**Pennsylvania Family Support Programs**

**Quarterly Narrative Template**

**Updated: September 6th, 2022**

**Template**

**Note:** This is only a template for the report to assist with the collection of the data, for the report to be considered officially submitted it must be entered into the Family Support Data System by the due date for each quarter.

**Waitlisted Incoming Referrals**

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| **Program Type** | **Funding Stream** | **County** | **Referral Source** | **Number on Wait List** | **Comments** |
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**Outgoing Referrals**

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| **Number of Families Referred** | **County** | **Referral To** | **Program Type** | **Comments** |
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**\*Success Stories, Family Leadership, and Staffing**

Please provide a response for each success type if applicable, if not applicable please write Not Applicable at this time in the response. Programs must always include at least one Family or Program success in their report.

**\*Family Success**

Please provide up to three success stories, they can be family successes or program successes. These should be written in narrative form and not a list of accomplishments. Indicate which program and program type the success story belongs to. This cannot be reported as three overall successes and does not have to include three for each program type. Please do not include the Caregiver, Family Name, or Initials in the responses.

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| **Narrative:**  |
| **Program (Funding) Type(s): [Multiple Can be Selected]**[ ]CCYA – Family First[ ]CCYA – Needs Based Budget[ ]CCYA – Other[ ]Children’s Trust Fund[ ]Community Based Child Abuse Prevention - American Rescue Plan (CBCAP ARP)[ ]Community Based Child Abuse Prevention (CBCAP)[ ]DOH – Title V[ ]Family Centers[ ]Family Support[ ]Fatherhood[ ]Health Enterprise Zone (HEZ)[ ]Home Visiting Expansion 17-18[ ]Home Visiting Expansion 19-20[ ]MANAGED CARE ORGANIZATION – Home Visiting[ ]Medical Assistance | [ ]MIECHV[ ]MIECHV ARP[ ]OCDEL NFP[ ]OCYF – Other[ ]OCYF & CCY[ ]Other Local Funding - County[ ]Other Local Funding - Other[ ]Other Local Funding - United Way[ ]OUD/SUD Pilot (Home Visiting)[ ]OUD/SUD Pilot (Parenting Classes)[ ]Promoting Safe and Stable Families - American Rescue Plan (PSSF ARP)[ ]Promoting Safe and Stable Families (PSSF)[ ]UNITED WAY |

**\*Program Success**

Please provide up to three success stories, they can be family successes or program successes. These should be written in narrative form and not a list of accomplishments. Indicate which program and program type the success story belongs to. This cannot be reported as three overall successes and does not have to include three for each program type.

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 **\*Family Leadership**

Provide up to three examples of Family Leadership, which includes the involvement of Caregivers in the ongoing planning, implementation, and evaluation of programs.

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**\*Staffing**

Describe implemented policies and procedures regarding the equitable and accessible provision of culturally and linguistically responsive services this quarter. Include information on any relevant trainings, any information on how your organization is addressing this from both the leadership and local level, and any updates on policies or procedures put in place to ensure families are receiving culturally relevant services that address their needs.

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| **Narrative:**  |
| **Program (Funding) Type(s): [Multiple Can be Selected]**[ ]CCYA – Family First[ ]CCYA – Needs Based Budget[ ]CCYA – Other[ ]Children’s Trust Fund[ ]Community Based Child Abuse Prevention - American Rescue Plan (CBCAP ARP)[ ]Community Based Child Abuse Prevention (CBCAP)[ ]DOH – Title V[ ]Family Centers[ ]Family Support[ ]Fatherhood[ ]Health Enterprise Zone (HEZ)[ ]Home Visiting Expansion 17-18[ ]Home Visiting Expansion 19-20[ ]MANAGED CARE ORGANIZATION – Home Visiting[ ]Medical Assistance | [ ]MIECHV[ ]MIECHV ARP[ ]OCDEL NFP[ ]OCYF – Other[ ]OCYF & CCY[ ]Other Local Funding - County[ ]Other Local Funding - Other[ ]Other Local Funding - United Way[ ]OUD/SUD Pilot (Home Visiting)[ ]OUD/SUD Pilot (Parenting Classes)[ ]Promoting Safe and Stable Families - American Rescue Plan (PSSF ARP)[ ]Promoting Safe and Stable Families (PSSF)[ ]UNITED WAY |

**\*Outreach to Specific Populations**

Please describe the outreach methods to maximize the participation of caregivers and child that fall into the following categories: racial and ethnic minorities, children and adults with disabilities, and members of other underserved or underrepresented groups during the quarter.

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| **Narrative:**  |

**\*Activities to promote culturally competent and culturally relevant services and activities for families accessing the program(s).**

Describe implemented policies and procedures regarding the equitable and accessible provision of culturally and linguistically responsive services this quarter. Include information on any relevant trainings, any information on how your organization is addressing this from both the leadership and local level, and any updates on policies or procedures put in place to ensure families are receiving culturally relevant services that address their needs.

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| **Narrative:**  |

**\*Public Information Activities**

Describe any public information activities your agency conducted during the quarter. Such as: Participation in a Community Street Fair, Etc.

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| **Narrative:**  |

**\*Professional Development**

Please list any EXTERNAL trainings or conferences attended during the quarter. Do not include internal trainings, meetings, and/or reflective supervision. Describe any professional development opportunities staff has attended during the quarter that directly relate to the service delivery and goals of the program.

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| **Narrative:**  |

**\*Community Connections**

Please provide one example per quarter on how your agency strengthened or continued to develop working relationships with other key provider of services and programs in the community.

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| **Narrative:**  |

**\*Connections with Early Intervention**

Please provide one example per quarter on how your agency strengthened or continued to develop working relationships with the Early Intervention (EI) provider in a community or communities you serve. Please note the EI County when responding.

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| **Narrative:**  |

**\*Connections with Children and Youth**

Describe your collaboration this past quarter with the Children and Youth agencies in the county or counties you serve.

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| **Narrative:**  |

**\*Technical Assistance Requests**

Identify any concerns that may require Technical Assistance, including CQI and Data. Please indicate if these concerns relate to a specific program type.

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| **Narrative:**  |

**\*Barriers and Challenges**

Identify by Program Type any major barriers or challenges you have encountered during this quarter. Describe how the challenges were handled and resolved.

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| **Narrative:**  |

**\*Services, Events, Community Engagement Beyond the Implemented Models**

Please use this space to discuss any services, events, or community engagement that is being offered beyond the EBHV or Family Support Program. Such as a Food Pantry, Father-Daughter Dance, Clothing Drives, Reading Programs, Kindergarten Readiness Programs, Community Closet, Community Computer Use, and but not limited to Approved Special Trips (if OCDEL funded). Please also include any funding information in this area, if not funded by OCDEL.

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| **Narrative:**  |

**\*Services to Children or Caregivers with Disabilities**

Per quarter of how your agency provides services specifically to these families and/or what steps you take to identify and encourage these families to participate.

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| **Narrative:**  |

**\*Family Support Enhancements (Select one or more), select N/A in the data system report if not Applicable.**

**Cat 1 - Evidence Informed Programing (EIP)**

Please describe and identify the EIP(s) funded through the grant award. Please describe any successes or challenges with the implementation of the EIP programs. Please provide one Family or Program success story related to the implementation of the EIP(s) if available each quarter.

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| **Narrative:**  |

**Cat 2 - EBHV Model Enhancements**

Briefly describe and identify the EBHV Model Enhancements funded through the grant award, provide updates on the number of families served (if applicable) by each enhancement. Please also describe any successes or challenges implementing the EBHV model Enhancements.

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| **Narrative:**  |

**Cat 3 - Program Enhancements**

Briefly describe and identify the Program Enhancements funded through the grant award, provide updates on the number of families served (if applicable) by each enhancement. Please also describe any successes or challenges implementing these enhancement(s). Enhancements in this section are such as but not limited to: Behavioral / Mental Health Consultant(s), Community Service Coordinator(s), Lactation Consultants(s); or peer specialists should be discussed in the response.

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| **Narrative:**  |

**Family Center - Family Support Services**

Briefly describe any services, events, or community engagement that will be provided with Family Center funding beyond the implementation of the EBHV program. Please describe any successes or challenges with the implementation of these services. If applicable, please provide one Family or Program success story related to the implementation of the Services each quarter.

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| **Narrative:**  |

**MIECHV ARP FUNDING SUPPLEMENTAL QUESTIONS**

Only complete this section only if your agency is receiving MIECHV ARP funding, selected no if not receiving MIECHV ARP funding.

**Use of MIECHV ARP FUNDS**

Describe how the ARP funds were used this Quarter to provide technology and supplies to those at-risk communities disproportionately impacted by COVID-19, including communities of color. If training activities were provided explain how it will benefit the at-risk communities.

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| **Narrative:**  |

#### Home Visitor Training

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| **Description of Training** | **Date of Training** | **Number of MIECHV Home Visitors Participating in Training** |
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In the space below, please provide a short description of grant activities related to home visitor training (e.g., describe how training needs, relevant topics, and target audiences were identified and prioritized; describe efforts related to developing or evaluating training).

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| **Narrative:**  |

**Family Technology**

Families receiving technology in the most recent quarter should only be counted once in this table, even if the household receives technology multiple times in the same quarter

Number of Families that received technology this quarter: \_\_\_\_\_\_\_\_\_\_\_

In the space below, please provide a short description of grant activities related to acquiring necessary technological means, for families enrolled in the program, to conduct and support virtual home visiting (e.g., describe how technology needs were identified, prioritized, and addressed; describe what hardware or software was acquired describe who (MIECHV home visitors, MIECHV families) received or used hardware/software).

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| **Narrative:**  |

**Family Emergency Supplies**

Families receiving emergency supplies in the most recent quarter should only be counted once in this table, even if the household receives emergency supplies multiple times in the same quarter.

Number of Families that received supplies this quarter: \_\_\_\_\_\_\_\_\_\_\_

In the space below, please provide a short description of grant activities related to providing emergency supplies to eligible families (e.g., describe the processes for identifying a need for specific supplies, distributing emergency supplies, general categories of and amount of supplies provided).

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| **Narrative:**  |

**Staff Emergency Supplies**

Staff receiving emergency supplies in the most recent quarter should only be counted once in this table, even if the household receives emergency supplies multiple times in the same quarter

 Number of Staff that received supplies this quarter: \_\_\_\_\_\_\_\_\_\_\_

In the space below, please provide a short description of grant activities related to providing emergency supplies to eligible staffs (e.g., describe the processes for identifying a need for specific supplies, distributing emergency supplies, general categories of supplies and amount of supplies provided).

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| **Narrative:**  |

**Diaper Bank Coordination**

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| **Name of Diaper Bank** | **New or Existing MIECHV/Diaper Bank Partnership** | **Count of MIECHV Families Provided Supplies** |
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In the space below provide a short description of the grant activities related to coordination with diaper banks to provide enrolled families with emergency supplies through purchase or reimbursement (e.g., how were diaper bank partners identified, how were supplies distributed to MIECHV families, how were referrals made, if families received supplies from multiple diaper banks).

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| **Narrative:**  |

**Staff Hazard Pay**

Number of MIECHV-Implementing Agency Staff Conducting Home Visiting: \_\_\_\_\_\_\_

Number of Other MIECHV Implementing Agency Staff: \_\_\_\_\_\_\_

Total: \_\_\_\_\_\_\_

In the space below, please provide a short description of grant activities related to hazard pay or other staff costs (e.g., staff costs associated with administration for MIECHV programs, such as hiring costs, or incentive or overtime pay). Specifically describe any activities to use funds for other staff costs at the administrative levels, i.e., administrative support, activities related to building staff and program capacity.

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| **Narrative:**  |

**Pre-Paid Grocery Cards**

Households receiving prepaid grocery cards in the most recent quarter should only be counted once in this table, even if the household receives multiple prepaid grocery cards in the same quarter.

Count of MIECHV Families Receiving Prepaid Grocery Cards: \_\_\_\_\_\_\_\_\_

In the space below, please provide a short description of grant activities related to providing prepaid grocery cards to eligible families. For example, response might describe efforts to identify need; the distribution processes or how often households received/could receive gift cards (e.g., monthly, weekly, one-time)

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| **Narrative:**  |

**CBCAP ARP Supplemental Enhancements and Services**

Only complete this section only if your agency is receiving CBCAP ARP funding, selected no if not receiving CBCAP ARP funding.

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| --- | --- |
| **Service or Enhancement** | **Number of Families served** |
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In the space below, please describe any successes with the implementation of the CBCAP ARP funded supports

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| **Narrative:**  |

In the space below, please describe any challenges with the implementation of the CBCAP ARP funded supports

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| **Narrative:**  |

In the space below, please provide any additional relevant information related to the CBCAP ARP funded supports below

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| **Narrative:**  |