Maternal and Child Health Block Grant (MCHBG): Fiscal Year 2016 (7/1/15

Administrative Information

DRAFT - FOR REFERENCE ONLY. THE ACTUAL FORM WILL BE AVAILABLE ONLINE FROM AUGUST 1 - 15, 2016.

This report verifies county compliance with MCHBG Task Order requirements and should be filled out by the Contract Liaison/MCH Contact. The timeframe covers State Fiscal Year 2016 (7/1/15 - 6/30/2016). If you have any questions or concerns please contact Blair Lund, Health Services Grant Specialist, at (406) 444-0276 or blund@mt.gov.

1. County Name:

2. Did your county's health department send at least one staff member to a Family and Community Bureau sponsored MCHBG training?

- [ ] Yes
- [ ] No

Comment (optional)

3. IMPORTANT - Email a summary of your county health department's Client Survey results to the DPHHS MCHBG Contract Liaison (must be a Word document or PDF).

How were your county health department's Client Survey results used for Program Planning? (Please provide at least 1, and up to 3 examples)

Example #1

Example #2

Example #3

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4. Are services provided free of charge to clients AT or BELOW the federal poverty level?

- ◯ Yes
- ◯ No

5. What is your procedure when a client, who is ABOVE the federal poverty level, is in need of services? (For example, a sliding scale for fees, based on income.)

6. Does your county have a Memorandum of Understanding (MOU) regarding coordination of services with local Indian reservations? This can also be a written description of interagency coordination efforts.

- ◯ Yes
- ◯ No
- ◯ N/A

FICMMR Information

7. IMPORTANT - Email your county's updated FICMMR Operational Plan to the DPHHS FICMMR Program Coordinator by October 15th. This document must be in a PDF or Word format. For counties utilizing a neighboring county's FICMMR team, you will instead need to submit an updated county to county FICMMR MOU. Templates for the Operational Plan and MOU can both be found on the DPHHS website at: http://www.dphhs.mt.gov/publichealth/cdrp/index.shtml

If a neighboring county's team conducts your county's FICMMR reviews, please enter the name of that county below:

8. Please summarize the fetal, infant, child, or maternal death prevention activities or campaigns your county implemented during the reporting period (7/1/15 - 6/30/16). At least one activity / campaign description is required.

Activity #1

Activity #2

Activity #3

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Performance Measure Selection

9. Which National or State Performance Measure (NPM/SPM) did your county select for the reporting period (7/1/15 to 6/30/16)?

10. What was the NPM/SPM measurable goal that you submitted on your 2016 Pre-Contract Survey?

11. What was the actual rate of your NPM/SPM as of 6/30/16?

12. What impact did your county health department's NPM/SPM activities have in achieving the goal listed in question #10? Please refer to the evaluation plan submitted on the 2016 Pre-Contract Survey. At least 2 activity outcome descriptions are required.

Outcome of Activity #1

Outcome of Activity #2

Outcome of Activity #3

13. How did you use this information for selecting your SFY 2017 NPM/SPM (7/1/16 to 6/30/17)?

14. How can the DPHHS/MCHC section assist you with your SFY 2017 NPM/SPM activities?

15. I certify that the information on this Compliance and Activities Report is correct, and verify compliance with the SFY 2016 Maternal Child Health Block Grant Task Order:

Name of Person Completing Compliance and Activities Report	
Date	
Email Address	