revised Budget" column- not the "Estimated Unobligated Funds" column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use

column (2) for the second year, column (3) for the third year, and column (4) for the remaining six months of the project period.

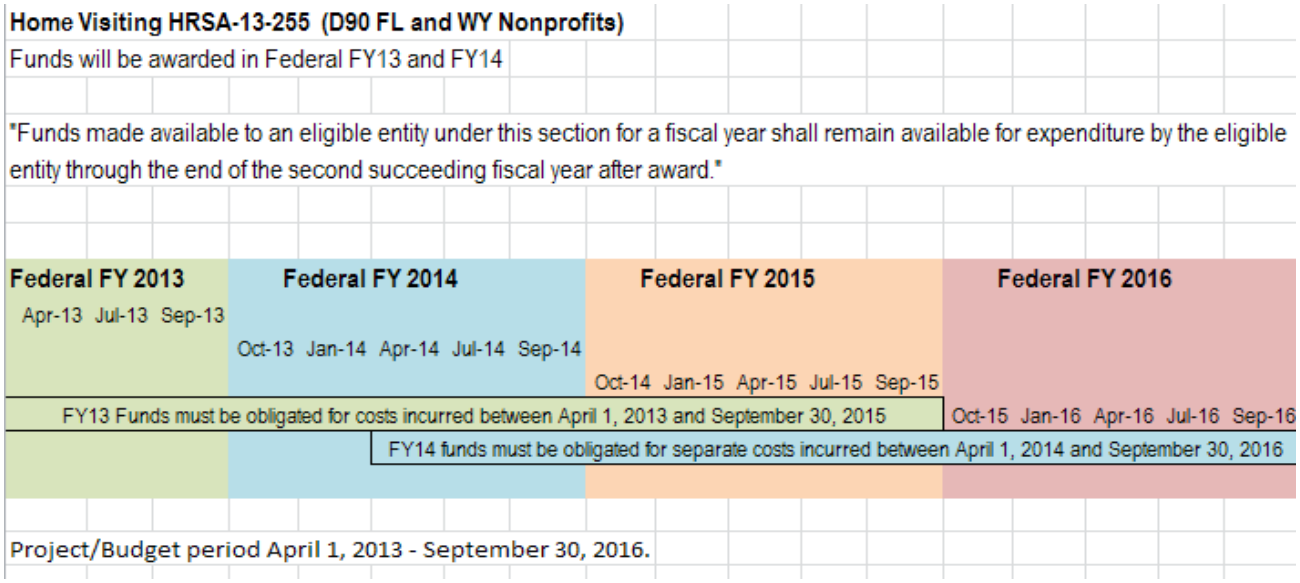
iv. Budget Justification

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The applicant **must** submit budgets that reflect costs to be incurred during the period of availability of funds for expenditure for the amount requested in FY13 and FY14 within the three and a half-year project period at the time of application. **PLEASE NOTE:** The periods of availability of funds for expenditure for FY13 and FY14 overlap during April 1, 2014 through September 30, 2015. Despite the overlap, the budget and budget justification for FY 13 and FY 14 should be distinct. Line item information must be provided to explain the costs entered in the SF-424A form. Be very careful about showing how each item in the "other" category is justified. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

Budget for Multi-Year Award

This announcement is inviting applications for a project period of three (3) years and six months. Awards, on a competitive basis, will be for the full three and a half year project and budget period. Submission and HRSA approval of the Progress Report(s) and any other required submission or reports is the basis for the release of FY14 funds. Funding beyond the first year is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

Per statute, funds made available to a grantee for a fiscal year shall remain available for expenditure by the grantee through the end of the second succeeding fiscal year after award. Funds that have not been expended during this period will be deobligated.



Administrative cap:
No more than 10 percent of the award amount may be spent on administrative expenditures.

Section 511(h)(2)(B) of the Social Security Act [42 U.S.C. 711(h)(2)(B)], requires that the Secretary specify MIECHV nonprofit organization program grant requirements that are "to the greatest extent practicable, consistent with the requirements applicable to eligible entities that are States." Section 511(i)(2)(C) of the Social Security Act requires that section 504(d) (relating to a limitation on administrative expenditures) "shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c)." The administration of the MCH Block Grant program is governed by 45 CFR Part 96, which states, "a State shall obligate and expend block grant funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds" (45 CFR 96.30(a)).

Therefore, while grantees that are nonprofit organizations are not expected to follow state government procedures relating to the obligation and expenditure of grant funds, they are expected to follow any relevant laws or regulations of the state within which they are providing services, to the maximum extent practicable, in order to determine which expenses are "administrative" in nature, and are therefore subject to the 10 percent spending cap. Awardees must use reasonable efforts to ascertain what constitutes "administrative expenses" under these state laws and regulations, to document their findings in this regard, and to maintain records that demonstrate that such administrative expenses do not exceed 10 percent of the award amount.

Nonprofit applicants that cannot adhere to the 10 percent administrative cost limitation must state so clearly in their application and provide persuasive evidence that it is not practicable for them to do so. MCHB prefers that nonprofit grantees under this program adhere to the limitation.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. The budget must allocate sufficient funds to provide for at least one or two representatives from the program to attend two federally-initiated grantee meetings for the MIECHV program: one at the regional level and another at the national level in the Washington, D.C. area. Please allow two to three days for each meeting. Meeting attendance is a grant requirement.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of $5,000 or more and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number. Consultants can also be listed in this section. For each consultant, specify the scope of work for the consultant, the hourly rate, and the number of hours of expected effort. Note: contracting and *subcontracting* is allowable under this grant program; however, *subgranting* is *not* allowable under this grant program.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

Indirect Costs: Indirect costs are not applicable.

v. Staffing Plan and Personnel Requirements

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in Attachment 4. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in Attachment 5. When applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

vi. Assurances

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

vii. Certifications

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

viii. Project Abstract

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including: the evidence-based model(s) and/or promising approach(es) that will be supported; the communities at risk selected for implementation, the needs to be addressed; the proposed services; and the population group(s) to be served.

Please place the following at the top of the abstract:

- Project Title
- The name of the state in which services are proposed to be provided.
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

The project abstract must be single-spaced and limited to one page in length.

Abstract content:

Applicants must identify the state in which they intend to provide services in the Abstract, either Florida or Wyoming. As noted earlier in this FOA, if a nonprofit organization wishes to apply to provide services in both states, a separate application, and thus a separate abstract, must be filed for each state in which services are proposed to be provided.

PROBLEM: Briefly (in one or two paragraphs) indicate the state and communities where services are proposed to be provided, and state the principal needs and problems that are being addressed by the project.

GOAL(S) AND OBJECTIVES: Identify the major goal(s) and objectives for the project period. Typically, the goal is stated in a sentence or paragraph, and the objectives are presented in a numbered list.

METHODOLOGY: Describe the programs and activities used to attain the objectives and comment on innovation, cost, and other characteristics of the methodology. This section is usually several paragraphs long and describes the activities that have been proposed or are being implemented to achieve the stated objectives. Include the model(s), where applicable the promising approach, number of communities, and number of families to be served.

COORDINATION: Describe the coordination either planned or in process with appropriate national, regional, state and/or local health and public health agencies and/or organizations, communities, and appropriate stakeholders in the area(s) served

by the project.

ANNOTATION: Provide a three- to five-sentence description of your project. This annotation will be posted on a HRSA web site. Please use key words that identify the project's purpose, goals and objectives, and activities.

ix. Project Narrative

The narrative provided in response to this funding opportunity announcement should provide a comprehensive framework and description of all aspects of the proposed MIECHV program. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Any references used in the Program Narrative may be listed under Attachment 7.

Section 1: Needs Assessment, Identification of the Targeted At-Risk Communities in the State for which the State Home Visiting Program is Being Proposed, and Community Understanding and Engagement

As noted in the Executive Summary, subsection (h)(2)(B) of the authorizing legislation requires that each nonprofit organization grantee carry out the program funded under this announcement based on the needs assessment that was previously conducted, in accordance with subsection (b) of the legislation, by the relevant state in which it is now proposing to provide services (i.e., either Florida or Wyoming). The relevant needs assessment reports may be accessed at http://mchb.hrsa.gov/programs/homevisiting/index.html.

Therefore, this section of the narrative must identify the state for which services are being proposed and, consistent with the state needs assessment, identify the proposed targeted at-risk community or communities for which home visiting services are proposed to be supported under the MIECHV program, and provide a justification for selection of those targeted areas. In addition, as noted above, this narrative description must demonstrate that the applicant's plan is based on the previous, state-conducted needs assessment and, to the greatest extent practicable, is consistent with the requirements applicable to eligible entities that are states.

This section should include as much detailed information as possible regarding specific community risk factors, other characteristics and strengths, the need for a home visiting program, and service systems currently available for families in that community, including information on any home visiting programs currently operating or recently discontinued (since March 23, 2010). Demographic data should be provided whenever possible to support the information provided.

Applications must demonstrate that the programs they propose are based on the needs assessment previously conducted by the state. If the applicant proposes to target different or additional at-risk communities from those that may have been identified in the state's needs assessment or Updated State Plan, a well-articulated written justification for the proposed deviation must be included.

Finally, an applicant must provide evidence that it has an understanding of the communities it proposes to serve and that it has established relationships with institutions in that community

that will allow it to successfully recruit and retain participants and appropriately draw on resources available in the community for services or supports a family might need. An applicant should provide evidence of its presence in and understanding of the communities. This can be done by indicating the kinds of services the organization already provides in the communities, providing evidence of support from relevant community institutions, such as other agencies – public and private – that provide services to pregnant women, families with young children, or others. In addition, an applicant should demonstrate that it has a plan for engaging relevant entities within the community to support successful program implementation.

For each targeted community proposed, please provide the following information.

- A detailed assessment of needs and existing resources, including:
    - Community strengths and risk factors.
    - Characteristics and needs of participants; to the extent possible, the target population must be described and documented in this section.
    - Any existing home visiting services[1] in the community, currently operating or discontinued since March 23, 2010, including
        - the number and types of home visiting programs and initiatives in the community; and
        - the models that are used by identified home visiting programs.
    - Existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the local or state level).
    - Referral resources currently available and needed in the future to support families residing in the community(ies).
- Local capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system, such as a governance structure or coordinated system of planning;
- A description of how coordination among existing programs and resources in those communities is promoted and implemented, and a description of how the program will address existing service gaps; and
- A discussion of the applicant's knowledge, presence, and engagement in the community.

Section 2: Home Visiting Program's Goals and Objectives

Please articulate clear goals and objectives for the proposed Home Visiting Program. The goals must be consistent with the goals of the Affordable Care Act's MIECHV program, which are to: (1) strengthen and improve the programs and activities carried out under Title V; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

[1] Including state-funded, federally-funded, locally-funded, and/or privately-funded programs in the community. Home visiting programs are defined for purposes of this program as those with home visiting as the primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents or primary caregivers of children birth to kindergarten entry, targeting the legislatively mandated participant outcome and benchmark areas.

The articulated goals and objectives must reflect the applicant's effort to address and meet the legislatively mandated benchmarks and ensure that high-quality evidence-based home visiting services are delivered. In addition, the goals and objectives should address the development of a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships. Lastly, strategies for integrating the program with other programs and systems in the community that are related to maternal and child health and early childhood health, development, and well-being should be reflected in the goals and objectives. An implementation timeline also should be provided.

Objectives included should be developed with a SMART objective framework in mind as much as possible. Specific, measurable, achievable, realistic, and time bound are characteristics of SMART objectives. (See Appendix C: Glossary)

Applicants must include an updated logic model for the proposed Home Visiting Program as a whole. The logic model for the Home Visiting Program as a whole may build on the model developer's logic model but should not duplicate it. The logic model should identify inputs, outputs and short-term and long-term outcomes. Please include the logic model as Attachment 1. For guidance on creating logic models see: http://www.childwelfare.gov/management/effectiveness/models.cfm or the W.K. Kellogg Foundation tool for developing a logic model at http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx.

Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of the Targeted Community(ies)

The applicant must describe a State Home Visiting Program using one or more evidence-based home visiting models (see Appendix A) aimed at addressing the particular risks in the targeted community(ies) and the needs of families residing there. Per the authorizing legislation, at least 75 percent of the funds must be utilized by grantees for evidence-based home visiting models.

The applicant may also propose not more than 25 percent of the grant funds per year to support a model that is a promising approach. The applicant must explain the selection of home visiting model(s) by demonstrating how the model(s) will address the needs identified in the targeted at-risk community(ies). In the case of a promising approach, the applicant must indicate the national organization or institution of higher education that developed or identified the model and how the model will be evaluated through a well-designed and rigorous process. The applicant should also describe how the at-risk community(ies) will be engaged in decision-making regarding the home visiting program.

In some cases, the applicant may wish to adapt an existing model that has been identified as evidence-based in order to meet the needs of targeted at-risk communities. Adaptations may include broadening the population served, additions, subtractions, or enhancements of the current model. For the purposes of the MIECHV program, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer *not to alter the core components related to program impacts*. Implementing agencies should discuss proposed adaptations with the model developers prior to implementation to ensure that changes do not alter core components. Changes to an evidence-based model that alter the core elements related to

program outcomes could undermine the program's effectiveness. Such changes (otherwise known as "drift") will not be allowed under the funding allocated for evidence-based models. Any proposed adaptations will be reviewed and approved by HRSA post award. Adaptations that alter the core components related to program impacts may be funded with funds available for promising approaches, if the applicant wishes to implement the program as a promising approach instead of as an adaptation of an evidence-based model.

Any home visiting model proposed in the applicant's response to this FOA must meet the criteria listed in this document to qualify for funding as an evidence-based home visiting model or a promising approach. For the purposes of this section, applicants should build upon the Updated State Plan previously submitted by the state. If the proposed plan deviates substantially from the state's previously-submitted Updated State Plan, a justification should be provided in the narrative.

The Updated State Plans for the State of Florida and the State of Wyoming are available at: http://mchb.hrsa.gov/programs/homevisiting/index.html.

Applicants proposing additional model(s) must[2]:

a. Select a model(s) from the list in Appendix A that meets the needs identified in the targeted at-risk community(ies); or
b. Propose the use of not more than 25 percent of the funds for a promising approach to home visiting.

(a) Selection of Approved Evidence-Based Home Visiting Model(s)

Appendix A identifies twelve home visiting models that have been determined to meet the evidenced-based criteria established by HRSA and ACF on the basis of a systematic review conducted through the HomVEE study and the public comments received in response to the July 23, 2010 Federal Register Notice.[3] The home visiting models known to meet the evidence criteria are listed in Appendix A. There is detailed information on each model reviewed, including the evidence available for each model and information on other models reviewed that did not meet the criteria at http://homvee.acf.hhs.gov/. Per the authorizing legislation, at least 75 percent of the funds must be utilized by grantees for evidence-based home visiting models. As noted previously, the applicant may propose, in addition, to expend not more than 25 percent of its grant funding for a fiscal year to implement a model that qualifies as a promising approach (see section (b) "Proposing a Promising Approach," below).

Applicants proposing to implement an approved evidence-based model must provide

[2] On an ongoing basis, the Home Visiting Evidence of Effectiveness (HomVEE) review will review the available evidence on home visiting models. Applicants will be informed whenever new models meet the criteria for evidence of effectiveness. Applicants, model developers, states, or others may make a request for reconsideration of an already-reviewed model for which there is currently insufficient evidence of effectiveness.
[3] Department of Health and Human Services, Health Resources and Services Administration, Administration for Children and Families, Maternal, Infant, and Early Childhood Home Visiting Program; Request for Public Comment, 75 Federal Register 141 (23 July 2010), pp. 43172-43177.

documentation of approval by the developer. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted, including any proposed adaptation, support for participation in the national evaluation, and any other related HRSA efforts to coordinate evaluation and programmatic technical assistance. This documentation should include the organization's status with regard to any required certification or approval process required by the developer. The approval letter should be submitted as Attachment 8.

In response to this FOA, the applicant must also include the following information regarding evidence-based model selection:

- Identify the evidence-based home visiting model(s) to be implemented in the state and describe how each model meets the needs of the community(ies) proposed. Applicants must engage the targeted community to assess the fit of the model and the community's readiness to implement it. Community involvement is expected to continue on an ongoing basis throughout the duration of this program;
- Provide a description of the applicant's current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- Submit a plan for ensuring implementation of the model with fidelity and include a description of the following: the applicant's overall approach to home visiting quality assurance; the applicant's approach to program assessment and support of model fidelity; and
- Discuss anticipated challenges and risks to implementing the selected program model(s), including risks to maintaining program quality and fidelity to the model, the proposed response to the issues identified, and any anticipated technical assistance needs.

For the purposes of this section, the applicant may include, if available, the information provided in the Updated State Plan submitted in the application for MIECHV FY 2010 formula grants by the state in which the proposed program will be implemented.

(b) Proposing a Promising Approach

Applicants may propose implementing a home visiting model that qualifies as a promising approach for achieving the benchmarks and outcomes required by law. A promising approach is one in which there is little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model; or a modified version of an evidence-based model that *includes significant alterations to core components*. The promising approach should be grounded in relevant empirical work and have an articulated theory of change. The promising approach must have been developed by or identified with a national organization or institution of higher education. The successful applicant must evaluate this approach through a well-designed and rigorous process.

No more than 25 percent of the amount of the grant may be used to implement a promising approach. In addition, the required evaluation of a promising approach must be funded from the 25 percent of funds available for promising approaches. A discussion of the expected evaluation activities for promising approaches is included in Appendix B.

If the applicant would like to propose implementing a promising approach, the application must:

- Describe the model(s) proposed as a promising approach;
- Identify the national organization or institution of higher learning affiliated with the model(s);
- Specify how the proposed promising approach(es) meets the needs of the at-risk community(ies). It is expected that the applicant will engage the proposed community to assess the fit of the approach and community readiness to implement it prior to the submission of the application and on an ongoing basis after implementation begins;
- Provide a description of the applicant's current and prior experience with implementing the promising approach, as well as its current capacity to support implementation;
- Include an evaluation plan specifying how the proposed promising approach(es) will be evaluated using a well-designed and rigorous process (see Appendix B);
- Submit a plan for ensuring implementation with fidelity to the model and include a description of the overall approach to home visiting quality assurance; the approach to program assessment and support of model fidelity; and,
- Discuss anticipated challenges to implementing or evaluating the promising approach, including risks to maintaining program quality and fidelity to the proposed approach, proposed responses to issues identified, and any anticipated technical assistance needs.

Section 4: Implementation Plan for the State Home Visiting Program

The applicant must provide a plan for implementing the State Home Visiting Program. The plan should consider the need for ongoing monitoring of the quality of implementation of chosen model(s) at the administering organization, community, and participant levels. The Plan must include the following information:

- A description of the applicant's approach to the development of home visiting program policy and approach to setting standards for the State Home Visiting Program;
- A description of approach on how the State Home Visiting Program will collaborate with public and private partners;
- A description of efforts to date and future plans for engaging the at-risk community(ies) around the proposed State Home Visiting Program, including identifying the organizations, institutions or other groups and individuals consulted;
- A description of how the applicant will work with the national model developer(s) and a description of the technical assistance and support expected to be provided through the national model(s). If there is more than one home visiting model selected, this information must be provided for each model;
- A timeline for implementation of the curriculum or other materials needed;
- A comprehensive description of initial and ongoing training and professional development activities, including model-specific training, that will be provided, as well as proposed training evaluation;
- A discussion of how recruitment, hiring, and retention of appropriate staff for all positions will be conducted;
- If subcontracts will be used, a plan for monitoring the subcontracts including site visits, audits, reporting time frames, etc.;
- If subcontracts will be used, a plan for recruitment of subcontractor organizations, and a plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s);
- A description of how the applicant will ensure that high quality clinical supervision and reflective practice for all home visitors and supervisors will be supported and

maintained;

- A description of how the State Home Visiting Program will identify and recruit program participants and how attrition rates will be minimized, including the estimated number of families to be served and an estimated timeline to reach maximum caseload in each location;
- An operational plan and activities for coordination between the proposed home visiting program and other existing programs and resources in those communities, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, injury, child maltreatment prevention, child welfare, education, and other social and health services;
- A description of how data systems will be utilized to ensure collection and transfer of data; interoperability with other data systems; and the minimizing of data entry duplication;
- A description of how data systems will be utilized to ensure implementation of continuous quality improvement (CQI) for the program;
- An explanation of the applicant's approach to monitoring, assessing, and supporting implementation with fidelity to the chosen model(s) and maintaining quality assurance;
- A discussion of anticipated challenges in maintaining quality and fidelity, and the proposed response to the issues identified;
- An updated list of collaborative public and private partners;
- An explanation of how the applicant will integrate this MIECHV program into the broader early childhood system(s) in the communities where services are proposed to be provided;
- Assurance that the home visiting program is designed to result in participant outcomes noted in the legislation;
- Assurance that individualized risk assessments will be conducted for participant families and that services will be provided in accordance with those individual assessments;
- Assurance that services will be provided on a voluntary basis; and
- Assurances that priority will be given to serve eligible participants who:
  - Have low incomes;
  - Are pregnant women who have not attained age 21;
  - Have a history of child abuse or neglect or have had interactions with child welfare services;
  - Have a history of substance abuse or need substance abuse treatment;
  - Are users of tobacco products in the home;
  - Have, or have children with, low student achievement;
  - Have children with developmental delays or disabilities;
  - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Research and Evaluation

The applicant must provide assurances in the application of participation in any national evaluation activities if selected to participate.

Section 5: Meeting Legislatively-Mandated Reporting on Benchmark Areas, Demographic Data, and Service Utilization Data

To meet the requirements for establishment of quantifiable, measurable 3- and 5-year in benchmarks,[4] the applicant must provide a proposal for the initial and ongoing data collection for each of the six benchmark areas listed below. If the state in which the applicant proposes to provide services has previously submitted such a plan, and if that plan if available, the applicant's proposal should build upon this plan, identifying any proposed additions, deletions, or revisions. It is expected that the grantee will continue to develop the plan in consultation with the Regional Project Officer and other MIECHV program staff until a final plan is approved by the Regional Project Officer. Technical assistance with developing plans for meeting benchmark area requirements will be available to successful applicants to this FOA.

The following requirements relate to measurable improvement under the benchmark areas:

- The grantee must collect data on all benchmark areas.
- The data must be collected for eligible families enrolled in the program who receive services supported by MIECHV program funds. [5]
- Each benchmark area includes various related constructs (or measurement concepts). The applicant must collect data for all constructs under each benchmark area. (Please see Overall Measurement Plan Requirements below, a more detailed description with illustrations of the various components of each indicator associated with individual constructs under the benchmark areas specified in the legislation.)
- A standard performance measure for each of the constructs within a benchmark area across all utilized home visiting models is strongly encouraged (if the applicant plans to implement more than one home visiting model).
- We recommend that applicants utilize these program-wide performance measures (or a subset of these indicators) for the purpose of CQI to enhance program operation and decision-making and to individualize services.[6] Technical assistance will be provided to grantees in utilizing data for CQI.
- Applicants may propose either to collect data on each participating family or to use a sampling approach for some or all benchmark areas.
- The performance measures and associated measurement tools proposed by applicants must be developmentally appropriate and appropriate for use with the populations served by the home visiting program.
- For the purposes of the benchmark area-related requirements, it is recommended that data collected across all benchmark areas take into account the importance of interoperability of systems and therefore be coordinated and aligned to the extent possible with other relevant state or local data collection efforts. For example, aligning indicators or linking data on children and families served by the home visiting program, with appropriate privacy protections, to data on the same children and families served by early childhood care and education, child welfare, early intervention programs, medical

[4] Benchmark areas (which encompass the broad goals of the MIECHV program) include: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; Improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports (per Section 511 (d) (1) of the Social Security Act).
[5] A family is to be considered enrolled as of the date of the first home visit.
[6] Section 511 (d)(2)(A) of the Social Security Act.

home/primary health care, substance abuse, Medicaid, statewide immunization registries, Special Supplemental Nutrition Program for Women and Infants (WIC) or other programs is strongly encouraged.

- Utilizing forms provided by HRSA, grantees must report annually on benchmark data as well as aggregate demographic and service-utilization data on the participants in their program, as necessary to analyze and understand the progress children and families are making. Grantees will also be required to report annually on progress in achieving improvement in the six benchmark areas.

  The due date to submit these data for the first (baseline) year of program implementation will be October 2014. Individual-level demographic and service- utilization data collected by grantees should include but are not limited to the following:

  - Indicators of families' participation in the home visiting program (e.g., families receiving services, families successfully completing the program, families that terminated services, clients served under the legislatively specified priority populations[7]).
  - Demographic data for the participant children, pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services including: age in months and gender of the index child; age, racial and ethnic background of all participants in the family; index child's exposure to a language other than English; family socioeconomic indicators (e.g., family income; employment, academic or training status of care giving adults).

Technical assistance will be available to grantees to strengthen any benchmark area-related indicators or other features of the performance measurement system. The *Benchmark Technical Assistance Brief* issued in November 2011 provides additional recommendations to strengthen benchmark area-related measurement plans. The document can be found at http://www.mdrc.org/dohve/dohve_resources.html.

Overall Measurement Plan Requirements

As noted above, the program measurement system should contain information about each performance measure selected for the individual constructs under each benchmark area, including a plan for data collection and analysis for each performance measure. Specifically, for each construct the measurement system should include:

A) Name and type of performance measure selected or developed
   - For each construct within each benchmark area (e.g. "breastfeeding" under benchmark area I, Maternal and Child Health), specify one proposed indicator (e.g.,

[7] The legislatively specified priority populations include: eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under this section; low-income eligible families; eligible families who are pregnant women who have not attained age 21; eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; eligible families that have a history of substance abuse or need substance abuse treatment; eligible families that have users of tobacco products in the home; eligible families that are or have children with low student achievement; eligible families with children with developmental delays or disabilities; eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

breastfeeding at three months post-partum; breastfeeding at six months post-partum, or exclusive breastfeeding at six months post-partum).

- Indicate the type of performance measure selected. Performance measures can be process- or outcome-oriented. Process measures typically relate to program operations or implementation. Outcome measures generally capture the intended results achieved by program participants.

B) Operational definition

- Provide a detailed, specific definition of the performance measure. Describe how the value of the measure can be unambiguously constructed from the data by specifying:
  - **Key terms**: clarify the meaning of the terms utilized in the definition (e.g., what counts as "care received" or "information provided"?); describe the criteria to be used to obtain consistent data (e.g., the time window during which the measurement ought to occur such as prenatally, post-partum, first month of life, or first year of life).
  - **Subgroups of focus**: for each specific measure define the categories of participants included and excluded from the calculation (e.g., is "child" the index child, all children in the household, or all siblings 0-5 years old?).
  - **Type of scoring:** Indicate if the measure is a count, a percentage, a rate or other type of scoring. If the measure is a percentage or a rate provide a clear description of the numerator and denominator.

C) Measurement tool utilized or question(s) posed to capture the construct of interest

- If a measurement tool is utilized to capture the construct, provide evidence of its reliability/validity for the population with which the tool will be used.
- Articulate the question or questions utilized (e.g., posed by the home visitor to a parent) that would suffice, given their face validity, to capture the construct of interest when no measurement tool or scale is needed.

D) Definition of improvement

- Grantees have discretion to define improvement for each construct in a way that is meaningful for their program taking into account contextual factors and different stages of measurement system implementation across grantees. Statistically significant change is not required. Any incremental change in the desired direction will count as improvement. Maintenance of program performance at or above an acceptable target for a given construct could also constitute an instance of improvement. For example, in some instances, ongoing quality improvement efforts will result in a grantee reaching a level of performance, over time, that is considered desirable or realistically acceptable. Frequently, after testing and implementation, a period of consolidation is needed to institutionalize the change or changes that resulted in improvement and to maintain the gains achieved (i.e. making the change a day-to-day feature of the program).
- Grantees should propose a definition of improvement for each individual construct. The definition of improvement (increase, decrease, maintain above a certain level) should be based on the performance measure selected. (e.g., "Increase in the percentage of pregnant women who are screened for cigarette use at intake").
- The specific population and the points of comparison for determining change should be included in the definition. For example, "Increase the rate of mothers enrolled prenatally with adequate health insurance coverage at the index child's first birthday

for participants enrolled in year 2 compared to those enrolled in baseline year 1."

- A numeric target is not required in the definition of improvement, unless the definition includes maintenance of an acceptable performance level.
- Note whether the comparison is within a cohort or across a cohort of enrollees. An example of measuring a characteristic at two points in time for the same group of individuals would be the percent of mothers enrolled in a given year at risk for post-partum depression and the percent of the same mothers at risk of depression six months later. An example of a comparison across groups of enrollees would be the percent of mothers enrolled in baseline year one who were screened for post-partum depression during the reporting period compared to the percent of mothers enrolled in year 3 who were screened for post-partum depression during the reporting period.

E) Plan for data collection and analysis

- For all indicators under all benchmark areas, the data collection plan would include the following basic specifications:
  - The persons responsible for actually collecting the data initially at the source (e.g., the home visitor, the analyst with access to a sister agency's relevant administrative data set, etc.) and those participating in subsequent data collection steps.
  - The data source, e.g., self report by parent, home visitor's observation, or administrative data set from another agency.
  - Frequency: when and how often will data be collected (e.g., within three months of enrollment, monthly, quarterly).
  - Any other consideration including how the data will be collected (e.g., manually entered into a log, sent via tablet to a secure server, etc.), analyzed (e.g., what statistics or graphs will be used), and reported (e.g., who will receive the results and how often).
  - Indicate the population to be assessed by each performance measure (e.g., parent or index child).
  - A plan for sampling, if proposed, that includes the sample selection procedures and data to ensure the sampling approach will be representative and produce stable estimates.
  - A plan and progress made on the selection and implementation of a local data system. The plan should consider the interoperability of management information systems and the ability to perform linkages between data on children and families served by the State Home Visiting Program and data on the same children and families served by early childhood care and education programs, child welfare, medical home/primary health care, substance abuse, Medicaid, statewide immunization registries, WIC or other programs.
  - A data collection schedule including how often the data are collected and analyzed (the minimum is annually for purposes of reporting to HRSA and ACF but programs should consider more frequent data collection for CQI purposes).
  - A plan for ensuring the quality of data collection and analysis. The plan should include minimum qualifications or training requirements for administrators of measures, qualifications of personnel responsible for data management at the implementing agency, qualifications of personnel responsible for data analysis at the implementing agency, and the time estimated for the data collection-related activities by personnel categories.
  - A plan for analyzing the data. This should include how data are being

aggregated and disaggregated to assess the progress made within different communities and for different groups of children and families.

- A plan for gathering and analyzing demographic and service-utilization data on the children and families served in order to assess the progress children and families are making. This may include data on the degree of participation in services, the child's age in months, the child's race and ethnicity, the child's home language, the child's sex, the parent's education or employment, and other relevant information about the child and family.
- A plan for using benchmark measurement system data for CQI at the local program level and the community level.
- A plan for data safety and monitoring including privacy of data, administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA. The plan must include training for all relevant staff on these topics.

Technical assistance related to the benchmark area measurement requirements will continue to be available to the grantee during the implementation of the program. Requests for technical assistance post-award should be made to the MIECHV Regional Project Officer, who will be identified at the time of award. Also, the *Benchmark Technical Assistance Brief* issued in November 2011 provides additional recommendations to strengthen benchmark plans. The brief draws from previous experience across grantees in developing plans to collect, analyze and report data on benchmark areas and includes illustrations and discussions on how to define improvement in meaningful ways, clarify points of comparison, and identify measurement time frames, among other topics. The document can be found at http://www.mdrc.org/dohve/dohve_resources.html.

Individual Benchmark Areas

Listed below are the given constructs under each of the six legislatively mandated benchmark areas for which performance measures need to be proposed and tracked. Information collected by model developers for these benchmarks is collected from participants voluntarily enrolled in the home visiting program and who have provided informed consent. The collected data is aggregated for state-level data reporting and personal identifiers are not reported to the federal government.

Under each benchmark area, we offer illustrations and comments relevant to the constructs listed. These examples and suggestions are organized under the following generally accepted steps involved in indicator development: A) name and type of performance measure, B) operational definition, C) measurement tool utilized or question(s) posed, D) definition of measurable improvement, and E) plan for data collection and analysis.

I. Improved Maternal and Newborn Health

A) Name of performance measure

Constructs for which performance data must be reported under this benchmark area follow (all constructs must be measured that are relevant for the population served; if newborns are not being served, constructs related to birth outcomes will not need to be reported):

- Prenatal care
- Parental use of alcohol, tobacco, or illicit drugs
- Preconception care
- Inter-birth intervals
- Screening for maternal depressive symptoms
- Breastfeeding
- Well-child visits
- Maternal and child health insurance status (note: these data may also be utilized under the family economic self-sufficiency benchmark area)

B) Operational definition

- Percentages and rates are frequent metrics utilized for indicators corresponding to the above constructs. Examples include the percentage of children birth-to-age-three in families participating in the program who receive the recommended schedule of well-child visits during the reporting period or the percentage of mothers enrolled in the program prenatally who breastfeed their infants at six months of age.
- For certain constructs under benchmark area I, such as breastfeeding, smoking for pregnant women or prenatal care, grantees may select performance measures currently operationally defined and utilized for federal reporting under Title V Maternal and Child Health Block Grant. For information about these performance measures see:
  - Maternal and Child Health Bureau National Performance Measures- https://mchdata.hrsa.gov/TVISReports/MeasurementData/MeasurementDataMenu.aspx
  - For information on other nationally utilized indicators under this benchmark area (e.g., well child visits, maternal depression screening, health insurance coverage), see the list of measurement standards endorsed by the National Quality Forum (such as NQF # 1401, NQF #1332, NQF # 1392, NQF # 0723) at http://www.qualityforum.org/Measures_List.aspx#.
  - See also *Healthy People 2020* at http://www.healthypeople.gov/hp2020.

C) Measurement tools utilized or questions posed

- For constructs such as depression screening that require a measurement tool, grantees may define their program performance measure in such a way that accommodates the use of different scales by individual home visiting models as long as all scales utilized are considered valid and reliable for the construct and population of interest.
- Grantees should articulate the question(s) posed to participants to capture constructs that do not require a measurement tool (e.g., timing of the first prenatal care visit or actual duration of inter-birth interval).

D) Definition of measurable improvement

- For prenatal care, preconception care, inter-birth intervals, screening of maternal depression, breastfeeding, adequacy of well-child visits, and health insurance coverage, increases over time for participating mothers and infants or maintenance would constitute instances of improvement. As with other benchmark areas, once an acceptable level is reached, maintenance of performance at or above that threshold

(during a period to consolidate the gains achieved) could also count as improvement for a given construct.

- For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs, decreases in use over time would indicate improvement. A reduction in the percentage of adult participants who use alcohol, illicit drugs or tobacco may be documented for the same population or across different cohorts of participants. Alternatively, an illustration of improvement utilizing a process measure for this construct would be an increase in the rate of screening among program participants to assess use of these substances noted between the baseline year and a subsequent year.

E) Data collection plan

- Data for the constructs under this benchmark area can be collected from interviews with family members, from observations by the home visitor or through administrative data, if available, at the individual and family level.

II. Prevention of Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits

A) Name of performance measure

Constructs that must be captured and reported under this benchmark area are:

- Visits for children to the emergency department from all causes
- Visits of mothers to the emergency department from all causes
- Information provided or training of adult participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (e.g., drowning; unsafe levels of lead in tap water), and playground safety
- Incidence of child injuries requiring medical treatment
- Reported suspected maltreatment for children in the program (allegations that were screened in by the child protective service agency but not necessarily substantiated)
- Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
- First-time victims of maltreatment for children in the program

B) Operational definition

- For reductions in emergency department visits: the operational definition could include emergency department visits divided by the number of children or mothers enrolled in the program.
- For training or information related to child injury prevention: the construct may be reported as the percentage of participants who receive information or training on injury prevention by the total number of families participating in the program. Criteria for what constitutes adequate training or information should be spelled out (i.e., operationalized).
- For reduction of incidence of child injuries: the performance measure selected would likely include child injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) for children participating in the

program.

- For child abuse, neglect and maltreatment, the denominator used in the calculation of the rate or percentage in the definition could include all children participating in the program.
  - The rate for suspected maltreatment is the number of cases of suspected maltreatment of children in the program, divided by the number of children in the program.
  - The rate for substantiated maltreatment should be calculated by counting the number of cases of substantiated maltreatment of children in the program and dividing by the number of children in the program.
  - To calculate the rate of first-time victims count the number of children in the program who are first-time victims divided by the total number of enrolled children in the program. A first time victim is defined as a child who:
    - had a maltreatment disposition of "victim" and
    - never had a prior disposition of victim

C) Measurement tools or questions posed to participants

- Injury-related medical treatment includes ambulatory care, emergency department visits, and hospitalizations due to injury or ingestions.
- For child abuse, neglect and maltreatment it is preferred that data be collected through administrative data provided by the state and local child welfare agencies. Grantees may propose collecting the data through self-report or direct measurement if the assessment utilizes a valid and reliable tool.
- Please see the Compendium issued by HRSA and ACF for resources and measurement tools for this and other benchmark areas.[8]

For additional information on child injury and maltreatment, see:

- Child Maltreatment; and List of the state contacts for National Child Abuse and Neglect Data System collection, available at: http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf#page=155
- National Data Archive on Child Abuse and Neglect (NDACAN): http://www.ndacan.cornell.edu.
- Centers for Disease Control and Prevention: http://www.cdc.gov/injury/
- National Health Survey: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2010/english
- Children's Safety Network and Child Death Review Resource Center's Best Practices website: http://www.childinjuryprevention.org/
- Children's Safety Network: State Injury Prevention Profiles:

[8] http://www.mdrc.org/dohve/dohve_resources.html.

http://www.childrenssafetynetwork.org/states

D) Definition of measurable improvement

- Improvement for individual performance measures under this benchmark area would include decreases over time for constructs other than information provided or training on preventing child injuries, for which an increase over time would count as improvement.

E) Data collection plan

- For reductions in emergency department visits and child injury prevention: data source options include participant report, medical records, emergency department patient records or hospital discharge systems.

III. Improvements in School Readiness and Achievement

A) Name of performance measure

Constructs for which an indicator must be selected and reported under this benchmark area are:

- Parent support for children's learning and development (e.g., having appropriate toys available, talking, and reading with their child)
- Parent knowledge of child development and of their child's developmental progress
- Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
- Parent emotional well-being or parenting stress (note: some of these data may also be captured for maternal health under benchmark area I)
- Child's communication, language, and emergent literacy
- Child's general cognitive skills
- Child's positive approaches to learning including attention
- Child's social behavior, emotion regulation, and emotional well-being
- Child's physical health and development

For more information see:

- http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html
- http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/eecd/Assessment/Child%20Outcomes/eduev_art_00090_080905.html
- Kagan, S. L., Moore, E., & Bradekamp, S. (1995). Reconsidering children's early development and learning: Toward common views and vocabulary. Washington, DC: National Education Goals Panel, Goal 1 Technical Planning Group. (See Child Trends summary here: http://www.childtrends.org/schoolreadiness/testsr.htm#_Toc502715209)

B) Operational definition

- Depending on the measure selected and the grantee plan for using the data, the definition of the performance measure could incorporate scale scores and thresholds when available. A score would be the calculated score for the individual

scale utilized. The scale scores should be calculated as instructed in the manual or other documentation provided by the measurement tool developer. The operational definition for the performance measures under this benchmark area could center on, for instance, the percentage of participants who are screened as being at risk at a point in time (e.g., the proportion of enrolled children screened at age one during the reporting period who appear at risk for language delay).

C) Measurement tools or questions posed to participants

- Suggested ideas or sources for scales within the area of "Improvements in School Readiness and Achievement" are included in the Compendium of measurement tools or scales issued by HRSA and ACF mentioned above, which can be found at http://www.mdrc.org/dohve/DOHVE%20TA%20Compendium_Updated.pdf.

D) Definition of measurable improvement

- For example, an increase over time (e.g., between baseline Year 1 and Year 3) in the screening rates for children of a certain age (e.g., one year old) enrolled in the program would constitute an instance of improvement utilizing a process measure (in this case involving a comparison across cohorts).
- For example, the reduction between two assessment points in the percentage of enrolled children (who are screened utilizing age-appropriate scales) at risk of developmental delays would show desirable change utilizing an outcome measure.

E) Data collection plan

- Data can be collected from a variety of sources including observation (e.g., by teacher, home visitor or other independent observer), direct assessment with a measurement tool, administrative data or health records (e.g. program-specific clinical information systems), parent-report, or teacher-report.

IV. Reduction in Crime or Domestic Violence

The legislation includes a requirement for grantees to report on reduction in "crime or domestic violence." States and non-profit organizations are not required to report on both domains, but must report on at least one.

Crime

A) Name of performance measure

If the grantee chooses to report crime, constructs that must be reported for this benchmark area for caregivers served by the home visiting program are:

- Arrests
- Convictions

B) Operational definition

- Data may be reported as annual aggregate rates for adults participating in the program.

C) Measurement tools

- Questions posed could distinguish the reason for the arrest or conviction.

D) Definition of measurable improvement

- For family-level crime rates, improvement may be defined as rate decreases over time in the arrests and/or convictions.

E) Data collection plan

- Data may be collected from interviews and surveys with families (i.e., with validated and reliable instruments) or through administrative data if available at the individual level.

Domestic Violence

A) Name of performance measure

If the grantee chooses to report on domestic violence, constructs for which performance measures must be reported under this benchmark area (all constructs must be measured) include:

- Screening for domestic violence
- Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters)
- Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.

B) Operational definition

- Depending on the measure used for each construct and the grantee plan for using the data, the data reported could incorporate the following:
  - Percentage of screenings for domestic violence of program participants.
  - With respect to referrals and safety plans, indicators for these constructs that are scored as percentages could include in the numerator the number of referrals to appropriate identified services and the number of safety plans completed respectively; the denominator would include the total number of identified participants in need of these services.

C) Measurement tools or questions

- For more information, please see the Compendium of measures at http://www.mdrc.org/dohve/dohve_resources.html.

D) Definition of measurable improvement

- For screenings, improvement could be defined as increases in the percentage of participants screened over time.

- For referrals related to domestic violence, improvement could be defined as an increase in the proportion of participants referred over time.
- For completion of safety plans related to domestic violence, improvement could be defined as an increase over time in the proportion of completed plans for participants who need them.

E) Data collection plan

- For family-level data, data can be collected from interviews and surveys with families using either administrative data or reliable and valid measures.

For more information, see:

- http://eccs.hrsa.gov/Resources/docs/4.6HVDOHVE_TA_Compendium_508C.pdf
- http://www.cdc.gov/ncipc/dvp/Compendium/Measuring_IPV_Victimization_and_Perpetration.htm
- http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/datasources.html

V. Improvements in Family Economic Self-Sufficiency

A) Name of performance measure

Constructs for which performance measures must be reported under this benchmark area (all constructs must be measured) are:

- Household income (including earnings, cash benefits, and in-kind and non-cash benefits)
- Employment or education of participating adults
- Health insurance status of participating adults and children

B) Operational definition

- Household includes the person(s) enrolled in the home visiting program funded by MIECHV. At a minimum this category should include the primary enrolled adult in the home visiting program. This unit of analysis can extend to more than one member of the household if more than one adult is enrolled in the program, participate in home visits or otherwise contributes to the support of the index child or pregnant woman.
- Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private, e.g., rent from tenants/boarders, cash assistance from friends or relatives, or they may be linked to public systems, i.e. child support payments, TANF, Social Security (SSI/SSDI/OAI), and Unemployment Insurance. In-kind benefits include non-cash benefits such as nutrition assistance programs (including SNAP, WIC, etc.), energy assistance, housing vouchers, etc. and could be estimated as the value of the benefit received.

C) Measurement tools or questions

- Programs may collect all sources of income and the amount gathered from each source. Alternatively, grantees could report on the aggregate amount received from

all sources during the reporting period by the adults in the household participating in the program.

- For in-kind and non-cash benefits, programs should capture program participation among eligible participant households. At their discretion, programs can collect/impute the value of in-kind benefits and add such benefits as a source of income. In either case, HRSA strongly recommends that home visitors discuss with participants available benefits for which the family may qualify.
- With respect to employment, grantees should collect the number of months employed in a year or the average hours per month worked by those participating adults.
- With respect to educational achievement, data collected should include either program completion/degree attainment or hours per month spent by participating adult household member in educational programs.
- Include health insurance status of all participants in the program or, at a minimum, of index child and primary enrolled adult.

D) Definition of measurable improvement

- For household income, improvement could be defined as: an increase in total household income over time; or an increase in income from earnings or employment; or an increase in the take-up of in-kind benefits among program participants; or an increase in the total amount of income and the value of in-kind benefits.
- Note: the second construct above refers to employment or education. We recognize that there can be an inverse relationship between the two in the short-run, i.e., while people are pursuing education, they may reduce their participation in the labor force, and vice versa. Therefore, sites should measure both of these related components but reporting on an improvement in one or the other shall be considered sufficient to show positive results for this construct.
    - For employment, improvement could be defined as an increase between two comparison points in time in the number of paid hours worked plus (up to 30) unpaid hours devoted to care of an infant by all participating adults.
    - For education, improvement could be defined as an increase in the educational attainment of participating adults over time or hours per month spent by participating adult household members in educational programs. Educational attainment may be defined by the completion not only of academic degrees, but also of training or certification programs.
- For health insurance status, improvement could be defined as an increase over time in the number of participating household members (or at a minimum of the index child and primary enrolled adult) who have adequate health insurance or maintenance of adequate insurance coverage for all participants.

E) Data collection plan

- Data may come from interviews or surveys with families. Data on child support and public benefit receipt may be gathered or verified from the relevant agencies, if data- sharing agreements can be developed. For employment, family-level data may also be gathered or verified using Unemployment Insurance data.
- For the purposes of federal reporting, family economic self-sufficiency data would be collected for the month of enrollment and the month one-year post enrollment.

The following are suggested sources for ideas, questions or measures within the area of "Family Self-Sufficiency:"

- "Observations from the Interagency Technical Working Group on Developing a Supplemental Poverty Measure," March 2010, http://www.census.gov/hhes/www/povmeas/SPM_TWGObservations.pdf.
- "National Directory of New Hires," http://www.acf.hhs.gov/programs/css/resource/a-guide-to-the-national-directory-of-new-hires
- Evaluation Data Coordination Project http://www.acf.hhs.gov/programs/opre/other_resrch/eval_data/index.html

VI. Improvements in Coordination and Referrals for Other Community Resources and Supports

For the purposes of the measurement system for improvement in home visiting, referrals include both internal referrals (to other services provided by the local organization implementing the program) and external referrals (to services provided in the community but outside of the local agency). As part of their initial and ongoing needs assessments, grantees should track the number of services available and appropriate for the participants in the program. The constructs related to coordination include capturing linkages both at the agency and the individual family level.

A) Name of performance measure

Constructs for which performance measures must be reported under this benchmark area are:

- Number of families identified for necessary services;
- Number of families that required services and received a referral to available community resources;
- Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided);
- MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community;
- Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies.

B) Operational definition

- With respect to families identified for necessary services, a percentage could be calculated, for example, as the number of families screened divided by the total number of families enrolled in the program during the reporting period. The need or needs for which participants are screened and the corresponding services provided should be defined.
- For families that required a specific service and received the appropriate referral, the performance measure could be calculated as a percentage (with the numerator and denominator respectively being the number of families who received the referral and the total number of families or participants identified as needing the

service of interest).

- For completed referrals, the definition of the performance measure could involve the proportion of referrals of participating families with identified needs whose receipt of service was verified, divided by the total number of participating families with identified needs, or by the total number of families who received a referral from the home visitor.
- With respect to formal agreements and communications with other agencies, grantees could report the total number of social service agencies with which the implementing organizations have an MOU and/or regular communication.

C) Measurement tools and/or questions posed to participants

For resources and examples of measures in this benchmark area, please see the *Optional Tool for the Measurement of Coordination and Referral Benchmark Constructs* issued by HRSA and ACF and available at http://www.mdrc.org/dohve/dohve_resources.html.

D) Definition of measurable improvement

- A meaningful definition of improvement for the first construct would involve an increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes.
- For families in need of specific services, program improvement would entail an increase over time in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities.
- For number of completed referrals: Increase in the percentage of families or individual participants with referrals for whom receipt of services can be confirmed.
- For MOUs: Increase in the number of formal agreements with other social service agencies.
- Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider.

E) Data collection plan

- Data for each of the constructs can be collected through direct measurement by the home visitors and/or administrative data provided by the local agency.

Section 6: Administration of the State Home Visiting Program

Applicants must include a description of the administrative structure in place to support the State Home Visiting Program. Applicants must also present a plan that indicates how the State Home Visiting Plan will be managed and administered. A description must be included of the existing community service and administrative structures available to support the State Home Visiting Program, such as availability of referral services, management capacity, and other essential structures.

In providing this description, please identify the following:

- The organization that is proposing to administer the program, including a discussion of the organization's established record of providing successful early childhood home visiting programs or initiatives in a state or several states; a list of

proposed collaborative partners in the private and public sector;
- An overall management plan for the program that describes who will be responsible for ensuring the successful implementation of the State Home Visiting Program;
- If the applicant proposes to provide more than one home visiting model within a community, a plan for coordination of referrals, assessment, and intake processes across the different models (e.g., a detailed plan for centralized intake, as appropriate);
- If the applicant is supporting a subcontract, a plan for monitoring subcontractor performance;
- Job descriptions for key positions, including resumes; and
- An organizational chart.

The narrative must also include a detailed description of how the proposed State Home Visiting Program will meet the legislative requirements, including:

- Well-trained, competent staff;
- High quality supervision;
- Strong organizational capacity to implement activities involved;
- Referral and service networks available to support the home visiting program and the families it serves in at-risk communities; and
- Monitoring of program implementation to ensure services are delivered with fidelity to a specified model.
- Plans to comply with any model-specific prerequisites for implementation, including those discussed in the implementation profiles available on the HomVEE website (http://homvee.acf.hhs.gov/);

Efforts should be made to coordinate the MIECHV program, to the extent feasible, with the state's early childhood programs including the State Advisory Council (SAC) and State Early Childhood Comprehensive Systems (ECCS) program. The narrative should address any collaborations established with any state early childhood initiatives as identified earlier in this document.

Section 7: Plan for Continuous Quality Improvement Program

The use of Continuous Quality Improvement (CQI) methods is likely to result in more effective program implementation and improved participant outcomes. Through consistent data collection and its regular use, home visiting programs can identify and rectify impediments to effective performance as well as document changes and improvements.[9] For these reasons, it is expected that the program will benefit from the grantee's development of a CQI Plan and structure for oversight of its data system, human resources, and program implementation.

Widespread use of the CQI approach in the prevention field has been encouraged for several reasons. A CQI approach has the potential to:

[9] R Ammerman et al. Development and Implementation of a Quality Assurance Infrastructure in a Multisite Home Visiting Program. *Journal of Prevention and Intervention in the Community.* 2007.

- Provide a means for community-based programs to benchmark their processes and outcomes and thus document results in the absence of comparison groups;
- Inform the adaptation of evidence-based home visiting models to the unique community settings in which they are implemented, taking advantage of local insights;
- Develop and incorporate new knowledge and practices in a data-driven manner;
- Inform programs about training and technical assistance needs;
- Help monitor fidelity of program implementation;
- Strengthen referral networks to support families; and
- Identify key components of effective interventions.

Accordingly, the applicant must provide a plan for a CQI program with a description of how CQI strategies and processes will be utilized. For the purposes of this funding opportunity announcement, applicants must describe the CQI plan and strategies that include but are not exclusive of:

- Description of the CQI leadership at all levels of the State Home Visiting Program and how accountable parties will involve the entire staff and subcontractors in the process.
- Personnel assigned to CQI;
- Administrative schedule of CQI cycle review(s) and feedback;
- Instruments and CQI tools deployed;
- Status of data systems deployed for CQI purposes;
- Description of data quality control;
- A matrix for the CQI data collection processes, reporting structure, timelines and frequency;
- Community and model specific CQI data collection processes, reporting structure, timelines and frequency;
- Description of the CQI priorities;
- Description of the relevant subjects of CQI in home visiting may include:
    - The home visitor
    - The home visit occurrence
    - Content of the home visits
    - The home visitor/family relationship
    - Supervision and management of home visiting
    - Benchmark area-related indicators (or a subset)
    - Universal screening and coordinated intake (outreach, screening, and referral for ancillary services
    - Interface and networking in the early childhood system.

Applicants are reminded that technical assistance will be provided on CQI systems.

Section 8: Technical Assistance Needs

HRSA intends to provide training and technical assistance to grantees throughout the implementation of the MIECHV program. HRSA will use a multi-dimensional and multi-faceted approach and will provide technical assistance including collaboration and coordination with other Federal Government agencies and the national model developers.

HRSA anticipates providing technical assistances in several areas to complement existing technical assistance efforts provided by home visiting models and institutions of higher learning, including: conducting ongoing needs assessments; strategic planning; collaboration and partnerships; communication and marketing; fiscal leveraging; implementing and supporting home visiting programs; selecting home visiting model(s) to meet the target populations' needs; data and information systems; special topical issues (e.g., substance abuse, mental health, domestic violence, tribal, and rural issues); continuous quality improvement/quality assurance; workforce issues; developing training systems; participant recruitment and retention; sustainability; and program evaluation. The list of topics is not meant to be exhaustive and HRSA intends to tailor technical assistance to meet needs identified by grantees.

Applicants should include a description of anticipated technical assistance needs.

Section 9: Meeting Reporting Requirements

The narrative should include assurance that the applicant will report on annual benchmark data (in October 2014) utilizing the Discretionary Grant Information System (DGIS) and related forms (see Appendix F). In addition, an assurance should be included that the applicant will submit a Non-Competing Continuation progress report prior to the end of the project year to address the components listed in Section VI.3. For both types of reports, applicants will be notified in advance of the specific due dates and formatting requirements for submission. For more details, please refer to Section VI. 3. Reporting of this funding opportunity announcement.

x. Program Specific Forms

Program specific forms for annual data reporting will be required. See Appendix F.

xi. Attachments

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit (80 pages). **Each attachment must be clearly labeled**.

Attachment 1: *Project Logic Model*

Attachment 2: *Project Timeline*

Attachment 3: *Project Organizational Chart*

Provide a one-page figure that depicts the organizational structure of the program, including subcontractors and other significant collaborators.

Attachment 4: *Staffing Plan and Job Descriptions for Key Personnel*

Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 5: *Biographical Sketches of Key Personnel*

Include biographical sketches for persons occupying the key positions described in Attachment 4, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of

commitment from that person with the biographical sketch.

Attachment 6: *Description(s) of Proposed/Existing Contract (subcontracts)*

Provide any documents that describe working relationships between the applicant organization and other agencies and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any deliverable. Letters of agreement must be dated.

Attachment 7: *References and Citations*

Attachment 8: *Model Developer Approval Letter(s)*

For each home visiting model proposed for implementation, the applicant must provide documentation of approval by the developer to implement the model as proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted, including any proposed adaptation, support for participation in the national evaluation, and any other related HRSA efforts to coordinate evaluation and programmatic technical assistance. This documentation should include the applicant's status with regard to any required certification or approval process required by the developer.

Attachment 9: *Maintenance of Effort Chart*

Applicants must complete and submit the following information:

NON-FEDERAL EXPENDITURES

FY 2011 (Actual)	FY 2012 (Estimated)
Actual FY 2011 non-federal funds, including in-kind, expended for activities proposed in this application. If proposed activities are not currently funded by the institution, enter $0. Amount: **$** _____	Estimated FY 2012 non-federal funds, including in-kind, designated for activities proposed in this application. Amount: **$** _____

Attachment 10: *Documentation of Nonprofit Status*

Attachment 11: *Letters of Support*

Applicants must provide letters of support signed by relevant partner agencies signifying approval of the proposed plan for a State Home Visiting Program. Upload current dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the project.

For purposes of meeting requirements for this funding opportunity announcement for a State Home Visiting Program, applicants must provide letters of support from organizations addressing one or more of the following issues:

- Maternal and child health;

- Child abuse prevention and treatment;
- Child welfare;
- Substance abuse and treatment services;
- Child care and development;
- Head Start;
- Early childhood education and care; and
- Elementary and secondary education or pre-kindergarten programs.

The applicant is encouraged to coordinate this application to the extent possible with:

- Domestic Violence Coalitions;
- Mental Health agencies;
- An agency charged with crime reduction;
- Organizations that assist with access and enrollment in benefit programs such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and WIC; and
- An Injury Prevention and Control program (if applicable).

Attachments 12 – 15: *Other Relevant Documents*
Include here any other documents that are relevant to the application.

3. Submission Dates and Times

Application Due Date
The due date for applications under this funding opportunity announcement is *February 15, 2013 at 11:59 P.M. Eastern Time*. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically to the correct funding opportunity number by the organization's Authorized Organization Representative (AOR) through Grants.gov and validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages to document the progress of an application through the system.

1) The first will confirm receipt in the system;
2) The second will indicate whether the application has been successfully validated or has been rejected due to errors;
3) The third will be sent when the application has been successfully downloaded at HRSA; and
4) The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

Late applications:
Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

4. Intergovernmental Review

The Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows states the option of setting up a system for reviewing applications from within their states for assistance under certain federal programs. Application packages made available under this funding opportunity will contain a listing of states which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Specialist listed in the Agency Contact(s) section, as well as from the following Web site: http://www.whitehouse.gov/omb/grants_spoc.

All applicants other than federally recognized Native American Tribal Groups should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the state's process used under this Executive Order.

Letters from the SPOC in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project and budget period of up to three and a half years, at no more than $16,205,648 in FY13 (for costs incurred during the period of availability of April 1, 2013 through September 30, 2015) and no more than $5,975,876 in FY14 (for separate costs incurred during the period of availability April 1, 2014 through September 30, 2016) for a project proposed to be conducted in **Florida**.

Applicants responding to this announcement may request funding for a project period of up to three and a half years, at no more than $3,567,800 in year one (for costs incurred during the period of availability April 1, 2013 through September 30, 2015) and no more than $1,000,000 in year two (for separate costs incurred during the period of availability of April 1, 2014 through March 31, 2016) for a project proposed to be conducted in **Wyoming**.

Per statute, funds made available to a grantee for a fiscal year shall remain available for expenditure by the grantee through the end of the second succeeding fiscal year after award. Funds that have not been obligated for expenditure during the specified period of availability will be deobligated.

Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Applications with budget requests exceeding the ceilings specified above will be deemed noncompliant and will not be considered for funding. These applications may be returned without further review.

Pre-award costs are allowable up to (and including) 90 days prior to the grant start date with Grants Management Officer approval. These costs are allowable only to the extent that they would have been allowable if incurred after the date of the award and only with the written approval of the awarding agency.

Administrative expenditures cap:
No more than 10 percent of the award amount may be spent on administrative expenditures. Please see *IV. 2. iv. Budget Justification* for more details.

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases, HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are ***required*** to submit ***electronically*** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at http://www.grants.gov. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that organizations ***immediately register*** in Grants.gov and become familiar with the Grants.gov site application process. Applicants that do not complete the registration process you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary to complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with the System for Award Management (SAM)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's SAM "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at http://www.grants.gov. Assistance is also available 24 hours a day, 7 days a week (excluding federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, an organization is urged to submit an application in advance of the deadline. If an application is rejected by Grants.gov due to errors, it must be corrected and resubmitted to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the Grants.gov application due date as the final and only acceptable application.

Tracking an application: It is incumbent on the applicant to track application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at https://apply07.grants.gov/apply/checkApplStatus.faces**.** Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. The MIECHV program has six (6) review criteria:

Criterion 1: NEED (15 points) *– Refer to Narrative Section: "Needs Assessment, Identification of Targeted At-Risk Communities, and Community Understanding and Engagement."*

Building on the targeted community needs assessment and the State Home Visiting Plan, the proposal should justify and provide the rationale for the selection of communities proposed to be served (or improvements/enhancements proposed).

In determining the need for the project, the following factors will be considered:

- The rationale for selecting the community(ies) at risk for which services are proposed; and

- The extent to which the applicant clearly describes the problem and the need of targeted at-risk communities for services;

Criterion 2: RESPONSE (20 points) *– Refer to Narrative Section's "Goals and Objectives" and "Selection of Proposed Home Visiting Models…"*

(a) Purpose, Goals, and Objectives

The extent to which the proposed project responds to the "purpose" included in the program description as well as the strength of the proposed goals and objectives and the relationship to the identified project. In determining these aspects of the proposal, the following factors will be considered:

- The extent to which the activities described in the application are sufficient to address the identified problem and attaining the project objectives; and

- The extent to which the proposed project has a clear set of goals and an explicit strategy (i.e., logic model), with actions that are (i) aligned with the priorities the applicant is seeking to meet, and (ii) expected to result in achieving the goals, objectives, and outcomes of the proposed project.

(b) Fit of the Proposed Home Visiting Model(s) with Community(ies) Needs

In determining fit with goals and capacities, the following factors will be considered:

- Fit of the selected model(s) with the needs of each of the at-risk community(ies) identified by the applicant;

- The appropriateness of the proposed intervention to meet identified community needs;

- The extent to which the applicant clearly describes the anticipated benefit of the proposed project; and

- Local conditions and capacities that increase the likelihood of successful model implementation, as well as any anticipated challenges or risks to successful implementation. Reviewers are looking for proposals that emphasize fit of the model to the specific needs of the targeted community(ies).

Criterion 3: IMPACT (25 points) – Refer to Narrative Section's *"Implementation Plan"*

The strength of the proposed implementation plan and the extent to which the activities described in the application are capable of attaining the proposed objectives for:

(a) Program and Community Impact

- Providing program assessment and support, monitoring, and technical assistance;

- Providing training and professional development;

- Recruiting and retaining program participants;

- Ensuring effective implementation, with fidelity to the model;

- Engaging the community(ies) around the proposed plan;

(b) Community Collaboration to Promote Home Visiting within an Early Childhood System

- The extent to which the applicant demonstrates a quality plan for engaging community stakeholders in the design and successful implementation of the State Home Visiting Program.

- The extent to which the applicant articulates a plan for ensuring successful implementation of the State Home Visiting Program, including monitoring of subcontracts, coordination of multiple models, and coordination and collaboration with other early childhood programs and other community entities.

Criterion 4: PLAN FOR DATA COLLECTION AND REPORTING ON BENCHMARK AREAS[10] (20 points) – Refer to Narrative Section's *"Meeting Legislatively- Mandated Reporting on Benchmark Areas…"*

- The extent to which the indicators or performance measures associated with the constructs provided under the six benchmark areas are clearly operationally defined (e.g., if the type of scoring is a percentage or rate, the numerator and denominator are sufficiently specified including population of participants involved)

- The appropriateness of measurement tools or questions asked to capture the information relevant to the selected indicator.

- The rationale for the selected indicators articulated, and the extent to which the comparisons utilized in the definition of improvement are clearly stated.

- The plan for utilizing the process and/or outcome indicators (or a subset of the indicators) under the six benchmark areas as input for CQI, including frequency of collection, clarification of persons responsible for obtaining the data, specificity about how the data will be collected and analyzed (what statistics or graphs will be utilized) and reported (e.g., who will receive the results and how frequently, including members of the CQI teams, etc.

Criterion 5: RESOURCES AND CAPABILITIES (10 points) *– Refer to Narrative Section's "Implementation Plan," "Administration," "Plan for Continuous Quality Improvement," and "Meeting Reporting Requirements"*

The capabilities of the applicant organization, the facilities, and the proposed personnel to fulfill the needs and requirements of the proposed project. The application will also be evaluated based on the experience of the applicant with implementing efforts related to the proposed project, including experience in implementing home visiting programs. In determining scoring under this review criterion, the following factors will be considered:

[10] The measurement plan for the benchmark areas will be subject to further post-award review by the Regional Project Officer, other MIECHV staff, model developers involved, and/or technical assistance contractors. Final approval of the plan will be made by the Regional Project Officer after this post-award review.

- The extent to which the applicant demonstrates an established record of providing early childhood home visiting programs or initiatives in a state or several states;

- The extent to which the applicant proposes to reach an appropriate number of individuals through the proposed project and has the capacity to reach the proposed number of individuals during the course of the grant period;

- The extent to which systems are in place to monitor CQI; and

- The extent to which project personnel are qualified by training or experience to implement and carry out the projects.

Criterion 6: SUPPORT REQUESTED (10 points) *– Refer to Budget Section*

The reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the proposed activities, the number of families to be served, and the anticipated results. The following will be taken into consideration:

- The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work; and

- The extent to which key personnel have adequate time devoted to the project to achieve project objectives.

- The inclusion in travel expenses an allowance for program staff to attend one meeting in the Washington, DC area and one regional meeting each year.

- The clarity of the budget justification narrative fully explaining each line item. For subsequent budget years, the extent to which changes from year one are highlighted;

- If a promising approach is proposed in addition to an evidence-based home visiting model, the extent to which the budget demonstrates that at least 75 percent of resources will be allocated toward evidenced based programs.

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in Section V. 1. Review Criteria of this funding opportunity announcement. The review criteria are designed to enable the review

panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to April 1, 2013.

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award (NoA) sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of April 1, 2013.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92 Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

Non-Discrimination Requirements
To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see http://www.hhs.gov/ocr/civilrights/understanding/index.html. HHS also provides specific

guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P.L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.

Trafficking in Persons
Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.html.

Smoke-Free Workplace
The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Cultural and Linguistic Competence
HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA funded programs embrace a broader definition to incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15. Additional cultural competency and health literacy tools, resources and definitions are available online at http://www.hrsa.gov/culturalcompetence and http://www.hrsa.gov/healthliteracy.

Healthy People 2020
Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the

achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at http://www.healthypeople.gov/.

National HIV/AIDS Strategy (NHAS)
The National HIV/AIDS Strategy (NHAS) has three primary goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see http://www.aidsinfo.nih.gov/Guidelines/Default.aspx as a reliable source for current guidelines). More information can also be found at http://www.whitehouse.gov/administration/eop/onap/nhas.

Health IT
Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- Health Information Technology (HHS)
- What is Health Care Quality and Who Decides? (AHRQ)

3. Reporting

a. Audit Requirements

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

b. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to http://www.dpm.psc.gov for additional information.

c. Status Reports

1) **Federal Financial Report**. The Federal Financial Report (SF-425) is required according to the following schedule: http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the NoA.

2) **Program-Specific Data Reporting**
Program-specific data reporting forms include five DGIS forms plus two program-specific data forms (see Appendix F). The successful applicant shall comply with the requirement for submission of an annual program-specific data report to HRSA in October 2014. Grantees will be notified in advance of the specific due dates and formatting requirements for submitting this report.

3) **Non-competing Continuation (NCC) Progress Report(s).** The awardee must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of grantee Progress Report(s) triggers the budget period renewal and release of subsequent year funds. The successful applicant shall comply with the legislative requirement for submission of an annual report (one year and thirty days post date of issuance of the individual grantee's NoA) to HRSA regarding the program and activities carried out under the program.

Grantees will be notified in advance of the specific due dates and formatting requirements for submitting this report. This report shall address the following:

Home Visiting Program Goals and Objectives

(1) Progress made under each goal and objective for the MIECHV program during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them;

(2) Any updates/revisions to goal(s) and objectives previously identified;

(3) To the extent not articulated above, a summary regarding efforts to contribute to a comprehensive high-quality early childhood system, including collaboration as follows:

- Patient-Centered Medical Home initiatives and partners, e.g., Joint Principles Statement by the: American Academy of Pediatrics (AAP), American Academy of Family Practice (AAFP), American College of Physicians (ACP); the American College of Obstetricians and Gynecologists (ACOG);
- Bright Futures, Reach Out and Read, AAP State Chapter initiatives;
- Title V programs, e.g., Children with Special Health Care Needs, Healthy Start, Newborn Screening, Newborn Hearing Screening, Childhood Injury Prevention;
- Other HRSA programs e.g., Community Health Centers, HIV/AIDS;

- Other federal programs, e.g., ACF Tribal MIECHV funded program.

(4) Updates or changes to the logic model, if necessary.

(5) Confirmation or whether progress is on track with the implementation timeline proposed in this application, and if not, updates or changes to the timeline

Home Visiting Promising Program Update

(1) Update on successes and barriers and to implementation of the State Home Visiting Program overall;

(2) Updates on the grantee's evaluation of any promising approaches, if being implemented;

Progress toward Implementing Home Visiting Program(s) in the Targeted At-risk Community(ies)

Updates regarding experience in planning and implementing the home visiting programs for each of the selected at-risk communities, addressing each of the items listed below. Where applicable, applicants should discuss any barriers/challenges and successes encountered in the specific community(ies) where the program is being implemented and steps taken to overcome identified barriers/challenges.

- Update on progress in engaging the targeted at-risk community(ies) in the proposed plan;
- Update on any additional at-risk community selection;
- Update on work/activities completed to date in all selected communities based on the proposed timeline;
- Update on work to-date with national model developer(s) and a description of the technical assistance and support provided through the national model(s) in each of the selected communities;
- Update on work to-date with promising approaches and a description of the technical assistance and support provided to each of the applicable communities;
- Where applicable, update on technical assistance received from Technical Assistance Coordinating Center (TACC) or other federally-contracted technical assistance;
- Based on the timeline provided, an update on securing curricula and other materials needed for the State Home Visiting Program;
- Update on training and professional development activities provided by the national model developer(s), by the implementing organization, or by any other sources;
- Update on the plan for implementation of high quality supervision and reflective practice for all home visitors and supervisors;
- Update on staff recruitment, hiring, staffing ratios and retention for all positions, including subcontracts;
- A list of all staff hired with MIECHV funds and the percent of each staff person's effort dedicated to this grant. Please include in-kind staff in this list.
- Update on participant recruitment, attrition, retention efforts, and timeline to maximum caseload;

- Update on referral, intake and screening process(es);
- Status of the MIECHV program caseload within each at-risk community;
- Update on the community-level coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services), including collaboration with other HRSA grantees (community health centers, HIV/AIDS programs, Healthy Start, etc); and
- A discussion of challenges to maintaining quality of and fidelity to each home visiting model being implemented and the proposed CQI plan and response to the issues identified.

Progress toward Meeting Legislatively Mandated Benchmarks

Update on data systems and data collection efforts for each of the six benchmark areas, which would include an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, success as well as barriers/challenges encountered during data collection efforts, and steps taken to overcome them.

Home Visiting Program's CQI Efforts

Update on the grantee's progress in planning and implementing a CQI program for the State Home Visiting Program, including infrastructure; priority issues identified, processes to address them, and tools utilized; and data-driven findings to date.

Administration of the State Home Visiting Program

- Updated organization chart, if applicable;
- Updates regarding changes to key personnel,[11] if any (include resumes for new staff, if applicable); and
- Updates on the creation, development, dissemination, and implementation of policies to support integration of the State Home Visiting Program into a comprehensive early childhood system.

Technical Assistance Needs

Please provide:

- An update on technical assistance received to date.
- A description of anticipated need for technical assistance with implementing the State Home Visiting Program.

4) **Final Report(s).** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal, and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted online by awardees in the Electronic Handbooks system at https://grants.hrsa.gov/webexternal/home.asp.

[11] Changes in key personnel require prior approval by HHS.

d. Transparency Act Reporting Requirements

New awards ("Type 1") issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of $25,000 or more in federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at http://www.hrsa.gov/grants/ffata.html). Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the Notice of Award.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this grant announcement by contacting:

Mickey Reynolds
Grants Management Specialist
HRSA Division of Grants Management Operations,
OFAM Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0724
Fax: (301) 443-6686
Email: mreynolds@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Angela Ablorh-Odjidja, JD, MHS
Division of Home Visiting and Early Childhood Systems
Health Resources and Services Administration
Maternal and Child Health Bureau
Parklawn Building, Room 10-86
5600 Fishers Lane
Rockville MD 20857
Email: aablorh-odjidja@hrsa.gov
Telephone: (301) 443-8932
Fax: (301) 443-8918

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: http://grants.gov/iportal

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

A Technical Assistance Webinar is scheduled for the FY 2013 application cycle on Wednesday, December 19, 2012, at 3:00 pm ET. Webinar and registration information is available on the Maternal and Child Health Bureau Home Visiting Technical Assistance Website at http://mchb.hrsa.gov/programs/homevisiting/ta/training/index.html. The webinar will help prepare applicants for the FY 2013 application period, highlight significant program requirements, and offer participants an opportunity to ask questions.

For additional information, please refer to Appendices A through F.

Periodic technical assistance has been provided to grantees under the MIECHV program. Such technical assistance has included webinars, briefs on benchmark data collection and evaluation of promising approaches, and other assistance. Technical assistance that has been provided to date is available on line and may be accessed by clicking on http://mchb.hrsa.gov/programs/homevisiting/ta/index.html.

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance webpage to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The website can be accessed online at: http://www.hrsa.gov/grants/apply/index.html.

In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: http://dhhs.gov/asfr/ogapa/grantinformation/apptips.html.

APPENDIX A: MODELS THAT MEET THE CRITERIA FOR EVIDENCE BASE

This appendix lists the models that meet the criteria for evidence of effectiveness for the MIECHV program. HRSA intends to continue to review the available evidence of effectiveness for other home visiting models. In prioritizing models for review, HRSA will use the criteria described on the HomVEE website (*http://homvee.acf.hhs.gov/*) and will also take into consideration state requests. HRSA will re-review models previously determined not to meet the evidence criteria, if the application of the HHS criteria for evidence of effectiveness included errors, if requested to do so by a state, model developer, researcher, or others. All grantees will be notified if any additional models are identified that meet the HHS criteria for evidence of effectiveness.

As noted, extensive information about these and other programs that have been reviewed is available on the HomVEE website (http://homvee.acf.hhs.gov/).

(Note: Models are listed alphabetically)

Child FIRST

Population served: Child FIRST provides services to pregnant women and families with children birth to age 6, in cases in which the child has emotional, behavioral, or developmental concerns or the family faces multiple risks that are likely to lead to negative child outcomes. Families are served without regard for ability to pay, or number of children in the family.

Program focus: The goal of Child FIRST is to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and families. Child FIRST model is based on the most current research on brain development, which shows that extremely high-stress environments (including poverty, maternal depression, domestic violence, abuse and neglect, substance abuse and homelessness) are "toxic" to the developing brain of the young child. A clinician and care coordinator provide services that include comprehensive assessment of child and family needs, observation and consultation in early care and education settings, parent-child mental health intervention, development of a family/child plan of care and care coordination/case management.

Early Head Start – Home-Based Option

Population served: Early Head Start (EHS) targets low-income pregnant women and families with children birth to age three years, most of whom are at or below the federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act in their state.

Program focus: The program focuses on providing high quality, flexible, and culturally competent child development and parent support services with an emphasis on the role of the parent as the child's first, and most important, relationship. EHS programs include home- or center-based services, a combination of home- and center-based programs, and family child care services (services provided in family child care homes).

The Early Intervention Program for Adolescent Mothers (EIP)

Population served: The Early Intervention Program for Adolescent Mothers (EIP) focuses on pregnant Latina and African American women 14 to 19 years of age and infants birth to 11 months. The women are eligible for EIP if they were not more than 26 weeks gestation; pregnant with their first child; and planning to keep the infant. Expectant mothers who were chemically dependent or had serious medical or obstetric problems were ineligible.

Program focus: http://homvee.acf.hhs.gov/document.aspx?sid=39&rid=1&mid=1. The Early Intervention Program (EIP) was designed to help pregnant adolescents who were referred to the county health department for public health nursing care to achieve social competence. EIP included home visits from mid-pregnancy through the child's first year of life. During home visits, public health nurses used a variety of teaching methods to cover five main content areas: (1) health, (2) sexuality and family planning, (3) maternal role, (4) life skills, and (5) social support systems. EIP aimed to improve internal competence or the mother's ability to manage her inner world through training in self-management skills and techniques for coping with stress and depression. External competence or the ability to interact effectively with partners, family, peers, and social agencies was addressed through training in communication and social skills.

Early Start

Population served: Early Start is a voluntary home visiting program designed to improve child health; reduce child abuse; improve parenting skills; support parental physical and mental health; encourage family economic well-being; and encourage stable, positive partner relationships. Early Start targets at-risk families with newborns and children up to age five.

Program focus: Early Start aims to create a collaborative, problem-solving partnership between the home visitor and family to maximize child health, increase child and family well-being, build strengths, and eliminate deficiencies. Early Start recognizes that child well-being can occur only through the more general health and well-being of the family, although the target child is treated as the primary focus of services.

Family Check-Up

Population served: Family Check-Up is designed as a preventative program to help parents address typical challenges that arise with young children before these challenges become more serious or problematic. The target population for this program includes families with risk factors including: socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use. Families with children age 2 to 17 years old are eligible for Family Check-Up.

Program focus: The program focuses on the following outcomes: (1) child development and school readiness and (2) positive parenting practices.

Healthy Families America (HFA)

Population served: HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of abuse, substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve. Families must be enrolled prenatally or within the first three months after a child's birth.

Once enrolled, services are provided to families until the child enters kindergarten.

Program focus: HFA aims to (1) reduce child maltreatment; (2) increase use of prenatal care; (3) improve parent-child interactions and school readiness; (4) ensure healthy child development; (5) promote positive parenting; (6) promote family self-sufficiency and decrease dependency on welfare and other social services; (7) increase access to primary care medical services; and (8) increase immunization rates.

Healthy Steps

Population served: Healthy Steps is designed for parents with children from birth to age 30 months. Healthy Steps can be implemented by any pediatric or family medicine practice. Residency training programs can also implement Healthy Steps. Community health organizations, private practices, hospital based clinics, child health development organizations, and other types of clinics can also become Healthy Steps sites if a health care clinician is involved and the site is based in or linked to a primary health care practice. Any family served by the participating practice or organization can be enrolled in Healthy Steps.

Program focus: The program focuses on the following outcomes: (1) child development and school readiness; and (2) positive parenting practices.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Population served: Home Instruction for Parents of Preschool Youngsters (HIPPY) aims to promote preschoolers' school readiness by supporting parents in the instruction provided in the home. The program is designed for parents who lack confidence in their ability to prepare their children for school, including parents with past negative school experiences or limited financial resources. HIPPY offers weekly activities for 30 weeks of the year, alternating between home visits and group meetings (two one-on-one home visits per month and two group meetings per month). HIPPY sites are encouraged to offer the three-year program serving three to five year olds, but may offer the two-year program for four to five year olds. The home visiting paraprofessionals are typically drawn from the same population that is served by a HIPPY site, and each site is staffed by a professional program coordinator who oversees training and supervision of the home visitors.

Program focus: Home Instruction for Parents of Preschool Youngsters aims to promote preschoolers' school readiness.

Nurse-Family Partnership (NFP)

Population served: The Nurse-Family Partnership (NFP) is designed for first-time, low-income mothers and their children. It includes one-on-one home visits by a trained public health nurse to participating clients. The visits begin early in the woman's pregnancy (with program enrollment no later than the 28th week of gestation) and conclude when the woman's child turns two years old. During visits, nurses work to reinforce maternal behaviors that are consistent with program goals and that encourage positive behaviors and accomplishments. Topics of the visits include: prenatal care; caring for an infant; and encouraging the emotional, physical, and cognitive development of young children.

Program focus: The Nurse-Family Partnership program aims to improve maternal health and

child health; improve pregnancy outcomes; improve child development; and improve economic self-sufficiency of the family.

The Oklahoma Community-Based Family Resource and Support Program

Population served: Oklahoma's Community-Based Family Resource and Support (CBFRS) was designed to be initiated before 28 weeks gestation and continue to the child's first birthday.

Program focus: Oklahoma's CBFRS program was developed to improve maternal and child health and child development.

Parents as Teachers (PAT)

Population served: The goal of the Parents as Teachers (PAT) program is to provide parents with child development knowledge and parenting support. The PAT model includes home visiting for families and professional development for home visiting. The home visiting component of PAT provides one-on-one home visits, group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits, using the Born to Learn curriculum. Local sites decide on the intensity of home visits, ranging from weekly to monthly and the duration during which home visitation is offered. PAT may serve families from pregnancy to kindergarten entry.

Program focus: The Parents as Teachers program aims to provide parents with child development knowledge and improve parenting practices.

Play and Learning Strategies (PALS) Infant

Population served: PALS Infant is designed to strengthen parent-child bonding and stimulate children's early language, cognitive, and social development. The program is designed for children five months to one year.
Program focus: PALS Infant was developed to facilitate parents' mastery of specific skills for interacting with their infants. It is designed as a preventive intervention program to strengthen the bond between parent and child and to stimulate early language, cognitive, and social development. It consists of one-on-one home visits between a trained parent educator and a parent.

SafeCare Augmented

Population served: SafeCare Augmented is designed for families with a history of child maltreatment or risk factors for child maltreatment, including young parents; parents with multiple children; parents with a history of depression or other mental health problems, substance abuse, or intellectual disabilities; foster parents; parents being reunified with their children; parents recently released from incarceration; parents with a history of domestic violence or intimate partner violence; and parents of children with developmental or physical disabilities. SafeCare is available to parents with children ages birth to 5. SafeCare Augmented was adapted for high-risk, rural families who do not have a long history of involvement with child welfare services.
Program focus: SafeCare focuses on three areas: (1) infant and child health care, (2) home safety, and (3) parent-child/parent-infant interactions. SafeCare emphasizes learning in a social context and uses behavioral principles for parent training across the three focus areas.

APPENDIX B: EXPECTATIONS FOR PROMISING APPROACHES AND OTHER RESEARCH AND EVALUATION ACTIVITIES

HRSA and ACF expect that all evaluation activities funded under the MIECHV program will contribute to developing a knowledge base around successful strategies for the effectiveness, implementation, adoption and sustainability of evidence-based home visiting programs. The legislation does not require that applicants conduct implementation or impact evaluation other than research on promising approaches.[13]

HRSA and ACF have a particular interest in research and evaluation approaches that develop knowledge about:

- Efficacy in achieving improvements in the benchmark areas and participant outcomes specified in the legislation.
- Factors associated with developing or enhancing capacity to support and monitor the quality of evidence-based programs; and
- Effective strategies for adopting, implementing, and sustaining evidence-based home visiting programs.

Furthermore, HRSA and ACF are especially interested in the use of evaluation strategies that emphasize the use of research to help guide program planning and implementation (e.g., participatory or empowerment evaluation).[14] To support the applicant's evaluation efforts around promising programs, applicants must allocate an appropriate level of funds for a rigorous evaluation in all years of the grant.

HRSA and ACF expect grantees to engage in an evaluation of sufficient rigor to demonstrate potential linkages between project activities and improved outcomes. Rigorous research incorporates the four following criteria:

Credibility: Ensuring what is intended to be evaluated is actually what is being evaluated; making sure that descriptions of the phenomena or experience being studied are accurate and recognizable to others; ensuring that the method used is the most definitive and compelling approach that is available and feasible for the question being addressed. If conclusions about program efficacy are being examined, the study design should include a comparison group (i.e., randomized control trial or quasi-experimental design); see the HomVEE website for standards for study design in estimating program impacts: http://homvee.acf.hhs.gov/).

[13] As noted previously in this Funding Opportunity Announcement, the applicant must provide assurances about participation in any national evaluation activities. It is the Secretary's intent to fund and carry out the national evaluation. However, HRSA and ACF would not prohibit grantees from conducting research and evaluation outside of the national evaluation and other ongoing federal research.

[14] Participatory evaluation engages stakeholders in the development, implementation, and interpretation of evaluation results to maximize the usefulness of the results for stakeholders. Empowerment evaluation supports stakeholders to learn the tools on conducting effective evaluation to foster inquiry and self-evaluation or installation of continuous quality improvement.

Applicability: Generalizability of findings beyond current project (i.e., when findings "fit" into contexts outside the study situation). Ensuring the population being studied represents one or more of the population being served by the program.

Consistency: When processes and methods are consistently followed and clearly described, someone else could replicate the approach, and other studies can confirm what is found.

Neutrality: Producing results that are as objective as possible and acknowledge the bias brought to the collection, analysis, and interpretation of the results.

The application should provide a narrative addressing how the evaluation of the promising approach will be conducted. The application should address the proposed evaluation methods, measurement, data collection, sample and sampling (if appropriate), timeline for activities, plan for securing IRB review, and analysis. It should also identify the evaluator, cost of the evaluation, and the source of funds. If the research is measuring the impact of the promising or new home visiting model on participant outcomes, an appropriate comparison condition should be utilized. The plan should also include a logic model or conceptual framework that shows the linkages between the proposed planning and implementation activities and the outcomes that these are designed to achieve. For assistance in developing a logic model, see http://toolkit.childwelfare.gov/toolkit/. HRSA has already initiated a contract for the provision of technical assistance for evaluation of promising programs and will be providing information about the technical assistance available to successful grantees.

If the applicant does not have the in-house capacity to conduct an objective, comprehensive evaluation of a proposed promising approach or other evaluation the applicant wishes to conduct under the MIECHV program, then HRSA and ACF advise that the applicant subcontract with an institution of higher education, or a third-party evaluator specializing in social sciences research and evaluation, to conduct the evaluation. In either case, it is important that the evaluators have the necessary independence from the project to assure objectivity. A skilled evaluator can help develop a logic model and assist in designing an evaluation strategy that is rigorous and appropriate given the goals and objectives of the proposed project.

Additional assistance may be found in a document titled, "Program Manager's Guide to Evaluation." A copy of this document can be accessed at: http://www.acf.hhs.gov/sites/default/files/opre/program_managers_guide_to_eval2010.pdf.

APPENDIX C: GLOSSARY

Adaptation

In some cases, the grantee may wish to adapt an existing model that has been identified as evidence-based in order to meet the needs of targeted at-risk communities. For the purposes of the MIECHV, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer *not to alter the core components related to program impacts*. Literature around adaptation of evidence-based programs consistently recommends that implementing agencies should discuss proposed adaptations with the program developers prior to implementation to ensure that changes do not alter core components. Changes to an evidence-based model that alter the core elements related to program outcomes undermine the program's effectiveness. Such changes (otherwise known as "drift") will not be allowed under the funding allocated for evidence-based models.

Administration for Children and Families

The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities.

Aggregate Data

Data combined from multiple related measurement tools capturing the same construct to build the cumulative value of a statewide performance measure and/or data combined from multiple subjects.

At-Risk Community

A community with concentrations of: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; or child maltreatment. *See Section 511 (b)(1)(A).*

Baseline Data

Basic information collected to establish and understand the existing conditions. Specifically, data collected during the first year of program implementation to serve as the basis of comparison with subsequent years in order to track performance and show improvement across program measures. Baseline data need not cover the entirety of the first year or reporting period but be adequate to provide a stable value for the performance measure reported (e.g., depending on the measure and the population of participants affected, six months worth of data may suffice to gain a preliminary understanding of the level at which the program is operating with regard to the construct of interest).

Benchmark Area Data

Data collected for the purposes of measuring progress towards an intended goal.

Birth to Birth Interval	Birth to Birth interval is defined as the number of months between the birth of the child and the immediately preceding birth to the mother. Used to assess maternal and perinatal outcomes in order to determine an optimal range in months or years during which risk of an adverse birth outcome is lowest.
Community Involvement	A grantee's effort to establish two-way communication with the public to create understanding of the MIECHV program and related actions, to ensure public input into decision-making processes related to affected communities, and to make certain that the grantee is aware of and responsive to public concerns. Adapted from the Environmental Protection Agency's definition of 'community involvement:' http://www.epa.gov/waste/hazard/correctiveaction/training/key_terms.htm.
Continuous Quality Improvement (CQI)	A systematic approach to improving processes and outcomes through regular data collection, examination of performance relative to baseline data, review of practices that promote or impede improvement, and application of changes in practices that may lead to improvements in performance.
Early Childhood System	An integrated early childhood service system that address the critical components of access to comprehensive health services and medical homes, social-emotional development and mental health of young children, early care and education, parenting education, and family support. http://eccs.hrsa.gov/About/index.htm
Enrollment	A family is to be considered enrolled in a home visiting program as of the date of the first home visit.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A program for Medicaid beneficiaries under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Federal Educational Rights and Privacy Act (FERPA)	A federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. *See http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html*.
Health Resources and Services Administration (HRSA)	An agency of the U.S. Department of Health and Human Services, the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.
High- or Moderate-Quality Study Design	In order to meet criteria for evidence of effectiveness, a home visiting model must have been (1) evaluated using rigorous methodology and

(2) shown to have a positive impact on outcomes.

With respect to determining the quality of the methodology of a research study, there are a number of variables that should be considered in order to ensure the highest probability that the study will produce unbiased estimates of program impacts. These variables include study design (i.e. randomized controlled trial [RCT] or quasi-experimental design [QED]), level of attrition, baseline equivalence, reassignment of participants from one condition to another in the trial, and confounding factors. Two types of impact study designs have the potential to be both well designed and rigorous: randomized controlled trials and quasi-experimental designs. A randomized controlled trial is defined as a study design in which sample members are assigned to the program and comparison groups by chance. A quasi-experimental design is defined as a study design in which sample members are selected for the program and comparison groups in a nonrandom way.

An impact study is considered high-, moderate- or low-quality depending on the study's capacity to provide unbiased estimates of program impact. Studies that are rated ''high'' and ''moderate'', therefore, meet requirements to be considered ''well-designed, rigorous impact research.'' In brief, the high rating is reserved for random assignment studies with low attrition of sample members and no reassignment of sample members after the original random assignment or regression discontinuity or single case designs that meet WWC design standards (http://ies.ed.gov/ncee/wwc/pdf/wwc_rd.pdf The moderate rating applies to random assignment studies that, due to flaws in the study design or execution (for example, high sample attrition), do not meet all the criteria for the high rating; and to studies that use a matched comparison group design; or a regression discontinuity design or a single case design that meets the WWC design standards with reservations. Studies that do not meet all the criteria for either high or moderate quality are considered low quality studies. More detailed information about study design quality is available at: http://homvee.acf.hhs.gov/.

Health Insurance Portability and Accountability Act (HIPAA), Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html

Home Visiting Evidence of Effectiveness Review (HomVEE) Study	The Office of Research, Planning and Evaluation, Administration for Child and Families (OPRE/ACF) launched Home Visiting Evidence of Effectiveness (HomVEE) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting programs that target families with pregnant women and children ages birth to five. To carry out the HomVEE review, Mathematica Policy Research conducted a thorough search of the research literature on home visiting, issued a call for studies to identify additional research, reviewed the literature, assessed the quality of research studies, and evaluated the strength of evidence for specific home visiting program models. http://homvee.acf.hhs.gov/
Home Visiting Models	For the purposes of the MIECHV, ***home visiting models*** are defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting participant outcomes which may include improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.
Household	Household shall be defined as all those living in a home (who stay there at least 4 nights a week on average) who contribute to the support of the child or pregnant woman linked to the HV program.
Infants	Children less than one year of age not included in any other class of individuals. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Institutional Review Board	An ***institutional review board (IRB)*** is "a specially constituted review body established or designated by an entity to protect the welfare of human subjects recruited to participate in biomedical or behavioral research." http://www.hhs.gov/ohrp/archive/irb/irb_glossary.htm
Key Positions	Any position that is vital to the planning, implementation, administration, and evaluation of the home visiting program.
Legislatively Mandated Benchmarks	The Legislatively Mandated Benchmark Areas for the MIECHV represent the broad goals for the program and include: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-

sufficiency; and improvements in the coordination and referrals for other community resources and supports. See Section 511 (d) (1)(A).

Legislatively Mandated Outcomes

The ***Legislatively Mandated Outcomes*** refer to the "improvements in outcomes for individual families." These outcomes include: (i) improvements in prenatal, maternal, and new born health, including improved pregnancy outcomes; (ii) improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators; (iii) improvement in parenting skills; (iv) improvements in school readiness and child academic achievement; (v) reduction in crime or domestic violence; (vi) improvements in family economic self-sufficiency; (vii) improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with state child welfare agency training. *See Section 511 (d) (2)(B).*

Life Course Development

Life course development points to broad social, economic, and environmental factors as contributors to poor and favorable health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families.

Logic Model

A map or simple illustration of what you do, why you do it, what you hope to achieve, and how you will measure achievement. It includes the anticipated outcomes of your services, indicators of those outcomes, and measurement tools to evaluate the outcomes. http://toolkit.childwelfare.gov/toolkit/ and http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx

Low Income

An individual or family with an income determined to be below the official poverty line defined by the U.S. Department of Health and Human Services (HHS) and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

Patient Protection and Affordable Care Act of 2010	On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148), legislation designed to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program, the Act responds to the diverse needs of children and families in communities at risk and provides for collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.
Performance Management	The systematic process by which an agency involves its employees, as individuals and members of a group, in improving organizational effectiveness in the accomplishment of agency mission and goals. http://www.opm.gov/hcaaf_resource_center/assets/Ropc_tool3.pdf A performance management system continuously uses 1) performance standards, 2) performance measures, 3) documents and reports to show the progress in meeting standards and targets while providing feedback, and 4) maintains a program of quality improvement to manage change. http://www.turningpointprogram.org/toolkit/pdf/Silos_to_Sytems.pdf
Perinatal	Period from gestation of 28 weeks or more to seven days or less after birth. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Reflective Practice	Reflective practice is "the process of continuous learning through thoughtful examination of one's work." From Mentoring, Coaching, and Reflective Practice: An Annotated Resource List http://main.zerotothree.org/site/DocServer/Final_Resources_for_Mentoring.pdf?docID=1796
Reliability of Measurement	Consistency of a measure to capture the intended construct (e.g., a person answering the questionnaire will most likely answer in a similar way both today and tomorrow). It is most frequently quantified through inter-rater reliability, test-retest reliability or internal consistency.
Risk Factors	Scientifically established direct causes of, and contributors to, negative outcomes for a specific population, such as maltreatment, juvenile delinquency, morbidity and/or mortality. Changes in behavior or physiological conditions are the indicators of achievement of risk factor targets. Risk factor reduction tends to be considered an intermediate, rather than a final, outcome.

Sampling	Selecting a group of participants that are representative of the population to which the data is intended to generalize. Sampling is used in instances where it is not feasible or appropriate to measure every single member of a specific population.
SMART Objectives	Statements of end results to be achieved within a given period of time. They are linked to goals and spell out the degree of accomplishment expected. One methodology used to create effective objectives is called SMART. SMART objectives are: *Specific*: Concrete, detailed, and well defined so that you know where you are going and what to expect when you arrive *Measureable*: Numbers and quantities provide means of measurement and comparison Achievable: feasible and easy to put into action *Realistic*: Considers constraints such as resources, personnel, cost, and time frame *Time-Bound*: A time frame helps to set boundaries around the objective **http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html**
Socio-Ecological Perspective	Emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. This perspective reflects the understanding that development is a process involving transactions between the growing child and the social environment or ecology in which development takes place and considers the complex interplay between individual, family, community, and societal factors. CDC
Statewide Needs Assessment	In completing the FY 2010 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program application, states and eligible jurisdictions were required to complete three steps, the second of which was submission of a statewide needs assessment as a condition for receiving FY 2011 Title V Block Grant allotments. The needs assessment included an identification of communities with concentrations of premature birth, low-birth-weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health, poverty, crime, domestic violence, high rates of high-school drop-outs, substance abuse, unemployment, or child maltreatment, identification of the quality and capacity of existing programs or initiatives for early childhood home visiting in the state, and a discussion of the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

Technical Assistance The process of providing grant recipients with expert assistance to build their capacity to fully meet the requirements of and successfully implement the program. Technical assistance may be provided by federal staff or contract providers and may include training, research, peer learning, and consultation on the federal requirements which include a broad range of topics regarding health and human services and program administration and evaluation.

Title V The authorizing legislation for the Maternal and Child Health Block Grant to States, which is found in Title V of the Social Security Act. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)

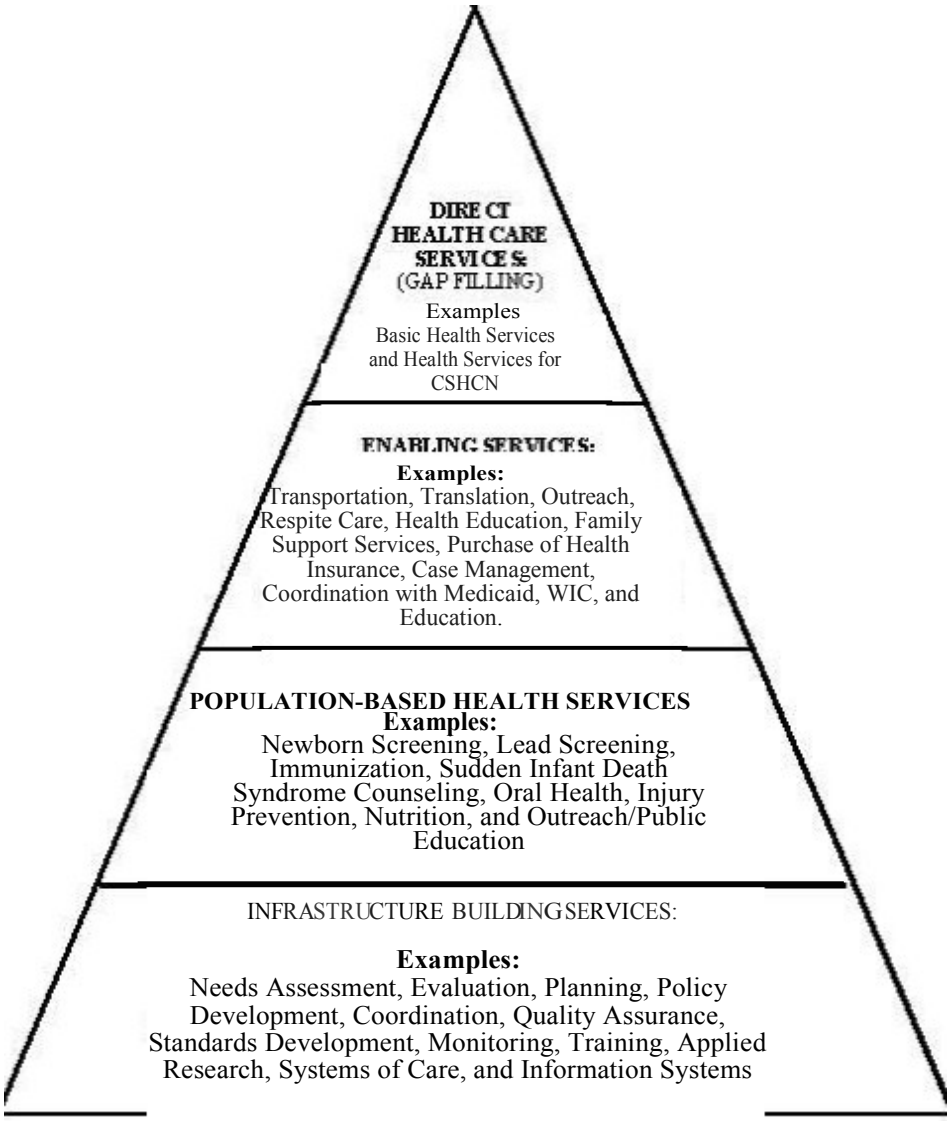
Updated State Plan In completing the FY 2010 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program application, states were required to complete three steps, the third of which was submission of an Updated State Plan for a State Home Visiting Program. The Updated State Plan includes identification of the at-risk community(ies) where home visiting services are to be provided, a detailed assessment of the particular needs of that community(ies) in terms of risk factors and existing services, identification of home visiting services proposed to be implemented to meet identified needs in that community(ies), a description of the state and local infrastructure available to support the program, specification of any additional infrastructure support necessary to achieve program success, and a plan for collecting benchmark data, conducting continuous quality improvement, and performing any required research or evaluation.

APPENDIX D: DESIGN OPTIONS FOR HOME VISITING EVALUATION (DOHVE) COMPENDIUM OF MEASURES

The Design Options for Home Visiting Evaluation (DOHVE) Compendium of Measures for MIECHV Grantees is available for review and use and can be found at the MDRC website at the following link. http://www.mdrc.org/project_12_104.html The compendium was generated by conducting a scan of the literature on home visiting and compiling a list of measures commonly used to assess maternal, child and family outcomes in home visiting models. A list of domains, sub-domains, the respective measures and their description as derived from eight compendia are presented in table format. While measures are listed according to the domain that best fits the intended use of the measure, some measures may fit under multiple domains. This list is not exhaustive. Web links are provided to obtain additional information about the assessments, some of which are links to publisher websites. These links are not an endorsement of the publishers, but a resource to obtain additional information. The domains include: Family (Family Functioning), Caregiver (Caregiver Physical Health, Domestic Violence, Caregiver Mental Health, Caregiver Alcohol and Substance Use, Social Support, Parenting, Parenting Stress, Parental Knowledge, and Relationship between Caregivers), Child (Child Physical Health, Child Behavior, Child Development, Child Development, Child Safety, Child Well-Being).

APPENDIX E: MATERNAL AND CHILD HEALTH PYRAMID

CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES



APPENDIX F: MCHB ADMINISTRATIVE FORMS AND PERFORMANCE MEASURES

HRSA has developed reporting requirements for MIECHV grants that are needed to generate national performance measures in accordance with the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. These program-specific forms, including performance measures, which must be completed by grantees/awardees, are selected according to the type and focus of the program and include: Financial forms, Demographic Data forms, Performance Measures, and Additional Data Elements.

HRSA has identified seven forms to collect this required data from MIECHV grantees. These forms are divided into two sets: (a) Discretionary Grant Information System (DGIS) forms that already are utilized by MCHB grantees; and (b) program-specific forms to address the unique data reporting requirements of the MIECHV program. DGIS forms are publicly available; the program-specific forms will be made publicly available in final form and incorporated into DGIS after approval by the Office of Management and Budget.

The following five DGIS forms are required to be completed by all MIECHV grantees:

- DGIS Form 1: MCHB Project Budget Details
- DGIS Form 2: Project Funding Profile
- DGIS Form 4: Project Budget and Expenditures by Types of Services
- DGIS Form 6: MCH Discretionary Grant Project Abstract and
- DGIS Products, Publications, and Submissions Data Form

The two additional program-specific forms developed to meet the unique data reporting needs of the MIECHV program include:

- MIECHV Form 1: Demographic and Service Utilization Data for Enrollees and Children.
  This form will include data to determine the unduplicated number of participants and of participant groups by primary insurance coverage. This form will also call for data on the demographic characteristics of program participants.
- MIECHV Form 2: Grantee-defined Performance Measures.
  This form provides a template for grantees to report aggregate data on their selected performance measures under the six benchmark areas.

To request more information or to obtain a copy of the proposed forms applicants may email paperwork@hrsa.gov or call the HRSA Reports Clearance Officer at (301) 443-1984.

FORM 1
MCHB PROJECT BUDGET DETAILS FOR FY _____

1.	**MCHB GRANT AWARD AMOUNT**		$ _____
2.	**UNOBLIGATED BALANCE**		$ _____
3.	**MATCHING FUNDS**		$ _____
	(Required: Yes [ ] No [ ] If yes, amount)		
	A. Local funds	$ _____	
	B. State funds	$ _____	
	C. Program Income	$ _____	
	D. Applicant/Grantee Funds	$ _____	
	E. Other funds: _____	$ _____	
4.	**OTHER PROJECT FUNDS** (Not included in 3 above)		$ _____
	A. Local funds	$ _____	
	B. State funds	$ _____	
	C. Program Income (Clinical or Other)	$ _____	
	D. Applicant/Grantee Funds (includes in-kind)	$ _____	
	E. Other funds (including private sector, e.g., Foundations)	$ _____	
5.	**TOTAL PROJECT FUNDS** (Total lines 1 through 4)		$ _____
6.	**FEDERAL COLLABORATIVE FUNDS**		$ _____
	(Source(s) of additional Federal funds contributing to the project)		
	A. Other MCHB Funds (Do not repeat grant funds from Line 1)		
	1) Special Projects of Regional and National Significance (SPRANS)	$ _____	
	2) Community Integrated Service Systems (CISS)	$ _____	
	3) State Systems Development Initiative (SSDI)	$ _____	
	4) Healthy Start	$ _____	
	5) Emergency Medical Services for Children (EMSC)	$ _____	
	6) Traumatic Brain Injury	$ _____	
	7) State Title V Block Grant	$ _____	
	8) Other: _____	$ _____	
	9) Other: _____	$ _____	
	10) Other: _____	$ _____	
	B. Other HRSA Funds		
	1) HIV/AIDS	$ _____	
	2) Primary Care	$ _____	
	3) Health Professions	$ _____	
	4) Other: _____	$ _____	
	5) Other: _____	$ _____	
	6) Other: _____	$ _____	
	C. Other Federal Funds		
	1) Center for Medicare and Medicaid Services (CMS)	$ _____	
	2) Supplemental Security Income (SSI)	$ _____	
	3) Agriculture (WIC/other)	$ _____	
	4) Administration for Children and Families (ACF)	$ _____	
	5) Centers for Disease Control and Prevention (CDC)	$ _____	
	6) Substance Abuse and Mental Health Services Administration (SAMHSA)	$ _____	
	7) National Institutes of Health (NIH)	$ _____	
	8) Education	$ _____	
	9) Bioterrorism	_____	
	10) Other: _____	$ _____	
	11) Other: _____	$ _____	
	12) Other _____	$ _____	
7.	**TOTAL COLLABORATIVE FEDERAL FUNDS**	$ _____	

INSTRUCTIONS FOR COMPLETION OF FORM 1
MCH BUDGET DETAILS FOR FY ____

Line 1. Enter the amount of the federal MCHB grant award for this project.

Line 2. Enter the amount of carryover (e.g., unobligated balance) from the previous year's award, if any. New awards do not enter data in this field, since new awards will not have a carryover balance.

Line 3. If matching funds are required for this grant program list the amounts by source on lines 3A through 3E as appropriate. Where appropriate, include the dollar value of in-kind contributions.

Line 4. Enter the amount of other funds received for the project, by source on Lines 4A through 4E, specifying amounts from each source. Also include the dollar value of in-kind contributions.

Line 5. Displays the sum of lines 1 through 4.

Line 6. Enter the amount of other federal funds received on the appropriate lines (A.1 through C.12) **other** than the MCHB grant award for the project. Such funds would include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts.

Line 6C.1. Enter only project funds from the Center for Medicare and Medicaid Services. Exclude Medicaid reimbursement, which is considered Program Income and should be included on Line 3C or 4C.

If lines 6A.8-10, 6B .4-6, or 6C.10-12 are utilized, specify the source(s) of the funds in the order of the amount provided, starting with the source of the most funds. .

Line 7. Displays the sum of lines in 6A.1 through 6C.12.

FORM 2
PROJECT FUNDING PROFILE

	FY ____		FY ____		FY ____		FY ____		FY ____	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1 MCHB Grant Award Amount *Line 1, Form 2*	$	$	$	$	$	$	$	$	$	$
2 Unobligated Balance *Line 2, Form 2*	$	$	$	$	$	$	$	$	$	$
3 Matching Funds (If required) *Line 3, Form 2*	$	$	$	$	$	$	$	$	$	$
4 Other Project Funds *Line 4, Form 2*	$	$	$	$	$	$	$	$	$	$
5 Total Project Funds *Line 5, Form 2*	$	$	$	$	$	$	$	$	$	$
6 Total Federal Collaborative Funds *Line 7, Form 2*	$	$	$	$	$	$	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 2
PROJECT FUNDING PROFILE

Instructions:

Complete all required data cells. If an actual number is not available, use an estimate. Explain all estimates in a note.

The form is intended to provide funding data at a glance on the estimated budgeted amounts and actual expended amounts of an MCH project.

For each fiscal year, the data in the columns labeled Budgeted on this form are to contain the same figures that appear on the Application Face Sheet (for a non-competing continuation) or the Notice of Award (for a performance report). The lines under the columns labeled Expended are to contain the actual amounts expended for each grant year that has been completed.

FORM 4
PROJECT BUDGET AND EXPENDITURES
By Types of Services

	TYPES OF SERVICES	FY _____ Budgeted	FY _____ Expended	FY _____ Budgeted	FY _____ Expended
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN.)	$	$	$	$
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education.)	$	$	$	$
III.	**Population-Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$	$	$	$
IV.	**Infrastructure Building Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$	$	$	$
V.	**TOTAL**	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 4
PROJECT BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Complete all required data cells for all years of the g rant. If an actual number is not available, make an estimate. Please explain all estimates in a note. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on lines I, II, II or IV. If an estimate of administrative funds use is necessary, one method would be to allocate those dollars to Lines I, II, III and IV at the same percentage as program dollars are allocated to Lines I through IV.

Note: Lines I, II and II are for projects providing services. If grant funds are used to build the infrastructure for direct care delivery, enabling or population-based services, these amounts should be reported in Line IV (i.e., building data collection capacity for newborn hearing screening).

Line I Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Line II Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Line III Population-Based Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Population Based Services are preventive interventions and personal health services, developed and available for the entire MCH population of the state rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Line IV Infrastructure Building Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Infrastructure Building Services are the base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Line V Total – Displays the total amounts for each column, budgeted for each year and expended for each year completed.

FORM 6
MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY____

PROJECT:_____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. E-mail address:

II. BUDGET

1.	MCHB Grant Award (Line 1, Form 2)	$_____
2.	Unobligated Balance (Line 2, Form 2)	$
3.	Matching Funds (if applicable) (Line 3, Form 2)	$
4.	Other Project Funds (Line 4, Form 2)	$
5.	Total Project Funds (Line 5, Form 2)	$

III. TYPE(S) OF SERVICE PROVIDED (Choose all that apply)

[ ] Direct Health Care Services
[ ] Enabling Services
[ ] Population-Based Services
[ ] Infrastructure Building Services

IV. PROJECT DESCRIPTION OR EXPERIENCE TO DATE

A. Project Description

1. Problem (in 50 words, maximum):

2. Goals and Objectives: (List up to 5 major goals and time-framed objectives per goal for the project)

Goal 1:
Objective 1:
Objective 2:
Goal 2:
Objective 1:
Objective 2:
Goal 3:
Objective 1:
Objective 2:
Goal 4:
Objective 1:
Objective 2:
Goal 5:
Objective 1:
Objective 2:

3. Activities planned to meet project goals

4. Specify the primary *Healthy People 2010* objectives(s) (up to three) which this project addresses:

   a.

   b.

   c.

5. Coordination (List the State, local health agencies or other organizations involved in the project and their roles)

6. Evaluation (briefly describe the methods which will be used to determine whether process and outcome objectives are met)

B. Continuing Grants ONLY

1. Experience to Date (For continuing projects ONLY):

2. Website URL and annual number of hits

V. KEY WORDS

VI. ANNOTATION

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. The completed form should be no more than 3 pages in length. Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title: Displays the title for the project.
Project Number: Displays the number assigned to the project (e.g., the grant number)
E-mail address: Displays the electronic mail address of the project director

Section II – Budget - These figures will be transferred from Form 1, Lines 1 through 5.

Section III - Types of Services

Indicate which type(s) of services your project provides, checking all that apply.

Section IV – Program Description OR Current Status (DO NOT EXCEED THE SPACE PROVIDED)

A. New Projects only are to complete the following items:
   1. A brief description of the project and the problem it addresses, such as preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs.
   2. Provide up to 5 goals of the project, in priority order. Examples are: To reduce the barriers to the delivery of care for pregnant women, to reduce the infant mortality rate for minorities and "services or system development for children with special healthcare needs." MCHB will capture annually every project's top goals in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 goals. For each goal, list the two most important objectives. The objective must be specific (i.e., decrease incidence by 10%) and time limited (by 2005).
   3. Displays the primary Healthy people 2010 goal(s) that the project addresses.
   4. Describe the programs and activities used to attain the goals and objectives, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented. Lists with numbered items can be used in this section.
   5. Describe the coordination planned and carried out, in the space provided, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.
   6. Briefly describe the evaluation methods that will be used to assess the success of the project in attaining its goals and objectives.

B. For continuing projects ONLY:
   1. Provide a brief description of the major activities and accomplishments over the past year (not to exceed 200 words).
   2. Provide website and number of hits annually, if applicable.

Section V – Key Words

Provide up to 10 key words to describe the project, including populations served. Choose key words from the included list.

Section VI – Annotation

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals, and the materials, which will be developed.

Products, Publications and Submissions Data Collection Form

Part 1

Instructions: Please list the number of products, publications and submissions addressing maternal and child health that have been published or produced by your staff during the reporting period (counting the original completed product or publication developed, not each time it is disseminated or presented). Products and Publications include the following types:

Type	Number
Peer-reviewed publications in scholarly journals – published (including peer-reviewed journal commentaries or supplements)	
Peer-reviewed publications in scholarly journals – submitted	
Books	
Book chapters	
Reports and monographs (including policy briefs and best practices reports)	
Conference presentations and posters presented	
Web-based products (Blogs, podcasts, Web-based video clips, wikis, RSS feeds, news aggregators, social networking sites)	
Electronic products (CD-ROMs, DVDs, audio or videotapes)	
Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles)	
Newsletters (electronic or print)	
Pamphlets, brochures, or fact sheets	
Academic course development	
Distance learning modules	
Doctoral dissertations/Master's theses	
Other	

Part 2
Instructions: For each product, publication and submission listed in Part 1, complete all elements marked with an "*."

Data collection form: Peer-reviewed publications in scholarly journals – published

*Title: _____
*Author(s): _____
*Publication: _____
*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL): _____
Key Words (No more than 5): _____
Notes: _____

Data collection form: Peer-reviewed publications in scholarly journals – submitted

*Title: _____
*Author(s): _____
*Publication: _____
*Year Submitted: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
Key Words (No more than 5): _____
Notes: _____

Data collection form: Books

*Title: _____
*Author(s): _____
*Publisher: _____
*Year Published: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
Key Words (No more than 5): _____
Notes: _____

Data collection form for: Book chapters

Note: If multiple chapters are developed for the same book, list them separately.
*Chapter Title: _____
*Chapter Author(s): _____
*Book Title: _____
*Book Author(s): _____
*Publisher: _____
*Year Published: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Reports and monographs

*Title: _____
*Author(s)/Organization(s): _____
*Year Published: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Conference presentations and posters presented

(This section is not required for MCHB Training grantees.)
*Title: _____
*Author(s)/Organization(s): _____
*Meeting/Conference Name: _____
*Year Presented: _____
*Type: ☐ Presentation ☐ Poster
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Web-based products

*Product: _____
*Year: _____
*Type: ☐ blogs ☐ podcasts ☐ Web-based video clips
wikis RSS feeds news aggregators
☐ social networking sites ☐ Other (Specify)
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Electronic Products

*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Type: ☐ CD-ROMs ☐ DVDs ☐ audio tapes
☐ videotapes ☐ Other (Specify)
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Press Communications

*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Type: ☐ TV interview ☐ Radio interview ☐ Newspaper interview ☐ Public service announcement ☐ Editorial article ☐ Other (Specify)
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Newsletters

*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Type: ☐ Electronic ☐ Print ☐ Both
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
*Frequency of distribution: ☐ weekly ☐ monthly ☐ quarterly ☐ annually ☐ Other (Specify)
Number of subscribers: _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Pamphlets, brochures or fact sheets

*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Type: ☐ Pamphlet ☐ Brochure ☐ Fact Sheet
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Academic course development

*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Distance learning modules

*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Media Type: ☐ blogs ☐ podcasts ☐ Web-based video clips

☐ wikis
☐ social networking sites
☐ audio tapes

RSS feeds
CD-ROMs
videotapes

news aggregators
DVDs
Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Doctoral dissertations/Master's theses

*Title: _____
*Author: _____
*Year Completed: _____
*Type: ☐ Doctoral dissertation ☐ Master's thesis
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Other

(Note, up to 3 may be entered)
*Title: _____
*Author(s)/Organization(s): _____
*Year: _____
*Describe product, publication or submission: _____
_____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____