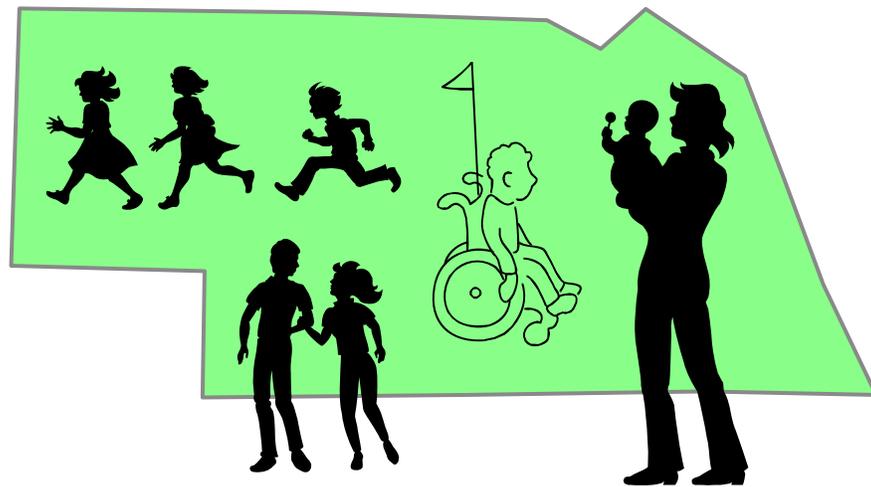


# PROCEDURE MANUAL

## NEBRASKA MATERNAL & CHILD HEALTH (MCH) GRANT CFDA #93.994

FY 2009 - 2011  
(October 1, 2008 – September 30, 2011)



Nebraska Department of Health and Human Services (DHHS)  
Division of Public Health  
Lifespan Health Services  
Planning & Support  
301 Centennial Mall South  
P.O. Box 95026  
Lincoln, Nebraska 68509-5026

**Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant**

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## Part I. Introduction

### A. Purpose of the Procedure Manual

- Provide general information about the Maternal and Child Health (MCH) Services / Title V Block Grant.
- Clarify relationships of the federal Maternal and Child Health Bureau (MCHB), Nebraska Health & Human Services, and Nebraska MCH Grant Subrecipients.
- Identify the responsibilities of Lifespan Health Services / Planning & Support within DHHS to administer Nebraska's MCH / Title V Block Grant, and specifically the portion of the Block Grant subgranted to local communities, referred to as **Nebraska MCH Grant**.
- Assist Subrecipients in the management / oversight of their Nebraska MCH Grant-funded activities.<sup>1</sup>
- Detail specific requirements for implementation and reporting outcomes of the approved Work Plan.
- Detail specific requirements for financial reporting.
- Provide resources to assist Subrecipients in their compliance with federal laws and regulations. The manual is intended to augment the federal Office of Management and Budget (OMB) Circulars and Code of federal Regulations (CFR). Please refer to these documents on the Internet for continuous, up-to-date information.

### B. Organization of the Procedure Manual

- Most of the information in this manual is arranged in a question and answer format with step-by-step instructions for identifying important information, including completing forms and reports.

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<sup>1</sup> However, not all references in these procedures are relevant for all subrecipients funded during this project period. *For example*, a sliding fee scale is relevant for some and not for others. In this project period, providing a service for which a fee is charged is based on a broader life course health approach and not for a more time-limited benefit. This is due to the MCH Grant shift from routine, direct health care services to one of the following themes:

1. An emphasis on population-based, primary prevention and wellness models
2. Social ecological model, including social determinants of health and health equity
3. A life course approach to improving health outcomes, including the importance of preconception and interconception health
4. Importance of community-wide and system level change.

**Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant**

- Additional information is incorporated in the manual by reference. Information incorporated by reference has at least equal importance as if fully set forth in the manual. Website references helps ensure continuously updated and accurate information that is readily available generally, and provided in a more cost-efficient manner.
- Some key information from the Request for Applications (RFA) issued May 5, 2008 is set forth in this Procedure Manual for convenience and clarity. However, the RFA in its entirety should be incorporated in Subrecipient document files.
- Subrecipients previously awarded these funds who are familiar with earlier versions of the Procedure Manual should be aware that there have been revisions from prior project periods. ***This manual supercedes all previous manuals.***

## **Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant**

### **Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant**

#### **A. Background**

The Title V / Maternal and Child Health (MCH) Block Grant is one of the oldest federal funding sources to ensure the health of our Nation's mothers and children. Since passage of the Social Security Act in 1935, the federal Government has pledged its continuous support of Title V of the Act, making Title V the longest lasting public health legislation in United States history. Title V funding was converted to a block grant as part of the Omnibus Budget Reconciliation Act of 1981 (OBRA '81) when seven categorical funds were consolidated into a "block" of funding to broadly address a variety of health needs of mothers and children. OBRA '89 amendments require that State and federal Title V program activities "**improve the health of all mothers and children**" consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the Year 2000, i.e. now Healthy People 2010 objectives.

States and territories are allocated funds based on a formula through the United States Department of Health and Human Services, Maternal and Child Health Bureau (MCHB). A state's acceptance of federal Title V / MCH Block Grant funds imparts responsibility to the state to assure the health of all mothers and children in the state; to systematically assess health needs and determine health priorities; to develop systems that build capacity across the state to address these priority needs; and to be accountable for programs and services and their outcomes. States identify their specific health needs of the population through a five-year statewide needs assessment; submit an annual plan for meeting the needs identified by the statewide needs assessment; and report annually on performance measures. Also, States must match three dollars to every four dollars of Title V / MCH Block Grant funds, thereby creating a federal-State Partnership.

#### **State Requirements**

States prepare and transmit a standardized grant request and report July 15<sup>th</sup> each year based on the Block Grant Guidance, a comprehensive resource book of required application forms and submission guidelines approved by the Office of Management and Budget (OMB). OMB is organizationally within the Executive Office of the President. There are major requirements in the application, including a Statewide needs assessment, a plan for meeting the needs identified by that assessment, and other specific items on which States must report.

The Title V / MCH Block Grant Program requires that every \$4 of federal money must be matched by at least \$3 of State and local money. This "match" results in the

## Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant

availability of more than 2 billion additional dollars nationwide for MCH programs annually at the State and local level. States must use at least 30% of federal Block Grant funds for preventive and primary care services for children (defined as a child from 1<sup>st</sup> birthday through the 21<sup>st</sup> year), and at least 30% for children with special health care needs (see detailed definition of these populations in the Glossary [Attachment 12, RFA], and no more than 10 percent for administration. States must meet the 30-30-10 statutory requirement for each federal allotment. Funds allocated to States are available for obligation and expenditure over a two-year period. **For more information:**

[https://perfddata.hrsa.gov/mchb/mchreports/LEARN More/Block Grant Program/block grant program.asp](https://perfddata.hrsa.gov/mchb/mchreports/LEARN%20More/Block%20Grant%20Program/block%20grant%20program.asp)

State MCH programs meet their Title V Block Grant responsibilities through a wide range of programs, with specific goals for:

- Reducing morbidity and mortality by assuring pregnant women, infants, children, and adolescents full access to quality, community-based preventive and primary care
- Developing family-centered, coordinated, community-based systems of care
- Participating in interagency coordination, especially with Medicaid; Women, Infants, and Children (WIC) Supplemental Nutrition program; Individuals with Disabilities in Education Act (IDEA); and other children's health, education, and social services programs
- Providing rehabilitative services to SSI recipients under age 16 who are not covered by Medicaid
- Linking Title V efforts to national year 2010 objectives
- Conducting comprehensive needs assessments every 5 years and preparing annual plans as part of a standardized application process
- Submitting to MCHB State annual reports reviewing program developments, health status and service data, and progress in meeting State and national health objectives. A report for the previous fiscal year and application for the following fiscal year are a combined process due each July 15<sup>th</sup>.

### **B. Restrictions**

Title V funds, including the amounts paid to Subrecipients awarded Nebraska MCH Grant funds, may not be used for:

- inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;
- cash payments to intended recipients of health services;

## Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant

- the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;
- satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
- providing funds for research or training to any entity other than a public or nonprofit private entity; or
- payment for any item or service (other than an emergency item or service) furnished
  - by an individual or entity during the period when such individual or entity is excluded from providing service under the Maternal and Child Health Act or Title XVIII (Medicare), Title XIX (Medicaid) or Title XX (Services for Families, Children, Aged or Disabled) of the Social Security Act pursuant to section 42 U.S.C. 1320a-7, 42 U.S.C. 1320a-7a, 42 U.S.C. 1320c-5, or 42 U.S.C. 1395u(j)(2) of the Social Security Act; or
  - at the medical direction or on the prescription of a physician during the period when the physician is excluded from providing services in the Maternal and Child Health program or Title XVIII (Medicare), Title XIX (Medicaid) or Title XX (Services for Families, Children, Aged and Disabled) of the Social Security Act pursuant to 42 U.S.C. Section 1320a-7, 42 U.S.C. Section 1320a-7a, 42 U.S.C. Section 1320-5, or 42 U.S.C. 1395u(j)(2) of the Social Security Act and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

### C. Federal Organizational Charts and Information

To view the U.S. Department of Health & Human Services (HHS) organization chart, see <http://www.hhs.gov/about/orgchart.html>. Within HHS, learn about the Health Resources and Services Administration (HRSA) by either clicking on the HRSA organizational box at the HHS organization chart, or by going directly to the HRSA website found at <http://www.hrsa.gov/> That site describes various functions of HRSA, including its role as the organizational parent of the Maternal and Child Health Bureau (MCHB).

HRSA's organizational structure is illustrated at <http://www.hrsa.gov/about/orgchart.htm>.

MCHB's organizational structure is shown by clicking on its box within HRSA, or linking at <http://www.hrsa.gov/about/org/mchb.htm>.

## **Part II. Title V of the Social Security Act / Maternal & Child Health Block Grant**

For additional information about Title V of the Social Security Act, the MCH Block Grant, and other current issues in the maternal and child health population, see MCHB's website at <http://mchb.hrsa.gov/>. The Title V Information System provides the most current nationwide MCH data reported to MCHB <https://performance.hrsa.gov/mchb/mchreports>.

Part III. Nebraska MCH Grant

A. Nebraska's Ten MCH Priority Needs

These priority needs were identified through a comprehensive needs assessment completed in 2005.

- Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.
- Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco *and* reduce the percent of infants, children and youth exposed to second hand smoke
- Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.
- Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.
- Reduce the number and rates of child abuse, neglect, and intentional injuries of children.
- Reduce the rates of infant mortality, especially racial/ethnic disparities.
- Reduce alcohol use among youth.
- Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth, including children and youth with special health care needs, with emotional and behavioral health conditions.
- Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.
- Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years. **Restated programmatically in 2008:** *"Build capacity of Title V programs for Children with Special Health Care Needs to provide transition clinics for youth with special health care needs 17-22 years by coordinating all services."*

## B. Funding Components

The portion of Nebraska's Title V / MCH Block Grant that is subgranted in FY 2009, funds are channeled through two mechanisms:

- 1) A portion of the MCH Block Grant, totaling approximately **\$1 million**, is **subgranted through a competitive process to community-based organizations** that propose activities to reduce the rates of overweight and obesity, to reduce rates of premature and low birth weight births with attention to adolescent pregnancy, and to reduce rates of infant mortality disparities.
- 2) Annual funds totaling **\$200,000** are subgranted to the four federally-recognized Tribes of Nebraska through a **non-competitive tribal setaside** in recognition of their sovereignty and the unique government-to-government relationship with the State of Nebraska. The Nebraska Intertribal Health Coalition (comprised of Tribal Chairpersons and Tribal Health Directors), through DHHS staff, establish the methodology to delineate the setaside funds among the four Tribes. These subgrants to the Tribes are used for MCH services and infrastructure<sup>2</sup>.

**Subrecipients in each of the subgranted components are subject to the Procedures set forth in this manual.**

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<sup>2</sup> "*Services*" are activities directed at the needs of a population. At least one of Nebraska's Ten MCH Priority Needs will be addressed. "*Infrastructure or projects*" focus on overall capacity-building activities to address those needs. One or more of the Essential Public Health Services to Promote Maternal and Child Health in America will be addressed for capacity-building activities for *infrastructure*.

**C. Nebraska MCH Grant Subrecipient Award List**

Nebraska MCH Grant Awards - Three-Year Period  
 Competitive Subgrants of Federal Title V / Maternal and Child Health Block Grant, CFDA #93.994

Goals	Outcomes	Subrecipients FY2009-2011	FY 2009 Award	Activity Summary
Children enter kindergarten at a healthy weight.	Communities have increased capacity to provide services to promote healthy weight among children	Four Corners Health Dept	\$ 26,475	Implement <i>Animal Trackers</i> curriculum in daycares/preschools. Host Family Fun Nights to support families in physical activity and healthy eating.
Reduce rates of preterm and low birth weight births.	Increased access to preventive health care for women of reproductive age. Women demonstrate a reduction in adverse health behaviors and an increase in healthy behaviors.	Northeast NE Family Services	\$ 98,396	Enhance family planning visits to include preconception risk assessment and reproductive health plan. Increase access to early prenatal care via local health dept Call Care Line and referral to physicians.
Eliminate disparities among racial/ethnic minorities.	Health care systems provide culturally competent preconception health care.	Goldenrod Hills Community Action, Inc.	\$ 165,000	Enhance pre-existing Operation Great Start: 1) infant care home visitation; 2) teen parent education; 3) preconception and interconception care.
Reduce rates of infant mortality.	Women demonstrate a reduction in adverse health behaviors and an increase in healthy behaviors. Women/couples have improved health literacy as measured by their ability to understand and act on information and navigate the health system. Parents and other caregivers routinely provide safe sleeping environments for infants.			
Women of reproductive age are at a healthy weight, including prior to and between pregnancies.	More workplaces and schools will have effective wellness policies that address: nutrition and physical activity; breastfeeding support; and environmental supports for wellness.			
Reduce rates of preterm and low birth weight births.	Women at risk for or with history of poor birth outcomes receive targeted pre and interconception care.	Panhandle Public Health District	\$ 128,094	Campaign for and support workplace policy change and environmental supports for breastfeeding, physical activity and nutrition. Partner with clinics to assess reproductive women for preconception / interconception plan.

**Part III. Nebraska MCH Grant**

Women of reproductive age are at a healthy weight, including prior to and between pregnancies.	<p>More workplaces and schools will have effective wellness policies that address: nutrition and physical activity; breastfeeding support; and environmental supports for wellness.</p> <p>More women in school and/or workplace settings engage in healthy behaviors.</p>	South Heartland District Health Department	\$ 64,132	Assess, train, and support workplaces to develop teams to implement worksite wellness policy and supports.
Children enter kindergarten at a healthy weight.	Communities have increased capacity to provide services to promote healthy weight among children	Lincoln Lancaster County Health Department	\$ 22,500	Convene community partners and resources to pilot "54321 GO" project in three census tracts of Lincoln.
Reduce rates of preterm and low birth weight births.	<p>Increased access to preventive health care for women of reproductive age.</p> <p>Women/couples have a reproductive life plan.</p> <p>More women have pre-pregnancy health visits.</p>	Central Health Center	\$ 156,810	Integrate preconception and interconception care into clinic visits, develop reproductive life plans. Use information technology (My Space) to promote.
Reduce rates of preterm and low birth weight births.	Women at risk for or with a history of poor birth outcomes receive targeted preconception and interconception care.	University of Nebraska Medical Center	\$ 210,041	Expand scope of pre-existing Maternal Care Program to include pre- and interconception care. Add training and continuing education for medical students, residents, and practicing physicians on life course concept to improve birth outcomes.
Women of reproductive age are at a healthy weight, including prior to and between pregnancies.	Women demonstrate a reduction in adverse health behaviors and an increase in healthy behaviors.			
Eliminate disparities among racial/ethnic minorities.	Increased access to preventive health care for women of reproductive age.			
Reduce rates of infant mortality.	<p>Women at risk for or with a history of poor birth outcomes receive targeted preconception and interconception care.</p> <p>Women/couples have improved health literacy as measured by their ability to understand and act on information and navigate the health system.</p>	Northeast Nebraska Public Health Department	\$ 75,786	Create Northeast Nebraska Child-Fetal Infant Mortality Review Project with a Case Review Team and Community Action Team to perform death case reviews. Evaluate home visitation services in the district. Formation of Health Literacy Council.

Some awards are based on an adjusted 9-month period beginning January 1, 2009. The total reflects the obligations for the FY 2009 period October 1, 2008 -- September 30, 2009.

\$ 947,234

**D. Essential Public Health Services to Promote Maternal and Child Health in America**

The following list is an adaptation of the essential public health services to specifically promote MCH. It serves as a backdrop for the Nebraska MCH Grant.

1. Assess and monitor maternal and child health status to identify and address problems.
2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.
3. Inform and educate the public and families about maternal and child health issues.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.
6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.
7. Link women, children, and youth to health and other community and family services and assure access to comprehensive, quality systems of care.
8. Assure the capacity and competency of the public health and personal health workforce to effectively address maternal and child health needs.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related programs.

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*"Public MCH Program Functions Framework: Essential Public Health Services To Promote Maternal and Child Health in America,"* Grason, H.A. and Guyer, B., The Johns Hopkins University Child and Adolescent Health Policy Center, December 1995.

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health, Lifespan  
Health Services, Planning & Support**

**A. Timelines**

The following is intended to clarify the roles and responsibilities of Nebraska Department of Health & Human Services (DHHS) for the administration of 1) Nebraska Title V / MCH Block Grant, and 2) Nebraska MCH Grant. Shaded entries show DHHS' role in its responsibilities to the federal Maternal and Child Health Bureau (MCHB).

**FY 2009**

October 1, 2008 .....	Nebraska MCH Grant period begins for Tribal setaside awards and 1 <sup>st</sup> round of the competitive awards
January 1, 2009.....	Nebraska MCH Grant period begins for the 2 <sup>nd</sup> round of competitive awards (issued 9-month awards beginning in 2 <sup>nd</sup> Quarter)
January 15, 2009.....	1 <sup>st</sup> Quarter Reports due (unless previously approved for extension)
April 15, 2009.....	2 <sup>nd</sup> Quarter Report due (unless previously approved for extension)
April & May, 2009 ....	Public input re: Nebraska's application for Title V/MCH Block Grant FY 2010 funds
July 15, 2009 .....	federal MCH/Title V Block Grant Report (FY 2008) & Application (FY 2010) due date
July 15, 2009 .....	3 <sup>rd</sup> Quarter report due (unless previously approved for extension)
August, 2009 * .....	Requests for continuation (non-competitive) FY 2010 funding
Sept. 30, 2009.....	Fiscal Year 2009 ends
Nov. 30, 2009 .....	4 <sup>th</sup> Quarter/Final Reports due (no extensions to allow for grant close-out)

**FY 2010**

October 1, 2009 .....	Nebraska FY 2010 MCH Grant period begins
January 15, 2010.....	1 <sup>st</sup> Quarter Reports due (unless previously approved for extension)
April 15, 2010.....	2 <sup>nd</sup> Quarter Report due (unless previously approved for extension)
April & May, 2010 ....	Public input re: Nebraska's application for Title V/MCH Block Grant FY 2011 funds
July 15, 2010 .....	federal MCH/Title V Block Grant Report (FY 2009) & Application (FY 2011) due date
July 15, 2010 .....	3 <sup>rd</sup> Quarter report due (unless previously approved for extension)
August, 2010 * .....	Requests for continuation (non-competitive) FY 2011 funding
Sept. 30, 2010.....	Fiscal Year 2010 ends

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

Nov. 30, 2010 ..... 4<sup>th</sup> Quarter/Final Reports due (no extensions to allow for grant close-out)

**FY 2011**

October 1, 2010 ..... Nebraska FY 2011 MCH Grant period begins

January 15, 2011..... 1<sup>st</sup> Quarter Reports due (unless previously approved for extension)

March, 2011\* ..... Issue competitive Request for Applications for the three-year cycle (FY 2012-2014)

April 15, 2011..... 2<sup>nd</sup> Quarter Report due (unless previously approved for extension)

April & May, 2011 Public input re: Nebraska's application for Title V/MCH Block Grant FY 2012 funds

July 15, 2011 ..... federal MCH/Title V Block Grant Report (FY 2010) & Application (FY 2012) due date

July 15, 2011 ..... 3<sup>rd</sup> Quarter report due (unless previously approved for extension)

Sept. 30, 2011..... Fiscal Year 2011 and three-year project period ends

Nov. 30, 2011 ..... 4<sup>th</sup> Quarter/Final Reports due (no extensions to allow for grant close-out)

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\* Approximate dates; all other dates confirmed.

**B. State-level Administration of the Block Grant**

The primary administration of Nebraska's Title V/MCH Block Grant is performed by Lifespan Health Services / Planning & Support within DHHS Division of Public Health.

The current organization chart for the Division of Public Health is available at <http://www.dhhs.ne.gov/OrgCharts/PublicHealth.pdf>. Lifespan Health Services is located on page 6 of 8 of the Public Health Division organization chart.

The day-to-day operations are the responsibility of the Federal Aid Administrator for the Lifespan Health Services unit, who is the primary contact for the Nebraska MCH Grant:

Rayma Delaney, MSW  
Title V / MCH Grant Administrator  
Lifespan Health Services -- Planning & Support  
P.O. Box 95026  
Lincoln NE 68509-5026  
[rayma.delaney@nebraska.gov](mailto:rayma.delaney@nebraska.gov)  
Phone: (402) 471-0197  
Fax: (402) 471-7049

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

Each state and territory awarded federal Title V / MCH Block Grant is required to have a oversight of an MCH Director and a CSHCN Director. Nebraska's MCH and CSHCN Directors are Paula Eurek and Ginger Goomis.

MCH Director	CSHCN Director
<i>Paula Eurek</i> Administrator, Lifespan Health Services <b>Division of Public Health</b>	<i>Ginger Goomis</i> Administrator, Long Term Care Programs Section <b>Division of Medicaid &amp; Long Term Care</b>

See <http://www.dhhs.ne.gov/OrgCharts/Medicaid.pdf> for the current organization chart of DHHS, Division of Medicaid & Long Term Care.

**C. Contact Information**

For general communication about Title V / MCH Block Grant and Nebraska MCH Grant, contact:

Nebraska Department of Health & Human Services,  
Division of Public Health  
Lifespan Health Services -- Planning & Support  
Attn: Tracy Welton, Administrative Assistant  
P.O. Box 95026  
Lincoln, Nebraska 68509-5026  
Phone: (402) 471-2907  
Fax: (402) 471-7049

Subrecipients may also contact a specific state-level staff person for technical assistance, as relevant:

Contact Person	Phone #, Email Address	Content Area
Rayma Delaney Planning & Support DHHS, Division of Public Health	(402) 471-0197 <a href="mailto:rayma.delaney@nebraska.gov">rayma.delaney@nebraska.gov</a>	grants management program interventions budgeting funding monitoring
Jennifer Severe-Oforah MCH Epidemiology DHHS, Division of Public Health	(402) 471-2091 <a href="mailto:jennifer.severeoforah@nebraska.gov">jennifer.severeoforah@nebraska.gov</a>	assessment planning evaluation
Cinde Swartz Grants & Cost Mgmt DHHS, Operations	(402) 471-2792 <a href="mailto:cinde.swartz@nebraska.gov">cinde.swartz@nebraska.gov</a>	indirect costs audit requirements

#### D. Compliance with Federal Statute, Regulations, and Circulars

The MCH Block Grant is authorized under the 1981 Omnibus Budget Reconciliation Act, as amended, and is codified at 42 USC 701 through 709. The implementing regulations for this and other HHS block grant programs are published at 45 CFR part 96.

[http://www.access.gpo.gov/nara/cfr/waisidx\\_07/45cfr96\\_07.html](http://www.access.gpo.gov/nara/cfr/waisidx_07/45cfr96_07.html) Those regulations include both specific requirements and general administrative requirements for the covered block grant programs in addition to 45 CFR part 92 (the HHS implementation of the A-102 Common Rule). Under 45 CFR part 96, a State may adopt its own written fiscal and administrative requirements for expending and accounting for block grant funds. DHHS chooses to defer to the federal OMB Circulars rather than a state version for requirements for cost and administrative principles.

DHHS must comply with the following federal authorities in the administration of the Title V / Maternal and Child Health Block Grant.

- *Social Security Act, Title V* (45 U.S.C. 701-709)
- *Code of federal Regulations* (42 C.F.R. 96)
- *federal Office of Management and Budget (OMB) Circulars* pertaining to cost principles, administrative requirements, and audit requirements.

## **E. Monitoring**

### **Q: What type of monitoring will be done on my program?**

- Monitoring of the Nebraska MCH Grant-funded programs is accomplished through several methods including review of written program and expenditure reports, telephone calls, electronic mail, or site visits.
- DHHS staff will incorporate all or some of these methods in their review of program activities.
- Official records of each program's progress in addressing MCH priority needs and outcomes in the Subrecipient work plan as set forth in the approved application are maintained by Lifespan Health Services -- Planning & Support.
- DHHS staff provides review of federally required audits and performs on-site fiscal monitoring, as needed, to ensure that financial management systems are adequate to meet federal requirements and to provide technical assistance in financial management.

### **Q: What is the purpose of a site visit?**

- Site visits are the first-hand opportunity to review program activities and progress made in addressing the MCH priority needs of the programs funded by Nebraska MCH Grant funds.
- Site visits are one way that Lifespan Health Services -- Planning & Support staff provides technical assistance to enhance Subrecipient's MCH program and grant management. Examples include needs assessment, program planning, budgeting, implementation, reporting, and program evaluation. In addition, site visits help foster working relationships between staff of Lifespan Health Services -- Planning & Support and Subrecipients.

### **Q: What is the process for site visits?**

- Subrecipients will be notified in writing of the monitoring site visit.
- The letter will specify information concerning how long the visit will take, who will need to be available for the visit, what activities will occur during the visit, and type of source documentation to be reviewed.

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

- The site visit will be followed by a letter indicating findings and recommendations for corrective actions, if any.
- The DHHS is responsible for fiscal monitoring as required by federal regulations found in OMB Circular A-133. A financial reviewer may conduct an on-site assessment of the fiscal management of the activities.
- All records and documentation shall be made available to DHHS as the pass-through granting agency, State of Nebraska auditors, or independent auditors retained by Subrecipient, as warranted.

**Q: How often should I expect a site visit?**

- Site visits will be conducted as needed.

**Q: Should I expect unannounced visits?**

- Although less likely, Lifespan Health Services -- Planning & Support staff reserves the right to conduct site visits without prior notice. This may include observation of scheduled activities and events.
- Lifespan Health Services -- Planning & Support will take advantage of opportunities to consolidate travel to between site visits or other meetings. This could include an unannounced visit to a Subrecipient to meet face-to-face to discuss the activities and to answer any questions.

**Q: Can we request a site visit?**

- Subrecipients are encouraged to invite Lifespan Health Services -- Planning & Support staff to events or activities of the MCH Grant. Opportunities to observe activities in action improve understanding.
- Subrecipients may request a site visit to receive technical assistance from Lifespan Health Services -- Planning & Support. Lifespan Health Services -- Planning & Support will consider the request based on the most effective and feasible option to provide technical assistance.

**Q: Site visits make me nervous. What if I receive a report with many recommendations? Will funding for my activities be in jeopardy?**

- Site visits should not be viewed as a win or lose situation. Site visits are part of DHHS' monitoring responsibility for administration of these federal funds.

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

- Lifespan Health Services -- Planning & Support staff will work in partnership with you to make your activities successful and cost-effective. Reviews are conducted with this goal in mind.
- Recommendations to improve your activities are to help assure that these funds are maximized.
- Only in serious circumstances would Lifespan Health Services -- Planning & Support staff recommend to the Director of the DHHS that funding be suspended or terminated. However, improper administration of the Nebraska MCH Grant funded activities or lack of performance to carry out the activities set forth in the work plan could result in suspension or termination of the subgrant. The terms and conditions for suspension or termination are contained in the Subgrant Terms and Assurances by reference to the federal grants administrative requirements applicable to Subrecipient, i.e. OMB Circulars A-102 or OMB A-110. Subrecipients agreed to comply with the terms and conditions described in the Subgrant Terms and Assurances. The Subgrant Terms and Assurances are part of the approved application on file with the DHHS.

**F. Reimbursement**

Except for an approved Cash Advance, payments to Subrecipient are reimbursements of actual expenses. In any fiscal year if expenses are less than the award, Subrecipients will not be allowed to carry forward grant funds from a prior year into a succeeding year, e.g. any unobligated or unexpended funds in FY 2009 will not be added to the FY 2010 award.

**Q: What should I do to ensure timely reimbursement of expenditures?**

- Submit reports with original signatures, signed by individuals representing program and finance operations of the Subrecipient. To ensure confidence in the authenticity of the signatures of representatives authorized by the Subrecipient, persons signing the Expenditure Report shall be:
  - 1) the two persons indicated on the Cover Sheet of the approved grant application,  
  
*or, in the alternative*
  - 2) identified by name, title, and printed name on the Expenditure Report.

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

Lifespan Health Services -- Planning & Support reserves the right to hold a reimbursement payment request pending satisfaction of a concern of segregation of duties and other matters of internal control, or if a portion of a report is missing, incomplete, or unclear. Lifespan Health Services -- Planning & Support will notify Subrecipient if a payment is being held, the reason for holding, and identify what is needed to resolve the concern.

- Complete the upper portion of the Expenditure Report with accurate, complete information, e.g. Grant #, Subrecipient name and address, federal tax identification number (FTIN), reporting period, etc. Keep Lifespan Health Services -- Planning & Support informed of any address changes, and always use the current address on the Expenditure Report.
- Submit the Program Report and Expenditure Report together and on or before the due date. Refer to the Timeline in Part I. Introduction, or to Exhibit 1 of the Subgrant Terms and Assurances for the reporting due dates.

**Q: When a request for reimbursement is sent to Lifespan Health Services - - Planning & Support, how long does it take until the Subrecipient receives payment?**

- It generally takes at least three to four weeks **from the due date** before the warrant is sent to your agency. Incomplete and late reports may require additional time to process.
- Electronic payments have a shorter turnaround time. Reimbursements of \$75,000 or more must be electronic payment. If Subrecipient is not set up for electronic payment, and needs to be or would like to be, submit the request for electronic payment to Lifespan Health Services -- Planning & Support. Include the Grant #, the name and phone number of the finance representative for the Subrecipient. Lifespan Health Services -- Planning & Support will forward the request to the DHHS Accounting unit.

**Q: What is the process for reimbursement?**

- The Program Report and Expenditure Report are received in Lifespan Health Services -- Planning & Support.
- The Expenditure Report is checked for Subrecipient's current billing/payment address, mathematical accuracy, correct federal tax identification number, and two original signatures of authorized representatives of Subrecipient.

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health,  
Lifespan Health Services, Planning & Support**

- Expenditures are evaluated with respect to the corresponding Program Report to determine if expenses are allowable, allocable, reasonable and within budget. Match expenditures, including program income, are reviewed using the same criteria as grant expenditures.
- The Program Report is reviewed for current status and progress in moving towards expected outcomes from the approved Work Plan.
- If Lifespan Health Services -- Planning & Support has any questions, or needs clarification, a call is made or e-mail is sent to the relevant contact of Subrecipient, i.e. program or finance. In some cases, other DHHS staff may contact the Subrecipient for clarification.
- When the reporting requirements are satisfied, the MCH Grant Administrator approves the reports by signing and forwarding to the Administrator, Lifespan Health Services for final authorization.
- With authorization, the reimbursement request is sent to the Accounting unit of the Department of HHS Finance and Support where the payment process begins.
- The request is then sent to the Nebraska Department of Administrative Services (DAS) for issuance of the warrant. The warrant is sent U.S. Mail unless electronic payment has been previously established.

**G. Technical Assistance**

Throughout the funding period there will be opportunities identified by Lifespan Health Services -- Planning & Support for qualified individuals to provide Subrecipients with assistance of specific health related or administrative services. Topics that may be included are assessment, data analysis, planning, coordination, collaborative leadership, data system development, performance measures, and grants management.

**H. Fiscal Year Close-Out**

Fiscal year closeout activities are the final review and payment of funded activities. Lifespan Health Services -- Planning & Support checks to make sure that each of the following five items are satisfied: 1) reports, including the final reporting Tables 1-3, are accurate and completed fully 2) a full accounting of a start-up cash advance (as relevant) 3) the total reimbursement (shown as cumulative expenditures) does not exceed the grant award, 4) expenditures of match are at least 20% of grant expenditures 5) program income, if any, has been fully reinvested and as shown by cash match. Fiscal year closeout procedures are necessary to determine unliquidated

**Part IV. Roles & Responsibilities of DHHS, Division of Public Health, Lifespan Health Services, Planning & Support**

obligations of the federal award to the State. This assists in the accurate projection of funding available in the subsequent fiscal year, and to submit federal reports.

Subsequently, final expenditure reports must be received within 60 days from the end of the funding period to perform timely fiscal year close-out. **DHHS reserves the right to not process requests for reimbursement received more than 60 days after the end of the funding period.** In addition, a list of equipment purchased with grant funds may be submitted with the final expenditure report. For other fiscal year close-out information refer to the Program Income and Equipment/Supply Sections.

## Part V. Subrecipient Responsibilities

### Part V. Subrecipient Responsibilities

#### A. Timelines

The DHHS requested proposals for the three-year period October 1, 2008 – September 30, 2011. The project period is divided by fiscal years as referenced below:

Year 1 / Fiscal Year 2009 ..... October 1, 2008 – September 30, 2009 \*  
Year 2 / Fiscal Year 2010 ..... October 1, 2009 – September 30, 2010  
Year 3 / Fiscal Year 2011 ..... October 1, 2010 – September 30, 2011

Each fiscal year is divided into four quarters (*\*with the exception of some of the FY 2009 awards in the competitive component adjusted for a nine-month period January 1, 2009 through September 30, 2009*). The corresponding reports for the 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> Quarters are due on the 15<sup>th</sup> day following the close of each quarter, *unless otherwise arranged in advance at the beginning of each fiscal year*. For example, consideration will be given to requests from Subrecipients whose internal accounting system function necessitates a change in due date to the 30<sup>th</sup>/31<sup>st</sup> day of the month. The Final Report is due November 30th, 60 days after the Fiscal Year ending September 30th.

**FY 2009 nine-month adjusted awards do not have a 1<sup>st</sup> Quarter period. These adjusted awards begin with the 2<sup>nd</sup> Quarter.**

1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter
October 1 – December 31	January 1 – March 31	April 1 – June 30	July 1 – September 30
Reports due January 15	Reports due April 15	Reports due July 15	Reports due November 30

Subrecipients receive an award letter based on a one-year budget for Year 1. Subrecipients who applied for and were awarded based on a multi-year project period will be required to submit an updated work plan and budget for continuation Year 2 and Year 3.

The following timeline should be used by Subrecipients as an overview of the three-year project period and the specific dates of the fiscal years. Reporting due dates are specified (see also Appendix 1, Subgrant Terms & Assurances, RFA). Requests for extension will be considered prior to the reporting due date. To assist in long-range planning, the following is an approximate timeline for the next funding cycle.

#### **Year 1 – FY 2009**

October 1, 2008 ..... Project period begins for Tribal setaside awards and 1<sup>st</sup> round of the competitive awards  
January 1, 2009..... Project period begins for the 2<sup>nd</sup> round of competitive awards (issued 9-month awards beginning in 2<sup>nd</sup> Quarter)  
Dec. 31, 2008..... 1<sup>st</sup> Quarter ends

## Part V. Subrecipient Responsibilities

January 15, 2009..... 1<sup>st</sup> Quarter reports due (*unless an extension is requested*)  
March 31, 2009 ..... 2<sup>nd</sup> Quarter ends  
April 15, 2009..... 2<sup>nd</sup> Quarter reports due (*unless an extension is requested*)  
June 30, 2009 ..... 3<sup>rd</sup> Quarter ends  
July 15, 2009 ..... 3<sup>rd</sup> Quarter reports due (*unless an extension is requested*)  
August, 2009\* ..... updated work plans and budgets due for Year 2  
Sept. 30, 2009..... 4<sup>th</sup> Quarter; Fiscal Year 2009 ends  
Nov. 30, 2009 ..... 4<sup>th</sup> Quarter/Final Reports due (no extensions of this date)

### Year 2 – FY 2010

October 1, 2009 ..... Fiscal Year 2010 begins  
Dec. 31, 2009..... 1<sup>st</sup> Quarter ends  
January 15, 2010..... 1<sup>st</sup> Quarter reports due (*unless an extension is requested*)  
March 31, 2010 ..... 2<sup>nd</sup> Quarter ends  
April 15, 2010..... 2<sup>nd</sup> Quarter reports due (*unless an extension is requested*)  
June 30, 2010 ..... 3<sup>rd</sup> Quarter ends  
July 15, 2010 ..... 3<sup>rd</sup> Quarter reports due (*unless an extension is requested*)  
August, 2010\* ..... updated work plans and budgets due for Year 3  
Sept. 30, 2010..... 4<sup>th</sup> Quarter; Fiscal Year 2007 ends  
Nov. 30, 2010 ..... 4<sup>th</sup> Quarter/Final Reports due (no extensions of this date)

### Year 3 – FY 2011

October 1, 2010 ..... Fiscal Year 2011 begins  
Dec. 31, 2010..... 1<sup>st</sup> Quarter ends  
January 15, 2011..... 1<sup>st</sup> Quarter reports due (*unless an extension is requested*)  
March 2011\* ..... Request for Applications FY 2012-2014 issued  
March 31, 2011 ..... 2<sup>nd</sup> Quarter ends  
April 15, 2011..... 2<sup>nd</sup> Quarter reports due (*unless an extension is requested*)  
June 2011\* ..... proposals due for Project Period FY 2012-2014  
June 30, 2011 ..... 3<sup>rd</sup> Quarter ends  
July 15, 2011 ..... 3<sup>rd</sup> Quarter reports due (*unless an extension is requested*)  
August 2011\* ..... funding decisions for Fiscal Years 2012-2014 announced  
Sept. 30, 2011..... 4<sup>th</sup> Quarter; Fiscal Year 2011 and three-year grant cycle ends  
Nov. 30, 2011 ..... 4<sup>th</sup> Quarter/Final Reports due (no extensions of this date)

\* Approximate dates; all other dates confirmed.

## **B. Compliance with Subgrant Terms and Assurances; Certifications**

- The Subgrant Terms and Assurances and its Appendices 1, 2, 3 and 4 [ATTACHMENT 4 of the RFA] are part of Subrecipient's approved application on file with DHHS. Subrecipients must comply with the Subgrant Terms and Assurances throughout the project period.

## Part V. Subrecipient Responsibilities

- Signed Certifications [**ATTACHMENT 4**, Appendix 4 of the RFA] are also part of Subrecipient's approved application on file with DHHS. In addition, Subrecipients who use MCH Grant funds to contract with another entity must obtain and maintain signed certifications from each subcontractor. [Note: The Certification Regarding Drug-Free Workplace Requirements includes, as an alternate, instructions and a form for grantees who are individuals. This Certification is for subcontracted individuals of a Subrecipient, not for Subrecipients since individuals are not eligible to apply for these MCH Grant funds.]

### C. **Compliance with Federal OMB Cost Principles, Administrative and Audit Requirements**

The Office of Management and Budget (OMB) Circulars are instructions or information to recipients/subrecipients of federal funds. These are expected to have a continuing effect of two years or more. Refer to the OMB Circulars on the Internet for continuous, up-to-date information.

<http://www.whitehouse.gov/omb/circulars>

#### Q: **Which Circular do I Follow?**

- **Cost Principles**

A-21, Educational Institutions (05/10/2004) [HTML](#) or [PDF](#) (109 pages, 263 kb), [Relocated to 2 CFR, Part 220](#) (30 pages, 384 kb)

A-87, State and Local Governments (05/10/2004) [HTML](#) or [PDF](#) (57 pages, 199 kb), [Relocated to 2 CFR, Part 225](#) (18 pages, 362 kb)

A-122, Non-Profit Organizations (05/10/2004) [HTML](#) or [PDF](#) (55 pages, 220 kb) , [Relocated to 2 CFR, Part 230](#) (17 pages, 235 kb)

- [How are cognizant agencies determined for indirect costs?](#)
- [Where is the updated OMB list?](#)

- **Administrative Requirements**

Refer to awarding agency's codification(s) of A-110 and A-102 for information on how to comply with these requirements under specific assistance agreements.

[A-102](#), State and Local Governments (10/07/1994, amended 08/29/1997)

- [Where is the A-102 Common Rule?](#)
- [Where are the Attachments to A-102?](#)
- [Where have Agencies Codified the A-102 Common Rule?](#)

[A-110](#), Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations (11/19/1993, amended 09/30/1999, [Relocated to 2 CFR, Part 215](#) (32 pages, 243 kb))

## Part V. Subrecipient Responsibilities

- [Where are the Attachments to A-110?](#)
- [Where have Agencies Codified A-110?](#)
- **Audit Requirements**
  - [Audits of States, Local Governments, and Non-Profit Organizations](#), Revisions to Circular A-133 (June 26, 2007) (2 pages, 78 kb)
  - A-133, States, Local Governments, and Non-Profit Organizations (06/24/1997, includes revisions published in *Federal Register* 06/27/2003) [HTML](#) or [PDF](#) (33 pages, 127 kb)
    - 2008 Compliance Supplement  
[http://www.whitehouse.gov/omb/circulars/a133\\_compliance/08/08toc.html](http://www.whitehouse.gov/omb/circulars/a133_compliance/08/08toc.html)

Although there are six grant circulars, Subrecipient is covered by only three of them. Use the following guide to identify the OMB Circulars relevant to Subrecipient by type of entity:

### **States, local governments, and Indian Tribes follow:**

- [A-87](#) for cost principles, [Relocated to 2 CFR, Part 225](#) (362k)
- [A-102](#) for administrative requirements, and
- [A-133](#) for audit requirements

### **Educational Institutions (even if part of a State or local government) follow:**

- [A-21](#) for cost principles, [Relocated to 2 CFR, Part 220](#) (384k)
- [A-110](#) for administrative requirements, [Relocated to 2 CFR, Part 215](#) (280k), and
- [A-133](#) for audit requirements

### **Non-Profit Organizations follow:**

- [A-122](#) for cost principles, [Relocated to 2 CFR, Part 230](#) (362k)
- [A-110](#) for administrative requirements, [Relocated to 2 CFR, Part 215](#) (280k), and
- [A-133](#) for audit requirements

## **D. Compliance with Code of Federal Regulations (CFR): 45 CFR**

The *Code of Federal Regulations* (CFR) is a codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the federal Government. The CFR online is a joint project authorized by the publisher, the National Archives and Records Administration's Office of the federal Register, and the Government Printing Office (GPO) to provide the public with enhanced access to Government information.

## Part V. Subrecipient Responsibilities

The CFR is divided into 50 titles which represent broad areas subject to federal regulation. Each title is divided into chapters which usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations to the CFR will be provided at the section level. Each volume of the CFR is revised once each calendar year and is issued on a quarterly basis.

Refer to CFR Services online for a list of all titles:

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html#page1>

To link to specific sections pertaining to Department of Health and Human Services Block Grants, e.g. Maternal and Child Health Services (MCH) Block Grant, see Title 45 – Public Welfare, Part 96 (45 CFR 96):

[http://www.access.gpo.gov/nara/cfr/waisidx\\_07/45cfr96\\_07.html](http://www.access.gpo.gov/nara/cfr/waisidx_07/45cfr96_07.html)

To retrieve by citation, use the following link. (**NOTE:** The Section # is obtained from the Index in the previous link.)

<http://www.gpoaccess.gov/cfr/retrieve.html>.

EXAMPLE:

Revision Year	Title	Part	Section	Subpart	File Type
Most Recent Available ▼	45	CFR 96	. 1	OR	Text ▼

### E. Internal Policies

#### 1. Personnel Policy

Subrecipients must have a written personnel policy if:

- employees are paid with, in whole or in part, Nebraska MCH Grant funds;
- volunteers donate time to activities reported as in-kind (non-cash match).

Written policies and records must be established and maintained, to include:

- current job descriptions of program staff or volunteers; and
- documentation of staff or volunteer time to perform grant-related activities.

All policies, procedures, and time records must be kept on file and be available for inspection.

## Part V. Subrecipient Responsibilities

### 2. Records Retention

Subrecipient will develop a records retention policy and schedule regarding information associated with the MCH Grant. Use the following guidelines regarding the types of records and length of time to retain those records:

- Refer to OMB Circulars relevant to Subrecipient.
- The Subrecipient's records retention policy will be no less comprehensive than requirements in OMB Circulars relevant to Subrecipient, and may impose additional requirements specific to Subrecipient.
- If Subrecipient provides direct healthcare services, Subrecipient is advised to consult with a legal authority regarding the records retention policy and schedule for medical files of minor children.

### 3. Sliding Fee Scale

Subrecipients providing a service for which they intend to impose fees directly to the client must develop a sliding fee scale for those persons not low income and not covered by Medicaid. (See also the section entitled "Program Income" in this Part V. Subrecipient Responsibilities, which discusses using the federal Poverty Guidelines. While many programs use the guidelines to classify persons or families as either eligible or ineligible, some other programs use the guidelines for the purpose of giving priority to lower-income persons or families in the provision of assistance or services, the latter of which is the case for Maternal and Child Health programs.)

SAMPLE:

SLIDING FEE SCALE Poverty Level	Size of Family			
	1	2	3	4
At or below 100%	No charge	No charge	No charge	No charge
101%--150%	25% of cost	25% of cost	25% of cost	25% of cost
151%--200%	50% of cost	50% of cost	50% of cost	50% of cost
201% -- 300%	100% of cost	100% of cost	100% of cost	100% of cost

## F. Program Operations

### 1. Work Plans

The Work Plan is the result of a community-level planning process. The Work Plan for the MCH Grant includes two parts: Description and Summary. The approved Work

## Part V. Subrecipient Responsibilities

Plan (or revisions approved with Planning & Support) must guide the work throughout the grant year.

### **Q: How do I use the Work Plan from the application?**

- Your approved Work Plan is used to guide your activities throughout the grant year, and to measure progress. (Note: The approved Work Plan may not be the initial Work Plan submitted, i.e. if a contingency of funding required Work Plan revisions, the final Work Plan submitted to Lifespan Health Services -- Planning & Support prior to the final notification of the award is considered the approved work plan.)
- Program staff should refer to the Work Plan often to assure that activities are occurring as planned.
- Quarterly Reports include updates to Lifespan Health Services -- Planning & Support on the status of the Work Plan. Reporting on the Work Plan is a means to gauge achievements, or if limited progress is being achieved, may indicate that the Work Plan requires modifications.

### **Q: Can I make changes in my Work Plan?**

- Revising the Work Plan, specifically adding or deleting any of the following components of the Work Plan requires a written request to Lifespan Health Services – Planning & Support: goals, outcomes, objectives, and/or performance measures. A change in Work Plan activities and timeline do not require prior approval, but should be communicated in the Quarterly Report.
- A request to revise Work includes:
  - A letter or e-mail requesting the change, referencing requested revisions by the numbering system used for the goal(s), outcome(s), objective(s), and/or performance measure(s).
  - Using the approved Work Plan, revise the typewritten document with respect to the revision request.
  - If the request to revise the Work Plan impacts the Budget, the approved Line Item Budget and Budget Justification should be modified accordingly. (See the section entitled “Budget Revisions” in this Part V. Subrecipient Responsibilities.)
- Subrecipient will receive a written response regarding the decision to approve or disapprove the requested revision. [**Note:** Proposed changes that appear to significantly alter the direction of the Nebraska MCH Grant funded activities may

## Part V. Subrecipient Responsibilities

not be approved.]

- If the request is approved, the revisions must be incorporated in all future reporting, including both the Work Plan and the Budget.

**Q: The close of the project period is near and more time is needed to accomplish outcomes listed in my Work Plan. What can I do?**

A no-cost extension is applicable in the final year of a Subrecipient's project period.

- A no-cost extension may be requested only if extenuating circumstances have prevented substantial progress in achieving the outcomes as identified by performance measures. The maximum length of a no-cost extension is two months, or November 30 of the same year.
- Requests for a no-cost extension cannot include revisions to the outcomes and performance measures of the approved Work Plan. Subrecipient may however request revisions to the inputs and outputs.
- Subrecipient submits a written request no later than September 15th to Lifespan Health Services -- Planning & Support. The request must outline the reason for the requested no-cost extension and describe how the extended time will affect the outcomes and performance measures in the approved Work Plan.
- Depending on the level of unexpended funds at the time of the request, Subrecipient may be asked to submit a revised Line Item Budget and Budget Justification for the amount needed during the extended time. No additional funds will be awarded.
- If the no-cost extension is approved by Lifespan Health Services -- Planning & Support, an amended award letter will be issued to reflect the project period extension to November 30, and may include the specific amount of funds from the award authorized for the no-cost extension.
- The 4<sup>th</sup> Quarter/Final Report (for no-cost extensions only) is due January 31<sup>st</sup> in the calendar year following the conclusion of the no-cost extension, i.e. two months after the conclusion of the amended award. For example, the 4<sup>th</sup> Quarter Report and Final Report are due January 31, 2007 for an approved no-cost extension of the FY2006 amended award ending November 30, 2006.

## 2. National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

See [SEE ATTACHMENT 10, RFA]. Subrecipients are to move towards full compliance with the four mandated CLAS Standards. DHHS will provide technical assistance over the grant period to assist subrecipients meet this requirement. Compliance with the other standards is encouraged.

## 3. Review of Materials and Acknowledgement of Support of Federal Funds.

Materials produced with MCH Grant funds that will be disseminated to the public should be reviewed and approved by Lifespan Health Services -- Planning & Support prior to dissemination. Materials must acknowledge support from federal funds. A compilation of materials produced by other sources should not credit MCH Grant funds. [See Subgrant Terms & Assurances, RFA, ATTACHMENT 4, paragraph O. "Publications, Publicity, Conferences or Training and Acknowledgement of Support".]

Use the following acknowledgement on any materials supported by Nebraska MCH Grant funds:

*"This activity is supported by federal Title V / Maternal and Child Health Block Grant Funds awarded to [subrecipient name] by the Nebraska Department of Health and Human Services, Division of Public Health."*

### **Q: What types of products should be reviewed and credited to Federal Maternal and Child Health funds by DHHS?**

There are various types of products that may be supported with MCH Grant funds in a variety of forms, i.e. print, electronic, video, or sound productions. Examples include news releases, articles, brochures, flyers, newsletters, websites, video or audio tapes, and models. The products supported with the MCH Grant should contain an acknowledgment of that support (see the wording in item 3. above.)

### **Q: What is the reason that products supported with these grant funds should be reviewed and approved prior to dissemination to the public?**

Lifespan Health Services -- Planning & Support respects the uniqueness of communities, their diverse needs and interventions supported with these grant funds. Establishing a centralized process for products supported by these funds statewide is intended to complement the development of community-level products. Review and approval prior to dissemination of products maximizes existing resources, coordinates new development, and expands the Nebraska MCH resource library. The purposes of prior review and approval of products supported by MCH grant funds is to achieve consistent

content and quality, and to more readily share information statewide with other Subrecipients.

#### **4. Program Evaluation**

The extent of the evaluation design is relative to the value of the award. As a guideline, approximately 5-10% of the budget of MCH Grant funds should be designated for evaluation, e.g. costs associated with evaluation such as personnel, consultants, and supplies to collect and analyze data. Evaluation must be included not only in the planning stages, but throughout the three-year life cycle of the proposal. The process cannot be delayed until the mid-point or at the end of the project period for a valid evaluation plan. Evaluation activities must be incorporated in the Work Plan timeline.

### **G. Finance Operations**

#### **1. Cash Advance**

(See also Cash Advance in the Program Specific Requirements [Exhibit 2, Subgrant Terms and Assurances] which is Attachment 4 of the Request for Applications (RFA) for Nebraska MCH Grant FY 2009-2011.)

**Q: What can I do if I need working capital to get started?**

A cash advance may be requested if other funds are not available to pay for the startup costs of the activities for the 1<sup>st</sup> Quarter of a fiscal year. The maximum amount available for a one-time cash advance is 25% of the Subrecipient award. Subrecipient must send a written request, as described below, to be considered by Planning & Support.

**Q: What is the process for a cash advance?**

- Subrecipient determines if other funds are available to pay for start-up costs of the activities for the 1<sup>st</sup> Quarter of a fiscal year.
- If other funds are not available, a written request must include a declaration that Subrecipient will suffer serious cash flow problems without a cash advance. The declaration and rationale for the request must accompany the request, plus any supporting evidence as warranted.
- Complete the Request for Cash Advance form found in the following pages of this section. Instructions for completing the form are included. Note: Representatives for program and finance must both sign the form. Provide contact information for those signing the form for the purpose of notification

## Part V. Subrecipient Responsibilities

from Planning & Support regarding approval or non-approval of the request.

- Using the approved budget, describe the budget categories and/or line items where the cash advance will be used as “startup” in the 1<sup>st</sup> Quarter of the fiscal year.
- Submit the Request for Advance form, written declaration, rationale for the request, and explanation of the budget categories/lines where funds will be used, plus any supporting evidence as warranted. The submission may be faxed to expedite the request. If faxed, items with original signatures should be sent by U.S. Mail.

✓	<b>Checklist of Items to Submit a Request for Cash Advance</b>
	Completed <u>Request for Advance</u> form signed by representatives of both program and finance operations. Instructions are provided on the form to fill-in the blanks.
	Written declaration that Subrecipient will suffer serious cash flow problems without the cash advance.
	Explanation or rationale for the percentage of the request (maximum 25% of the one-year award). Include a description of the approved budget categories and/or line items where the cash advance will be used as “startup” in the 1 <sup>st</sup> Quarter of the fiscal year.
	Attach supporting evidence, as warranted.
<p>Send written request to:            Rayma Delaney, Title V/MCH Grant Administrator            Nebraska Department of Health &amp; Human Services, Division of Public Health            Lifespan Health Services / Planning &amp; Support            PO Box 95026            Lincoln NE 68509-5026            Fax: (402) 471-7049</p>	

- The request is reviewed by Planning & Support. Consideration of the request will also include past performance of Subrecipient in any current and/or prior grants, contracts, cooperative agreements, or subcontracts with DHHS, with particular consideration to timely reporting or other evidence of deliverables.
- Written notification regarding approval or non-approval will be sent by fax or e-mail to those who have signed the request, using the contact information provided by Subrecipient on the Request for Cash Advance form.

## Part V. Subrecipient Responsibilities

**Q: How is the advance accounted for in my expenditure reports?**

- Accounting for a cash advance will occur in each of the four quarters by deducting from the expenses one-fourth of the cash advance in each quarter.

EXAMPLE:

Based on a \$50,000 award, with an \$8,000 (16%) one-time advance, \$2,000 would be deducted from each of the four (4) quarter expense reimbursements. The "Cash Advance" and "Reimbursement" columns (shaded) reflect the "Payment to Date" column. Note: 4<sup>th</sup> Quarter expense reimbursement will be made up to the \$50,000 award, i.e. the total payments cannot exceed the award. For example in the scenario below, \$11,500 – 2,000 = \$9,500 (4<sup>th</sup> Quarter expenses minus deduction). However, the reimbursement is \$8,000 to not exceed the \$50,000 award.

Quarter	Expenses	Deduction	Cash Advance	Reimbursement	Pymt to-date
start-up			\$ 8,000		\$ 8,000
1 <sup>st</sup>	\$ 12,000	\$ 2,000		\$ 10,000	\$ 18,000
2 <sup>nd</sup>	\$ 13,000	\$ 2,000		\$ 11,000	\$ 29,000
3 <sup>rd</sup>	\$ 15,000	\$ 2,000		\$ 13,000	\$ 42,000
4 <sup>th</sup>	\$ 11,500	\$ 2,000		\$ 8,000	\$ 50,000
<b>Total</b>	<b>\$ 51,500</b>	<b>\$ 8,000</b>	<b>\$ 8,000</b>	<b>\$ 50,000</b>	<b>\$ 50,000</b>

- At the end of the program period, if more cash was advanced to the Subrecipient than the total expenses, Subrecipient will be required to refund the overage to DHHS.
- Questions about the process, should be directed to Planning & Support.

**Part V. Subrecipient Responsibilities**

NEBRASKA DEPARTMENT HEALTH & HUMAN SERVICES  
**Nebraska Maternal and Child Health (MCH) Grant**

**Request for Cash Advance**

**Instructions:**

- Use the required form. The Request for Advance form is available in print copy or electronically as a Word document.
- Fill-in the blank for Subrecipient name, grant number, and fiscal year. (the grant number for each fiscal year is found in the Final Award Letter, *for example* MCH-09-01, FY 2009)
- On Line 1, insert the total amount of MCH Grant funds awarded to your program for the fiscal year.
- On Line 2, identify the percent requested, maximum 25%.
- Multiply the amounts of Line 1 and Line 2. Insert the result on Line 3, which is the amount of the requested cash advance.
- Identify by name and contact information, representatives for program and finance operations for the MCH program. **Original** signatures are required.
- Submit to Planning & Support, along with the other items identified on the Checklist found earlier in this section.

Subrecipient: \_\_\_\_\_ Grant #: MCH-\_\_\_\_ - \_\_\_\_\_

- |   |   |          |
|---|---|----------|
| 1. FY 200____ Award                             |   | \$ _____ |
| 2. Percent Requested (maximum 25% of the award) | X | _____ %  |
| 3. Cash Advance Requested for Start-up Costs    |   | \$ _____ |

**By signing and submitting this request, the undersigned agrees on behalf of the Subrecipient to the following penalty for late reports from Subrecipients with an approved cash advance:**

*To encourage timely reporting and subsequently the deduction of ¼ of the cash advance from the reimbursement request, a \$25.00 per diem penalty will be assessed by Planning & Support and deducted from the reimbursement each day the quarterly report is past the reporting due date.*

**Program Representative**

**Finance Representative**

\_\_\_\_\_  
(signature)  
Dated: \_\_\_\_\_

\_\_\_\_\_  
(signature)  
Dated: \_\_\_\_\_

***Print or type:***

Name \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Fax \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

E-mail \_\_\_\_\_

## 2. Indirect Cost (IDC) Rate

An indirect cost (IDC) is a cost that cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are in contrast to direct costs. *See the Glossary [ATTACHMENT 2] for a more complete description of both terms.*

- Direct Costs -- Any cost that can be identified specifically with a particular project or program.
- Indirect Costs -- Indirect costs are those costs incurred for common or joint purposes.

The following “**order of preference**” should be followed to identify the means relevant to recover indirect costs (RFA, p. 19):

- 1) If there is a federal cognizant agency, use the IDC rate agreement negotiated by it. Attach a copy of the Applicant’s most current indirect cost rate agreement which supports the use of the “indirect costs” line item. A negotiated cost rate agreement is typically with an organization’s federal cognizant agency, i.e. if the Applicant receives federal funds directly.
- 2) If there is not a federal cognizant agency, use the IDC rate agreement negotiated by the state cognizant agency. E.g., in the event the Applicant receives federal funds only as passthrough from the primary recipient of a federal award, the cognizant agency is the primary recipient, or typically a state agency.
- 3) If the Applicant does not have a current negotiated IDC rate, the U.S. Dept of Health and Human Services Grant Policy Directive (referred to as “1/2 or 10%”) may be used.

See

[http://www.ihs.gov/NonMedicalPrograms/gogp/documents/HHS%20GPS\\_Oct%202006.pdf](http://www.ihs.gov/NonMedicalPrograms/gogp/documents/HHS%20GPS_Oct%202006.pdf) for the Grants Policy Statement by the U.S. Department of Health and Human Services. In particular, pages II-27 – II-29

“Reimbursement of Indirect Costs”, states: *“If the GMO determines that a recipient does not have a currently effective indirect cost rate, the award may not include an amount for indirect costs unless the organization has never established an indirect cost rate (usually a new recipient) and intends to establish one. **In such cases, the award shall include a provisional amount equaling one-half of the amount of indirect costs requested**”*

## Part V. Subrecipient Responsibilities

**by the applicant, up to a maximum of 10 percent of direct salaries and wages (exclusive of fringe benefits).** *If the recipient fails to provide a timely proposal, indirect costs paid in anticipation of establishment of a rate will be disallowed.” (emphasis added)*

If the Applicant exercises this option, include in the Budget Justification the rationale (calculations) for the rate requested. This is considered a provisional rate. During the award period the Applicant must complete their determination of an indirect cost rate under provisions of either option #1 or #2. If the Applicant does not complete an IDC rate determination during the award period, the Applicant will be required to return any funds awarded based on the provisional rate.

- 4) Applicant may choose to direct cost the *allocable* portion of costs associated with multiple programs. The methodology for allocable costs, as determined by the Applicant, should be well documented as it is subject to audit. (See the OMB Circular addressing cost principles as relevant by type of entity of Applicant. The OMB Circulars are on-line at <http://www.whitehouse.gov/omb/circulars>)

If “indirect costs” are used as a budgeted line item, a copy of the Subrecipient’s most current indirect cost rate agreement supporting the use of the “indirect costs” line item was provided to Lifespan Health Services -- Planning & Support. A Subrecipient’s negotiated indirect cost rate agreement identifies the base, provides a percentage, and must be signed to show approval. Approved rates under OMB A-87 may have another base than total costs. Unrecovered indirect costs may be used as match.

### 3. Budget Revisions

**Q: If I want to change my line item budget, how do I know if I need prior approval?**

Budgets can be revised *without prior approval* if:

- The cumulative change of all line items is **less than ten percent** of the total grant budget. Your total grant budget includes both MCH Grant funds and matching funds, AND
- A change would neither add nor eliminate a line item, AND
- A change in the budget does not change the goals and objectives of the program AND

## Part V. Subrecipient Responsibilities

- The budget change does not include equipment purchases.

**Q: What is the process revising my line item budget when prior approval IS required?**

Reimbursement will not be made unless the Subrecipient follows the proper procedures.

- The process for approval is:
  - Submit a written request to Lifespan Health Services -- Planning & Support explaining the need for the change. To request the adding a line item(s), see the Budget Justification examples in the RFA for guidance. **An e-mail message constitutes a written request, and is preferred if the review is to be expedited.**
  - Lifespan Health Services -- Planning & Support will provide written notification of approval or disapproval of the budget revision request.
  - If a request for budget revision is approved, modify the Budget section (left section) of the Expenditure Report. The procedure for "deleting a line item" in subsequent quarters is to "zero out" the line item. If approval is given to add a line item, enter the data in an existing row in the spreadsheet. Do not delete or insert rows, as these methods could affect the formulas and subsequent calculations in the spreadsheet.
  - Reimbursement may be denied if any expenditures are related to budget revisions requiring prior approval and a request was not sought, or if a request for budget revision was denied.

**Q: What is the process for changing a line item when prior approval IS NOT required?**

- Modify the Budget section (left section) of the Expenditure Report by shifting funds between existing line items, being careful to stay within the grant award and maintaining the minimum 20% match requirement.
- Notify Lifespan Health Services -- Planning & Support of the change by including it in the narrative of the next Quarterly Expenditure Report.

#### 4. Match

There are two types of match: “**Cash match**” is non-federal funds, program income, agency funds, etc. Projected program income should be identified in the line item(s) of cash match to show where program income is expected to be re-invested in the MCH activities. “**In-kind (Non-cash) match**” is a donated service or product contributed to the program to which a value can be assessed. Maintain records showing how a value is assessed to the donated product or service.

Identify both the type (cash or in-kind [non-cash]) and the source (non-federal funds, agency general funds, etc.) of matching share. Records for tracking match must be kept in the same manner as records for claiming grant expenditures. Subrecipients are not required to provide a full accounting of matching share as part of the Quarterly Expenditure Report, match expenditures will be monitored in the same manner as grant expenditures. Records for tracking match must be made available for review, if requested, or as part of DHHS site visits of Subgrantees. [See RFA, **ATTACHMENT 9** for additional information regarding match requirements.]

**Q: What kind of records must be kept to track match?**

- Subrecipients are required to maintain written records that fully document cash match and in-kind (non-cash match), just as they are expected to maintain documentation of expenditures of MCH Grant funds.
- Allowable match is determined in the same manner as costs charged to MCH Grant funds, i.e. the budgeted line items must be necessary to accomplish approved activities.
- Federal funds, with two exceptions, are unallowable as match. Exceptions: 1) Medicaid dollars received for services provided, and 2) Native American Tribes eligible under P.L. 93-638 may use those federal funds for match. Resources that are used to match other grants (federal, state, or foundation) cannot also be used to match MCH Grant funds.

**Q: It is near the end of the fiscal year and my entire match has not been contributed, what do I do?**

- Subrecipients of Nebraska’s MCH Grant funds are required to provide matching share in the amount of 20% of the award. (See Appendix 2, Subgrant Terms and Assurances, RFA). Lifespan Health Services -- Planning & Support places a high value on Subrecipient’s ability to enhance and support their MCH Grant activities with other local funding.

## Part V. Subrecipient Responsibilities

- When grant applications are reviewed, one consideration for funding is the Subrecipient's ability to gather support within the community that may help sustain ongoing activities. The Subrecipient's ability to meet the 20% match requirement was indicated in the approved application.
- As the end of fiscal year approaches, if you believe your organization will not be able to meet the 20% match requirement for the year, written notification must be provided to Lifespan Health Services -- Planning & Support to explain the reason. The reimbursement of expenses will be reduced to allow for a 20% proportion of match provided. Such a factor will also be given strong consideration in future funding decisions.

### 5. Program Income

Program income is any profit resulting from the MCH Grant-funded activity. **Program income is not the MCH Grant funds awarded to your organization.** Examples of program income include fees for services performed (Medicaid payments, client fees, insurance payments, cash donations), rental or usage fees for property acquired with grant funds, and income from the sale of commodities or items fabricated under the grant. Further explanation of the types of program income is provided in the Question/Answer format that follows.

- Program income shall be used to finance the non-federal share of the grant-funded activities (shown as cash match). If there is a balance from program income and the match requirement is met, program income shall be added to funds committed to the project or program to further approved outcomes.

For the MCH Grant, program income shall be cash match (until the match requirement is met). Program income is cash match, although cash match may not be program income.
--

#### **Q: What are the types of program income?**

Revenue generated as a result of MCH Grant funds is program income. Program income includes client fees, cash donations, Medicaid and private insurance reimbursements. The requirement of Title V/MCH Block Grant to serve all mothers and children emphasizes that there are no eligibility requirements established at the federal level to qualify for services paid by Title V/MCH Block Grant. However, high priority is placed on services to mothers and children who are under served or low income. To maximize federal funds to serve the low income population, it is expected that MCH Grant-funded will determine the health care coverage of persons they serve, determine coverable services, and pursue reimbursement from that source as allowable. If

## Part V. Subrecipient Responsibilities

program income results from multiple sources of funding, Subrecipient must establish an allocable method to determine the program income attributable to MCH Grant funds.

**Q: How do I know if my program is eligible to receive Medicaid reimbursement?**

- According to Title XIX of the Social Security Act, State Medicaid agencies are required to provide—if requested by the Title V recipient or subrecipient in accordance with arrangements specified in the Act—reimbursement for the cost of services furnished Medicaid recipients by or through the MCH Grant. The arrangements discussed in the Act require the state to specify “the kinds of services to be provided by local agencies that are covered by Medicaid.”
- Inpatient hospital services, though covered by Medicaid, are restricted with Title V funds, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary (of Health and Human Services) may approve.
- The Nebraska Medical Assistance Program (known as Nebraska Medicaid) covers a wide range of services, when medically necessary and appropriate, under program guidelines and limitations for each service. For a current list of services covered under regulations and the specifics for each types of services, see <http://www.hhs.state.ne.us/medindex.htm> Medicaid-covered services are subject to change, and should be confirmed with the Nebraska Medical Assistance Program periodically.
- If you believe your organization provides any service listed on the Nebraska Medicaid website and may be eligible to receive reimbursement from Medicaid for such service, it is very important to pursue reimbursement to maximize your MCH Grant funds.
- Contact Lifespan Health Services -- Planning & Support for assistance to identify the Medicaid Program Specialist in the Central Office. Depending on the nature of the issue, the Medicaid Program Specialist may direct you to other Medicaid staff responsible for provider enrollment, third-party liability, or billing.
- To provide Medicaid-covered services, you will need to enroll and be a Medicaid-approved provider. You will receive a Medicaid provider number and information on the billing process.
- Medicaid-enrolled providers bill for Medicaid-covered services provided to Medicaid-eligible clients to receive a reimbursement from Nebraska Medicaid.

## Part V. Subrecipient Responsibilities

You cannot bill Medicaid clients directly.

- Report Medicaid reimbursements in the program income section of the Quarterly Expenditure Reports. Indicate where program income is re-invested in the grant-funded activities as cash match or additive.

**Q: Can my organization bill private insurance for a service paid with MCH Grant funds?**

- Subrecipients are expected to determine the health care coverage of persons served and, when appropriate, bill private insurance companies for the service provided.
- It is critical to maximize MCH Grant funds in order to assist low income mothers and children who are uninsured and uninsurable.
- Private insurance payments are program income, and should be re-invested and shown on the Quarterly Expenditure Report as cash match or additive.

**Q: Is my MCH Grant-funded project allowed to charge fees directly to persons provided a service?**

- Fees may be imposed on persons served by the Subrecipient. However, certain restrictions apply.
- Fees cannot be directly assessed to an individual who is covered by Medicaid or who is low income.
- **As designated by *Title V of the Social Security Act*, "if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services;"**

"Low income" is defined here as a family whose gross annual income falls at or below 100% of the current federal poverty guidelines. The poverty guidelines are updated periodically in the federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). In certain cases, as noted in the relevant authorizing legislation or program regulations, a program uses the poverty guidelines as only one of several eligibility criteria, or uses a percentage multiple of the

## Part V. Subrecipient Responsibilities

guidelines (for example, 125 percent or 185 percent of the guidelines). Non-federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities also have the option of choosing to use a percentage multiple of the guidelines such as 125 percent or 185 percent. While many programs use the guidelines to classify persons or families as either eligible or ineligible, some other programs use the guidelines for the purpose of giving priority to lower-income persons or families in the provision of assistance or services. In some cases, these poverty guidelines may not become effective for a particular program until a regulation or notice specifically applying to the program in question has been issued.

<http://aspe.hhs.gov/poverty/>

### 2008 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

**SOURCE:** *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971–3972

- “Pursuant to a public schedule of charges,” and “adjusted to reflect the income, resources, and family size of the individual provided the services” is more commonly referred to as a sliding fee scale.
- Subrecipients providing a service for which they intend to impose fees directly to the individual served must develop a sliding fee scale for those persons not low income and not covered by Medicaid. (See sample of a sliding fee scale in Part V. Subrecipient Responsibilities regarding internal policies.)
- Approval from Lifespan Health Services -- Planning & Support is necessary prior to implementing a new sliding fee scale, and also prior to implementing any revisions to an approved scale.

## Part V. Subrecipient Responsibilities

- When implemented, such fees are considered program income, and should be so reflected on the Quarterly Expenditure Report. These fees must be re-invested in the MCH Grant-funded program either as cash match or additive.

**Q: Is my MCH Grant-funded project allowed to accept cash donations from persons served or impacted by the project?**

- Cash donations are allowed as optional—but not required—for persons served by Subrecipients.
- No person should be denied service from a MCH Grant-funded project for not offering a cash donation. Also, donations should not be solicited from an individual who is covered by Medicaid or who is low income.
- Cash donations are program income, and should be so reflected on the Quarterly Expenditure Report. Donations must be re-invested in the MCH Grant-funded project as cash match or additive.

**Q: How can program income be used?**

- There are several ways for organizations to use program income. The Lifespan Health Services -- Planning & Support permits Subrecipients to re-invest it in the project either as cash match or additive.
- With the matching alternative, program income is used to finance part or all of the cash match of the project budget.
- With the additive alternative, program income is added to the funds already committed to the program and used to support additional project outcomes. In this case, it is not used as match.
- If a project anticipated generating program income, the estimated amount and the plan for re-investment was to be included in the grant application.

**Q: It is near the end of the year and all of my program income has not been spent. What do I do?**

- Program income cannot be carried over from year to year.
- The program income beginning balance for each fiscal year must be zero.
- As program income is earned, it must be utilized to enhance the project, either

## Part V. Subrecipient Responsibilities

as cash match or additive, resulting in a zero balance on the final Expenditure Report for each fiscal year.

- If the 4<sup>th</sup> Quarter Expenditure Report reflects a program income balance, the reimbursement for the 4<sup>th</sup> Quarter will be reduced by that amount.
- In the event that 4<sup>th</sup> Quarter expenditures are less than the program income balance, Subrecipient must pay the difference to DHHS.

### 6. Equipment and Supplies

**Q: Are there any special procedures for purchasing equipment with grant funds?**

- **Equipment** is defined by the federal government as “tangible, non-expendable, personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit.” Lower limits may be established as consistent with subrecipient policy, i.e. a subrecipient may use its own definition of equipment provided that such definition would at least include all equipment defined above. Any equipment identified in the line item budget of a grant application for which revision was not required as a condition of the award is already “approved”. Equipment requests in a revised budget, i.e. postaward, may require prior written approval from Lifespan Health Services -- Planning & Support. Note: The acquisition of major medical equipment is restricted by federal Title V/MCH Block Grant funds.
- **Supplies** are defined by the federal government as “all tangible personal property other than *equipment* as defined in this part.”
- Subrecipients shall follow the requirements of applicable federal Regulations and OMB Circulars for maintaining equipment inventories and the disposition of equipment purchased with federal funds.

**Q: It is near the end of the project period and I want to buy a lot of office supplies, educational materials, and the like in order to use all the grant funds allocated to the project. Are these expenses allowable?**

- Supplies acquired under a federal grant should be accurately projected for the amount needed during the grant period. Do not stockpile supplies for use beyond the grant. If there is a residual inventory of unused supplies exceeding a total of \$5,000 at the completion of the project period, and if the supplies are not needed for any other federal sponsored programs or projects, the

## Part V. Subrecipient Responsibilities

subrecipient shall compensate DHHS for the value of the surplus supplies.

- Purchase of consumable supplies far in advance of using them is not good business practice and is subject to disallowance.

### 7. Financial Reviews and Audits

Financial management and accounting procedures must be sufficient for the preparation of required reports. In addition, the financial operations must be sufficient enough to trace revenue and expenditures to source documentation as part of a financial review or audit. The Office of Management and Budget (OMB) cost principles relevant to the type of organization will be used to determine if costs are allowable and allocable.

- All Subrecipient records and supporting documentation must be available for review by federal funding representatives, State of Nebraska Auditors, and DHHS personnel or contractors for auditing and monitoring purposes.
- Accounting records must be supported by source documentation such as canceled checks, paid bills, payroll, time and attendance records, and similar documents that would verify the nature of revenue and costs associated with the MCH Grant-funded project. Subrecipient's accounting system must provide for:
  - accurate, current, and complete disclosure of expenditures;
  - accounting records that adequately identify source of funds (federal, cash match, in-kind) and the purpose of an expenditure;
  - internal control to safeguard all cash, real and personal property, and other assets, and assure that all such property is used for authorized purposes; and
  - budget controls that compare budgeted amounts with actual revenues and expenditures.
- **Administrative and Audit Guidance**, as stated in the Subgrant Terms and Assurances (RFA, ATTACHMENT 4, Appendix 3), varies according to type of entity and the level of state and federal payments.
- The **Audit Requirement Certification** (RFA, ATTACHMENT 4, Appendix 4) was completed and submitted with your application or in response to a contingency to the award. The Certification is on record in the office of Grants and Cost Management, Financial Services, Nebraska Department of Health & Human Services, as well as incorporated in the Subrecipient file in the Lifespan Health

## Part V. Subrecipient Responsibilities

Services -- Planning & Support.

- Appendix 3 “Administrative and Audit Guidance” and the “Audit Requirement Certification” are instructive to organizations regarding the requirements. When an audit is to be performed, it must be completed as specified in the federal law or OMB circulars.
- A single audit performed in accordance with Circular A-133 must be submitted to the Federal Audit Clearinghouse. The reporting package, as evidence the audit was completed, must contain: a copy of Subrecipient’s financial statements, a schedule of Expenditure of Federal Awards, a Summary Schedule of Prior Audit Findings (if applicable), a corrective action plan (if applicable), and the auditor’s report.
- A copy of subrecipient’s financial statements, auditor’s report and *Data Collection Form for Reporting on Audits of States, Local Governments and Non-Profit Organizations (SF-SAC)* must be submitted at the same time these documents are submitted to the Federal Audit Clearinghouse to: DHHS, Financial Services Division, Grants and Cost Management, P.O. Box 95026, Lincoln NE 68509-5026

### H. Reporting

The Reporting packet [**ATTACHMENT 1**] includes forms, instructions, and examples. Follow the instructions to sufficiently complete the reporting requirements. The reporting format is identical for all quarters. The addition of Tables 1, 2, and 3 to the 4<sup>th</sup> Quarter reporting requirements comprises the Final Report. Questions should be directed to Rayma Delaney, Title V/MCH Grant Administrator, (402) 471-0197, [rayma.delaney@nebraska.gov](mailto:rayma.delaney@nebraska.gov).

#### Q: What is the purpose of reporting?

- Regular reporting assists in establishing a systematic framework for Subrecipients to monitor and evaluate their project.
- Reports are reviewed by Lifespan Health Services -- Planning & Support to comply, in part, with Subrecipient monitoring requirements which the state agency is charged with as the pass-through entity for federal Block Grant funds.
- Reporting is one source of ongoing communication. Technical assistance needs may be identified in the reporting process.
- Reporting is needed to pay Subrecipient’s expenses related to the MCH Grant-

funded activities.

**Q: What types of reports are required?**

Subrecipients are required to submit reports in order to receive a grant payment. The **Quarterly** Report for Nebraska MCH Grant has three distinct, yet interrelated components:

- the **Work Plan Report** – This is the opportunity to report on activities from the Work Plan during the period of the report. As available during the project period, Subrecipients shall also report on progress toward objectives by reporting on performance measures.
- the **Expenditure Report** (with sections for line item, program income, and supporting narrative) -- All expenditures must support the broader outcomes, *and specific activities in the Work Plan Report.*
- the quarterly report of "Expenditures by Types of Individuals Served", **Table 4**.
  - Table 4 requests information regarding MCH Grant and Match expenditures by types of individuals served.

The **Final** Report is comprised of:

- The 4<sup>th</sup> Quarter Work Plan Report and the Expenditure Report.
- Final Data Tables (Tables 1, 2 and 3)
  - **Table 1** requests information regarding the number of people receiving services by race and ethnicity.
  - **Table 2** requests information regarding the number of people receiving services by class of individuals and percent of health coverage.
  - **Table 3** requests information regarding MCH Grant and Match expenditures by types of service.

The activities conducted through MCH Grant-funded projects vary between organizations so the instructions for completing Tables 1-4 may not address each

## Part V. Subrecipient Responsibilities

concern for every project. Contact Lifespan Health Services -- Planning & Support for clarification of any reporting issues encountered.

**Q: How is the information provided in the Final Report used by Lifespan Health Services -- Planning & Support?**

- The information required of Subrecipients is part of a comprehensive report which DHHS submits to the federal Maternal and Child Health Bureau.
- This information is used in reports to Congress and in other arenas which influence future appropriations of Title V. Information from each of the state-level applications and reports is available, by state, to the public via the worldwide web at <https://perfddata.hrsa.gov/mchb/mchreports/Search/search.asp>
- Lifespan Health Services -- Planning & Support may use the information in the statewide needs assessment for Nebraska.
- The statistical information is one of the data sources for measuring progress toward the Year 2010 Health Objectives.

**Q: When are the reports due?**

Appendix 1 of the Subgrant Terms & Assurances, a part of the approved grant application, provides the due dates for reports. Quarterly Reports are due on the 15<sup>th</sup> day following the close of the 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> Quarter, *unless otherwise arranged in advance at the beginning of the fiscal year, or as early as possible in the quarter covered in the report.* For example, consideration will be given to requests from Subrecipients whose accounting system function necessitates a change in due date to the 30<sup>th</sup>/31<sup>st</sup> day of the month. Without exception, the 4<sup>th</sup> Quarter/Final Report is due November 30, which is 60 days after the close of the fiscal year.

1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter
October 1 – December 31	January 1 – March 31	April 1 – June 30	July 1 – September 30
Reports due January 15	Reports due April 15	Reports due July 15	Reports due November 30

**Q: What is the importance of timely reports?**

Every reasonable effort must be made to assure reports are received on or before the due date.

- Lifespan Health Services -- Planning & Support staff schedule time to review

## Part V. Subrecipient Responsibilities

reports during the week following due dates. Reports submitted after the due date will be reviewed as schedules permit.

- The Work Plan Report and Expenditure Report are reviewed together. Missing or incomplete reports will delay reimbursement.

### **Q: What is the purpose of Work Plan Report?**

- Reporting activities is a fundamental part of Subrecipients' responsibility for on-going project oversight and process evaluation.
- Work Plan Reports are used by DHHS to discuss the status of Maternal Child Health in Nebraska via the annual Title V / MCH Block Grant Application and Report to the federal Maternal and Child Health Bureau.
- Lifespan Health Services -- Planning & Support reviews Work Plan Reports to comply, in part, with Subrecipient monitoring requirements that the state agency is charged with as the pass-through entity for federal Block Grant funds.
- Reporting may identify technical assistance needs.

### **Q: What should I remember when completing the Work Plan Report?**

- Subrecipients should use the Work Plan from the approved grant application, or any revisions made with the technical assistance provided post award from Lifespan Health Services – Planning & Support, as the framework for the Work Plan Report. Most of the reporting will be quarterly updates on the activities towards the objectives. Subrecipients should report on performance measures towards reaching objectives, as relevant.
- **Include only the report of activities for the relevant quarter in the Work Plan Report.**
- Contact Lifespan Health Services -- Planning & Support with questions.

### **Q: What is the purpose of Expenditure Reports?**

The purpose of the Expenditure Report component is:

- to receive reimbursement for expenditures incurred during the quarter; and
- for monitoring of:

## Part V. Subrecipient Responsibilities

- grant funds to verify that expenditures are allowable, allocable, and reasonable costs, and which are clearly associated with the approved Work Plan
- the re-investment of program income
- the expenditures of matching share
- The 4th Quarter Expenditure Report doubles as the Final Expenditure Report for the fiscal year. Additional time (60 days) is given at the end of the funding period to allow for all bills associated with grant activities to pass through Subrecipients' accounting systems.
- **The due date for the Final Report is November 30. Lifespan Health Services -- Planning & Support reserves the right to deny payment on Final Reports received after the November 30 deadline.**

### Q: **What should I remember when completing the Expenditure Report?**

- Information should be submitted according to the Expenditure Report format. The form and instructions are located in Attachment 1 of this Procedural Manual.
- Use of the Microsoft Excel available at <http://www.dhhs.ne.gov/LifespanHealth/planning> is required, unless a Subrecipient provides substantial justification that it cannot reasonably use the spreadsheet provided for this purpose. The form has correct formulas for calculating the addition of columns (total expenditures of grant and match by quarter) and rows (cumulative expenditures for the fiscal year period by line item). Do not add or delete rows or columns to the spreadsheet form.
- Subrecipient enters the approved budget in the worksheet (tabbed as "Budget and Revisions") which feeds into the Expenditure Report. All line items as shown on your program's approved budget must appear on the expenditure report. This includes line items for both MCH Grant funds and matching funds.
- List all personnel by title/position and the person's name. Indicate the full-time equivalent (FTE) salary.
- Any budget revisions shall be made for the relevant quarter as indicated in the worksheet for the budget and indicated by the tab "Budget and Revisions".

## Part V. Subrecipient Responsibilities

- Enter values in the yellow hi-lited cells “expenditures for this quarter” for the relevant quarter as indicated in the tabs. The cumulative columns automatically calculate from prior reports.
- The completed report must bear two **original** signatures of individuals authorized by your agency to sign such documents, one from the person responsible for preparing the Expenditure Report (typically the fiscal director), and the other by a representative involved in the project activities. (See “F. Reimbursement”, p. 20 for specific instructions).
- The report must include the Subrecipient’s billing address.
- Complete all sections of the report, including the report of Program Income and explanation of where Program Income was re-invested to the program, plus supporting narrative as needed.
- Include the Subgrant # (*e.g.* MCH-09-01) on the report.
- Match expenditures are closely monitored. See the section entitled “Matching Share”.
- Rounding to the nearest dollar is acceptable. Subsequently, the spreadsheet is set up with 0 decimal places. An entry of \$254.49 will fill as \$254, whereas an entry of \$254.51 will fill as \$255.
- Reimbursable expenses must correlate with reported activities described in the Work Plan Report.
- Contact Lifespan Health Services -- Planning & Support with questions.

### **Q: What if my report will be late?**

Please follow these steps if it is anticipated that a Quarterly Report for 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> Quarters will not be submitted by the due date:

- Prior to the due date, request an extension (specify a date for the extension request) in **writing** to Lifespan Health Services -- Planning & Support. The request for extension can be expedited if sent through e-mail or fax.
- State the reason for requesting an extension in the reporting due date. Further documentation regarding the reason for an extension may be requested.

## Part V. Subrecipient Responsibilities

- If an extension request is approved, the Subrecipient will be receive written notification (by email or fax) of the revised due date from Lifespan Health Services -- Planning & Support. Reports approved for extension will not be considered late if received by the revised due date. If request is not approved, the report will be considered late.
- The 4<sup>th</sup> Quarter/Final Report is due November 30. No requests will be accepted for extension of the 4<sup>th</sup> Quarter/Final Report. If it is received after November 30, it will be considered late. **Lifespan Health Services -- Planning & Support, along with the accounting unit of the DHHS, reserves the right to deny payment on Final Reports received after the November 30 deadline.**

[**Note:** Subrecipient past performance, including the submission of timely reports, will be a consideration in future grant application review processes. Approved requests for extension will be viewed more favorably than late reports in the consideration of future grant applications.]

**Q: Where do I send reports?**

Submit the signed, original report by U.S. Mail to:

Rayma Delaney  
Nebraska Department of Health and Human Services  
Division of Public Health, Lifespan Health Services -- Planning & Support  
PO Box 95026  
Lincoln NE 68509-5026

Reports are reviewed and forwarded to DHHS accounting for payment upon approval. Any questions or clarification needed will be accomplished before approval and authorization of payment.

## Maternal and Child Health (MCH) Grant

**QUARTERLY REPORT**

Award Period: FY 2009

Report Period:             1<sup>st</sup> Qtr     2<sup>nd</sup> Qtr             3<sup>rd</sup> Qtr             4<sup>th</sup> Qtr

Subrecipient: \_\_\_\_\_ Grant #: MCH-09-\_\_\_\_\_

**INSTRUCTIONS:**

The Quarterly Report for Nebraska MCH Grant funds has three distinct, yet interrelated components:

- 1) the **Work Plan Report** provides updates primarily on the activities in 1<sup>st</sup> and 2<sup>nd</sup> Quarters as relevant and approved by objectives. The 3<sup>rd</sup> and 4<sup>th</sup> Quarter reports are more likely to also include reporting on performance measures relevant to the objectives. Use the template provided to provide quarter updates.
- 2) the **Expenditure Report** (includes several subsections: a) reporting costs based on the approved line item budget, b) program income, and c) narrative, as needed, to support the Expenditure Report). Do not estimate costs. Report actual costs which were incurred during the period of the report. All costs must be connected to activities from the approved Work Plan. More specific instructions precede the form in this Attachment.
- 3) \*The total expenditures for the quarter reported on the Expenditure Report for grant and match correspond to the expenditures in **Table 4** delineated by "types of individuals". Table 4 is a combined form to be used for the Quarterly Report. Completion of it in the 4<sup>th</sup> Quarter doubles as the information needed for a final report of these expenditures delineated by types of individuals.

The reporting format is basically identical for all quarters. The Final Report adds Tables 1, 2, and 3 in the 4<sup>th</sup> Quarter reporting period. Although these three tables should not be submitted until the conclusion of the 4<sup>th</sup> Quarter, identify early in the award period the necessary data collection required for these three tables.

Reports are due on the dates stated in the Subgrant Terms and Assurances, Appendix 1, and in the Procedure Manual. Submit the signed, original report by U.S. Mail to: Rayma Delaney, Nebraska Department of Health & Human Services, Lifespan Health Services, PO Box 95026, Lincoln NE 68509-5026. Questions should be directed to Rayma Delaney, Title V/MCH Grant Administrator, (402) 471-0197, [rayma.delaney@nebraska.gov](mailto:rayma.delaney@nebraska.gov).

Submitted by: \_\_\_\_\_  
**(signature of authorized representative)**

Work Plan Report

[ ] 1<sup>st</sup> Qtr    [ ] 2<sup>nd</sup> Qtr    [ ] 3<sup>rd</sup> Qtr    [ ] 4<sup>th</sup> Qtr

<b>Goal:</b>							
<b>Outcome:</b>							
Objective(s)	Activities	Timeline					Resources
		Y R	Q 1	Q 2	Q 3	Q 4	
1)	1.1	1					
	1.2	1					
	1.3	1					
	1.4	1					
	1.5	1					
	1.6	1					
	1.7	1					
	1.8	1					
	1.9	1					
	1.10	1					
<b>Performance Measures: Objective 1</b>							
1)							
2)							
3)							
<b>Goal:</b>							

<b>Outcome:</b>							
Objective(s)	Activities	Timeline					Resources
		Y R	Q 1	Q 2	Q 3	Q 4	
2)	2.1	1					
	2.2	1					
	2.3	1					
	2.4	1					
	2.5	1					
	2.6	1					
	2.7	1					
	2.8	1					
	2.9	1					
	2.10	1					
<b>Performance Measures: Objective 1</b>							
1)							
2)							
3)							
<b>Goal:</b>							
<b>Outcome:</b>							

Objective(s)	Activities	Timeline					Resources
		Y R	Q 1	Q 2	Q 3	Q 4	
3)	3.1	1					
	3.2	1					
	3.3	1					
	3.4	1					
	3.5	1					
	3.6	1					
	3.7	1					
	3.8	1					
	3.9	1					
	3.10	1					

**Performance Measures: Objective 3**  
 1)  
 2)  
 3)

Objective(s)	Activities	Timeline					Resources
		Y R	Q 1	Q 2	Q 3	Q 4	
4)	4.1	1					
	4.2	1					

	4.3	1					
	4.4	1					
	4.5	1					
	4.6	1					
	4.7	1					
	4.8	1					
	4.9	1					
	4.10	1					

**Performance Measures: Objective 4**  
 1)  
 2)  
 3)

INSTRUCTIONS for completing the **Expenditure Report**:Line Item Section

1. The Microsoft Excel spreadsheet is available electronically at <http://www.dhhs.ne.gov/LifespanHealth/planning>. Use of the template is required, unless a Subrecipient provides substantial justification that it cannot reasonably use the spreadsheet provided for this purpose. The template will expedite reporting by Subrecipients and also the reviews by Planning & Support – Lifespan Health. The template has correct formulas for calculating the addition of columns (total expenditures of grant and match by quarter) and rows (cumulative expenditures for the fiscal year period by line item). Do not add or delete rows or columns to the spreadsheet form.
2. List in the lefthand section labeled **"Budgeted Line Items"** all descriptive categories and/or line items as shown on your program's approved budget.
  - For some Subrecipients, this will be the budget submitted with the grant application.
  - For others, this will be the budget submitted with the response to contingencies before final approval of the application, or other subsequent approved revisions.
  - Describe any budget revisions in the narrative section.

If the approved budget includes personnel, list by title/position *and the name(s) for which reimbursement of costs is sought*.

3. In the **"Approved Budget"** section, list the budgeted dollars by line item, as shown on the final approved budget, or subsequent revisions.
4. Include the Subgrant # (e.g. MCH-09-01) on the form. Complete all other demographic information on the form, i.e. Federal Tax Identification Number, Reporting Period, Billing Address, etc. The warrant will be mailed to the address provided. [Note: Electronic payment is strongly encouraged and is a quicker method of payment. A Subrecipient completes a simple process to get set up for electronic payment. The State of Nebraska requires any single warrant over \$75,000 be an electronic payment. Electronic payments may be combined with payments.]
5. Expenses must correlate with the approved Work Plan and as described in the Work Plan Report. Rounding to the nearest dollar is acceptable. Subsequently, the spreadsheet is set up with 0 decimal places. An entry of \$254.49 will fill as \$254, whereas an entry of \$254.51 will fill as \$255.
6. List all expenses incurred during the reporting period under the heading

**"Expenditures for the Quarter"**. These expenses correspond to line items. If no costs were incurred for a particular line item during a given quarter, record "0" for that item or simply leave the cell blank.

Entry in the "Grant Award" column shall indicate a reimbursement with Title V grant funds. Without prior approval, reimbursement with grant funds will not be made for:

- Expenditures exceeding the approved line item amount, unless the cumulative change of all line items is less than 10% of the total budget;
- A new line item without prior approval;
- Costs that appear to be unrelated to Work Plan;
- A purchase of equipment (as defined in federal regulations) that is not included in the approved budget.

Report actual expenditures (rounding is acceptable), i.e. do not estimate by quarterly amounts for the budgeted line item. Unless the item can be reasonably divided (e.g. rent) budgeted line items should not be divided by 4 and reported as a quarterly expenditure. Supplies and telephone expenses each quarter are unpredictable and should not be reported as  $\frac{1}{4}$  of the total budgeted for the line item. An expense which exceeds a  $\frac{1}{4}$  of the line item budget could be exactly  $\frac{1}{4}$  of the budgeted line item if the Subrecipient seeks only to recover the cost up to the approved budget. In such cases, use the narrative section to explain how the reported figure was derived.

Entry in the "Cash" column indicates a product/service was paid with cash, i.e. non-federal funds, program income, agency funds, etc. Report exact expenditures, not a quarterly estimate. An entry could be  $\frac{1}{4}$  of the budgeted line as a result of an expenditure which is greater than the amount reported as match. In such cases, use the narrative section, as described below, to explain how the reported figure was derived.

Entry in the "In-Kind" column denotes a service or product contributed to the program to which a value has been assessed. If in-kind is reported, agency source files must contain the documentation to support the value assessed to the intangible product or service, e.g. maintain itemized and signed volunteer time records for valid documentation.

7. **"Cumulative Expenditures"** entries reflect the amount of program expense to-date (cumulative each quarter) by line item for each relevant column (grant funds, cash, and in-kind). The values in these cells will calculate automatically from entries of expenditures by quarter, and are protected cells, i.e. cannot be edited.

8. Print the report for signature. The completed report must bear two original signatures of individuals authorized by your agency to sign financial documents, one from the person responsible for preparing the Expenditure Report (typically the fiscal director), and the other by a representative involved in the grant activities. To ensure reviewer confidence in the authenticity of the signatures of representatives authorized by the Subrecipient, persons signing the Expenditure Report shall be:
  - the two signers of the Cover Sheet of the approved grant application,  
*or, in the alternative*
  - identified by name, title, and original signature contained in a letter signed by one of the signers of the approved grant.
9. Mail the print copy, signed report. Also, submit the completed Expenditure Report electronically (by email) each quarter. Submit to: [rayma.delaney@nebraska.gov](mailto:rayma.delaney@nebraska.gov)

### Program Income Section

Program income is *any profit to the subrecipient resulting from these grant funds.*

Examples of program income include fees, donations, insurance payments, and Medicaid reimbursement resulting from the activities paid with MCH Grant funds.

Please note the following main points:

1. This section must be completed by all subrecipients. If no program income is generated, "zero-fill" all table cells.
2. Do not report income resulting from any other grant funds or other grant funds reported as cash match. *Only income generated by MCH Grant funds is to be reported in this section.*
3. The program income "Beginning Balance" for the first quarter is zero (\$0).
4. All program income must be re-invested to the program/project by the end of the program year resulting in zero (\$0) for the 4<sup>th</sup> quarter "Ending Balance". Program income should be used first towards the cash match requirement. If program income exceeds the minimum match requirement, Subrecipient may designate the funds as "additive" to the award to further the approved outcomes.\* Program income cannot be carried over from year-to-year.
5. Identify where program income is re-invested in the project.
6. The Program Income section is a cumulative report, i.e. the "Ending Balance" from the first quarter Expenditure Report is the "Beginning Balance" on the 2<sup>nd</sup> Quarter Expenditure Report.
7. *Program income is usually cash match, but cash match is not always program income.* If the Title V-funded program does not generate income, or if program income is insufficient to meet the minimum match requirement (**20%**), the match requirement can be met by other options: a) any non-federal funds may be used as cash match which are not already used as match for another grant award, and/or b) non-cash match.
8. Calculation Formula:
  - A. = Always \$0 in 1<sup>st</sup> Quarter. For 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> Quarters it is the value of F.
  - B. = Identify the revenue by source.
  - C. = B.1.+B.2.+B.3.+B.4.
  - D. = A.+ C.
  - E. = **Program income expended during the quarter.**
  - F. = **D. – E. Always \$0 in the 4<sup>th</sup> Quarter.**

	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter
A. Beginning balance				
B. Revenue (by source)				
B.1. Medicaid				
B.2. Client Fees				
<i>Specify any other source:</i> B.3.				
<i>Specify any other source:</i> B.4.				
C. Total revenue				
D. Program income subtotal				
E. Expenditures				
F. Ending balance				

In the space provided, identify the line item(s) in the Expenditure Report (\*usually "cash match") where program income is re-invested in the program / project:

### **Narrative Section**

**Use this section to clarify and support, as needed, an entry in the line item section. Clarify, in narrative, any check marked boxes.**

Budget revisions. *Prior approval is required* for budget revisions that would create any of the following conditions: deleting or adding a line item, altering the approved Work Plan, purchasing equipment not in the approved budget, or having a cumulative effect exceeding 10% of the approved budget. If none of those conditions pertain, prior approval is not required, but should still be addressed in this section.

Unanticipated or unique expenditures in the reporting period. If checked, describe how the cost relates to the approved Work Plan.

Other.

Subrecipient Name: \_\_\_\_\_  
 Grant # MCH-09-\_\_\_\_\_

**FINAL REPORT  
 TABLE 1**

**Number of Individuals Who Received Services  
 Provided or Paid in Part by Title V/MCH Block Grant Funds FY 2009  
 by Race and Ethnicity**

**I. Unduplicated Count By Race**

Category of Person Served By the Title V-Funded Program	(A) TOTAL ALL RACES	(B) <u>WHITE</u>	(C) <u>BLACK</u> or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More Than One Race Reported	(H) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.								
2.) Infants (children < 1 year not included in any other class of individuals).								

*For each row, A=B+C+D+E+F, G & H even if count by race is estimated*

**II. Unduplicated Count By Ethnicity**

Category of Person Served By the Title V-Funded Program	(A) Total Not-Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	Hispanic or Latino (Sub-categories by country or area of origin)				
				(B1) Mexican	(B2) Cuban	(B3) Puerto Rican	(B4) CENTRAL & South American	(B5) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.								
2.) Infants (children < 1 year not included in any other class of individuals).								

*For each row, B=(B1)+(B2)+(B3)+(B4)+(B5), even if count by ethnicity is estimated.*

*If your program has significant Hispanic population, you are encouraged to report subpopulations by country or area of origin. (the shaded areas)*

NOTE: I.A = II.A + II.B + II.C for each category of person served

**INSTRUCTIONS and EXAMPLE** for Table 1:**\*\* EXAMPLE \*\***

Category of Person Served By the Title V-Funded Program	(A) TOTAL ALL RACES	(B) <u>WHITE</u>	(C) <u>BLACK OR</u> African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More Than One Race Reported	(H) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.	77	47	10	9	1	5	3	2
2.) Infants (children < 1 year not included in any other class of individuals).	169	138	9	7	4	4	4	3

Category of Person Served By the Title V-Funded Program	(A) Total Not- Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	Hispanic or Latino (Sub-categories by country or area of origin)				
				(B1) Mexican	(B2) Cuban	(B3) Puerto Rican	(B4) CENTRAL & South American	(B5) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.	55	15	7	9	1	2	0	3
2.) Infants (children < 1 year not included in any other class of individuals).	140	25	4	12	2	4	2	5

See the Glossary [ATTACHMENT 2] for terms applicable to this form. Complete all required data cells and check mathematical calculations. If an actual number is not available, make an estimate. Explain all estimates in a footnote. Give unduplicated number of persons who received a service by phone, in person, or through the process of a test, etc. (not just public information) by category of person served, race, and ethnicity.

For each category of person served, break down the total by race and ethnicity. For federal reporting requirements, Hispanic is an ethnicity. Generally, the Hispanic population considers Hispanic a race. Without a response category for Hispanic as race, it is offensive to Hispanic clients to be reported as "other & unknown" for race. It would be difficult, if not impossible, to change the federal categories for race and ethnicity. The response category for Hispanic could be included in race categories for purposes of data

collection. The corresponding data for Hispanic will be reported, however, as ethnicity. This practice is respectful to the population's identification as race, yet simultaneously satisfies the federal reporting requirement by reporting the corresponding data collected as ethnicity. For the final report to Nebraska Department of Health & Human Services, the total number of clients who identified as Hispanic should be reported under "other & unknown" for race, unless the client responds in one of the other categories for race, e.g. white.

- If your program has significant Hispanic population you are encouraged to report subpopulations by country-of-origin.

If a particular class of individuals is not provided services through your MCH Grant-funded project, write in "0" for the "Total Number Served" and for each race and ethnicity category.

Contact Planning and Support – Lifespan Health with questions.

Subrecipient Name: \_\_\_\_\_  
 Grant # MCH -09-\_\_\_\_\_

**FINAL REPORT  
 TABLE 2**

**Number of Individuals Served (Unduplicated)\*\*  
 Under Title V / MCH FY 2009  
 (by Types of Individuals and Health Coverage)**

Types of Individuals	Types of Health Coverage			
	(A) Title V MCH	(B) Medicaid (Title XIX & Title XXI)	(C) Private/Other	(D) None
(1) Pregnant women				
(2) Infants <1 year of age				
(3) Children 1 to 22 years of age				
(4) Children with Special Health Care Needs				
(5) Others				
(6) TOTAL				

\*\*For each row:  $A = B + C + D$ , even if coverage types are estimates, i.e.

$$\begin{aligned}
 1A &= 1B + 1C + 1D \\
 2A &= 2B + 2C + 2D \\
 3A &= 3B + 3C + 3D \\
 4A &= 4B + 4C + 4D \\
 5A &= 5B + 5C + 5D \\
 6A &= 6B + 6C + 6D
 \end{aligned}$$

For Column A:  $6A = 1A + 2A + 3A + 4A + 5A$ .

## INSTRUCTIONS for Table 2:

1. See the Glossary [ATTACHMENT 2] for terms applicable to this form.
2. Complete all required data cells.
3. **If an actual number is not available make an estimate. Explain all estimates in a footnote.**
4. In Column (A) enter the unduplicated count of individuals by class who received direct services (in person, by phone) from the Title V/MCH project regardless of the primary source of coverage. Row 6, "Total", should equal the sum of Rows 1 through 5.
5. In the following columns report by the class of individuals served by the Title V/MCH project the number of those who have as their primary source of coverage either:
  - Column B: Medicaid\*
  - Column C: Other (public or private) coverage
  - Column D: None

If individuals are covered by more than one source they should be listed under the column of their primary source. For each row, Column A should equal the sum of Columns B through D.
6. Identify coverage status at the end of the service period.
  - If the individual was pregnant or an infant, and had Medicaid as the primary payer for service, report Medicaid as the insurer, even though Title V/MCH or other third party insurance may have covered part of the care over the period.
7. There is not an "Unknown" Column on this form. **Everyone must be coded by health coverage.**
8. If you have questions, call Lifespan Health Services -- Planning & Support.

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\* Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program, *an expansion of Medicaid* effective September 1, 1998).

Subrecipient Name: \_\_\_\_\_  
 Grant #: MCH-09-\_\_\_\_\_

**FINAL REPORT  
TABLE 3**

**Title V / MCH and Match Expenditures FY 2009  
by "Types of Service" (per se)**

Types of Service	MCH Grant	Match
<b>I. Direct Health Care Services</b> (Basic Health Services And Health Services for CSHCN)	\$ _____	\$ _____
<b>II. Enabling Services</b> (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, Consumer Coordination with Medicaid, WIC, and Education)	\$ _____	\$ _____
<b>III. Population-based Services</b> (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition and Outreach/Public Education)	\$ _____	\$ _____
<b>IV. Infrastructure Building Services</b> (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems, Program Coordination with Medicaid, WIC, and Education)	\$ _____	\$ _____
<b>Total Expenditures</b>	\$ _____	\$ _____

**INSTRUCTIONS** for Table 3:

1. See the Glossary [ATTACHMENT 2] for terms applicable to this form.
2. Complete all required data cells by using a methodology of your choosing (e.g. the percentage for each type of individual served\*, multiplied by the actual expenditures). Explain the methodology in a footnote.
3. If a particular "type of service" was not provided through your MCH Grant-funded project, write in "0" for that line.
4. Total expenditures must equal the total reflected on the final Expenditure Report

Subrecipient Name: \_\_\_\_\_  
 Grant # MCH-09-\_\_\_\_

**QUARTERLY** AND FINAL REPORT  
 TABLE 4

**Title V / MCH and Match Expenditures FY 2009  
 by "Types of Individuals" Served / Impacted**

Types of Individuals	<b>Quarterly</b> Grant	<i>(optional)</i> <b>Quarterly</b> Match	Cumulative Grant	Cumulative Match
<b>Pregnant Women</b>	\$ _____	\$ _____	\$ _____	\$ _____
<b>Infants &lt; 1 year old</b>	\$ _____	\$ _____	\$ _____	\$ _____
<b>Children 1 – 22 Years Old</b>	\$ _____	\$ _____	\$ _____	\$ _____
<b>Children with Special Health Care Needs (CSHCN)</b>	\$ _____	\$ _____	\$ _____	\$ _____
<b>All Others</b>	\$ _____	\$ _____	\$ _____	\$ _____
<b>Total Expenditures</b>	\$ _____	\$ _____	\$ _____	\$ _____

**INSTRUCTIONS** for Table 4:

1. See the Glossary [ATTACHMENT 2] for terms applicable to this form.
2. Complete all required data cells by using a methodology of your choosing (e.g. the percentage for each type of individual served\*, multiplied by the actual expenditures). Explain the methodology in a footnote.
3. If a particular "type of individual" was not impacted through your MCH Grant-funded project, write in "0" for that line.
4. Total expenditures must equal the total reflected on the final Expenditure Report.
5. **Pay particular attention to the accuracy of Table 4**. Your organization's report of expenditures by types of individuals contributes to the State's report to the federal government. The report of aggregated expenditures identifies if the State has met the statutory requirement in Title V of the Social Security Act to expend 30% of the federal allotment for "Children" and another 30% for "Children with Special Healthcare Needs". Non-compliance with the expenditure requirements for these populations has potentially serious implications of loss of federal funding.

**\* Note: For projects that do not provide a service, per se, determine the populations impacted by the activities of this grant.**

## Glossary

### **access**

Often defined as the potential and actual entry of a population into the health care system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Utilization rates and subjective evaluations of care describe actual entry into the system. Ability to obtain wanted care or the distance one has to travel, waiting time, and total income may also influence needed services, and whether one has a regular source of care.

### **activities**

Describe the steps of a planned intervention.

### **allowable costs**

Allowable costs are those necessary and reasonable for proper and efficient performance and administration of Federal awards. See Office of Management and Budget (OMB) Cost Principles relevant by type of entity.

### **audits**

Fiscal review performed by an independent auditor (CPA) with a formal report being prepared. Refer to [ATTACHMENT 4].

### **budget justification**

Details about what funds will be spent on and how dollars were figured in development of the budget. Describes how planned expenditures will support proposed goals and activities.

### **CLAS Standards**

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) – the collective set of “culturally and linguistically appropriate services.” CLAS mandates, guidelines and recommendations were issued by the U.S. Department of Health and Human Services Office of Minority Health intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services. For more information: <http://www.omhrc.gov/clas/frclas2.htm>.

### **capacity**

Includes delivery systems, workforce, policies, and support systems, and other infrastructure needed to maintain services delivery and policy-making activities.

### **cash match**

Non-federal grant source, agency cash, donations, fees, insurance payments or Medicaid reimbursement. Medicaid is a state-federal partnership. Medicaid payments include federal funds. This is an allowable source of cash match since Medicaid programs are state-operated and financed in part by state funds.

**children**

A child from 1<sup>st</sup> birthday through the 21<sup>st</sup> year, who is not otherwise included in any other class of individuals. (*Note: Pregnant teens are categorized as Pregnant Women, Not Children. See definition of Pregnant Women in the Glossary.*)

**children with special health care needs (CSHCN)**

*(For budgetary purposes)* Infants of children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems.

*(For planning and systems development)* The following is a non-categorical framework which uses three definition components. All three elements must exist for a child to be classified as having a chronic health condition. This approach defines ongoing health conditions in children ages *birth to 21 years of age* as disorders that:

1. Have a biologic, psychologic, or cognitive basis, *and*
2. Have lasted or are virtually certain to last for at least 1 year (or result in death), *and*
3. Produce *2 or more* of the following sequelae:
  - a. Limitation of function, activities, or social role in comparison with healthy age peers in the general areas of physical, cognitive, emotional, and social growth and development.
  - b. Dependency on one of the following to compensate for or minimize limitation of function, activities, or social role:
    - (1) medications
    - (2) special diet
    - (3) medical technology
    - (4) assistive technology
    - (5) personal assistance
  - c. Need for medical care, mental health care, or other health-related services over and above the usual for the child's age, or for special ongoing treatments, interventions, or accommodations at home or in school.

**community-based care**

The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

**consumer**

One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

**continuity of care**

Health care provided on a continuous basis, starting with the patient's initial contact with the primary care practitioner and following the patient through all episodes of his or her health care needs.

**cost**

Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

**cost center**

Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

**culturally competent**

Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

**direct cost**

A cost which is identifiable directly with a particular activity, service, or product of the program experiencing the costs. The costs must be specifically identified in and for the purpose of accomplishing what is described in the grant Application. These costs do not include the allocation of costs to a cost center, which are not specifically attributable to that cost center. (contrast with indirect cost)

**direct services**

Direct services are those services generally delivered one-on-one between a professional and a patient or client in an office, clinic, or other setting which may include physicians, registered dietitians, public health or visiting nurses, social workers, nutritionists, dentists, dental hygienists, audiologists, therapists (occupational, physical, mental health, etc.), and counselors. Also includes services provided by lay and para professional staff such as dulas and peer counselors.

**Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)**

A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care

treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.

**evaluation**

Systematic study conducted to assess how a program/intervention is working. An evaluation typically examines achievement of objectives in the context of other aspects of program performance or in the context in which it occurs.

**evidence-based models**

"Evidence-based" models are methodologies that have been developed and evaluated using scientific processes. Expert's use commonly agreed upon criteria for rating the effectiveness of interventions, reaching a consensus that evaluation research findings are credible and sustainable. Evidence-based is also referred to as science-based and research-based models.

**family-centered care**

A system or philosophy of care that incorporates the family as an integral component of the health care system.

**federal allocation**

For the federal Title V / Maternal and Child Health (MCH) Services Block Grant, the monies appropriated to the States under in a given year with obligation and spending authority for that year and the succeeding year.

**federal fiscal year**

For the federal Title V / Maternal and Child Health (MCH) Services Block Grant, it is the period October 1 through September 30.

**grant year**

For MCH Grant, it is the period October 1 through September 30.

**health equity**

Equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige.

**health literacy**

Defined in *Healthy People 2010* as: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions"

**indirect cost**

A cost which cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the result achieved. Indirect costs are usually allocated among an entity's services in proportion to each service's share of direct costs. Because of the diverse characteristics and accounting practices of

governmental units, the types of costs, which may be classified as indirect costs, cannot be specified in all situations. However, typical examples of indirect costs, may included certain general administration of the grantee department or agency, accounting and personnel services performed within the grantee department or agency, and the costs of operating and maintaining facilities. (Contrast with indirect cost.)

**infant mortality**

The death of a live-born infant before its first birthday.

**in-kind**

A third-party contribution; a value assessed to a service or product not paid with cash (referred to as "in-kind match" in this RFA).

**interconception**

Interconception refers to the time between pregnancies, including, but not restricted to, the postpartum period.

**low birth weight**

Babies born weighing less than 5 pounds, 8 ounces (2,500 grams) are considered low birthweight.

**life course health**

How risk factors, protective factors, and early-life experiences affect people's long-term health and disease outcomes.

**management plan**

The procedures for successfully managing (maternal child health) activities including the agency's organizational structure, staff responsibilities and qualifications.

**match**

The value of third-party in-kind contributions and the portion of the costs of a federally-assisted project or program not borne by the Federal Government (Source: the "Uniform Administrative Requirements for Grants and cooperative agreements to State and Local Governments" for the Department of Human Services, 45 C.F.R. Part 92)

**Medicaid**

A federally funded, state operated program of medical assistance to people with low incomes, authorized by Title XIX of the Social Security Act. Under broad federal guidelines the individual states determine benefits, eligibility, rates of payment and methods of administration.

**mistimed pregnancy**

According to questions included in the National Survey of Family Growth, a pregnancy that was intended but occurred sooner than the mother would have liked.

**morbidity**

The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

**mortality**

Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

**needs assessment**

A systematic process of identifying the needs of a population within a jurisdiction for the purpose of setting priorities to improve conditions

**neonatal death**

Death of a live-born infant from birth to <28 days of life.

**in-kind match**

A value assessed to a service or product not paid with cash, also known as "in-kind".

**non-profit**

*Proof of Non-profit Status* -- Any of the following is acceptable evidence of non-profit status: (a) a reference to the applicant organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code; (b) a copy of a currently valid IRS tax exemption certificate; (c) a statement from a State taxing body, State Attorney General, or other appropriate State Official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals; (d) a certified copy of the organization's certificate of incorporation or similar document that clearly establishes nonprofit status; (e) any of the above proof for a State or national parent organization and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

**objective**

Identifies a change that is desired, is measurable over a specific period of time and for a specific target group. Objectives form the basis of program activities.

**obligated costs**

The amounts of orders placed, contracts awarded, goods and services received, and similar transactions during a given period that will require payment by the non-Federal entity during the same or a future period.

**operating cost**

In the health field, the financial requirements necessary to operate an activity which provides health services. These costs normally include the costs of personnel, materials, overhead, depreciation, and interest.

**outcome**

The statement of an intended result.

**overhead**

The general costs of operating an entity which are allocated to all the revenue producing operations of the entity but which are not directly attributable to a single activity. For a hospital, these costs normally include maintenance of plant, occupancy costs, housekeeping, administration, and others.

**periconceptual**

Occurring around the time of conception.

**performance management system**

The continuous use of practices, e.g. performance measures, quality improvement, and reporting, and integrated into an organization's core operations

**performance measurement**

The quantitative basis by which objectives are established and performance is assessed and gauged.

**planning**

The establishment of goals, policies, and procedures for the accomplishment of a goal, outcome or objective.

**policy**

A course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous, or expedient. The term is sometimes used less actively to describe any stated position and matters at issue, *i.e.*, an organization's policy statement on national health insurance. Policies bear the same relationship to rules (regulations) as rules do to law, except that unlike regulations, they do not have the force of law.

**population-based health**

Focuses on entire populations, is grounded in an assessment of the population's health, considers the broad determinants of health, emphasizes all levels of prevention, and intervenes with communities, systems, individuals and families. Adapted from Minnesota Department of Health, Center for Public Health Nursing, March, 2003.

**preconception care**

A set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. Improving preconception health and pregnancy outcomes requires more than effective clinical care for women. Changes in the knowledge and attitudes and behaviors related to reproductive health among both men and women need to be made to improve preconception health.

Taken and adapted from:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>

**prenatal care**

1. Care of the pregnant woman before delivery of the infant.
2. Monitoring and management of the woman during pregnancy to prevent complications of pregnancy and promote a health outcome for the mother and infant.

**preterm birth**

A baby born before 37 weeks of pregnancy is considered a preterm or premature birth.

**primary prevention (as compared to secondary and tertiary)**

The classic definitions used in public health distinguish between primary prevention, secondary prevention, and tertiary prevention (Commission on Chronic Illness, 1957). Primary prevention is the prevention of a disease before it occurs; secondary prevention is the prevention of recurrences or exacerbations of a disease that already has been diagnosed; and tertiary prevention is the reduction in the amount of disability caused by a disease to achieve the highest level of function.

**program income**

Program income is gross income received by the Subrecipient that is directly generated by a grant-supported activity, or earned only as a result of the grant during the project period. Any profit to the Subrecipient resulting from grant funds. Program income is required to be reinvested to help support the grant-funded work.

**project period**

The timeframe defined by an RFA to perform a Work Plan. For the MCH Grant, this is a three-year period, unless a Subrecipient does not reapply or is not approved for continuation funding in the two interim years.

**public health**

1. The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.
2. Application of scientific and technical knowledge to address community health needs, thereby preventing disease and promoting health. Core functions include collecting and analyzing data, developing comprehensive policies for entire populations, and assuring that appropriate services are delivered to all.

**reproductive life plan**

A reproductive life plan is a set of personal goals about having (or not having) children. It also states how to achieve those goals based on personal values and resources.

**revenue**

The gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts, or contractual allowances.

**scope of work**

Work plan activities for the provision of MCH services or development, implementation and maintenance of MCH infrastructure.

**social determinants of health**

Both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action. Examples are income, education, occupation, family structure, service availability, sanitation, exposure to hazards, social support, racial discrimination, and access to resources linked to health.

**social ecological model**

A framework that can be used to guide health promotion and disease prevention interventions. In this model, behavior is viewed as affecting and being affected by multiple levels of influence: 1) intrapersonal or individual factors; 2) interpersonal factors; 3) institutional or organizational factors; 4) community factors; and 5) public policy factors.

**sovereignty**

Total independence and self-government. A territory existing as an independent state.

**sovereign nation**

Self-governing, independent nation.

**subrecipients**

A nonfederal entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program.

**system**

A system is a set of interrelated components working together towards some kind of process. First, all systems are goal oriented: they have a specific function. Second, systems have inputs from their environment on which they act. Next, systems have outputs: products that they send out to their environment. Lastly, systems obtain feedback from the environment that offers information about their outputs.

**systems change**

Making change that endures and which are at the heart of the organization. Such change is systematic, takes time, planning and patience. Such change is not

done by just tweaking parts of the system in isolation. It means ultimately impacting change across all elements of the system.

**systems development**

Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the quality of service capacity of health care service providers.

**system-level approach**

Steps in a system-level approach include: 1) Identify the system. Not all things are systems. Some systems are simple and predictable, while others are complex and dynamic. Most human social systems are the latter. 2) Explain the behavior or properties of the whole system. 3) Explain the behavior or properties of the thing to be explained in terms of the role(s) or function(s) of the whole.

**terms and assurances**

Document agreed upon by both DHHS and Subrecipient regarding conditions placed on the Subgrant.

**underinsured**

People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.

**uninsured**

People who lack public or private health insurance.

**unintended pregnancy**

According to questions included in the National Survey of Family Growth, a pregnancy identified as either unwanted or mistimed.

**unintentional injury**

Injury arising from unintentional events.

**unwanted pregnancy**

According to questions included in the National Survey of Family Growth, a pregnancy occurring when the mother reported that she did not want a child at the time of conception or any time in the future.

**wellness model**

Wellness is a conscious, self-directed and evolving process of achieving full potential; it is multi-dimensional and holistic, encompassing lifestyle, mental and spiritual well-being, and the environment. Models vary, but common components include: social, occupational, environmental, spiritual, physical, intellectual, and emotional aspects of wellbeing.