| **Illinois Department of Human Services** **Healthy Families Illinois** Program Plan **FY 2019** | | | | |
| --- | --- | --- | --- | --- |
| **AGENCY NAME** | | | | |
| **Agency Name:** Click here to enter text. | | | | |
| **Address:** Click here to enter text. | | | | |
| **City:** Click here to enter text. | **State:** Click here to enter text. | | **ZIP:** Click here to enter text. | |
| **Phone:** Click here to enter text. | **Fax:** Click here to enter text. | | | **Email:** Click here to enter text. |
| **ADMINISTRATIVE CONTACT** | | | | |
| **Administrative Contact:** Click here to enter text. | | | | |
| **Address:** Click here to enter text. | | | | |
| **City:** Click here to enter text. | **State:** Click here to enter text. | | **ZIP:** Click here to enter text. | |
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| **Fiscal CONTACT** | | | | |
| **Fiscal Contact:** Click here to enter text. | | | | |
| **Address:** Click here to enter text. | | | | |
| **City:** Click here to enter text. | **State:** Click here to enter text. | | **ZIP:** Click here to enter text. | |
| **Phone:** Click here to enter text. | **Fax:** Click here to enter text. | | | **Email:** Click here to enter text. |
| **Program CONTACT** | | | | |
| **Program Contact:** Click here to enter text. | | | | |
| **Address:** Click here to enter text. | | | | |
| **City:** Click here to enter text. | **State:** Click here to enter text. | | **ZIP:** Click here to enter text. | |
| **Phone:** Click here to enter text. | **Fax:** Click here to enter text. | | | **Email:** Click here to enter text. |
| **Healthy Families America Accreditation/Affiliation, If Applicipable** | | | | |
| **Date Last Accredited:** Click here to enter text. | | **Date of FY18 Site Visit:** Click here to enter TExt. | | |
| **Target Population – 4 pages maximum** | | | | |
| * Include factors such as age, Medicaid eligibility, parenting status, e.g. first-time or all parents. * Include recent statistical data regarding the target population, (i.e., how many families meet all of the descriptors of the target population - for example, how many first-time births to mothers receiving Medicaid) * Ethnic/Racial demographics of community served, including any unique characteristics about the population in the service area. * Ethnic/Racial and age distribution. | | | | |
| Click here to enter text. | | | | |
| **program narrative – 8 pages maximum** | | | | |
| * Describe the need that will be addressed. * Describe the staff members that will be responsible for the delivery of services, including educational background, years of experience, and other relevant information. * Provide any additional information that might be relevant in determining the agency’s ability to carry out a quality program. | | | | |
| Click here to enter text. | | | | |
| **Geographic Area Served – 2 pages maximum** | | | | |
| * Describe the service area that will be covered. * Chicago – must include Community Area(s), by name, and corresponding ZIP codes. * If there are particular boundaries within the geographic area, these must be explicitly spelled out. * Please indicate if this is a change from the previous year. | | | | |
| Click here to enter text. | | | | |

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| **Community Partners – 2 PAGES MAXIMUM** | |
| * List community partners who will identify and refer families meeting the definition of the target population, that will enable the program to enroll participants prenatally, or shortly after the birth of the baby. * Describe how the program will link families to other resources, and list other community resources the program currently refers participants to on a routine basis. | |
| Click here to enter text. | |
| **DESCRIPTION OF SERVICES – 4 PAGES MAXIMUM** | |
| * Provide a brief description of all services to be provided. * Provide a timeline, activities and person(s) responsible for the work associated with the services. * Identify any specific goals your agency is aiming to achieve. * Describe of the methods that will be used to identify and recruit clients. * Describe the efforts that the program will make to involve fathers. | |
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| **OTHer**  **Applicants Currently Funded for HFI Programming in Other SERVICE aREAS ONLY** | |
| HFI policy/procedure Manual reviewed for accuracy. | Date: Click here to enter text. |
| Acceptance rate for the 1st - 3rd quarters during FY18? | Rate: Click here to enter text. |
| Changes in curricula implemented during FY18 | Changes: Click here to enter text. |
| Parental Support activities, other than home visits provided by HFI staff (e.g. Parent Support groups) | Click here to enter text. |
| Program Enhancements (e.g. Doula, Infant Mental Health) | Click here to enter text. |

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| HFI Program Staff – Provide the Name (indicate proposed positions as “Vacant”; % of time with HFI and % of time spent in each activity. Intended date by which appropriate training(s) will be completed.)  For your agency, Full-Time (FTE) is considered Click here to enter text. hours per week. | | | | | | |
| HFI Staff Name | %FTE\* | %SUP | %Outreach Worker | %FSW | Trained | |
| FAW -  Family Assessment Worker | FSW -  Family Support Worker |
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