| Illinois Department of Human ServicesHealthy Families IllinoisProgram PlanFY 2020 |
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| **AGENCY** |
| Agency Name:  |
| Address:  |
| City:  | State:  | ZIP:  |
| Phone:  | Fax:  | Email:  |
| **ADMINISTRATIVE CONTACT** |
| Administrative Contact:  |
| Address:  |
| City:  | State:  | ZIP:  |
| Phone:  | Fax:  | Email:  |
| **Fiscal CONTACT** |
| Fiscal Contact:  |
| Address:  |
| City:  | State:  | ZIP:  |
| Phone:  | Fax:  | Email:  |
| **Program CONTACT** |
| Program Contact:  |
| Address:  |
| City:  | State:  | ZIP:  |
| Phone:  | Fax:  | Email:  |
| **Healthy Families America Accreditation/Affiliation If Applicipable** |
| Date Last Accredited:  | Date of FY19 Site Visit:  |

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| 1. **EXECUTIVE SUMMARY**
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| The executive summary will serve as a stand-alone document for the successful applicant that will be shared with various state-level stakeholders and others requesting a brief overview of the funded project. **(2 pages maximum)** |
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| 1. **AGENCY QUALIFICATIONS/ORGANIZATIONAL CAPACITY**
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| The purpose of this section is for the applicant to present an accurate picture of the agency’s capacity, qualifications and ability to successfully implement the proposed program described in this Funding Notice. **(4 pages maximum)** |
| 1. **Agency History**
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| 1. **Leadership**
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| 1. **Staffing Structure**
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| 1. **Governance**
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| 1. **Fiscal**
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| 1. **Partners/Sites**
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| 1. **DESCRIPTION OF SERVICES**
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| The purpose of this section is to provide a comprehensive description of the home visiting services to be delivered, including but not limited to geographic area, target population, program components and evaluation. **(8 pages maximum)** |
| 1. **Geographic Area Served**
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| 1. **Target Population/Community Need**
	1. Definition of Target Population
	2. Rationale for Targeting Services
	3. Justification of proposed number of children/families served
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| 1. **Service Delivery**
	1. Intensity of home-visiting
	2. Individualizing Services
	3. Content of Home Visits
		1. Child development
		2. Parent-child interaction
		3. Parent’s development
	4. Program Length
	5. Father Involvement
	6. Program Evaluation
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| 1. **Program Enhancements**
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| For HFI programs that were funded during the FY19 program year, please complete the following. |
| HFI policy/procedure Manual reviewed for accuracy. | Date:  |
| Average enrollment rate for the 1st - 3rd quarters during FY19, based on caseload capacity. | Rate:  |
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| Changes in curricula implemented during FY19 |

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| **TABLE C1: 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 | FSW |
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| 1. **COMMUNITY PARTNERS**
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| The purpose of this section is for the applicant to demonstrate that a network of community partners has been established that will support the agency in maintaining 85% of the agency caseload capacity (caseload capacity is determined by multiplying the full-time equivalency of Family Support Workers by the maximum caseload weight); connect children and families to critical resources; and recruit, hire, and retain staff. (**2 pages maximum)** |
| 1. **Recruitment Linkage Agreements**

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| **Table D1: RECRUITMENT LINKAGE AGREEMENTS** |
| **Organization** | **Services Provided** | **Formal Written Agreements****(Yes or No)** |
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| 1. **Community Partners**

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| **Table D2: LIST OF COMMUNITY PARTNERS** |
| **Organization** | **Services Provided** | **Formal Written Agreements****(Yes or No)** |
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| 1. **Recruitment of Staff**
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