HRSA
Health Resources & Services Administration

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO STATES PROGRAM

GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT

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TITLE V MATERNAL AND CHILD HEALTH (MCH) SERVICES BLOCK GRANT TO STATES PROGRAM APPLICATION/ANNUAL REPORT GUIDANCE

TENTH EDITION

The Title V Maternal and Child Health (MCH) Services Block Grant to States Program (hereafter referred to as the MCH Block Grant) is authorized by Sections 501-509 of Title V of the Social Security Act (42 U.S.C. §§ 701-709), and is a formula grant under which funds are awarded to 59 states and jurisdictions[1] upon their submission of an acceptable plan that addresses the health services needs within a state for the target population of mothers, infants and children, which includes infants and children with special health care needs (CSHCN), and their families. Through the MCH Block Grant, each state and jurisdiction supports and promotes the development and coordination of systems of care for the MCH population, which are family-centered, community-based, and culturally appropriate.

The Application/Annual Report Guidance is used by the 50 states and nine jurisdictions in applying for their MCH Block Grants under Title V of the Social Security Act and in preparing the required Annual Report. States and jurisdictions report annually on national and state outcome/performance measures, which document their progress towards the achievement of established annual objectives, ensure accountability for the ongoing monitoring of health status in women and children and lend support to the delivery of an effective public health system for the nation's MCH population. Complementary to the reporting of outcome and performance measure data is the narrative description of the state or jurisdiction's Title V program activities.

The tenth edition of the *Title V Maternal and Child Health Services Block Grant to States Program Guidance* provides instructions to the states on completing the required Application/Annual Report and Reporting Forms. As with previous editions, this Guidance adheres to the specific statutory requirements outlined in Sections 501-509 of the Title V legislation and honors the rights of states to determine their individual MCH program priorities, to develop tailored strategies for addressing their unique MCH population needs, and to assume accountability in achieving measurable progress towards stated program goals.

This edition of the *Title V MCH Services Block Grant to States Program Guidance* builds on and further refines the reporting structure and vision that was outlined in the previous edition and is designed to reduce reporting duplication and burden. While retaining the organizational structure, definition of family partnership and focus on the implementation of evidence-based or -informed strategies and measures, this edition introduces a revised performance measure framework that strengthens the

[1] The following nine jurisdictions receive Title V Maternal and Child Health Block Grant Program funding: the District of Columbia, the Republic of the Marshall Islands, the Federated States of Micronesia, the Republic of Palau, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

measurement model currently in use. The revised framework addresses social determinants of health, provides more choices for national performance measures (NPMs) for each domain, and introduces a standard set of measures that can be used as state performance measures, if the state so chooses. To accelerate progress on federal and state priorities, two NPMs are identified as Universal NPMs that every state is required to report on in its MCH Block Grant Application/Annual Report. These two Universal NPMs—Postpartum Visit and Medical Home—were selected for their focus on access and quality of essential primary and preventive care for mothers and children, including children with special health care needs. Greater emphasis is placed on health equity as a guiding principle of the Guidance. This Guidance introduces concepts from the *Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs* to advance the vision that CSHCN enjoy a full life and thrive in systems that support families and their needs while ensuring dignity, autonomy, and active participation in communities.[2]

States apply annually for MCH Block Grant funding using the online Title V Information System (TVIS). Administered by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), the TVIS consists of two components: 1) MCH Block Grant Application/Annual Report Data Entry (used by state/jurisdictional MCH Block Grantees to submit their financial, program, and performance data); and 2) TVIS Reports (a Web-based interface that allows public users to generate reports from Title V data). Since its development in 2002, TVIS continues to contribute to numerous efficiencies in the Application/Annual Report submission process. Examples include the automatic calculations of ratios, rates, and percentages; capturing of past years' narrative and data reporting; assurance that the data presented in multiple tables are entered only once by the state; and supporting prepopulation of Federally Available Data for national performance and outcome measures. The TVIS Web Reports further contribute to program transparency and accountability in making the financial, program and performance data submitted by the MCH Block Grantees publicly available in a searchable database.

Questions and comments regarding this edition of the Application/Annual Report Guidance may be addressed to:

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[2] HRSA Maternal and Child Health Bureau. 2022. *Blueprint for change: A national framework for a system of services for children and youth with special health care needs (CYSHCN) where they enjoy a full life and thrive in their community from childhood through adulthood*. Health Resources and Services Administration. https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn/blueprint-change.

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PART ONE: BACKGROUND AND ADMINISTRATIVE INFORMATION

I. Purpose of the Maternal and Child Health (MCH) Block Grant Program

As defined in section 501(a)(1) of the Title V legislation, the purpose of the MCH Block Grant is to enable each state:

A. *To provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;*

B. *To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;*

C. *To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX; and*

D. *To provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families.*

This legislative purpose is further affirmed through the Title V Vision and Mission statements, as shown below.

Vision of Title V

Title V envisions a nation where all mothers, infants, children, including CSHCN, and their families are healthy and thriving.

Mission of Title V

The Mission of Title V is to improve the health and well-being of the nation's mothers, infants, children and youth, including those with special health care needs, and their families.

II. Background and Brief History

Since its original authorization in 1935, Title V of the Social Security Act has been amended several times to reflect an ongoing commitment to improving the health and well-being of our Nation's mothers, children, and their families. Block-granted in 1981, with new accountability requirements added in 1989, Title V has remained a vitally important public health program for serving the MCH population. In 2015, an updated performance measure framework was introduced to reflect more clearly the contributions of Title V in improving health outcomes among the MCH population. A more complete history of Title V can be found in the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources.

The MCH Block Grant is a formula grant under which funds are awarded to 59 states and jurisdictions upon the submission of an acceptable plan that addresses the health services needs within a state for the target population of mothers, infants, and children, including CSHCN. Through this process, each state and jurisdiction supports and promotes the development and coordination of systems of care for the MCH population.

Annual submission of an Application is required by law to entitle a state to receive MCH Block Grant funds (Section 505 of Title V of the Social Security Act). Per Section 506, a state is further required to submit an Annual Report on the expenditure of the previous year's funds. In addition, Section 505(a) requires a state to conduct a comprehensive and statewide needs assessment every five years. The information and instructions for the preparation and submission of the Application/Annual Report and Five-Year Needs Assessment are contained in the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report* (hereafter referred to as the Application/Annual Report Guidance).

III. High Level Overview of Narrative Reporting Concept

This version of the Application/Annual Report Guidance introduces a new reporting concept that is designed to further reduce the burden associated with completing the Application/Annual Report. This new reporting concept allows the following:

- **Five-Year Comprehensive Needs Assessment Reporting Year:** During the year when the five-year comprehensive needs assessment summary is submitted, applicants will be required to provide new narrative and form data for ***all*** sections and forms in the Application/Annual Report. This submission will serve as the baseline submission for each five-year period.
- **Enhanced Flexibility during Interim Reporting Years:** During the four interim reporting years after the Need Assessment, applicants will have enhanced flexibility to determine whether updates are required for certain narrative sections and forms. Sections with this enhanced flexibility will be identified in the Application/Annual Report Guidance. If the information provided in the most recent submission does not require updates, applicants will be able to easily identify that updates are not needed, and the most recent narrative or form data will be populated for these sections.
    - **Identification of Sections with Enhanced Flexibility:** Throughout this document, the sections with the option to indicate that updates are not needed during interim reporting years are identified, next to narrative section titles, as "Reporting Flexibility in Interim Years."
    - **Identification of Sections Requiring Annual Update:** Throughout this document, the sections that continue to require annual updates during interim reporting years are identified, next to the narrative section titles, as "Annual Update Required."

IV. Guiding Principles for the Development of the MCH Block Grant Application/Annual Report Guidance

The development of the application/reporting structure for this edition of the Application/Annual Report Guidance incorporates key principles that are common to all state Title V programs. These principles are: 1) delivery of Title V services within a public health service model; 2) data-driven programming and performance accountability; 3) partnerships with individuals/families/family-led organizations (hereafter referred to as family partnership) to ensure systems and services that support the interests of all MCH populations; and 4) health equity and assurance that all MCH populations achieve their full health potential. These principles have contributed to the MCH Block Grants' success in operationalizing the legislative requirements and in delivering public health services and systems of care that address the needs of the MCH population.

A. Public Health Services Systems Model for MCH Populations

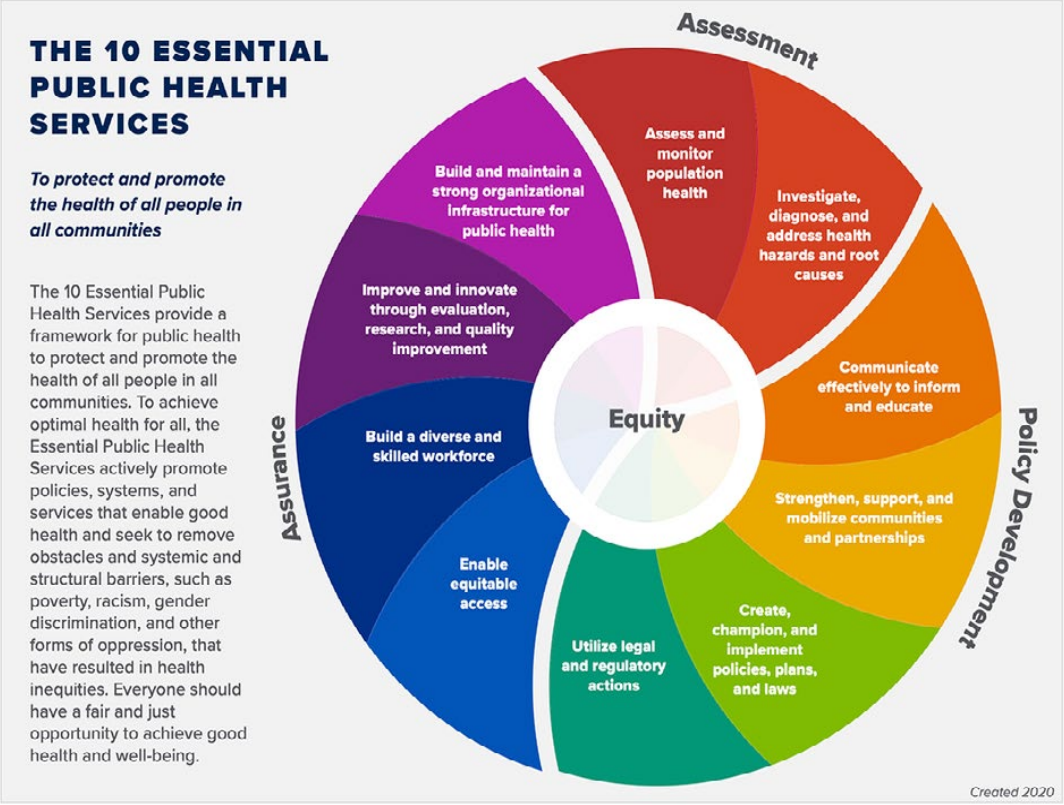
A 1988 Institute of Medicine (IOM) Report[3] defined the core functions of public health as assessment, policy development and assurance. In operationalizing the core public health functions and in ensuring that the unique needs of mothers and children were addressed, the MCH community worked with the Public Health Service and

[3] Institute of Medicine. (1988). The Future of Public Health. Washington, D.C.: National Academy Press.

the IOM to identify 10 "Essential Public Health Services"[4] in 1994. Since that time, the 10 Essential Public Health Services have provided a framework for the delivery of MCH services.

The Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation engaged the public health field in a 2020 review and update of the 10 Essential Public Health Services framework to better reflect current and emerging public health practice needs. The revised framework was released on September 9, 2020, as reflected in Figure 1. More information on this work can be found on the PHNCI website at: https://phnci.org/national-frameworks/10-ephs.

Figure 1:



A crosswalk of the 10 Essential Public Health Services with the purpose of the State MCH Block Grants, as defined in Section 501(a)(1) of Title V of the Social Security Act, yielded the following strategies for states to use in their program planning.

(1) Conduct ongoing assessment of the changing health needs of the MCH population to drive priorities for achieving equity in access and positive health outcomes;

(2) Expand surveillance and other data systems capacity to support rapid investigation of emerging health issues that affect the MCH population (e.g., mental health impacts related to the COVID-19 pandemic)

(3) Inform and educate the public and families about the unique needs of the MCH population;

[4] Public Health in America. (1994), Washington, DC: US Public Health Service. Essential Public Health Services Working Group of the Core Public Health Functions Steering Committee.

(4) Mobilize partners, including families and individuals, at the federal, state and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services and developing supportive policies;

(5) Provide expertise and support for the formation and implementation of state laws, regulations and other policies pertaining to the health of the MCH population (e.g., perinatal regionalization/risk appropriate care and suicide prevention);

(6) Integrate systems of public health, health care and related community services to ensure equitable access and coordination to achieve maximum impact;

(7) Promote the effective and efficient organization and utilization of resources to ensure access to necessary comprehensive services for CSHCN and families through public health services, systems, and population health efforts.

(8) Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and the efficient and equitable use of resources;

(9) Support or conduct applied research resulting in evidence-based policies and programs;

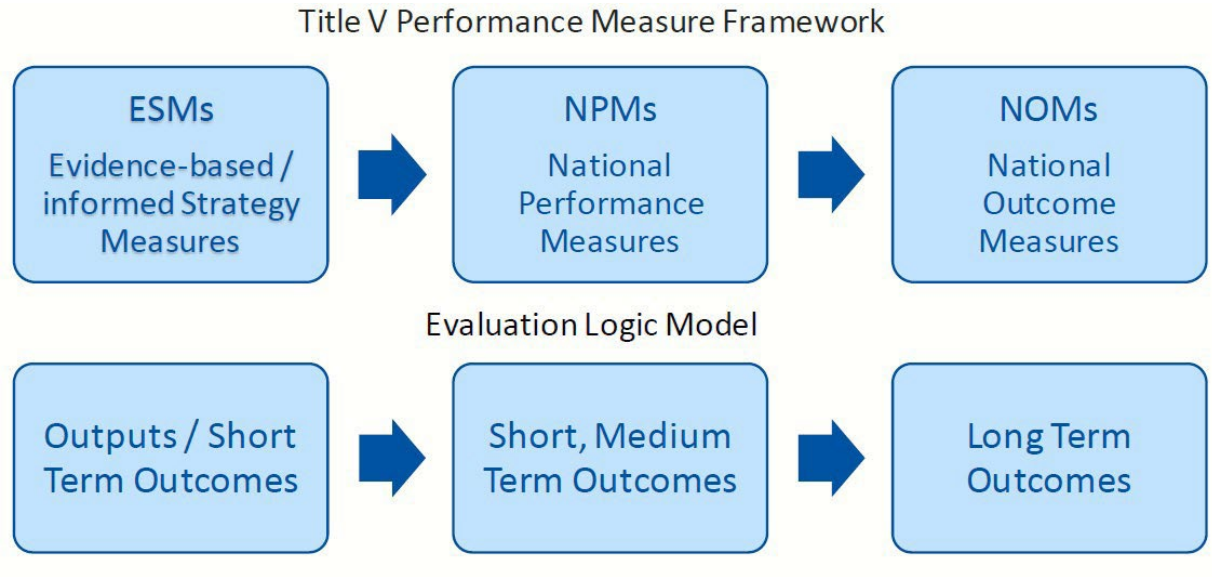
(10) Facilitate rapid innovation and dissemination of effective practices through quality improvement and other emerging methods; and

(11) Provide services to address unmet needs in health care and public health systems for the MCH population (i.e., gap-filling services for individuals).

B. Data Driven Programming and Performance Accountability (National Performance Measure Framework)

The MCH Block Grant utilizes a three-tiered national performance measure framework (Figure 2), based on an evaluation logic model framework, which includes National Outcome Measures (NOMs), National Performance Measures (NPMs) and state-initiated Evidence-based or -informed Strategy Measures (ESMs).

Figure 2: Performance Measure Framework



The NPMs are a set of short-term and medium-term performance measures that utilize population-based, state-level data derived from national data sources and for which a state Title V program tracks prevalence rates and works towards demonstrated impact. They are intended to drive improved outcomes relative to one or more medium and long-term indicators of health status, quality of life, preventable morbidity, and mortality (i.e., NOMs) for the MCH population. Thus, a state tracks the NOMs to monitor the impact of the NPMs.

ESMs are the third tier of the national performance measurement framework, and they are the structural or process measures through which a state can achieve intended impact on the NPMs. State-specific and actionable, the ESMs seek to track a state Title V program's strategies/activities and to measure evidence-based or -informed practices that will impact individual, population-based NPMs. The ESMs are developed by the state, and they provide accountability for improving quality and performance related to the NPMs and to the MCH public health issues that they are designed to address. While not part of the NPM framework, a state will also develop State Performance Measures (SPMs) to address its identified priority needs to the extent that they have not been fully addressed through NPMs and ESMs. To support states in developing SPMs, a set of standardized measures are available for use (see the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources for a list of standardized measures).

Title V is responsible for promoting the health of all mothers and children, including CSHCN and their families. There are 20 NPMs, which address key MCH priority areas within five MCH population domains. These domains are: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; and 5) CSHCN. The NPM framework also applies the life course theory, which identifies critical stages (i.e., beginning before a child is born and continuing throughout life) that can influence lifelong health and well-being.

A sixth domain addresses Cross-cutting and Systems Building needs. While there are currently no NPMs included in this last domain, a state may choose to develop one or more SPMs to address a priority need that is related to program capacity and/or systems-building (e.g., applies to all MCH population domains). A state is not required to identify a measure for this domain. If an SPM is developed, the state should define strategies for determining success. Examples of topics addressed by SPMs in this domain are:

(1) Partnerships with individuals, families, and family-led organizations;
(2) Social determinants of health;
(3) Health Equity;
(4) Organizational change;
(5) Workforce development; and
(6) Enhanced data infrastructure

It should be noted that the five MCH population health domains reflected in the NPM framework are contained within the three legislatively defined MCH populations [Section 505(a)(1)]. For example, the first two domains are included under "preventive and primary care services for pregnant women, mothers and infants up to age one," which is the first of the three defined MCH populations. Child and adolescent health are included in the second defined MCH population, specifically "preventive and primary care services for children." CSHCN is the third legislatively defined MCH population. This latter population is inclusive of children and youth with special health care needs.

The NOMs and NPMs have been updated for this edition of the MCH Block Grant Application/Annual Report Guidance to reflect salient and emergent priorities at the state and national levels. In addition to being distributed within the five population health domains, the NPMs also represent three different measure domains of action which aim to improve the NOMs. The measure domains include: 1) clinical health systems; 2) health behaviors; and 3) social determinants of health. Within each MCH population health domain, there are at least three NPM options, with at least one NPM for each measure domain. The exception is for CSHCN where there is a greater focus on the need to improve clinical health systems. With this Guidance, there are now 20 NPMs, which provide a state more measurement options for selection in each domain.

Required Reporting on Universal NPMs: Each year, every state is required to address and report on two Universal NPMs. These two Universal NPMs were selected for their focus on access and quality of primary and preventive care and will serve to accelerate progress to "provide and assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services." [Sec 501(a)(1)(A)]. The two Universal NPMs are Postpartum Visit - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components; and Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Addressing the maternal health crisis is a HRSA priority, as well as a state-level priority more broadly; therefore, for this Guidance, Postpartum Visit is the first Universal NPM. The universal reporting of Postpartum Visit is intended to drive improvement in the Maternal mortality rate. Untreated chronic conditions and pregnancy-related complications increase the risk of adverse health outcomes in the weeks and months following delivery. A comprehensive postpartum visit is an opportunity to improve maternal health by providing recommended clinical services, including screening, counseling, and management of health issues.[5] These services can lead to identification, treatment, and prevention of adverse outcomes to optimize maternal health following pregnancy.

The second Universal NPM is Medical Home, selected in the CSHCN, Child, and Adolescent population health domains, which is intended to drive improvement in the core CSHCN outcome, Well-functioning system of care, as well as access to quality health care for all infants, children, and adolescents. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing

[5] ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstet Gynecol. 2018 Sept; 132(3): 784-785. doi: 10.1097/AOG.0000000000002849. https://journals.lww.com/greenjournal/Fulltext/2018/09000/ACOG_Committee_Opinion_No__736__Optimizing.50.aspx

comprehensive and coordinated care to children in a medical home is the standard of pediatric practice.[6] Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

A state must report on a minimum of five (5) NPMs, which includes the two Universal NPMs, with at least one NPM for each of the five MCH population domains. States have the flexibility to select as many NPMs and SPMs as necessary to address each of its priority needs including the other NPMs within the Women/Maternal Health, Child Health, Adolescent Health, and CSHCN domains. There is no maximum for the number of NPMs that a state can select. See the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources for detailed information about the NPM Framework, NOMs, and NPMs.

[6] American Academy of Pediatrics. National Resource Center for Patient/Family-Centered Medical Home. (n.d.) https://medicalhomeinfo.aap.org

Table 1. NPMs, MCH Population Domains, and Measure Domains

NPM Short Title	NPM Title	MCH Population Domains**	Measure Domain
Postpartum Visit*	A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components	Women/Maternal Health	Clinical Health Systems
Postpartum Mental Health Screening	Percent of women screened for depression or anxiety following a recent live birth	Women/Maternal Health	Clinical Health Systems
Postpartum Contraception Use	Percent of women using a most or moderately effective contraceptive following a recent live birth	Women/Maternal Health	Health Behavior
Perinatal Care Discrimination	Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care	Women/Maternal Health or Perinatal/Infant Health	Social Determinants of Health
Risk-Appropriate Perinatal Care	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Perinatal/Infant Health	Clinical Health Systems
Breastfeeding*	A) Percent of infants who are ever breastfed B) Percent of children, ages 6 month through 2 years, who were breastfed exclusively for 6 months	Perinatal/Infant Health	Health Behavior
Safe Sleep*	A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult	Perinatal/Infant Health	Health Behavior
Housing Instability – Pregnancy** Housing Instability – Child**	Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth Percent of children, ages 0 through 11, who experienced housing instability in the past year	Perinatal/Infant Health, Women/Maternal Health, and/or Child Health	Social Determinants of Health
Developmental Screening	Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	Child Health	Clinical Health Systems
Childhood Vaccination	Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	Child Health	Clinical Health Systems
Preventive Dental Visit – Pregnancy** Preventive Dental Visit – Child**	Percent of women who had a preventive dental visit during pregnancy Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	Women/Maternal Health, Child Health, and/or Adolescent Health	Clinical Health Systems
Physical Activity	Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	Child Health	Health Behavior
Food Sufficiency	Percent of children, ages 0 through 11, whose households were food sufficient in the past year	Child Health	Social Determinants of Health
Adolescent Well-Visit	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	Adolescent Health	Clinical Health Systems
Mental Health Treatment	Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling	Adolescent Health	Clinical Health Systems
Tobacco Use	Percent of adolescents, grades 9 through 12, who currently use tobacco products	Adolescent Health	Health Behavior
Adult Mentor	Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance	Adolescent Health	Social Determinants of Health
Medical Home – Overall** Medical Home – Personal Doctor** Medical Home – Usual Source Of Sick Care** Medical Home – Family	Percent of children with and without special health care needs, ages 0 through 17, who have a medical home Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care Percent of children with and without special health care needs,	Children with Special Health Care Needs (CSHCN), Child Health, and Adolescent Health	Clinical Health Systems

NPM Short Title	NPM Title	MCH Population Domains**	Measure Domain
Centered Care** Medical Home – Referrals** Medical Home – Care Coordination**	ages 0 through 17, who have family centered care Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination		
Transition	Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	Children with Special Health Care Needs (CSHCN) and/or Adolescent Health	Clinical Health Systems
Bullying	Percent of adolescents with and without special health care needs, ages 12 through 17, who are bullied or who bully others	Children with Special Health Care Needs (CSHCN) and/or Adolescent Health	Social Determinants of Health

*NPMs that have multiple sub-measures (e.g., have an "A" and "B" component)

**NPM with multiple population domains and/or sub-components that can be individually selected and count once toward the minimum of 5 NPMs.

The same measure can be selected in multiple domains (Perinatal care discrimination, Housing Instability, Preventive dental visit, Transition, and Bullying), but will only count once toward the requirement of a minimum of five NPMs and one per domain. For example, if a state selects a compound measure such as Housing Instability for both Perinatal/Infant and Child Health, it would only count once towards the minimum of five NPMs, and another measure would need to be selected in either Perinatal/Infant or Child Health to satisfy the requirement of one measure in each population domain. Medical Home must be reported on for Child Health and CSHCN domains, but it will only count once towards the minimum of five NPMs. The state can choose which domain it counts in to fulfill the requirement of one NPM per population domain. Discussion within the Child Health and CSHCN domains may cover infants, children, and adolescents per the measure definition of children ages 0 through 17 years. States may optionally report on Medical Home in the Adolescent Health domain in addition to the required Child Health and CSHCN domains.

Medical Home has sub-measures for the overall composite measure, as well as each individual sub-component. For this Universal NPM, states additionally have the option to select one or more of the sub-components to focus on for the five-year cycle. Either option will count only once toward the minimum of five (5) reported NPMs. Only one ESM is required for Medical Home, even though it is reported in the Child Health and CSHCN domains, and it may be specific to a selected sub-component or the overall composite measure.

C. Family and Community Partnership

Building the capacity of women and children, including CSHCN, and their families to partner in decision-making with Title V programs at federal, state and community levels is a critical strategy in helping states to achieve the identified MCH priorities. Title V programs must also build knowledge, skills, confidence, and resources related to family partnerships. Expanding the capacity of both families and Title V is crucial to building equitable family partnerships. Title V's commitment to these partnerships is strong, as states expand and strengthen family engagement activities in all MCH population domains.

Traditionally, state Title V programs have partnered with families in a variety of program activities. Specific examples include:

(1) Contracting with Family-Led Organizations, including Family-to-Family Health Information Centers;
(2) Paid Program Staff;
(3) Advisory Committees/Task Forces;

(4) Agency Decision-Making and Policy Development;
(5) Program Outreach;
(6) Training; and
(7) Peer Support.

For purposes of the MCH Block Grant, family partnership is defined as, "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making—to improve health and health care. This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course."[7] Relevant resources include, but are not limited to, the National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs, authored by the Association of Maternal and Child Health Programs Version 2.0 (2017); a series of reports and case studies entitled, Sustaining and Diversifying Family Engagement in Title V MCH and CYSHCN Programs (AMCHP, 2016); and the Family Engagement in Systems Assessment Tool (FESAT) and Family Engagement in Systems (FES) Toolkit developed and released by Family Voices in 2019/2020. The *Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs* outlines principles and strategies in four critical areas to advance the system of services. Specifically, the Family and Child Well-being and Quality of Life domain describes principles and strategies that prioritize quality of life and well-being for CSHCN and their families.[8] See the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources for more information.

The Application/Annual Report Guidance emphasizes the need for a state to demonstrate the value of family and community partnerships in improving health outcomes across all sectors of the MCH population. In addition, a state should:

(1) Assure families and individuals are key partners in health care decision-making at all levels across the health care system and the services that support them, especially those who are vulnerable and medically underserved, including efforts to engage diverse families and family-led organizations;
(2) Provide training, both in orientation and ongoing professional development, for program staff, family leaders, volunteers, contractors, and subcontractors in the areas of addressing bias, discrimination, and cultural/linguistic competence;
(3) Collaborate with community leaders/organizations and families of every background in needs/assets assessments, program planning, service delivery and valuation/monitoring/quality improvement activities. For more details on critical partnership, reference the *Blueprint for Change*: *A National Framework for a System of Services for Children and Youth with Special Health Care Needs*, which outlines principles and strategies to advance the system of services; and
(4) Measure the engagement of families and communities. For more details on measurement, reference the Family Engagement in Systems Assessment Tool (FESAT) and the *Blueprint for Change*: *A National Framework for a System of Services for Children and Youth with Special Health Care Needs,* which outlines principles and strategies to advance the system of services.

[7] Carman K., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtcl, C., Sweeney, J. "Patient and Family Engagement: A framework for understanding the elements and developing interventions and policies." *Health Affairs*. 2013; 32:223-231.

[8] HRSA Maternal and Child Health Bureau. 2022. *Blueprint for change: A national framework for a system of services for children and youth with special health care needs (CYSHCN) where they enjoy a full life and thrive in their community from childhood through adulthood*. Health Resources and Services Administration. https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn/blueprint-change.

D. Health Equity

Title V MCH programs support access to quality services and service delivery for all MCH populations to achieve their full health potential. The focus on advancing health equity is at the center of Title V's work and highlights efforts improving equity and promoting fairness of services for the MCH populations, as states address their health care priority needs. Advancing health equity requires valuing everyone equally; making meaningful progress on mitigating or eliminating systemic barriers, such as poverty, racism, ableism, gender discrimination, and geographic disparities; and aligning resources to eliminate health and health care inequities. Addressing health equity includes focusing on major upstream drivers of health for MCH populations and integrating and centering the lived experience of diverse individuals, families, and communities into policy and program planning, implementation, and monitoring. This Guidance communicates this principle throughout the sections of the document.

V. Legislative Requirements

The MCH Block Grant is authorized by Title V of the Social Security Act, which is the longest-standing public health legislation in American history. The law continues to support efforts to improve the health of the nation's women and children. The law can be viewed at: https://www.ssa.gov/OP_Home/ssact/title05/0500.htm[9]. A general overview of some of the legislative requirements (which include statutory citations in brackets) and the way in which these requirements are implemented by MCHB is set out below.

A. Use of Allotment Funds [Section 504]

The state may use its MCH Block Grant funds for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its application. [Section 504(a)]. In addition, the state may request supplemental funds from MCHB to support identified technical assistance needs. Related to technical assistance, the state should plan for and allot funds for the MCH and CSHCN Directors to attend two required meetings each year in person. One of these meetings is the required MCH Block Grant Application/Annual Report review, which is held at a site designated annually by the Division of State and Community Health (DSCH) in HRSA's MCHB. The other meeting is a MCH Federal-State Partnership Meeting, which aims to: 1) update State MCH and CSHCN Directors on relevant legislation and MCHB initiatives; 2) convene leaders, disseminate best practices, and share innovations in the field of MCH; and 3) provide opportunities for information exchange, networking, and collaboration among states and with MCHB. States should plan for this meeting to be held in the Washington, DC area.

The state should also plan for and participate in regular engagement with its DSCH Project Officer for the purpose of ongoing technical assistance and oversight, including monthly or quarterly conference calls, and site visits.

The MCH Block Grant funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment. [Section 504(b)(2)-(3)]. Other restrictions apply, as specified in Section 504(b).

[9] Another version of Title V of the Social Security Act, which provides more detailed editorial notes and updates, can be viewed at: https://uscode.house.gov/view.xhtml?req=granuleid%3AUSC-prelim-title42-chapter7-subchapter5&saved=%7CKHRpdGxlOjQyIHNlY3Rpb246NzA4IGVkaXRpb246cHJlbGltKSBPUiAoZ3JhbnVsZWlkOlVTQy1wcmVsaW0tdGl0bGU0Mi1zZWN0aW9uNzA4KQ%3D%3D%7CdHJlZXNvcnQ%3D%7C%7C0%7Cfalse%7Cprelim&edition=prelim[10] Wirth, B. and Van Landeghem, K. "Strengthening the Title V-Medicaid Partnership: Strategies to Support the Development of Robust Interagency Agreements between Title V and Medicaid." April 2017. https://oldsite.nashp.org/wp-content/uploads/2017/04/Strengthening-the-Title-V-Updated.pdf

B. Application for Block Grant Funds [Section 505]

The Application shall be developed by, or in consultation with, the state MCH agency and shall be made public within the state in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal. [Section 505(a)].

Each state is required to conduct a statewide Needs Assessment once every five years. [Section 505(a)(1)]. A detailed overview of the MCH Five-Year comprehensive statewide Needs Assessment process is presented in the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources. The Needs Assessment findings will be integrated into that year's Application/Annual Report as a Five-Year Needs Assessment Summary. During the four interim years of the five-year reporting period, a state will submit an annual update of its ongoing needs assessment activities and findings in the appropriate section of the state Application/Annual Report. By law, the Application/Annual Report will contain information that is consistent with the health status goals and national health objectives regarding the need for:

(1) Preventive and primary care services for all pregnant women, mothers, and infants up to age one;
(2) Preventive and primary care services for children; and
(3) Services for children with special health care needs (as specified in section 501(a)(1)(D)). (Section 501(a)(1)(D) specifies that MCH block grants funds are for the purpose of enabling each state "to provide and to promote family-centered, community-based, coordinated care (including care coordination services …) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families").

[Section 505(a)(1)(A)-(C)].

The state will organize its reporting on the three legislatively defined MCH populations in the context of five population health domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; and 5) CSHCN. Although the Application/Annual Report Guidance defines children as ages 1 year through 21 years, a separate Adolescent Health domain is included in the NPM framework, due to their unique health needs. Adolescents often require different strategies than the strategies used to address the needs of the broader child health population.

Each year, at least thirty percent (30%) of federal Title V funds must be used for preventive and primary care services for children. [Section 505(a)(3)(A)]. Additionally, at least thirty percent (30%) of federal Title V funds must be used each year for services for CSHCN (as specified in section 501(a)(1)(D)), which include providing and promoting family-centered, community-based, coordinated care (including care coordination services) for CSHCN and facilitating the development of community-based systems of services for such children and their families. [Section 505(a)(3)(B)]. Provisions for waiving the thirty percent (30%) requirements are set out in Section 505(b)(1)-(2). A request for waiver must be included in the Application letter of transmittal. [Section 505(b)]. In addition, of the amount paid to a state under Section 503 from an allotment for a fiscal year under Section 502(c), not more than ten percent (10%) may be used for administering the funds paid under such section. [Section 504(d)].

The state must maintain the level of funds being provided solely by such state's MCH programs at the level provided in fiscal year 1989. [Section 505(a)(4)].

Other requirements for allocation of funds, charging for services, maintenance of a toll-free hotline, and coordination of services with other programs are found in Section 505.

C. Annual Report [Section 506]

An Annual Report must be submitted to MCHB each year, in order to evaluate and compare the performance of different states assisted under Title V and to assure the proper expenditure of funds. [Section 506(a)(1)]. Each Annual Report shall be prepared by, or in consultation with, the state MCH agency. [Section 506(a)(1)]. The Annual Report will include a description of program activities, a complete record of the purposes for which funds were spent, the extent to which the state has met its goals and performance objectives, as well as the national health objectives, and the extent to which funds were expended consistent with the state's application. [Section 506(1)]. The Action Plan includes the Annual Report narrative on the state's Title V program strategies and activities. States will utilize the Action Plan section of the Application/Annual Report to provide narrative discussion on the progress (by population health domain) achieved during the reporting year relative to the implementation of planned activities and gains in meeting the established performance measure targets. The standardized format of the Annual Report, as described, will allow for consistency in reporting and will facilitate the preparation of a report to Congress, as required in Section 506(a)(3).

In accordance with Section 509(a)(5), MCHB has made a substantial effort to not duplicate other federal data collection efforts. MCHB will collect and provide National Outcome and Performance measure data, as well as Other State Data (OSD), for the individual states, as available. Given that limited data are available from the National Center for Health Statistics (NCHS) and other federal sources for Puerto Rico, Guam, the Republic of the Marshall Islands, Federated States of Micronesia, Republic of Palau, Commonwealth of the Northern Mariana Islands, American Samoa, and Virgin Islands, HRSA's MCHB developed an MCH Jurisdictional Survey. Like the National Survey of Children's Health (NSCH), the MCH Jurisdictional Survey collects information on factors related to the well-being of children. These factors include health status, visits to health care providers, health care costs, and health insurance coverage. In addition, the MCH Jurisdictional Survey collects information on factors related to the well-being of mothers, such as health risk behaviors, health conditions, and preventive health practices. The MCH Jurisdictional Survey enables MCHB to provide data for most National Outcome and Performance measures to these jurisdictions.

D. Nondiscrimination [Section 508]

All Title V programs and activities funded in whole or in part are considered to be programs and activities receiving Federal financial assistance and subject to Federal nondiscrimination statutes. [Section 508(a)(1)]. These statutes include prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], on the basis of handicap under section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794], on the basis of sex under Title IX of the Education Amendments of 1972 [20 U.S.C. 1681 et seq.], or on the basis of race, color, or national origin under Title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.]. [Section 508(a)(1)]. No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available under this Title. [Section 508(a)(2)].

E. Administration of Federal and State Programs [Section 509]

MCHB in HRSA has been designated as the organizational unit responsible for the administration of Title V. [Section 509(a)]. Within the Bureau, DSCH serves as the federal liaison to Title V MCH programs, providing consultation to states as they implement a wide range of MCH programs. DSCH collaborates with other Divisions within MCHB, HRSA Bureaus and Offices, other federal agencies, community partners, and other organizations on issues pertinent to Title V programs.

DSCH Project Officers (POs) oversee the ongoing work of the Title V Block Grant in each of the 59 states and jurisdictions. The work of the PO is the foundation for monitoring and oversight for the program, and this work

promotes successful fulfillment of the goals and objectives of the Block Grant. The PO has responsibility for 1) understanding and communicating programmatic objectives as detailed in the Block Grant Guidance, including how applications will be evaluated for their alignment with those objectives; 2) providing advice on the scientific/technical/programmatic suitability of applications for funding (preceding, as part of, or following the Block Grant Review); and 3) providing support in the post-award administration, including technical assistance to states. This monitoring and oversight are performed through site visits, annual Title V Block Grant reviews to ensure statutory compliance, and ongoing, regular communication to help state Title V programs achieve their state action plans. The PO serves as the first point of contact for providing technical assistance to the states.

Applicants may obtain additional information regarding administrative, technical, and program issues concerning the Block Grant Application/Annual Report by contacting:

Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N33
Rockville, Maryland 20857
Telephone: (301) 443-2204

Within each state, the state health agency is responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State under Title V. [Section 509(b)].

PART TWO: APPLICATION/ANNUAL REPORT INSTRUCTIONS

I. General Annual Requirements

A. Letter of Transmittal

An electronic letter of transmittal from the responsible state health agency official must be the first page of the MCH Block Grant Application/Annual Report. The letter must also contain the documentation for waiver of a 30 percent allotment if the state is so requesting. The letter of transmittal is uploaded in TVIS as an image to Section I.A. of the Application/Annual Report.

B. Face Sheet

Each section of the Application Face Sheet (Standard Form 424) must be completed and submitted electronically along with the rest of the Application/Annual Report.

C. Assurances and Certifications

The appropriate Assurances and Certifications for the State MCH Block Grants, which are part of Standard Form (SF)-424B, Assurances for Non-Construction Programs and Certifications for debarment and suspension, drug free workplace, lobbying, program fraud and tobacco smoke, are included in Appendix 2. The state does not have to submit these forms as part of the Application/Annual Report, but they must be maintained on file in the state's MCH program's office. TVIS provides capability for the state to certify that the required assurances/certifications are maintained on file and the state can provide them at HRSA's request.

D. Table of Contents

The Table of Contents is automatically generated by TVIS and conforms to the headings in the different Parts/Sections of this Guidance.

II. MCH Block Grant Workflow

In follow-up to a legislatively required comprehensive Five-Year Needs Assessment, the state develops a five-year Title V Action Plan. Consistent with the block grant concept, the state has flexibility in the types of programs and activities that it implements to address the unique needs of its individual MCH populations. As depicted by the process flow diagram in Figure 3, a state's priority needs should "drive" the development of a five-year Action Plan that is responsive to the needs identified and is performance driven.

Figure 3: MCH Block Grant Workflow

The state begins each five-year cycle by conducting a comprehensive Title V Five-Year Needs Assessment. This Needs Assessment includes a comprehensive review of MCH population needs, program capacity, and partnerships/collaborations that are critical components of a state's system of care for addressing the needs of its MCH population. Based on the findings of the Five-Year Needs Assessment, the state identifies 7-10 Title V MCH priority needs. Using the State Action Plan Table as a working tool, the state develops strategies and overarching five-year objectives to address the identified priority needs. The state examines areas of potential alignment between its MCH priority needs and the Title V NOMs and NPMs. States must report on a minimum of five (5) NPMs, including the two Universal NPMs, with at least one NPM for each of the five MCH population domains for programmatic focus over the five-year cycle. Priority needs not addressed by the NPMs should be addressed through an SPM. States can develop their own SPM, or they may select one from the Standard Measure Set (See the

Title V Block Grant Technical Assistance Resources at: https://mchb.tvisdata.hrsa.gov/Home/Resources). The state can choose to develop or select as many SPMs as needed to ensure that each priority need is addressed either by an SPM or by an NPM. While not required, the state may choose to also develop a State Outcome Measure (SOM) to complement the NOMs that can be linked to an NPM or SPM. For each NPM, the state is required to develop at least one ESM that further defines how the state plans to monitor and assess its annual progress in addressing the NPMs. States may also choose to develop an optional ESM for one or more of their SPMs. To help address health equity, states have the option to additionally select a demographic stratifier and priority population within the stratifier (i.e., stratifier sub-group) for each NPM that they can track over the five-year cycle. In the four interim year Application/Annual Reports, the state reports on its ongoing needs assessment efforts, its success in implementing the five-year Title V State Action Plan, and its progress in achieving the established performance objectives for each NPM (and priority population), SPM, and ESM.

III. Components of the Application/Annual Report

Each year, states and jurisdictions are required to submit an Application/Annual Report for the federal funds they receive through the MCH Block Grant. In addition, the state is required to conduct and report on a comprehensive, statewide Needs Assessment every five years. See the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources for the Application/Annual Report Timeline. The findings of this Needs Assessment and the priority needs identified from this process provide the basis for the development of a five-year Action Plan for the state Title V program. As new findings become available through the state's ongoing/updating needs assessment efforts and the analyses of annual performance data, the state may refine its Action Plan in interim years to achieve targeted outcomes in state and national MCH priority areas. These changes may include the updating of performance objectives, the substitution of new or revised strategies, ESMs and/or SPMs for existing strategies and measures. States are encouraged not to change the NPMs during the five-year reporting cycle. If a state determines that an NPM needs to be changed, clear justification must be provided to the MCHB Project Officer.

The state's narrative Application/Annual Report includes the following sections:

A. Executive Summary;
B. Overview of the State;
C. Needs Assessment;
D. Financial Narrative;
E. Five-Year State Action Plan;
F. Public Input;
G. Technical Assistance

States should structure the narrative discussion of the Application/Annual Report to include the sections cited above. A detailed explanation of the specific discussion points that the state should include in each section is provided below.

A. Executive Summary

Comprised of three sections, the Executive Summary is intended to be a standalone document that enables the reader to acquire a clear understanding of the state's Title V program without having to read the entire MCH Block Grant Application/Annual Report. Limited to no more than five printed pages, the Program Overview (Section III.A.1) is the main narrative section in the Executive Summary. While limited to no more than one printed page per section, the remaining two sections (Section III.A.2 and Section III.A.3) enable a state to reflect

on the value and impact of the MCH Block Grant program in promoting the health and well-being of its MCH population.

In addition to serving as an introduction to the state's MCH Block Grant Application/Annual Report, the Executive Summary serves as the narrative portion of the TVIS State Snapshot. Publicly available as a TVIS Web report, this document serves as a quick point of reference for policy makers, national MCH leadership associations and programs, local and state MCH stakeholders, state Title V programs, families, academia, and other interested individuals. The State Snapshot incorporates key information contained in the State's MCH Block Grant Application/Annual Report into a formatted document that states can use in their Title V program outreach and health promotion efforts.

1. Program Overview (Reporting Flexibility Option in Interim Years)

The goal of the Program Overview section is to convey key descriptors about the state's Title V program (i.e., operational framework, needs assessment findings, MCH priorities, program goals and strategies, five-year action plan and performance monitoring) in a concise, yet substantive, overview. While a state can update its Executive Summary annually, the overall content should reflect the state's five-year action plan.

Specifically, the state should address the following components as part of the narrative discussion in this section.

a. A brief introduction to the state's Title V program and how it operates;
b. A high-level overview of the program's framework used by the state to carry out its needs assessment, program planning and performance reporting activities;
c. A concise summary of the state's needs assessment findings (i.e., 2020 Five-Year Needs Assessment and interim year needs assessment updates, as needed), which includes a description of the state's MCH population needs, emerging needs, Title V program capacity and internal/external partnerships;
d. A synopsis of the state Title V program's identified MCH priorities and Five-Year State Action Plan, which addresses the selected NPMs and established SPMs in the context of a state's identified MCH priority needs;
e. The role of the state Title V program in supporting and assuring comprehensive, coordinated and family-centered services, including services for CSHCN;
f. A synopsis of the state's approach to eliminating health inequities and advancing just and fair conditions, and a description of how the state integrates or centers the lived experience of individuals, communities, families, and caregivers in its work; and
g. A description of program evaluation efforts, noted accomplishments, and ongoing challenges, with a focus on the implementation of evidence-based or -informed practices and the effectiveness of current program strategies in improving MCH outcomes.

2. How Federal Title V Funds Complement State-Supported MCH Efforts (Reporting Flexibility Option in Interim Years)

The Title V MCH Block Grant is a federal/state partnership with 59 states and jurisdictions, which enables each state/jurisdiction to address the individual health service needs of the mothers, infants and children, including CSHCN, in the state. Consistent with the block grant concept, states have discretion in determining how to best invest their federal Title V funds to most effectively complement state-supported efforts in meeting their unique MCH needs.

The purpose of this section is to allow a state the opportunity to reflect on the critical role of federal Title V funds in supporting the state's overall MCH efforts. In its narrative discussion, the state should clearly

demonstrate the federal-state partnership in action. The state should identify specific programming areas in which federal Title V funds have served to complement state-led efforts in assuring the health and well-being of the MCH population while contributing to a strong public health infrastructure. Specific discussion points for demonstrating the impact of federal Title V funds on state-led MCH efforts may include, but are not limited to, the following:

a. Augmentation of State and other non-federal funds to assure the delivery of core MCH services;
b. Comparison of federal Title V expenditures with state Title V expenditures, by service level of the MCH Pyramid (see Appendix 1), to demonstrate how federal Title V funds complement state funds in providing a range of MCH services;
c. Comparison of federal Title V expenditures with state Title V expenditures, by individual MCH populations, to illustrate how federal Title V funds support gap-filling services, specialty services and other initiatives targeted at specific MCH populations or sub-populations;
d. Core support for the state's MCH program capacity and public health infrastructure, which includes enhancing the Title V program management structure, securing an adequate and well-trained MCH workforce, investing in family partnerships and navigator services, improving MCH data analytics and facilitating other systems-building efforts; or
e. Expansion of State and local agency MCH services.

3. MCH Success Story (Annual Update Required)

This section provides an opportunity for the State Title V program to highlight an MCH success. While the success story may have been achieved through multiple partnerships and funding sources, the specific contributions of the Title V program in achieving the successful outcome should be clearly documented. The success story may be specific to one or more MCH population domains or related to a state's cross-cutting and systems-building efforts. Capacity and systems-building successes should be framed in the context of how they ultimately impacted the lives of mothers, children, and families in the state. A state could consider stories of communities, individuals, and families of all structures including stories of fathers, grandparents, and diverse families. Stories of lived experience would demonstrate how Title V impacts the various communities and families in the state. For CSHCN, a state could consider plans for implementing strategies that address the four critical areas in the Blueprint for Change: health equity, family and child well-being and quality of life, access to services, and financing of services. This kind of success story would illustrate how any one of these critical areas enhances the quality of life and well-being for CSHCN and their families.

In selecting one success story to highlight, a state should consider the purpose of the Title V program and if the selected success story clearly reflects this purpose. Consideration of the success story should be given to how clearly it demonstrates the value of the Title V program and if the noted success could have been achieved in the absence of Title V funding.

State Title V programs have numerous successes and may provide multiple success stories if desired, as long as the requirements outlined above for one success story to highlight are met. A state also has the option to present a different success story each year in its MCH Block Grant Application/Annual Report, which will provide for greater representation of the breadth and impact of Title V-funded services across the five-year reporting period.

B. Overview of the State

1. State Description (Reporting Flexibility Option in Interim Years)

The intended purpose of this overview is to introduce a reader to the applicant state. Principal characteristics of the state, such as its demographics, geography, economy, and health care environment,

should be succinctly summarized to provide the reader with needed context for understanding the Title V program structure and approaches described in the Application/Annual Report.

Specifically, the State Overview should include a description of:

a. The state's demographics, geography, economy, and urbanization;
b. The state's unique strengths and challenges (e.g., availability and access to health care and supportive services) that impact the health status of its MCH population, including CSHCN;
c. The defined roles, responsibilities, and targeted interests of the state health agency and how they influence the delivery of Title V services; and
d. State-specific statutes and regulations that have relevance to the MCH Block Grant authority and impact the state's MCH and CSHCN programs.

2. State Title V Program

a. Purpose and Design (Reporting Flexibility Option in Interim Years)

Each state Title V program is unique in its organizational and fiscal structure; state-specific statutes and regulations; available resources; targeted MCH needs; established performance goals; and portfolio of supported programs and services. Building upon the information provided in the "Overview of the State" and the Health Care Delivery System" sections, states should use this section to provide a "big picture" overview of their Title V program, giving context for the activities and approaches that are described in the State Action Plan. Noted discussion points should include:

i. The Title V program's partnership and leadership roles in accomplishing the MCH Block Grant's goals and mission;
ii. The Title V program's framework (e.g., life course model) and strategic approach to addressing the identified MCH priorities while considering program successes, ongoing challenges and emerging issues;
iii. The purpose and commitment of the Title V program in providing a foundation for family and community health across the state and in assuring access to the delivery of quality health care services for mothers, infants and children, including CSHCN.

Given the uniqueness of each state, the Title V program has flexibility in writing a narrative description that best conveys the elements it considers to be the most critical in providing context for the Title V program priorities, strategies, and initiatives. This description should respond to the question, "What does a reader need to know about the Title V program to understand the activities and approaches that are described in the State Action Plan?" Most relevant to this discussion is the Title V program's demonstrated leadership in such areas as:

i. Serving as a convener, collaborator, and partner in addressing MCH issues, including supporting partnerships to address upstream social determinants of health;
ii. Supporting coordinated, comprehensive and family-centered systems of services at state and local levels, which may include the implementation of MCHB's *Blueprint for Change: National Framework for a System of Services for Children and Youth with Special Health Care Needs* or other population health strategies;
iii. Developing and utilizing innovative and evidence-based or -informed approaches to address cross-cutting issues that impact the health status of specific MCH populations and sub-populations, such as social determinants of health; and

iv. Implementing the core public health functions of assessment, assurance, and policy development through program efforts that are supported by the MCH Block Grant.

b. Organizational Structure (Reporting Flexibility Option in Interim Years)

In reporting on the organizational structure of the Title V program, the state should:

i. Describe the organizational structure and placement of the state health agency and the Title V MCH and CSHCN programs in the state government.
ii. Clarify how the state health agency is "responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State" under Title V. [Section 509(b)]. This description should include all programs that are funded by the MCH Block Grant, including by Federal funds and the state match.

Organizational charts must be included as attachments to indicate the location of the Title V program within the State Health Department. The organizational charts should provide enough detail to help the reader understand how the state's Title V program is structured organizationally and to indicate what other programs and authorities fall under the supervision of the Title V MCH Director. For programs that are important in addressing needs of the MCH population in the state, but are not under the authority of the Title V Director, the organizational charts should help the reader understand their location in relation to Title V. Clearly outlining the state structure allows for a better understanding of the ease or difficulty related to the collaboration and alignment of resources within the state.

3. Health Care Delivery System

This narrative should describe the components of the state's systems of care for meeting the needs of the MCH population, with a focus on underserved and vulnerable populations, and with separate sections for describing: (a) the overall system of care for mothers, children, and families; and (b) those aspects of the system of services that uniquely address the needs of CSHCN. For each section, this discussion may include, but is not limited to, the following descriptors:

a. Population served;
b. Health services infrastructure (e.g., number of birthing hospitals, children's hospitals, maternal specialists, pediatric specialists, accountable care organizational structure, etc.);
c. Integration of services, such as medical, physical, behavioral and mental health, social services, and education; and
d. Financing of services (including managed care arrangements and Medicaid eligibility).

If not described elsewhere in the Application/Annual Report, states should provide a description of their collaborative work with other federal, state, and non-governmental partners and how this work complements Title V program efforts to provide a systems approach to ensure access to quality health care and needed services for the MCH population. The state also should describe key strategies and opportunities for strengthening the integration of health care delivery systems that serve women and children, key partners, alignment of resources, and shared program goals. Efforts to assess the effectiveness of the state's health care delivery system in meeting the needs of women and children, including the state's consideration of new, innovative health care delivery models, also should be discussed. Efforts to provide fair and equitable access for health care should be described.

a. System of Care for Mothers, Children, and Families (Reporting Flexibility Option in Interim Years)

This section should explain the key components of the overall state system of care for meeting the needs of mothers, children, including adolescents, and families, including strengths as well as gaps in the

system of care. The capacity of the system to address the needs of underserved and vulnerable populations should be described. The public health infrastructure that addresses the needs of the MCH population also should be described. In describing the state's system of care for mothers, infants, and children, the role of the Title V program in addressing key MCH issues, which may include access to quality services, prenatal and postpartum care, maternal morbidity and mortality, stillbirth, newborn screening, infant mortality, and preventive and primary care services for children and adolescents, immunizations, injury prevention, oral health, behavioral and mental health, bereavement care, and/or substance use, should be clearly identified.

b. System of Services for CSHCN (Reporting Flexibility Option in Interim Years)

This section should explain the key components of the state system of services for uniquely meeting the needs of CSHCN, including strengths and gaps in the system. A well-functioning system of services for CSHCN is measured through the National Survey of Children's Health (NSCH) using the following six core outcomes that facilitate integrated systems for CSHCN: families as partners in decision-making; medical home; adequate health insurance; early and continuous screening; ease of community-based services; and transition to adult care. The capacity of the system to address the needs of underserved and vulnerable CSHCN should be described. The public health infrastructure that addresses CSHCN needs also should be described. In describing the state's system of services for CSHCN, the role of the Title V program should be clearly identified.

c. Relationship with Medicaid (Annual Update Required)

Within a state, the Title V program and Title XIX Medicaid program share a common goal of working to improve the overall health of the MCH population, including CSHCN, through affordable health care delivery systems and expanded coverage. Partnership and collaboration between these two programs allow for the effective leveraging of federal and state resources, which yields administrative efficiencies to help ensure that women and children are provided needed preventive services, health examinations, treatments and follow-up care. Section 509(a)(2) of Title V of the Social Security Act cites the need to promote "coordination at the Federal level of activities authorized under this title [Title V] and under title XIX…." Also, Section 1902(a)(11) of Title XIX requires State Medicaid agencies to enter into Inter-Agency Agreements (IAAs) with state Title V agencies. This provision further clarifies that Medicaid funds are to be used to reimburse expenditures made by the Title V agency for Medicaid-covered services to Medicaid recipients, as appropriate (i.e., that Medicaid should be the first payer).

The Code of Federal Regulations (CFR) further sets forth specific requirements for Medicaid State plans to describe coordination with relevant agencies, which includes Title V. (See Figure 4 below.)

Figure 4: Code of Federal Regulations: 42 CFR 431.615

Under 42 CFR 431.615, Medicaid State plans are required to describe their coordination with relevant agencies, including Title V, and include a description of specific items, as appropriate, within their interagency agreements.

"(c) *State plan requirements* – A state plan must –

(1) Describe cooperative arrangements with the State agencies that administer, or supervise the administration of, health services and vocational rehabilitation services designed to make maximum use of these services;

(2) Provide for arrangements with title V grantees, under which the Medicaid agency will utilize the grantee to furnish services that are included in the State plan;

(3) Provide that all arrangements under this section meet the requirements of paragraph (d) of this section; and

(4) Provide, if requested by the title V grantee in accordance with the arrangements made under this section, that the Medicaid agency reimburse the grantee or the provider for the cost of services furnished beneficiaries by or through the grantee.

(d) *Content of arrangements*. The arrangements referred to in paragraph (c) must specify, as appropriate –

(1) The mutual objectives and responsibilities or each party to the arrangement;

(2) The services each party offers and in what circumstances;

(3) The cooperative and collaborative relationships at the State level;

(4) The kinds of services to be provided by local agencies; and

(5) Methods for –

(i) Early identification of individuals under 21 in need of medical or remedial services;

(ii) Reciprocal referrals;

(iii) Coordinating plans for health services provided or arranged for beneficiaries;

(iv) Payment or reimbursement;

(v) Exchange of reports of services furnished to beneficiaries;

(vi) Periodic review and joint planning for changes in the agreements;

(vii) Continuous liaison between the parties, including designation of State and local liaison staff; and

(viii) Joint evaluation of policies that affect the cooperative work of the parties.

Source: Electronic Code of Federal Regulations, "42 CFR 431.615 – Relations with State health and vocational rehabilitation agencies and title V grantees" (current 2023). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-M/section-431.615

The state should provide a detailed description of the existing relationship between the Title V program and the Medicaid program, which builds on the noted areas of coordination and collaboration in the IAA/Memorandum of Understanding (MOU). A copy of the most recently signed IAA/MOU is a required attachment for this Application/Annual Report.

The state's narrative discussion should address areas of defined coordination between the two programs and the benefits that have been realized. At a minimum, the discussion should address Title V program impacts in the following areas:

i. Program outreach and enrollment;
ii. Health care financing (e.g., the percent of services delivered by managed care organizations (MCO), primary care case management (PCCM) and fee for service, administrative draw down, and expansion of Medicaid reimbursement for school-based health service, if applicable);
iii. Waivers or state plan amendments that influence health care delivery for the MCH population, particularly CSHCN, including children with medical complexity;
iv. Joint policy level decision making on issues related to MCH services delivery and coverage, particularly for CSHCN; and
v. Medicaid Core Set measures.

In working to strengthen their Title V – Title XIX IAAs, states may wish to consider the strategies developed by the National Academy of State Health Policy (NASHP) under funding support provided by the HRSA/MCHB.[10]

4. MCH Emergency Planning and Preparedness (Reporting Flexibility in Interim Years)

In the face of natural disasters, outbreaks, pandemics and other emergency situations, State Title V programs are often called upon to provide leadership and support in delivering critical MCH services and in assisting local communities to respond to the emerging threats and needs. Such a role requires the State Title V program to be proactive in its emergency preparedness planning and to coordinate with partners at the state and local levels to develop emergency preparedness and response plans that include the needs of the MCH population.

In this section, State Title V programs should describe their involvement in the administering agency's emergency preparedness and response planning activities. There is no expectation for Title V programs to develop a new or separate Emergency Operations Plan (EOP). The discussion in this section should focus on the extent to which MCH is integrated into the state's EOP, the role of the Title V program in the state's emergency structure, and its participation in emergency preparedness planning activities (e.g., data assessment and surveillance, training, development of communications plans, and coordination with other public health programs).

Specifically, the state should speak to the following questions in their narrative reporting:

i. Does the state have a written EOP, and how often is this plan reviewed?
ii. Does the state's EOP specifically consider the needs of the MCH population, which includes at-risk and medically vulnerable women, infants, and children?
iii. Were Title V program staff involved or consulted in the planning and development of the State's EOP?
iv. Is Title V leadership included in the State's emergency preparedness planning before a disaster?
v. Is Title V leadership part of the Incident Management Structure (IMS)? If so, where are they located within the IMS?
vi. Based on ongoing Title V program needs assessment efforts and lessons learned from previous emergency responses, were critical gaps in emergency preparedness and/or surveillance data identified that could impact the state's ability to adequately assess and respond to MCH population and program needs in a future disaster or public health emergency?
vii. To what extent has the Title V program participated in the development of emergency preparedness and response training, communication plans and tools/strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population?
viii. To what extent has the Title V program participated in the development of coordination plans with public health programs (e.g., newborn screening; newborn hearing screening; immunization; home visiting; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); shelters, and other MCH programs), to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population, particularly for those at risk?

[10] Wirth, B. and Van Landeghem, K. "Strengthening the Title V-Medicaid Partnership: Strategies to Support the Development of Robust Interagency Agreements between Title V and Medicaid." April 2017. https://oldsite.nashp.org/wp-content/uploads/2017/04/Strengthening-the-Title-V-Updated.pdf

This narrative reporting is intended to assist the State Title V program in assessing the adequacy of the existing EOP in responding to an emerging public health threat or disaster that impacts the MCH population.

C. Needs Assessment

The Title V legislation (Section 505(a)(1)) requires the state, as part of the Application, to prepare and transmit a comprehensive statewide Needs Assessment every five years that identifies (consistent with the health status goals and national health objectives) the need for:

a. Preventive and primary care services for pregnant women, mothers and infants up to age one;
b. Preventive and primary care services for children; and
c. Services for children with special health care needs.

Findings from the Five-Year Needs Assessment serve as the cornerstone for the development of a five-year Action Plan for the State MCH Block Grant. States are required to provide annual Needs Assessment updates during interim reporting years.

The three-year period covered by this Guidance will include two interim years requiring Needs Assessment Updates, and one year requiring a comprehensive Five-Year Needs Assessment Summary, as shown in Table 2 below:

Table 2: Needs Assessment Requirements and Relevant Guidance Sections

Calendar Year	Fiscal Year (FY) Application/Annual Report Year	Related 5-Year Cycle	Need Assessment Year	Needs Assessment Required
2024	FY25 Application/ FY23 Annual Report	2020 - 2025	Interim Year 5	Needs Assessment Update
2025	FY26 Application/ FY24 Annual Report	2025 - 2030	Year 1 Baseline	Needs Assessment Summary
2026	FY27 Application/ FY25 Annual Report	2025 - 2030	Interim Year 2	Needs Assessment Update

Table 3 outlines the sections required to be updated with the Five-Year Needs Assessment and the Needs Assessment Update.

Table 3: Needs Assessment Reporting Requirements

Section	Needs Assessment Year (Required Every Five Years)	Annual Update Required in Interim Years	Flexible Reporting Option in Interim Years
III.C. Needs Assessment			
III.C.1. Five-Year Needs Assessment Summary			
III.C.1.a. Process Description (Needs Assessment Year)	X		
Process Description for Needs Assessment Update (Interim Years)		X	
III.C.1.b. Findings			
III.C.1.b.i. MCH Population Health and Wellbeing (Needs Assessment Year)	X		
MCH Population Health and Wellbeing (Interim Years)		X	
III.C.1.b.ii Title V Program Capacity			
III.C.1.b.ii.a. Impact of Organizational Structure	X		X
III.C.1.b.ii.b. Impact of Agency Capacity	X		X
III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development	X		X
III.C.1.b.ii.d. State Systems Development Initiative	X	X	
III.C.1.b.ii.e. Other Data Capacity	X		X
III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination	X		X
III.C.1.b.iv. Family and Community Partnerships	X		X
III.C.1.c. Identifying Priority Needs and Linking to Performance Measures	X		X

1. Five-Year Needs Assessment Summary and Annual Updates

States will submit a Five-Year Needs Assessment Summary in 2025 (during year two of the three-year period covered by this Application/Annual Report Guidance).

The mechanism for states to report on the legislatively required, comprehensive and statewide Five-Year Needs Assessment is the Needs Assessment Summary, which is submitted as part of the first year Application/Annual Report of a new five-year cycle. The state should present a concise summary of the Five-Year Needs Assessment process, methodology and findings, as described below. Given that the findings

inform the development of the state MCH Block Grant's five-year State Action Plan, the Needs Assessment Summary is linked to the four subsequent interim year Applications/Annual Reports. As it reflects a point-in-time, the state does not update the Five-Year Needs Assessment Summary in the interim years. Such updates are presented in the Needs Assessment Update section of the interim year Applications/Annual Reports. Each annual update, along with the original Five-Year Needs Assessment Summary, is linked to each year's Application/Annual Report across the five-year reporting cycle.

The Needs Assessment Summary is intended to emphasize only the key findings of the state's Five-Year Needs Assessment. Given the scope and comprehensive nature of the Five-Year Needs Assessment, a state's findings may exceed the required content for the Needs Assessment Summary. States may opt to develop a more detailed and complete Five-Year Needs Assessment document, which is tailored to meet their individual MCH program needs. If such a document is created by the state and made accessible on a public website, the state is encouraged to cite the URL for the website as part of its Application/Annual Report discussion. States may also choose to submit more detailed documentation on their Five-Year Needs Assessment findings as an attachment for this section.

a. Process Description (Required Every Five Years)

This description of the overall process/methodologies used by the state in conducting its Title V Five-Year Needs Assessment provides context for the interpretation of the reported findings and the priority needs subsequently identified. There are four characteristics for states to consider in moving from a solely data-driven needs assessment effort to conducting a comprehensive assessment of its priority issues and stakeholder needs. These characteristics are:

(i) A clear leadership structure for assembling data from both public and private sources, including data from family organizations);
(ii) Engagement of stakeholders representing diverse communities, including those that face the greatest barriers to access and inequities in outcomes, for soliciting meaningful programmatic input;
(iii) A structured and inclusive priority-setting process that involves the diverse communities and families identified above; and
(iv) Collaborative program planning, implementation, evaluation/assessment, and continuous quality improvement.

In describing the Five-Year Needs assessment process, states should provide a high-level summary that includes:

(i) Goals, framework, and methodology that guided the Needs Assessment process;
(ii) Level and extent of stakeholder involvement, including families, individuals with lived experience, and family-led organizations (such as Family-to-Family Health Information Centers (F2Fs), which should include the different MCH populations in a state, such as the American Indian/Alaska Native population, if appropriate. This summary would include meaningful engagement of communities, persons with lived experience, individuals, and families, including those of CSHCN, representing the diverse populations in the state including those who face the greatest barriers to access and the poorest outcomes, in the needs assessment and priority needs selection processes;
(iii) Quantitative and qualitative methods that were used to assess the strengths and needs of the MCH population in each of the five identified population health domains, MCH program capacity, and supportive partnerships/collaborations;
(iv) Data sources utilized to inform the Needs Assessment process, including data from other HRSA- and MCHB-funded investments (e.g., the National Survey of Children's Health (NSCH); and

(v) Interface between the collection of Needs Assessment data, the finalization of the state's Title V priority needs, and the development of the state's Action Plan.

Process Description for Needs Assessment Update (Annual Update Required)

The changing MCH population demographics, emerging health trends, and shifting program capacity require that states routinely engage in selected steps of the Needs Assessment process. During any interim year when a state is not reporting on its Five-Year Needs Assessment, a state should reference and summarize the Process For its ongoing needs assessment activities. This section of the needs assessment update should include a brief description of the state's ongoing needs assessment activities, which may include MCH data collection and analyses, program evaluation, key informant interviews, customer satisfaction surveys, advisory councils, and other approaches for soliciting individual feedback and conducting ongoing performance monitoring and assessment. It also should discuss the extent to which families, caregivers, individuals, and other stakeholders were engaged in the needs assessment update process.

b. Findings

Findings from the comprehensive Five-Year Needs Assessment inform the Title V program's strategic planning, decision-making, and resource allocation. These findings also provide a benchmark against which states can compare and assess the progress they achieve during the five-year reporting period.

The Needs Assessment Summary should highlight the state's noted MCH strengths/needs in three main areas:

(i) MCH Population Health and Wellbeing
(ii) Title V Program Capacity
(iii) Title V Program Partnerships, Collaboration and Coordination.

i. MCH Population Health and Wellbeing (Required Every Five Years)

The state should clearly describe the health and wellbeing of the MCH population within each of the five population health domains (i.e., Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and CSHCN), based on the quantitative and qualitative analyses conducted. Specific discussion points should include:

(1) A summary of the noted strengths and needs in the overall MCH population and in specific MCH sub-population groups;
(2) A concise description of the state's successes, challenges, and gaps related to major morbidity, mortality, health risks, or wellness for each of the five population health domains. At a minimum, the discussion should include the major health issues reflected in the state's priority needs relative to the MCH population as a whole or specific sub-populations when stratified by age, income, geography, frontier/rural/urban status, or other relevant characteristics; and
(3) An analysis of current MCH Block Grant efforts in addressing the needs of its MCH population to determine areas of success and areas in which new or enhanced strategies/activities are needed.

MCH Population Health and Wellbeing (Annual Update Required)

The state should clearly describe any significant updates or changes to the health status of the MCH population within each of the five population health domains (i.e., Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and CSHCN), based on any quantitative and qualitative analyses conducted as part of the needs assessment update process. This section also

should describe emerging public health issues, their impact or potential impact on the MCH population, and the state's actual or anticipated capacity and resources to address them.

ii. Title V Program Capacity

This section should build upon, but not repeat, the description of the state Title V program organizational structure provided as part of the "Overview of the State" section. A state's assessment of its Title V program capacity should critically examine the strengths and sufficiency of its current resources, staffing, and organizational structure, state agency coordination, and family partnerships. States should summarize the findings from their Five-Year Needs Assessment relative to each of these categories in the following sections.

a. Impact of Organizational Structure (Required Every Five Years) (Reporting Flexibility in Interim Years)

In this section, the state should reflect on how Title V's location and organizational structure within the State Health Department, as described in the "Overview of the State" section, impacts its ability to respond to the findings of the needs assessment. This section should address strengths, opportunities, and challenges associated with Title V's organizational placement, including its impact on Title V's ability to partner with and/or leverage the resources of other state programs and agencies to respond to MCH needs.

b. Impact of Agency Capacity (Required Every Five Years) (Reporting Flexibility in Interim Years)

In this section, the state should reflect on Title V's capacity, including the impact of this capacity on Title V's ability to respond to the findings of the needs assessment. This section should address strengths, opportunities, and challenges associated with Title V's capacity to respond to MCH needs.

In summarizing the state Title V program capacity, the state should describe the state Title V agency's capacity to promote and protect the health of all mothers and children, including CSHCN. Included in this description should be a discussion of the steps taken by the MCH and CSHCN programs to ensure a statewide system of services that reflects the components of comprehensive, community-based and family-centered care. The state should also describe the extent to which the Title V program collaborates with other state agencies, health services entities, and private organizations to support health services delivery at the community level.

Specifically, the state's summary on Title V program capacity should include the following:

(1) A description of the state's Title V capacity to provide and assure services within each of the five population health domains.
(2) An expanded discussion on the state's capacity for serving CSHCN, which includes the Title V program's ability to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (the Supplemental Security Income for the Aged, Blind, and Disabled Program), to the extent that medical assistance for such services is not provided under Title XIX (Medicaid). If applicable, states may describe their capacity to serve CSHCN and their families by referencing the *Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs.*

c. *Title V Workforce Capacity and Workforce Development (Required Every Five Years) (Reporting Flexibility in Interim Years)*

State Title V program efforts to implement the core public health functions (assessment, policy development, and assurance) and to assure accountability through ongoing performance measurement and monitoring require an adequately sized and skilled workforce. Form 7, *Title V Program Workforce*, provides data on the Title V workforce composition. In this section, states should include narrative that augments the Form 7 workforce data and addresses the following:

(1) The capacity of the Title V workforce to address Title V priorities;
(2) Strengths and needs of the Title V workforce (including the epidemiology workforce), including developing a diverse workforce that reflects the population served;
(3) Unique skillsets or composition of Title V staff that facilitate efforts to address Title V priorities;
(4) Impact of organizational changes (e.g., organizational restructuring, integration/collaboration with the Title V program, shifts in staffing, emerging demands for new skillsets and training) on the Title V workforce capacity, and planned areas for continued development or change; and
(5) Number of parents and family members, including CSHCN and families, who are on the state's Title V program staff and a brief description of their roles (e.g., paid consultant or volunteer).

The state also should describe its plans for strengthening the MCH workforce and advancing a future MCH workforce vision (e.g., types of personnel and skill sets needed), including discussion of the following:

(1) Recruitment and retention of a qualified Title V staff, including those with lived experience;
(2) Assessment of training and professional development needs for new and seasoned Title V staff and family leaders;
(3) Engagement of the Title V workforce in training the next generation of MCH professionals (including activities with MCHB-funded training programs, internships, other universities);
(4) One innovation/example of a key partnership that enhances capacity of the Title V workforce to meet its goals (i.e., partnerships with academic institutions, other training providers, student internships, family-led organizations, community organizations, etc.)

In addition to this narrative discussion of the state's MCH workforce activities, a state completes Form 7 to compare, organize, and annually monitor its MCH workforce data and training information.

d. *State Systems Development Initiative (SSDI) (Annual Update Required)*

The purpose of the SSDI discretionary grant program is to improve MCH outcomes by increasing state capacity to collect, analyze, and use reliable data for state Title V policy and program development. SSDI funds support expansion of data linkages of key MCH datasets for analysis; improved access to and analysis of health equity data; and translation of data into action at the state/jurisdictional level. The SSDI program assures foundational MCH data capacity support for the Title V MCH Block Grant program. SSDI provides the flexibility to shift focus, including addressing MCH data capacity needs during an emergency and as emerging issues or threats arise, such as COVID-19. Data are central to state/jurisdictional reporting on their Title V MCH

Block Grant assessment, planning, implementation, and evaluation efforts, in the Title V MCH Block Grant Application/Annual Report.

States that receive SSDI funding should provide a narrative update that describes the state's progress in completing its SSDI work plan that aligns with the four goals of the SSDI program, as described below:

(1) Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming;
(2) Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability;
(3) Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming; and
(4) Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.

States also should address the following items as part of the narrative discussion:

(1) The contributions of the SSDI grant in building and supporting accessible, timely, and linked MCH data systems, as documented on Form 12; and
(2) A description of key SSDI products or resource materials that were developed to support State Title V program efforts in addressing its identified MCH priority needs, conducting the Five-Year Needs Assessment, implementing the Five-Year State Action Plan, and advancing data-driven MCH programming.

Since the purpose of SSDI is to build and support MCH data capacity for State Title V programs, SSDI program successes are largely demonstrated in the state's MCH Block Grant Application/Annual Report. As such, this SSDI narrative section is designed to serve as the annual progress report for the state's SSDI grant.

If a state does not receive SSDI funding, a statement should be entered in this section to indicate that the state is not an SSDI grant recipient.

e. Other Data Capacity (Required Every Five Years) (Reporting Flexibility in Interim Years)

In this section, states should describe Title V data capacity efforts funded by sources other than SSDI, which support up-to-date MCH data and information systems. This description should highlight the state's MCH epidemiological and data enhancement activities and how they support Title V program activities, such as the Five-Year Needs Assessment, annual MCH Block Grant performance measure reporting/monitoring, and data-driven programming. Such efforts may include, but are not limited to, activities such as the ones listed in the SSDI section above but not funded by SSDI, the state's partnership and collaboration in implementing national surveys and monitoring systems, the availability/accessibility of state and local MCH data information systems, the collection and tracking of real-time data, creation of data review boards, provision and sharing of data with other state/local and external partners, and advances in information technology that facilitates automated data analyses and reporting. States should also describe key challenges they face in their efforts to improve the use of MCH data, such as challenges Title V programs may face with respect to data privacy.

iii. Title V Program Partnerships, Collaboration, and Coordination (Required Every Five Years) (Reporting Flexibility in Interim Years)

In this section, states should describe partnerships with other federal, state, and local entities, both public and private, to enhance state Title V capacity to meet the needs of the MCH population, including CSHCN, and to address the priorities identified through the Five-Year Needs Assessment. This section should include descriptions of partnerships and stakeholder engagement in programmatic decisions, as well as relationships that expand the capacity and reach of the state Title V program.

In summarizing its partnerships and collaborations, the state should describe relationships with programs, such as the following:

(1) Other MCHB investments, which may include Maternal Health Innovation grants; Pediatric Mental Health Care Access Grants; Family-to-Family Health Information Centers; MCHB investments related to newborn and early childhood screenings, epilepsy, genetics, blood disorders; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grants; Healthy Start Grants; Early Childhood Comprehensive Systems (ECCS) Grants; MCH Training programs; and MCHB investments relating to injury prevention, autism, developmental disabilities, adolescent health, workforce development, oral health, vision and hearing, bullying, and emergency medical services for children;
(2) Other HRSA programs (e.g., community health centers, HIV/AIDS programs, and Area Health Education Centers);
(3) Other Federal investments (e.g., ACF, CDC, and USDA-funded programs, such as maternal mortality reviews, community health workers, immunizations, and WIC);
(4) Local MCH programs and organizations (e.g., community-based organizations, local health departments, and urban MCH programs);
(5) Other State programs, including other programs within the State Department of Health (e.g., chronic disease prevention and health promotion, immunization, vital records and health statistics, injury prevention, behavioral and mental health, and substance abuse);
(6) Other governmental agencies (e.g., Medicaid, CHIP, Education, Social Services/Child Welfare, Housing, Social Security Administration, Corrections and Vocational Rehabilitation Services);
(7) Tribes, Tribal Organizations, and Urban Indian Organizations;
(8) Public health and health professional educational programs and universities; and
(9) Non-governmental organizations.

iv. Family and Community Partnerships (Required Every Five Years) (Reporting Flexibility in Interim Years)

As discussed under the Guiding Principles in Part One, Section IV, in the MCH Block Grant, family partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level.

The state should provide an overarching discussion of its organizational capacity and vision for partnering with families, individuals, and family-led organizations in all aspects of their Title V Action Plan development and implementation across all population domains. Descriptions of partnership activities may include, but are not limited to, the following areas:

(1) Advisory Committees;
(2) Strategic and Program Planning;
(3) Quality Improvement;
(4) Workforce Development and Training;
(5) Block Grant Development and Review;
(6) Materials Development; and
(7) Program Outreach and Awareness

Training activities that serve to strengthen and advance family partnership in the Title V program, both in orientation and ongoing professional development, which are conducted for staff, family leaders, volunteers, contractors, and subcontractors should be discussed. The state should describe the contributions of family and community leaders to Title V program processes, such as assessment of needs/assets, program planning, MCH and CSHCN services delivery, and evaluation/monitoring/quality improvement activities. This discussion should include the state's efforts to partner with families and individuals who are representative of the MCH communities being served to ensure that their needs are properly identified and appropriately addressed.

The state should further address specific roles and responsibilities of families, individuals, and F2Fs and other family-led organizations at the direct care, organizational and governance, and policymaking levels and describe the outcomes and impacts of its established family partnerships on Title V program policies and activities. Specific impacts of family partnership on each of the five MCH populations and on the Title V program's cross-cutting and systems building activities should be included in the appropriate MCH domain narrative discussion.

c. Identifying Priority Needs and Linking to Performance Measures (Required Every Five Years) (Reporting Flexibility in Interim Years)

Consistent with Figure 3, findings from the Five-Year Needs Assessment should drive the state's identification of its seven to 10 highest MCH priority needs for the five-year reporting cycle. The selected priorities may address the defined MCH population groups and/or cross-cutting/systems building areas, and they should reflect the unique needs of the state. In addition, the identified priority needs should address areas in which a state believes that targeted interventions can result in needed improvements to its health care delivery systems. Once identified, the priority needs inform the selection of NPMs and the development of SPMs. Collectively, the NPMs and SPMs should address the state's identified priority needs.

TVIS will prepopulate the priority needs provided in the previous year. States should review their priority needs to ensure alignment within the State Action Plan where priorities are linked with the existing National Outcome Measures (NOMs), NPMs, SPMs and ESMs. States can classify priority needs as New, Continued, or Revised under the following conditions:

- New: Priority Need is added
- Revised: Description is changed for a Priority Need provided in the previous interim year
- Continued: No changes for a Priority Need provided in the previous interim year.

The TVIS will record up to 10 priority needs, but a state can include additional priorities in a field note, if desired.

The narrative discussion supplements the listing of the final priority needs by providing a rationale for how the priority needs were determined and how they link with the selected national and state performance measures. Specifically, this discussion should include:

(1) Methodologies used to rank the broad set of identified needs and the state's process for selecting its final seven to 10 priorities;
(2) Emerging issues or other frequently cited needs that were not included in the final list of priority needs and a rationale for why they were not selected;
(3) Factors that contributed to changes in the state's priority needs since the previous five-year reporting cycle;
(4) Relationship between the priority need and the selected national and/or state performance measures in driving improvement; and
(5) The extent to which diverse stakeholders, including families and constituents, as well as family and constituent-led organizations, were involved in ranking the broad set of identified needs and selecting the state's final priorities.

D. Financial Narrative (Annual Update Required)

The development and implementation of a workable State Action Plan requires careful analysis and utilization of available funding and resources. Building on the assessment of state MCH population needs and Title V program needs, the state should present a budget plan for the Application year that aligns its proposed Title V program activities with the identified MCH needs. In addition, the state should report and reflect on its MCH Block Grant expenditures for the Annual Report year. This reflection should include a comparison of planned, budgeted activities with actual expenditures for that fiscal year and link the allocation of financial resources with outcomes achieved relative to the State's Title V program plan.

The combined Expenditure and Budget narrative sections should demonstrate accountability in the state's use of its federal and state MCH Block Grant funds to comply with the program's requirements and legislative intent, i.e., "to improve the health of all mothers and children." [Section 501(a)]. States should reflect on whether the Title V program efforts and outcomes discussed in the State Action Plan and other sections of the Application/Annual Report could have been achieved without federal MCH Block Grant funding support.

States should maintain expenditure and budget documentation for the MCH Block Grant, consistent with the requirements in Section 505(a) and Section 506(a). Per Section 506(b)(1), each state is required to conduct an audit of its expenditures every two years.

1. Expenditures (Annual Update Required)

In describing its MCH Block Grant expenditures, states should reflect on the federal and non-federal monies that have been obligated and spent. This discussion is intended to provide the reader with an understanding of how the supported programs and services link with the state's MCH priority needs and meet the requirements of Title V legislation.

The expenditure narrative should demonstrate the Federal/State partnership and how federal support complements the state's total MCH investment, as reflected on Form 2, Lines 3-6 (i.e., reported State, Local, Other, and Program Income expenditures). States should monitor expenditures regularly to ensure compliance with all applicable financial requirements. The state should document and explain how the reported expenditures comply with the 30%/30%/10% requirements, as specified in Section 505(a)(3) and Section 504(d), respectively. Significant variations of more than 10% in the expenditure data reported on Form 2 and Form 3, as compared to the state's planned budget for that same fiscal year, should be

explained in the narrative discussion. The state should describe the method by which funds are allocated among individuals, areas, and localities within the state for MCH services, particularly with support for specific populations in the state (e.g., Title V support for American Indian/Alaska Native populations). The state should highlight how funding supported family engagement in the Title V program, as well as how funding addressed health equity in services and program planning. The state should reflect on the number/percent of the MCH population who are served by Title V, as reported on Form 5, and provide a description of the state's efforts to expand its reach. Challenges faced by the state should be noted and addressed.

In some cases, funds for the reporting year may not be fully expended at the time of submission. Given that the state is required to submit a Federal Financial Report (FFR) with the final financial data following the expiration of funds, the most recent expenditure data should be reported at the time of submission. The state may use the form or field notes on Forms 2 and Form 3 to explain any discrepancies in its submitted financial data and work with its MCHB Project Officer in reporting final expenditures.

States report the federal and non-federal MCH Block Grant expenditures separately on the budget/expenditure forms. This breakdown should be further examined as part of the narrative discussion.

With respect to Medicaid, Title V should be the payer of last resort, and MCH Block Grant funds cannot be used to reimburse a claim for a service that is otherwise covered under Medicaid. Additionally, service providers receiving MCH Block Grant funds are strongly encouraged to seek payment from other public and private insurance providers when applicable. The state should describe how services supported by the MCH Block Grant reflect services that were not covered or reimbursed through the Medicaid program or another provider.

2. Budget (Annual Update Required)

In its budget narrative, the state should present a plan that describes how federal and non-federal Title V funds will be used to address the state's priority needs, improve performance related to the targeted MCH outcomes, and expand its systems of care for both the MCH and CSHCN populations. The budget narrative should also demonstrate and assure the state's commitment to complying with all applicable financial requirements (e.g., 30%/30%/10% requirements) and block grant program regulations.

Similar to the narrative description that the state provided for its expenditures, the budget narrative should demonstrate the federal-state partnership and how federal MCH Block Grant support will be utilized to complement the state's planned total match (i.e., State, Local, Other, and Program Income funds) for the Application year. The budget narrative should highlight the State's MCH/CSHCN program and align with the identified MCH/CSHCN priorities. This discussion should clearly articulate how federal and non-federal MCH Block Grant funds will support the activities that are described in the State Action Plan for the upcoming budget period.

While the final federal MCH Block Grant allocation is not yet known, states should use the allocation for the current fiscal year as a basis for determining budget estimates for federal and non-federal MCH Block Grant funds in the Application year. In the budget narrative discussion, the state should describe sources of other federal MCH dollars (as noted on Form 2, Line 9), state matching funds and other state funds used by the agency in its Title V programming. This discussion should include how MCH Block Grant funds support essential services, as defined by the Title V MCH Services Block Grant Pyramid, for the three legislatively defined MCH populations. [Section 505(a)(1)]. The narrative discussion should provide an explanation of how the planned funding will support the budget estimates for individuals served and types of services

provided, as reported on Form 3a and Form 3b. The state should describe the method by which funds are allocated among individuals, areas, and localities within the state for MCH services, particularly with support for specific populations in the state (e.g., Title V support for American Indian/Alaska Native populations). This discussion should include how families are engaged and financially supported by the program, as well as how funding is used to support health equity.

Significant variations in the budgeted amounts reported by a state on Form 2 and Form 3, as compared to previous years' reporting, should be explained. Any budget notes provided on Form 2, Form 3a, and Form 3b should be further clarified in the narrative discussion.

The state should describe its plan to meet and monitor the required match requirements, which includes a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended [Section 503(a)] and the maintenance of effort from 1989 [Section 505(a)(4)]. The state should also briefly describe any continuation funding for special projects [Section 505(a)(5)(C)(i)] or consolidated health programs as defined in Section 501(b)(1), and how funding will only be used consistent with Title V nondiscrimination provisions in Section 508 [Section 505(a)(5)(B)].

States are reminded that "any amount payable to a state under this title from allotments for a fiscal year, which remains unobligated at the end of such year, shall remain available to such state for obligation during the next fiscal year. No payment may be made to a state under this title from allotments for a fiscal year for expenditures made after the following fiscal year" [Section 503(b)]. While states apply annually for MCH Block Grant funding, a state has two years in which to expend the federal MCH Block Grant allocation awarded in any fiscal year.

E. Five-Year State Action Plan (Annual Update Required)

Building on its needs assessment, budget planning, and performance reporting, the state's five-year action planning begins with the completion of the State Action Plan Table. The State Action Plan table shall be established based on the findings in the Needs Assessment Summary. The State Action Plan Narrative serves as the Application/Annual Report discussion for the state on their planned activities for the Application year and the activities that were implemented in the Annual Report year. Activities should be discussed relative to the pertinent domain, state priority need, Title V program goal, evidence-based or -informed strategies, and national and state-specific performance and outcome measures.

1. Five-Year State Action Plan Table (Required Every Five Years)

Based on the MCH Block Grant workflow presented in Figure 3, the State Action Plan Table (Figure 5) is intended to serve as a planning tool for states to use in identifying key strategies, objectives, and relevant performance measures to align with the selected priority needs. Organized by the five MCH population health domains (i.e., Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and CSHCN) and the sixth cross-cutting and systems building domain, the State Action Plan Table should include the following components:

a. Priority Needs – Title V legislation directs states to conduct a state-wide MCH Needs Assessment every five years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and CSHCN. From this assessment, states select seven to 10 priorities for focused programmatic efforts over the five-year reporting cycle.
b. Five-year Objectives – Objectives are statements of intention with which actual achievement and results can be measured and compared. SMARTIE objectives are Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable. These objectives should clearly identify the improvement the

state is seeking to attain, related to the priority need at the end of the five-year period covered by the state action plan. This could mean that the Five-Year Objectives pertain to NOMs/SOMs, NPMs/SPMs, ESMs, or other appropriate indicators chosen by the state.

c. Strategies – Strategies are the general approaches taken to achieve the objectives; activities are specific actions to implement the strategies. Program activities for implementing the identified strategies will be discussed and updated annually as part of the State Action Plan narrative.
d. Performance Measures – For purposes of the MCH Block Grant, performance measures include both national and state-specific measures (i.e., NPMs, ESMs, SOMs, and SPMs). States select performance measures that align with their identified strategies, and to the NOMs and SOMs.

States should update the Five-year State Action Plan Table as needed for each year's Application/Annual Report.

Figure 5: Five-Year State Action Plan Table

Priority Needs	Five-Year Objectives	Strategies	Evidence–Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Perinatal/Infant Health					
Child Health					
Adolescent Health					
CSHCN					
Cross-cutting/Systems Building					

2. State Action Plan Narrative Overview (Reporting Flexibility Optional)

A state may opt to insert a brief introduction prior to the domain-specific narrative discussions, if helpful in providing needed context. However, this introductory section is not required.

3. State Action Plan Narrative by Domain (Annual Update Required)

The State Action Plan Narrative is the state's detailed reporting, by MCH domain, on its specific Title V program activities for the Annual Report year and for the Application year. The order of the narrative reporting is organized to allow states to discuss their strategies, achievements, and performance trends, relevant to the specific MCH domain, in the Annual Report year prior to presenting the planned activities and performance objectives for the Application year. As noted above, in addition to the State Action Plan Narrative itself, the state should also plan for and participate in regular engagement with its DSCH Project Officer for the purpose of ongoing technical assistance and oversight, including monthly or quarterly conference calls, and site visits.

The six MCH domains are:

Five MCH Population Domains

1. Women/Maternal Health
2. Perinatal/Infant Health
3. Child Health
4. Adolescent Health
5. CSHCN

Optional Domain

6. Cross-cutting/Systems Building

The state should include a discussion of the Universal NPMs and other selected NPMs, plus any SPM, and their related ESMs, along with any SOMs, in each of the five MCH population domains. While there is not an associated NPM in the Cross-cutting/Systems Building domain, the state should report on any state-initiated activities or established SPMs/SOMs and related ESMs that fall within this domain. This discussion will likely build on the high-level discussion in the Five-Year Needs Assessment Summary and include more detailed descriptions on how family partnerships, addressing social determinants of health, expanding MCH data capacity, enhancing public health surveillance/reporting systems, and securing a qualified and well-trained MCH workforce are being implemented in Title V program activities in each domain.

The domain-specific State Action Plan narrative discussion should focus on the alignment of the strategies, objectives, and performance measures for a corresponding priority need, as outlined in the State Action Plan Table. This discussion should primarily include strategies and activities for which the Title V program has a leadership role in administering the activity. Critical partnerships with other MCHB-supported programs (e.g., MIECHV, MCH Training Programs, and Healthy Start programs) should be highlighted, along with family partnerships, in the relevant MCH domain narrative discussions.

For the Annual Report year, the state should:

1. Provide an analysis that gives context to the state of this population domain;
2. Summarize programmatic efforts and the use of evidence-based or -informed approaches to address each of the identified priority needs;
3. Re-assess the alignment of the NPMs, ESMs, SPMs, and SOMs, if applicable, with its related priority need;
4. Analyze the state's progress in achieving its established performance measure targets along with other

programmatic impacts;
5. Note challenges and emerging issues that have resulted in changes to the State Action Plan;
6. Assess the overall effectiveness of the implemented program strategies and approaches in addressing the identified MCH population needs and in promoting continuous quality program improvement;
7. Demonstrate the value of family and community partnerships in improving health outcomes across all domains;
8. Discuss efforts to address health equity to assure services for its MCH populations; and
9. In the CSHCN population domain, discuss how state priorities and completed activities align with the four critical areas in *The Blueprint for Change*: health equity, family and child well-being and quality of life, access to services, and financing of services

For the Application year, the state should:

1. Describe the planned activities for the Application year, with ongoing emphasis on their relevance to the identified priority needs;
2. Align planned activities with the priority needs that were identified based on the Five-Year Needs Assessment and the annual needs assessment updates;
3. Assess if new priorities have emerged that take precedence over the established priority needs;
4. Assess the relevance of the current ESM(s) for a NPM and determine if a new ESM needs to be established;
5. Assess if changes are needed in the established SPMs (and related ESMs) and SOMs, if applicable;
6. Discuss updates to the Five-year Action Plan Table that reflect new or revised priority needs, evidence-based or -informed strategies or performance measures for driving improved performance;
7. Explain the planned approach to engage family and community partnerships to improve health and well-being across all domains;
8. Discuss efforts to address health equity to assure services for its MCH populations; and
9. In the CSHCN population domain, discuss how state priorities and planned activities align with the four critical areas in *The Blueprint for Change*: health equity, family and child well-being and quality of life, access to services, and financing of services

The Application/Annual Report should provide a comprehensive understanding of the role of Title V in the state. As such, MCH strategies and activities that reflect ongoing efforts and support the overall system of care for the MCH population but do not directly align with a State's identified priority needs should be discussed in the relevant MCH domain. For example, State Title V program support for newborn screening and for maternal mortality reviews should be described in the narrative discussion for Perinatal/Infant Health and Women/Maternal Health, respectively, regardless of whether there is a related priority need.

F. Public Input [Section 505(a)] (Annual Update Required)

In its Application/Annual Report, the state should describe its process for making the Application/Annual Report available to the public for comment during its development and after its transmittal. This discussion should include efforts by the state to solicit public comments during the development of the Application/Annual Report. The number and nature of the comments received and how they were addressed in the final Application/Annual Report should be noted for each year. The state should clearly identify specific activities for engaging families and other stakeholders prior to, during and after the Application process. Such activities may include:

(1) Public Hearings;
(2) Advisory Council Review;
(3) Web Posting;

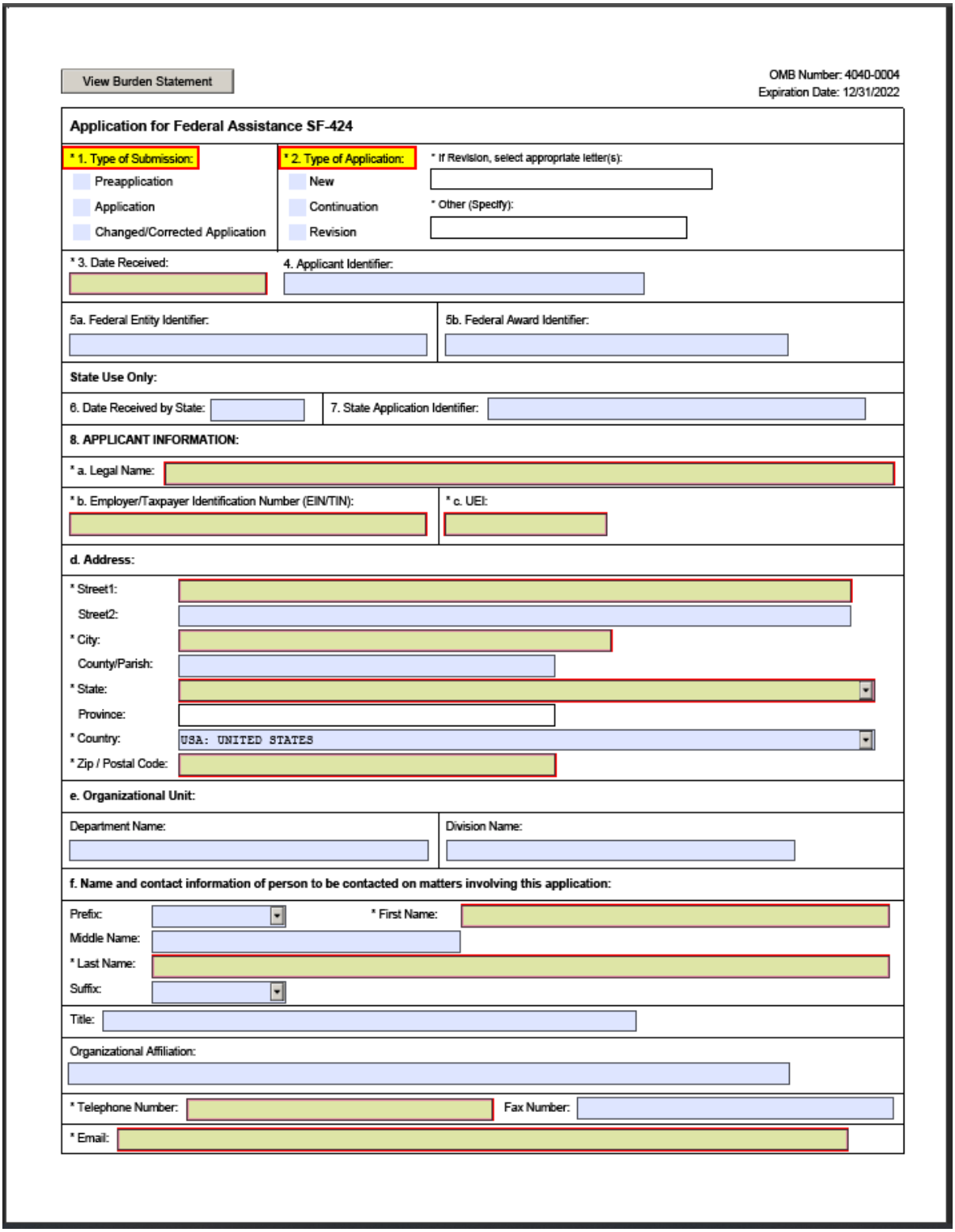
(4) Social Media;
(5) Public Notices;
(6) Other Use of Media;
(7) Outreach to Specific Stakeholders (e.g., MCH Training Grantees, F2Fs, organizations providing services to the most underserved populations such as FQHCs, immigrant-serving organizations, community-based agencies, etc.); and
(8) Partnering with/engaging a family-led organization, such as F2Fs, to assist the state in soliciting comments and recommendations from families and youth.

G. Technical Assistance (Annual Update Required)

States should describe potential areas of needed technical assistance as they work to implement their five-year Action Plan. In accordance with the responsibilities specified in Section 509 of the Title V legislation, MCHB makes available to states and jurisdictions needed technical support and resources, as determined by a state. The state must complete and submit a Technical Assistance Request Form to receive MCHB-supported technical assistance. This form is available upon request from the MCHB Project Officer.

PART THREE: REPORTING FORMS

FORM 1 - APPLICATION FOR FEDERAL ASSISTANCE (SF-424)



View Burden Statement

OMB Number: 4040-0004
Expiration Date: 12/31/2022

Application for Federal Assistance SF-424

* 1. Type of Submission:
- Preapplication
- Application
- Changed/Corrected Application

* 2. Type of Application:
- New
- Continuation
- Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:

* b. Employer/Taxpayer Identification Number (EIN/TIN):

* c. UEI:

d. Address:

* Street1:
Street2:
* City:
County/Parish:
* State:
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code:

e. Organizational Unit:

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name:

Middle Name:

* Last Name:

Suffix:

Title:

Organizational Affiliation:

* Telephone Number:

Fax Number:

* Email:

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

*** 12. Funding Opportunity Number:**

* Title:

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant | * b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: | * b. End Date:

18. Estimated Funding ($):

* a. Federal	
* b. Applicant	
* c. State	
* d. Local	
* e. Other	
* f. Program Income	
* g. TOTAL	

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- a. This application was made available to the State under the Executive Order 12372 Process for review on .
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

Yes No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: | * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number: | Fax Number:

* Email:

* Signature of Authorized Representative: | * Date Signed:

Instructions for Application for Federal Assistance (SF-424)

This is a standard form required for use as a cover sheet for submission of an application. Many of the items are prepopulated by the grant system. Required fields on the form are identified with an asterisk (*) and are also specified as "Required" in the instructions below.

Item	Field Name	Information
1.	Type of Submission:	(Required) The grant system prepopulates the type of submission as “Application.”
2.	Type of Application:	(Required) The grant system prepopulates the type of application as “New.”
3.	Date Received:	This field is prepopulated by the grant system.
4.	Applicant Identifier:	This field is prepopulated by the grant system.
5a.	Federal Entity Identifier:	This field is prepopulated by the grant system.
5b.	Federal Award Identifier:	For new applications leave blank.
6.	Date Received by State:	This field is left blank.
7.	State Application Identifier:	This field is left blank.
8.	Applicant Information:	Enter the following in accordance with agency instructions:
	a. Legal Name:	(Required) Enter the legal name of applicant that will undertake the assistance activity. This is the organization that has registered with the Central Contractor Registry (CCR). Information on registering with CCR may be obtained by visiting www.Grants.gov.
	b. Employer/Taxpayer Number (EIN/TIN):	(Required) Enter the employer or taxpayer identification number (EIN or TIN) as assigned by the Internal Revenue Service. If your organization is not in the US, enter 44-4444444.
	c. UEI:	(Required) Enter the organization’s UEI received from SAM. The UEI is a unique 12 character organization identifier. Information on registering with System for Award Management (SAM.gov) may be obtained by visiting the Grants.gov website.
	d. Address:	Enter address: Street 1 (Required); city (Required); County/Parish, State (Required if country is US), Province, Country (Required), 9-digit zip/postal code (Required if country US).
	e. Organizational Unit:	Enter the name of the primary organizational unit, department or division that will undertake the assistance activity.
	f. Name and contact information of person to be contacted on matters involving this application:	Enter the first and last name (Required); prefix, middle name, suffix, title. Enter organizational affiliation if affiliated with an organization other than that in 7.a. Telephone number and email (Required); fax number.
9.	Type of Applicant: (Required)	The grant system prepopulates the type of submission as “A. State Government.”
10.	Name Of Federal Agency:	(Required) This field is prepopulated by the grant system.
11.	Catalog Of Federal Domestic Assistance Number/Title:	This field is prepopulated by the grant system.

Item	Field Name	Information
12.	Funding Opportunity Number/Title:	(Required) This field is prepopulated by the grant system.
13.	Competition Identification Number/Title:	This field is prepopulated by the grant system.
14.	Areas Affected By Project:	Not applicable.
15.	Descriptive Title of Applicant's Project:	(Required) This field is prepopulated by the grant system.
16.	Congressional Districts Of:	15a. (Required) Enter the applicant's congressional district. 15b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters state abbreviation - 3 characters district number, e.g., CA-005 for California 5th district, CA-012 for California 12 district, NC-103 for North Carolina's 103 district. If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. If nationwide, i.e. all districts within all states are affected, enter US-all. If the program/project is outside the US, enter 00-000. This optional data element is intended for use only by programs for which the area(s) affected are likely to be different than place(s) of performance reported on the SF-424 Project/Performance Site Location(s) Form. Attach an additional list of program/project congressional districts, if needed.
17.	Proposed Project Start and End Dates:	(Required) This field is prepopulated by the grant system.
18.	Estimated Funding:	(Required) Enter the amount requested, or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses.
19.	Is Application Subject to Review by State Under Executive Order 12372 Process?	(Required) This field is prepopulated by the grant system.
20.	Is the Applicant Delinquent on any Federal Debt?	(Required) Select the appropriate box. This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of federal debt include; but, may not be limited to: delinquent audit disallowances, loans and taxes. If yes, include an explanation in an attachment.
21.	Authorized Representative:	To be signed and dated by the authorized representative of the applicant organization. Enter the first and last name (Required); prefix, middle name, suffix. Enter title, telephone number, email (Required); and fax number. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain federal agencies may require that this authorization be submitted as part of the application.)

FORM 2 - MCH BUDGET/EXPENDITURE DETAILS

[SECTIONS 503(A), 504(D) AND 505(A)(3)-(4)]

		FY__ Application Budgeted	FY__ Annual Report Expended
1.	**FEDERAL ALLOCATION** (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$_____	$_____
	Of Federal Allocation, the amount earmarked for:		
	A. Preventive and Primary Care for Children:	$_____ (__%)	$_____ (__%)
	B. Children with Special Health Care Needs:	$_____ (__%)	$_____ (__%)
	C. Title V Administrative Costs:	$_____ (__%)	$_____ (__%)
2.	**SUBTOTAL OF LINES 1A-C** (This subtotal does not include Pregnant Women and All Others)	$_____	$_____
3.	**STATE MCH FUNDS** (item 18c of SF-424)	$_____	$_____
4.	**LOCAL MCH FUNDS** (item 18d of SF-424)	$_____	$_____
5.	**OTHER FUNDS** (Item 18e of SF-424)	$_____	$_____
6.	**PROGRAM INCOME** (Item 18f of SF-424)	$_____	$_____
7.	**TOTAL STATE MATCH** (Lines 3 through 6) a. Enter your state's FY 1989 Maintenance of Effort Amount: $_____		
8.	**FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL** (total lines 1 and 7)	$_____	$_____
9.	**OTHER FEDERAL FUNDS [Select Appropriate Funding Sources from the Drop Down Box]** (Report only funds under the control of the Title V Program Administrator) Select the Appropriate Federal Department Select the Appropriate Federal Agency Select the Appropriate Federal Grant Program	$_____	$_____
10.	**OTHER FEDERAL FUNDS** (SUBTOTAL of all funds under item 9)	$_____	$_____
11.	**STATE MCH/BUDGET/EXPENDITURE GRANT TOTAL**	$_____	$_____

INSTRUCTIONS FOR COMPLETION OF FORM 2
MCH BUDGET/EXPENDITURE DETAILS

Title V Citation: *Section 503(a) provides that the Secretary shall make payments to each State, for each quarter, "an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title." Section 504(d) states: "Of the amounts paid to a State...not more than 10 percent may be used for administering the funds paid...." In order to be entitled to payments for allotments under Title V, Section 505(a)(3) provides that the State will use: "(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and (B) at least 30 percent of such payment amounts for services to children with special health care needs…." Section 505(a)(4) provides that a State receiving funds for maternal and child health services "...shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989...."*

Instructions: This form provides details of the State's MCH budget and expenditures for the Application year and Annual Report year, respectively, and the fulfillment of certain spending requirements under Title V for a given year. The Annual Report expenditures represent the expenditures associated with the grant budget period as states have two years to expend the federal allocation awarded in any fiscal year. Reporting definitions that contain terms applicable to this form are provided in Appendix 1. **Note:** It is recognized that States may not have final expenditure data at the time of submission of the application/annual report. States are encouraged to estimate final expenditures and explain estimates in a form or field note. States will report final expenditure data at grant closeout.

LINE NUMBER	INSTRUCTIONS FOR APPLICATION BUDGETED
1	The Title V Information System (TVIS) will prepopulate the Federal Title V allocation from the SF 424 (Item 18a).
1A	Enter the amount of the Federal allotment for preventive and primary care for children. The percentage of the total (Line 1) that this amount represents will be calculated by TVIS.
1B	Enter the amount of the Federal allotment for children with special health care needs. The percentage of the total (Line 1) that this amount represents will be calculated by TVIS.
1C	Enter the amount of the Federal allotment for the administration of the allotment. The percentage of the total (Line 1) that this amount represents will be calculated by TVIS.
2	The TVIS will calculate the subtotal of Lines 1A, 1B and 1C. Please note that Pregnant Women and All Others will not be included in this amount.
3	The TVIS will prepopulate the amount of your State total funds for the Title V allocation (match) from the SF 424 (Item 18c).
4	The TVIS will prepopulate the amount of total MCH dedicated *matching* funds garnered from local jurisdictions within your State from the SF 424 (Item 18d).
5	The TVIS will prepopulate the total of MCH funds available from other sources such as foundations from the SF 424 (Item 18e).
6	The TVIS will prepopulate the amount of MCH program income funds collected by your State's MCH agencies from insurance payments, MEDICAID, HMO's, etc. from the SF 424 (Item 18f).
7	The TVIS will calculate the sum total of Lines 3, 4, 5, and 6 for the total of your State match and overmatch.
7A	The TVIS will prepopulate your State's FY 1989 Maintenance of Effort amount.
8	The TVIS will calculate the total for Lines 1 and 7. This amount is the "Federal-State Title V Block Grant Partnership."
9	Use the respective drop-down menus in TVIS to select all Federal funding award programs planned to be received by the State MCH program other than the Title V Block Grant that are directly under the control of the Title V Program Administrator and enter planned amounts.

LINE NUMBER	INSTRUCTIONS FOR APPLICATION BUDGETED
10	The TVIS will calculate the sum of all lines in item 9.
11	The TVIS will calculate the sum of Lines 8 and 10. This amount is the total of all MCH funds administered by your State's MCH program.

LINE NUMBER	INSTRUCTIONS FOR ANNUAL REPORT EXPENDED
1	Enter the Federal Title V allocation received. Note: TVIS will display the original budgeted amounts for reference.
1A	Enter the amount of the Federal allotment for preventive and primary care for children. The percentage of the total (Line 1) that this amount represents will be calculated by TVIS.
1B	Enter the amount of the Federal allotment for children with special health care needs. The percentage of the total (Line 1) that this amount represents will be calculated by TVIS.
1C	Enter the amount of the Federal allotment for the administration of the allotment. The percentage of the total (Line 1) that this amount represents will be calculated by TVIS.
2	The TVIS will calculate the subtotal of Lines 1A, 1B and 1C. Please note that Pregnant Women and All Others will not be included in this amount.
3	Enter the amount of your State total funds for the Title V allocation (match).
4	Enter the amount of total MCH dedicated matching funds garnered from local jurisdictions within your State.
5	Enter the total of MCH funds available from other private sources such as foundations.
6	Enter the amount of MCH program income funds collected by your State's MCH agencies from insurance payments, MEDICAID, HMO's, etc..
7	The TVIS will calculate the sum total of Lines 3, 4, 5, and 6 for the total of your State match and overmatch.
7A	The TVIS will prepopulate your State's FY 1989 Maintenance of Effort amount.
8	The TVIS will calculate the total for Lines 1 and 7. This amount is the "Federal-State Title V Block Grant Partnership"
9	The TVIS will prepopulate programs and amounts. Adjust the amounts to reflect actuals expended during the budget period. Use field and form notes for any major changes to awards from what had been projected to be received. For Federal awards budgeted or received that are not included in the menu in TVIS, select "Other" and enter the appropriate information.
10	The TVIS will calculate the sum of all lines in item 9.
11	The TVIS will calculate the sum of Lines 8 and 10. This amount is the total of all MCH funds administered by your State's MCH program.

FORM 3a - BUDGET AND EXPENDITURE DETAILS BY TYPES OF INDIVIDUALS SERVED

[Section 506(a)(2)(A)(iv), Section 505(a)(2)(A)-(B) and Section 506(a)(1)(A)-(D)]

I. TYPES OF INDIVIDUALS SERVED

	FY ____ Application	FY ____ Annual Report
IA. Federal MCH Block Grant	**Budgeted**	**Expended**
1. Pregnant Women	$_____	$_____
2. Infants < 1 year	$_____	$_____
3. Children 1 through 21 years	$_____	$_____
4. CSHCN	$_____	$_____
5. All Others	$_____	$_____
Federal TOTAL	**$**_____	**$**_____

	FY ____ Application	FY ____ Annual Report
IB. Non-Federal MCH Block Grant	**Budgeted**	**Expended**
1. Pregnant Women	$_____	$_____
2. Infants < 1 year	$_____	$_____
3. Children 1 through 21 years	$_____	$_____
4. CSHCN	$_____	$_____
5. All Others	$_____	$_____
Non-Federal TOTAL	**$**_____	**$**_____

	FY__ Application Budgeted	FY__Annual Report Expended
FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL	**$**_____	**$**_____

INSTRUCTIONS FOR COMPLETION OF FORM 3a
BUDGET/EXPENDITURE DETAILS BY TYPES OF INDIVIDUALS SERVED

Title V Citation: *Section 506(a)(2)(A)(iv) requires that each State submit an annual report of its activities under its Title V program. Among the items required to be reported are, "...the amount spent under this title...by class of individuals served."*

Instructions: Complete all required data cells. If an actual number is not available, the State should provide an estimate. All estimates should be explained in a form or field note in TVIS. Reporting definitions that contain terms applicable to this form are provided in Appendix 1.

LINE NUMBER	INSTRUCTIONS
I.A.1 – I.A.5	Enter the budgeted (Application year) and expended (Annual Report year) amounts for the Federal MCH allocation. Any discrepancies should be addressed with a field or form note in TVIS. ***Note: The amounts for Children 1 through 21 years and CSHCN should match the amounts reported on Form 2, Lines 1a and 1b for budgeted (Application year) and expended (Annual Report year), respectively.* ***Note: Line 2 on Form 2 should not equal 100% if amounts are reported for Pregnant Women.*
I.A.1 Federal TOTAL	The TVIS will calculate the sum of the amounts entered for Lines I.A.1 through I.A.5. ***Note: The Federal TOTAL should equal the Federal Allocation total minus the Title V Administrative Costs.*
I.B.1 - I.B.5	Enter the budgeted (Application year) and expended (Annual Report year) amounts for the non-Federal Title V program funds.
I.B.1 Non-Federal TOTAL	The TVIS will calculate the sum of the amounts entered for Lines I.B.1 through I.B.5.
Federal-State MCH Block Grant Partnership TOTAL	The TVIS will calculate the sum of the amounts entered for the I.A.1 TOTAL and I.B.1 TOTAL. Use form or field notes in TVIS to explain any discrepancies or unexpected variations.

FORM 3b - BUDGET AND EXPENDITURE DETAILS BY TYPES OF SERVICES

[Section 506(a)(2)(A)(iv), Section 505(a)(2)(A)-(B) and Section 506(a)(1)(A(-(D)]

II. TYPES OF SERVICES

	FY__ Application	FY__ Annual Report
IIA. Federal MCH Block Grant	**Budgeted**	**Expended**
1. Direct Services	**$**_____	**$**_____
a. Preventive and primary care services for all pregnant women, mothers, and infants up to age one	$_____	$_____
b. Preventive and primary care services for children	$_____	$_____
c. *Services for CSHCN*	$_____	$_____
2. Enabling Services	**$**_____	**$**_____
3. Public Health Services and Systems	**$**_____	**$**_____

4. Review below the specific types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service.

1. Pharmacy	$_____
2. Physician/Office Services	$_____
3. Hospital Charges (Includes Inpatient and Outpatient Services)	$_____
4. Dental Care (Does Not Include Orthodontic Services)	$_____
5. Durable Medical Equipment and Supplies	$_____
6. Laboratory Services	$_____
7. Other _____	$_____

	FY___ Application Budgeted	FY___ Annual Report Expended
FEDERAL TOTAL	**$**_____	**$**_____

FORM 3b - BUDGET AND EXPENDITURE DETAILS BY TYPES OF SERVICES (Continued)
[Section 506(a)(2)(A)(iv), Section 505(a)(2)(A)-(B) and Section 506(a)(1)(A)-(D)]

II. TYPES OF SERVICES

IIB. Non-Federal MCH Block Grant	FY__ Application Budgeted	FY__ Annual Report Expended
1. Direct Services	**$**_____	**$**_____
a. Preventive and primary care services for all pregnant women, mothers, and infants up to age one	$_____	$_____
b. Preventive and primary care services for children	$_____	$_____
c. *Services for CSHCN*	$_____	$_____
2. Enabling Services	**$**_____	**$**_____
3. Public Health Services and Systems	**$**_____	**$**_____

4. Review below the specific types of non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of non-Federal MCH Block Grant funds expended for each type of reported service.

1. Pharmacy	$_____
2. Physician/Office Services	$_____
3. Hospital Charges (Includes Inpatient and Outpatient Services)	$_____
4. Dental Care (Does Not Include Orthodontic Services)	$_____
5. Durable Medical Equipment and Supplies	$_____
6. Laboratory Services	$_____
7. Other _____	$_____

	FY___ Application Budgeted	FY___ Annual Report Expended
NON-FEDERAL TOTAL	**$**_____	**$**_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 3b
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Title V Citation: *Section 505(a)(2) states, in part, "In order to be entitled to payments for allotments...a State must prepare and transmit to the Secretary an application...that includes for each fiscal year (A) a plan for meeting the needs identified by the statewide needs assessment...and (B) a description of how funds allotted to the State...will be used for the provision and coordination of services to carry out such a plan that shall include - (iii) an identification of the types of services to be provided...."*
Section 506(a)(1) states, "Each State shall prepare and submit to the Secretary annual reports on its activities under this title." Among the items required to be reported (Section 506(a)(2)(A)(i)-(iv)) are, the number of individuals served by the State under this title (by class of individuals), the proportion of each class of such individuals which has health coverage, the types (as defined by the Secretary) of services provided under this title to individuals within each such class, and the amounts spent under this title on each type of services, by class of individuals served.

Instructions: Complete all required data cells. If an actual number is not available, the State should make an estimate. All estimates should be explained in a form or field note in TVIS. Reporting definitions that contain terms applicable to this form are provided in Appendix 1.

LINE NUMBER	INSTRUCTIONS
II.A.1	Of the **Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services**.
II.A.1.a – II.A.1c	Of the **Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services by types of services and MCH population group**.
II.A.2	Of the **Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Enabling Services**.
II.A.3	Of the **Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Public Health Services and Systems.**
II.A.4	**Enter** the amount of Federal Title V funds expended for services that are closely related to each type of direct service listed. If a service cannot be related to one of the provided choices, the state can choose "Other" and enter the type of service that is supported and amount.
Federal TOTAL	The TVIS will calculate the sum of the **Federal** amounts entered for Line II.A.1, Line II.A.2 and Line II.A.3.

INSTRUCTIONS FOR THE COMPLETION OF FORM 3b (Continued)
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

LINE NUMBER	INSTRUCTIONS
II.B.1	Of the **non-Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services**.
II.B.1.a – II.B.1c	Of the **non-Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services by types of services and MCH population group**.
II.B.2	Of the **non-Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Enabling Services**.
II.B.3	Of the **non-Federal** MCH allocation, **enter** the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Public Health Services and Systems.**
II.B.4	**Enter** the amount of non-Federal Title V funds expended for services that are closely related to each type of direct service listed. If a service cannot be related to one of the provided choices, the state can choose "Other" and enter the type of service that is supported and amount.
Non-Federal TOTAL	The TVIS will calculate the sum of the **non-Federal** amounts entered for Line II.B.1, Line II.B.2 and Line II.B.3.

FORM 4 - NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED AND TREATED

[SECTION 506(a)(2)(B)(iii)]

Annual Report Year: _____

Total Births by Occurrence: _____ **Data Source Year: _____**

Type of Screening Tests	(A) Aggregate Total Number Receiving at Least One Valid Screen[11]		(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases[12]	(D) Aggregate Total Number Referred for Treatment [13]	
	No.	%			No.	%
1. Newborn Screening Program Select all applicable screening tests from the core in the Recommended Uniform Screening Panel (RUSP) using the drop down list. ⇩						
Type of Screening Tests	**(A) Total Number Receiving at Least One Screen[1]**		**(B) Total Number Presumptive Positive Screens**	**(B) Total Number Confirmed Cases[2]**	**(B) Total Number Referred for Treatment[3]**	
	No.	%			No.	%
2. Other Newborn Screening Tests (Specify by Name) 1. _____ 2. _____ 3. _____						
3. Screening Programs for Older Children & Women 1) _____ 2) _____ 3) _____						

4. Long-term follow-up (follow-up beyond referring an infant for treatment) varies based on State policy and practice. Briefly describe your State's practice for monitoring infants with confirmed diagnoses, including what information is obtained and for how long infants are monitored.

[11] TVIS will use occurrent births as denominator.
[12] Report only those from resident births.
[13] TVIS will use number of confirmed cases as denominator.

INSTRUCTIONS FOR THE COMPLETION OF FORM 4
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Title V Citation: *Section 506(a)(1) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following: (2)(B)(iii) "... information on such other indicators of maternal, infant, and child health care status as the Secretary may specify."*

Instructions: Complete all required data cells for the reporting year. If an actual number is not available, make an estimate. All estimates should be explained in a form or field note in TVIS.

LINE NUMBER	INSTRUCTIONS
Annual Report Year	TVIS will prepopulate the annual report year.
Lines: "Total Births by Occurrence" and "Data Source Year"	**Enter** the total number of occurrent births for the State and the year for which the data apply. Total births by occurrence are to be defined as "all births that occur in the State regardless of residency." States should use the number submitted by the Vital Records program to the National Center for Health Statistics. **The data source year is to be defined as calendar year, January 1 – December 31**. Please note that the "Total Births..." figure is related to the "Total infants < 1 year of age" row in Form 5a and 5b, and the "TOTAL INFANTS IN STATE" row in section I of Form 6. While these figures are not expected to match, there should be a fairly close relationship between them.
1. Newborn Screening Program	All States now screen for at least 29 out of the 34 core conditions on the Recommended Uniform Screening Panel (RUSP). Using the drop-down box, select the names of all screening tests specific to your state's newborn population. a. In column A, **enter** the aggregate total number of occurrent births that received one of the tests indicated. TVIS will calculate the percentage based on occurrent births receiving one test out of the total listed at the top of the form. b. In column B, **enter** the aggregate total number of presumptive positive screens. c. In column C, **enter** the aggregate total number of confirmed cases discovered. Use only those from resident births. d. In column D, **enter** the aggregate total number of those confirmed cases that were referred for treatment. TVIS will calculate the percentage by using the confirmed cases as the denominator.
2. Other Newborn Screening Tests	**Optional: Enter** additional screening tests specific to your state's newborn population, such as screenings for other conditions that are not listed in the RUSP. Complete Columns A through D for each of the listed screenings. TVIS will calculate the percentages.
3. Screening Programs for Older Children and Women	**Optional: Enter** any screening tests that are specific to older children and women. Complete Columns A through D for each of the listed screenings. Note that the % (percentage) portion of Column A is not to be completed since the denominator of Total Births by Occurrence does not apply. Manually enter the specific names of any other screens that are not listed and complete Columns A through D.

FORM 5a - COUNT OF INDIVIDUALS SERVED BY TITLE V

(By Class of Individuals and Percent of Health Coverage)
[Section 506(a)(2)(A)(i)-(ii)]

Annual Report Year_____	**(A)**	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
	TITLE V	PRIMARY SOURCE OF COVERAGE				
Type of Individuals Served	Total Served	Title XIX %	Title XXI %	Private/Other %	None %	Unknown %
1. Pregnant Women						
2. Infants < 1 year of age						
3. Children 1 through 21 years of age						
a. Children with Special Health Care Needs 0 through 21 years of age *						
4. Others						
TOTAL						

FORM 5b - TOTAL PERCENTAGE OF POPULATIONS SERVED BY TITLE V

(By Class of Individuals)
[Section 506(a)(2)(A)(i-ii)]

Annual Report Year _____	
Population Served by Title V	**Total % Served**
1. Pregnant Women	_____
2. Infants < 1 year of age	_____
3. Children 1 through 21 years of age	_____
a. Children with Special Health Care Needs 0 through 21 years of age *	_____
4. Others	_____

*Represents a subset of all infants and children

INSTRUCTIONS FOR THE COMPLETION OF FORM 5a and FORM 5b
COUNT OF INDIVIDUALS SERVED BY TITLE V
AND
TOTAL PERCENTAGE OF POPULATIONS SERVED BY TITLE V
[Section 506(a)(2)(A)(i)-(ii)]

Title V Citation: *Section 506(a)(1) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following: "(2) Each annual report...shall include the following information: (A)(i) The number of individuals served by the State under the title (by class of individuals)…(ii) The proportion of each class of such individuals which has health coverage."*

Instructions: Complete all required data cells for the reporting year. If an actual number is not available, the State should make an estimate. In particular, Form 5b and the insurance coverage section in Form 5a may require estimation. All methods, data sources and included services/programs should be explained in field notes in TVIS. Reporting definitions that contain terms applicable to this form and examples of included services/programs in each participant category is provided in Appendix 1.

The purpose of Form 5a and Form 5b is two-fold.

Form 5a, *Count of Individuals Served by Title V*, enables the State to track and report on the number who received an individually delivered service funded by the Title V program without full reimbursement within the top two levels of the MCH Pyramid (direct and enabling services).

Form 5b, *Total Percentage of Population Served by Title* V, enables the State to track and report on the total percentage who received a Title V-supported service within all levels of the MCH Pyramid (direct services, enabling services, and public health services and systems).

Since States began to report Title V program participant data in the 1990's, MCH programs have seen a shift in the delivery of services from direct primary care MCH services to public health and preventive services within well-coordinated and comprehensive systems of care that are designed for the MCH population. This shift has resulted in a need for more complete reporting of individuals served by Title V, which goes beyond an unduplicated count of individuals served (often derived from reimbursement data or individual client records for MCH direct and enabling services).

It is recognized that precisely quantifying the number of individuals reached through the administration or promotion of population-based services and systems (e.g., injury prevention and education, regionalized systems of perinatal care, newborn screening programs) is difficult, and informed estimates are often required. Relying only on reimbursement data or individual client program records supported by Title V, however, can lead to serious underestimates of the number of individuals in a State who actually received and benefitted from a Title V-supported service. For this reason, Form 5b was developed to better capture the full "reach" of the State's Title V program in serving its MCH population.

Unlike Forms 3a and 3b, the totals reported on Forms 5a and 5b reflect both Federal and Non-federal Title V program dollars.

INSTRUCTIONS FOR THE COMPLETION OF FORM 5a and FORM 5b (Continued)
COUNT OF INDIVIDUALS SERVED BY TITLE V
AND
TOTAL PERCENTAGE OF POPULATIONS SERVED BY TITLE V
[Section 506(a)(2)(A)(i)-(ii)]

FORM/LINE NUMBER	INSTRUCTIONS
Form 5a	States should report the number of individuals who received a direct or enabling service funded by Title V in each of the listed MCH population groups, along with the percentage of each group by insurance coverage type.
Report Year	TVIS will prepopulate the annual report year for which the data apply.
1 – 5, Column A	Enter the best possible estimate for the number who received an individually delivered direct or enabling service funded by the Title V program without full reimbursement. This number includes individuals who received a service funded by total Federal and Non-federal dollars as reported on line 8 of Form 2, and it should align with the combined totals on Form 3a and 3b for direct and enabling services. Pregnant women may also receive non-pregnancy related services and be counted in other participant categories (i.e., Children ages 1 through 21 and Others). All remaining categories are mutually exclusive with CSHCN reported as a subset of all infants and children ages zero (0) through 21. Within each reporting category, the count of individuals served should be unduplicated to the fullest extent possible. All methods, data sources, and included services/programs should be explained in field notes in TVIS.
1 -5, Columns B - F	Enter the percentages of individuals reported in Column A by their primary source of coverage. If insurance status is unknown, states should report an estimate. Estimates from population-based data sources will be provided by MCHB to facilitate reporting.
Form 5b	States should report an estimate for the *total percentage of populations* who received a Title V-supported service in each of the listed MCH population groups across all levels of the MCH Pyramid, including public health services and systems.
Report Year	TVIS will prepopulate the annual report year for which the data apply.
1-5	Enter the best possible estimate for a total percentage of each population group served by the Title V program across all levels of the MCH Pyramid (i.e., direct services, enabling services, and public health services and systems). This estimate includes all individuals and populations served by the total Federal and State dollars as reported on line 8 of Form 2 and the combined totals on Form 3a and 3b for all service levels. Non-Title V programs that provide direct and enabling services (e.g., WIC, Home Visiting) may be included if Title V funds or staff time are used to promote or enhance services (individual services that are Title V funded may also be counted in 5a). To avoid duplication, numerators for the percentage estimate should focus on the programs and services that have the largest reach for a given population, which generally involves public health services and systems. Approximate denominators for each population group will be prepopulated in TVIS by MCHB, where available, to facilitate percentage estimation. Within public health services and systems, only those populations who are reached by activities that directly promote access or quality of specific population-based services and systems should be counted, thus public health services such as needs assessment, surveillance, mortality review, and other data collection would be excluded (see examples in Appendix 1). All methods, data sources, and included services/programs should be explained in field notes in TVIS.

FORM 6 - DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX

(By Race and Ethnicity)

[Section 506(a)(2)(C)-(D)]

I. UNDUPLICATED COUNT BY RACE/ETHNICITY

Annual Report Year: _____

	(A) TOTAL	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Alaska Native	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Un-known
1. TOTAL DELIVERIES IN STATE									
TITLE V SERVED									
ELIGIBLE FOR TITLE XIX									
2. TOTAL INFANTS IN STATE									
TITLE V SERVED									
ELIGIBLE FOR TITLE XIX									

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX

Title V Citation: *Section 506 (a)(1) requires each State to submit an Annual Report on its activities under Title V. Included in this requirement is the following:*

(2)(C) "Information (by racial and ethnic group) on--
- *(i) the number of deliveries in the State in the year, and*
- *(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.*

(2)(D) Information (by racial and ethnic group) on--
- *(i) the number of infants under one year of age who were in the State in the year, and*
- *(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX … at any time during the year."*

Instructions: Complete all required data cells for the annual report year. If an actual number is not available, the State should make an estimate. All methods, data sources, and included services/programs should be explained in field notes in TVIS. Reporting definitions that contain terms applicable to this form are provided in Appendix 1. It is recognized that there will be overlap between the reported totals for "Title V Served" and "Eligible for Title XIX", due to an individual's changing insurance eligibility status during the course of a year (i.e., "churning".) Form 6 asks for all individuals who are served by Title V and an estimate of the individuals in the State who are eligible for Title XIX. The form does not ask for a report on those individuals served by Title V who are also eligible for Title XIX.

LINE NUMBER	INSTRUCTIONS
Section I: Unduplicated Count by Race/Ethnicity	
Annual Report Year	TVIS will prepopulate the annual report year for which the data apply.
Total Deliveries in State	In Columns B-I, enter the number for the population-based total of all deliveries in the State for the reporting year by race and ethnicity. Of the total deliveries, enter the number of deliveries to pregnant women who were served by Title V and the number who were eligible for Title XIX by race and ethnicity in Columns B-I. TVIS will calculate the total in Column A based on the numbers provided by race/ethnicity. The "Total Deliveries" served by Title V is related to the count of pregnant women served in Form 5b. Estimates from population-based data sources will be provided by MCHB to facilitate reporting.
Total Infants in State	In Columns B-I, enter the number of infants by race and ethnicity. Of the total infants, enter the number of infants served by Title V and the number of infants who were eligible for Title XIX by race and ethnicity in Columns B-I. TVIS will calculate the total in Column A based on the numbers provided by race/ethnicity. The "Total Infants" served by Title V is related to the count of infants served in Form 5b. Estimates from population-based data sources will be provided by MCHB to facilitate reporting.

FORM 7 - TITLE V PROGRAM WORKFORCE

A. Title V Program Workforce FTEs

Title V-Funded Positions

1. Total Number of FTEs: _____
    a. Total Number of FTEs (State Level): _____
    b. Total Number of FTEs (Local Level): _____

2. Total Number of MCH Epidemiology FTEs (subset of A.1) _____

3. Total Number of FTEs eliminated in the past 12 months: _____

4. Total Number of Current Vacant FTEs: _____
    a. Total Number of Vacant MCH Epidemiology FTEs: _____

5. Total Number of new FTEs onboarded in the past 12 months: _____

B. Training Needs

Current or Anticipated Title V Professional Development and Training Needs

1. _____
2. _____
3. _____
4. _____

INSTRUCTIONS FOR THE COMPLETION OF FORM 7
TITLE V PROGRAM WORKFORCE

Instructions: States must complete all required data fields with current workforce data every five years, as part of the five-year comprehensive needs assessment. States are encouraged, but not required, to make updates to Form 7 during interim years two through five. If an actual number is not available, states should make an estimate. All estimates should be explained in a form or field note in TVIS.

LINE NUMBER	INSTRUCTIONS FOR TITLE V PROGRAM WORKFORCE
A.1.	Enter the number of Title V-funded Full-Time Equivalents (FTEs) currently on staff. Positions should be quantified as FTEs. Responses should include whole and partial FTEs that are Title V-funded (e.g., 1.0 FTE + 0.5 FTE = 1.5 FTEs). Of this total: a. Enter the number of FTEs employed on the state level. b. Enter the number of FTEs employed on the local level.
A.2.	Enter the number of MCH Epidemiology FTEs (state and local level). The MCH Epidemiology FTEs reported in this field should be a subset of the overall number of FTEs reported in line A.1.
A.3.	Enter the number of Title V-funded FTE positions, if any, that have been eliminated in the past 12 months. Positions should be quantified as FTEs. Responses should include whole and partial FTEs that are Title V-Funded (e.g., 1.0 FTE + 0.5 FTE = 1.5 FTEs).
A.4.	Enter the total number of Title V-funded FTEs that are currently vacant. a. Of this total, enter the total number of currently vacant MCH Epidemiology FTEs.
A.5.	Enter the total number of Title V-funded FTEs that have been onboarded in the past 12 months.
B.	Write in up to four current or anticipated professional development and training needs of Title V-funded staff. Training needs listed here should not duplicate information reported in narrative Section G – Technical Assistance. Technical Assistance (Section G) should focus on systems/statewide needs. Training Needs (Form 7) should focus on individual-level needs to build capacity.

FORM 8 - STATE CONTACT INFORMATION

FOR APPLICATION YEAR _____

STATE: _____

1. Title V Maternal and Child Health (MCH) Director

Name and Credentials:

Title:

Street Address:

Room Number:

City/State/Zip:

Telephone:

Email:

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name and Credentials:

Title:

Street Address:

Room Number:

City/State/Zip:

Telephone:

Email:

3. State Family Leader (Optional)

Name and Credentials:

Title:

Street Address:

Room Number:

City/State/Zip:

Telephone:

Email:

4. State Youth Leader (Optional)

Name and Credentials:

Title:

Street Address:

Room Number:

City/State/Zip:

Telephone:

Email:

5. SSDI Project Director

Name and Credentials:

Title:

Street Address:

Room Number:

City/State/Zip:

Telephone:

Email:

6. State MCH Toll-Free Telephone Line [Sections 505(a)(5)(E) and 509(a)(8)]

State MCH Toll-Free "Hotline" Telephone Number:

INSTRUCTIONS FOR THE COMPLETION OF FORM 8
STATE CONTACT INFORMATION

Title V Citation: *Section 505(a)(5)(E) states, in part, "the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners..."*

The Maternal and Child Health Bureau is the designee of the Secretary of the Department of Health and Human Services to carry out the mandate of Section 509(a)(8) of Title V, which requires that a national directory of toll-free numbers be made available to State agencies that administer the State's Title V programs.

LINE NUMBER	INSTRUCTIONS FOR STATE CONTACTS
A	TVIS will prepopulate the name of the State and the application year.
1 - 5	**Enter** the name of the Title V MCH Director, CSHCN Director, SSDI Project Director and, at the option of the State, the Family Leader and Youth Leader. For each of the listed contacts, provide the title, address, telephone number and email address.
6	Enter the State's primary toll-free MCH information line telephone number. States have the option to provide a form note in TVIS.

FORM 9 - LIST OF MCH PRIORITY NEEDS

[Section 505(a)(1)]

Your state's Five-Year Statewide Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs. The established priorities should guide the activities that are included in the State's Five-year Action Plan. In order to evaluate success in meeting the goals of the priority needs, the State should determine, at the time of priority setting, its plan for assessing if priority needs have been addressed. This assessment should include the development of State Performance Measures (SPMs), which are specifically tailored to a priority need to the extent that such need is not fully addressed by the National Performance Measures (NPMs) or the State Evidence-based or –informed Strategy Measures (ESMs).

Instructions: With each year's Block Grant Application, TVIS will prepopulate the priority needs provided in the previous year. States should review their priority needs to ensure alignment within the State Action Plan where priorities are linked with the existing National Outcome Measures (NOMs), NPMs, SPMs and ESMs. States can classify priority needs as New, Continued, or Revised under the following conditions:

- New: Priority Need is added
- Revised: Description is changed for a Priority Need provided in the previous interim year
- Continued: No changes for a Priority Need provided in the previous interim year.

In listing its MCH priority needs, the state should use a simple descriptive phrase or sentence that clearly defines the need. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women," and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in TVIS for comparison, tracking, and reporting purposes. The State must list at least 7 priority needs, and the form will only accept up to 10. If desired, the State may list and describe additional priority needs in a form note in TVIS. Note that the order of the priority needs in the table is solely for a numerical listing and is not meant to indicate a priority order.

STATE_____ **APPLICATION YEAR**_____

PRIORITY NEEDS	NEW (N), REVISED (R) OR CONTINUED (C) PRIORITY NEED FOR THIS FIVE-YEAR REPORTING PERIOD		
	N	R	C
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

FORM 10 - TRACKING MEASURES

National Performance Measures (NPMs), Evidence-based or –Informed Strategy Measures (ESMs), State Performance Measures (SPMs) and State Outcome Measures (SOMs)
[Sections 505(a)(2)(B)(i),(iii) and 506(a)(2)(A)(iii)]

Form 10 NPM Annual Report Year: Objective and Performance Data

MEASURE #__ (Measure Title)	**Annual Report Year:**	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Objective	_____	_____	_____	_____	_____	_____
Annual Indicator	_____					
Numerator	_____					
Denominator	_____					

Data Source: _____ **Data Source Year:** _____

Provisional or Final?: ◯ Provisional ◯ Final

Form 10 ESM/SPM/SOM Annual Report Year: Objective and Performance Data

MEASURE #__ (Measure Title)	**Annual Report Year:**	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Objective	_____	_____	_____	_____	_____	_____
Annual Indicator	_____					
Numerator	_____					
Denominator	_____					

Data Source: _____ **Data Source Year:** _____

Provisional or Final?: ◯ Provisional ◯ Final

Form 10 ESM/SPM/SOM Detail Sheet

ESM/SPM/SOM #		
Measure Title:		
For SPMs/SOMs only: **Population Domain(s)**	◯ Women/Maternal Health ◯ Perinatal/Infant Health ◯ Child Health ◯ Adolescent Health ◯ Children with Special Health Care	◯ Cross-Cutting/Systems Building

	Needs	
For ESMs Only: **National Performance Measure**	Select the related National Performance Measure ⇩	
State Performance Measure	Select the related State Performance Measure ⇩	
Evidence-based/informed strategy		
Goal		
Significance		
Definition	Unit Type:	
	Unit Number:	
	Numerator:	
	Denominator:	
Data Sources and Data Issues		
For SPMs/SOMs only: **Healthy People 2030 Objective**		

INSTRUCTIONS FOR THE COMPLETION OF FORM 10
TRACKING MEASURES
National Performance Measures (NPMs), Evidence-based or –Informed Strategy Measures (ESMs), State Performance Measures (SPMs) and State Outcome Measures (SOMs)

Title V Citation: *Section 505(a)(2)(B)(i),(iii) requires the States to submit an Application that includes, ...a statement of the goals and objectives consistent with the health status goals and national health objectives...for meeting the needs specified in the State plan...[and]...an identification of the types of services to be provided... "Section 506(a)(2)(A)(iii) requires the States to report annually on the ...types (as defined by the Secretary) of services provided under this title..."*

Instructions: As the standard form to be used by States in tracking all measurement types (e.g., NOMs, NPMs, ESMs, SPMs and SOMs) specified in this Guidance, this form serves a dual purpose: 1) Displays 5-year planned objectives (targets) for each NPM, ESM, SPM and SOM, as applicable, as part of the Application, and 2) Reports Annual Indicators, values actually achieved during a reporting year, for each NPM, SPM, ESM and SOM, as applicable, as part of the Annual Report. States are not required to establish annual objectives for the NOMs. For the NPMs and the NOMs, the Annual Indicator data will be populated annually by the Maternal and Child Health Bureau, as available, using the referenced national data source identified on the detail sheet for each specific NPM and NOM. While not responsible for entering an Annual Indicator, States will be responsible for tracking their annual progress on the NPMs and their related NOMs.

Form 10 reporting changes in this iteration of the guidance are as follows:

1. For NPMs, the Universal NPMs will be automatically selected. Additional selections can be made.
2. For NPMs, states have the ability to identify a priority population by establishing annual objectives and report annual indicator data for a specific Federally Available Data (FAD) stratifier and stratifier subgroup.
3. For the Medical Home NPM, states will designate which sub-component(s) of Medical Home they will focus on.
4. A standardized set of measures will be available to allow states to select as SPMs, which would include a standardized detail sheet and the population of FAD, if available. States will still have the ability to create SPMs as they have done in the past.
5. States have the ability to create ESMs for SPMs. There is not a requirement to have an ESM for an SPM.
6. States have the ability to associate an NOM or SOM with a SPM. There is not a requirement for a SPM to be linked to an NOM or SOM.
7. States have the ability to associate an SOM with an NPM. There is not a requirement for a NPM to be linked to an SOM.
8. States have the ability to select an NOM to create as a State Outcome Measure if a state would like to provide annual objectives.

Reporting definitions that contain terms applicable to this form are provided in Appendix 1.

For the Application Year, States will establish annual objectives for the current five-year needs assessment cycle for each NPM, ESM, SPM and SOM, as applicable. Within the five-year period, annual objectives that were established by the State in previous years' Applications will be prepopulated on the form.

For the annual report year, TVIS will prepopulate the federally available indicator data, if available, for the NOMs, NPMs, and the standardized SPMs (e.g., only SPMs selected from the standardized set of measures). If federal indicator data is not available for a measure chosen by the state, the state will be required to provide state data for

their chosen NPMs and standardized SPMs. States will complete the required data cells (i.e., Annual Indicator, Numerator, Denominator, Data Source and Data Source Year) for the ESMs, SPMs and SOMs, if applicable. If the final data are not available, the State should provide provisional or estimated data with an explanation in a field note in TVIS.

LINE NUMBER	INSTRUCTIONS FOR FORM 10 OBJECTIVE & PERFORMANCE DATA TABLES
Measure Number	The TVIS will prepopulate the measure number.
Annual Report Year	The TVIS will prepopulate the annual report years.
Annual Objective	**Enter** the Annual Objective (for the most recently added out-year). The TVIS will prepopulate objectives provided in previous years.
Annual Indicator	For the current annual report year, **enter** the Annual Indicator, including the Numerator and Denominator, for each ESM, SPM and SOM. The TVIS will prepopulate the Annual Indicator from federal sources, where available for the NPMs, and standardized SPMs (e.g., only SPMs selected from the standardized set of measures). If federal data is not available, enter the Annual Indicator, including the Numerator and Denominator for the chosen NPMs, and standardized SPMs.
Data Source	For the current annual report year, **enter** the Data Source for the reported Annual Indicator for each ESM, SPM and SOM. The TVIS will prepopulate the Data Source from federal sources, where available for the NPMs, and standardized SPMs. If federal data is not available, enter the Data Source for the chosen NPMs, and standardized SPMs.
Data Source Year	For the current annual reporting year, **enter** the Data Source Year for the reported Annual Indicator for each ESM, SPM and SOM. The TVIS will prepopulate the Data Source Year from federal sources, where available for the NPMs, and standardized SPMs. If federal data is not available, enter the Data Source Year for the chosen NPMs, and standardized SPMs.
Provisional/Final?	**Check** the button in TVIS to indicate if the data is provisional or final.
Note	For the current annual reporting year, **enter** a data note to clarify any estimated or provisional data and to describe other limitations which impact the reporting of an Annual Indicator for each NPM, ESM, SPM and SOM.

Instructions: The purpose of the detail sheet is to describe the state measure by completing each section as appropriate. Note that the measure title and numerator and denominator data will be displayed in TVIS. Unit type (e.g., percentage, rate, ratio, scale, yes/no, count) for an ESM, SPM or SOM cannot be changed the year after the respective measure was created in TVIS. Reporting definitions that contain terms applicable to this form are provided in Appendix 1.

LINE NUMBER	INSTRUCTIONS FOR FORM 10 DETAIL SHEETS
ESM, SPM, or SOM #	TVIS will prepopulate the measure number.
Measure Title	**Enter** a brief, narrative description of the measure.
For SPMs/SOMs only: Population Domain(s)	**Select** the related population domain(s), as applicable. Note: If Cross-Cutting/Systems Building is selected, none of the five population domains can be selected.
For ESMs Only: National Performance Measure	**Select** the related national performance measure to link the ESM in TVIS.
State Performance Measure	**Select** the related state performance measure to link the ESM in TVIS.
Evidence-based/informed strategy	**Indicate** the evidence-based/informed strategy that this ESM measures and where you accessed the evidence on this strategy. Briefly describe the evidence for how this strategy influences the selected NPM or SPM. Please refer to the *Title V Block Grant Technical Assistance Resources* at: https://mchb.tvisdata.hrsa.gov/Home/Resources for an additional explanation and examples for describing the strategy.
Goal	**Enter** a short statement indicating what the State hopes to accomplish by tracking this measure.
Significance	**ESMs**: Briefly **describe** why this measure is significant; especially as it relates to the selected evidence/based informed strategy and goal. What aspect of the strategy does it measure and why is measuring it important to showing progress? **SOM & SPMs**: Briefly **describe** why this measure is significant, especially as it relates to the selected goal.

LINE NUMBER	INSTRUCTIONS FOR FORM 10 DETAIL SHEETS
Definition	Unit Type: **Select** the type of measure from the pick list in TVIS (e.g., percentage, rate, ratio, scale, yes/no, count) Unit Number: • If the measure is a percentage, rate, ratio, or yes/no, **indicate** the units in which the measure is to be expressed. • If the measure is a scale or count, **indicate** the maximum scale or count for the measure. Numerator: If the measure is a percentage, rate, scale, count, yes/no or ratio, **provide** a clear description of the numerator. In TVIS, this is the field used for count and yes/no measures that do not have a denominator. Denominator: If the measure is a percentage, rate, scale or ratio, **provide** a clear description of the denominator. In TVIS, this field will not be required for count or yes/no measures.
Data Source & Data Issues	**Enter** the source(s) of the data used in determining the value of the measure and any issues concerning the methods of data collection or limitations of the data used.
For SPMs/SOMs only: Healthy People 2030 Objective	If the measure is related to a *Healthy People 2030* objective, **describe** the objective and corresponding number.

FORM 11 - OTHER STATE DATA (OSD) – #01 - #03

(Prepopulated by MCHB)

OSD #01 – Rates of infant mortality, low birth weight, and preterm birth by race and ethnicity
[SECTION 506 (a)(2)(B)(i)]

Annual Report Year _____

CATEGORY RATE BY RACE/ETHNICITY	STATE RATE	NON-HISPANIC WHITE	NON-HISPANIC BLACK OR AFRICAN AMERICAN	HISPANIC	NON-HISPANIC AMERICAN INDIAN OR ALASKA NATIVE	NON-HISPANIC ASIAN	NON-HISPANIC NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	NON-HISPANIC MULTIPLE RACE
Infant Mortality (Rate per 1,000)								
Low Birth Weight (%)								
Preterm Birth (%)								

OSD #02 – Rates of infant mortality, low birth weight, and preterm birth by county
[SECTION 506 (a)(2)(B)(i)]

COUNTY (List each County)	INFANT MORTALITY (Rate per 1,000)	LOW BIRTH WEIGHT (%)	PRETERM BIRTH (%)

OSD #03 –State MCH Workforce
[SECTION 506 (a)(2)(E)(i)-(vi)]

WORKFORCE CATEGORY	RATIO OF PROVIDERS TO 100,000 POPULATION
OBSTETRICIANS	
FAMILY PRACTITIONERS	
CERTIFIED FAMILY NURSE PRACTITIONERS	
CERTIFIED NURSE MIDWIVES	
PEDIATRICIANS	
CERTIFIED PEDIATRIC NURSE PRACTITIONERS	

OSD #04 –Prevalence of Children with Special Health Care Needs (CSHCN) and Select Conditions
[SECTION 506 (a)(2)(B)(iii)]

CSHCN (%)	Autism (%)	ADD/ADHD (%)

INSTRUCTIONS FOR THE COMPLETION OF FORM 11
OTHER STATE DATA (OSD) – #01 - #03

Title V Citation: See OSD reporting tables above.

Instructions: States are not required to collect or report on any of the OSD elements. The purpose of this form is to make available, annually, other State data required by the Title V legislation. Required data elements on this form will be provided by the Maternal and Child Health Bureau (MCHB) in TVIS, as available, for the States. States should review and monitor the annual data.

The racial and ethnic population categories included in these tables are based on the Office of Management and Budget guidelines. More specific instructions are provided below.

TVIS will provide the year for which the data are being reported.

FORM NUMBER	INSTRUCTIONS
OSD #01:	In the column labeled "STATE RATE," the rate for the State is provided in TVIS in the category specified. In the next seven columns the rate of the State in the racial/ethnic categories indicated at the head of each column and in the categories specified is provided in TVIS. Since these data are reported by rates, these data are not totaled.
OSD #02	Data are provided in TVIS for the rate of infant mortality, low birth weight, and preterm birth by each county in the State. In the first column of the first row, the name of the county is provided. In the second cell of the first row, the rate of infant mortality for that county is provided. In the third cell of the first row, the rate of low birth weight for that county is provided. In the fourth cell of the first row, the rate of preterm birth is provided. In subsequent rows, the names of each county and the rates requested are provided. Depending on the size of the population being reported for each county, rates may use a three-year moving average. Since these data are reported by rates, these data are not totaled.
OSD #03	Data are provided in TVIS for the numbers of MCH workforce professionals noted that are licensed in the State in the reporting year identified. In the second cell of the first row, the ratio of obstetricians per 100,000 population is provided. In the second cell of the each remaining rows, the ratio of family practitioners, certified family nurse practitioners, certified nurse midwives, pediatricians, and certified pediatric nurse practitioners per 100,000 population are provided, as noted.
OSD #04	Data are provided in TVIS for the prevalence of children, ages 0 through 17, with special health care needs (CSHCN), children, ages 3 through 17, diagnosed with an autism spectrum disorder, and children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD). Data are weighted frequencies derived from a population-based household survey. In the first cell, the prevalence of children with a special health care need is provided. In the second cell, the prevalence of children, ages 3 through 17, diagnosed with an autism spectrum disorder is provider, and in the third cell, the prevalence of children, ages 3 through 17, diagnosed with ADD/ADHD is provided.

FORM 12 - MCH DATA ACCESS, LINKAGES, PRODUCTS, AND PUBLICATIONS

PART 1: MCH DATA ACCESS AND LINKAGES

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Select from the Pulldown Menu • Yes • No	Select from the Pulldown Menu • Yes • No	Select from the Pulldown Menu • Daily • More often than monthly • Monthly • Quarterly • Semi-Annually • Annually • Less Often than Annually • Never	Manually Enter an Integer Between 0-60 or Never	Select from the Pulldown Menu • Yes • No	Optional: Manually Enter Another Linked Data Source Data Source
2) Vital Records Death						
3) Medicaid						
4) WIC						
5) Newborn Bloodspot Screening						
6) Newborn Hearing Screening						
7) Hospital Discharge						
8) PRAMS or PRAMS-like						
9) Other Data Source (Optional) • **User may add additional rows as needed**	Optional: Manually Enter Another Data Source Data Source					

PART 2: PRODUCTS AND PUBLICATIONS (OPTIONAL)

Description of Product/Publication:

Type of Product: _____

Title: _____

Author(s)/Organization(s): _____

Year: _____

Describe product, publication, or submission: _____

Target Audience:

Consumers/Families _____
Public Health Professionals _____
Health Care Providers _____
Policymakers _____
MCH Students _____
Public payer (Medicaid) _____
Private payer _____

To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

INSTRUCTIONS FOR COMPLETION OF FORM 12, PART 1 and 2
MCH DATA ACCESS AND LINKAGES

Instructions Part 1: Part 1 of this form provides information on the State Title V Program's capacity for consistently accessing electronic health data to support planning, monitoring, and evaluation on a timely basis. Please complete all data cells for the reporting year. All cells, except as noted in the instructions below, are required fields for completion of this form. A form note can be added for the form, and a field note can be added for each row in TVIS.

ITEM	FIELD NAME	INSTRUCTIONS
Column A	**State Title V Program has Consistent Annual Access to Data Source (Column A, Rows 1-9)**	➢ **Item Response Choices:** • YES/NO ➢ **Definition: Column A, Rows 1-9; Consistent Annual Access** • **Must be:** - Received or accessed at least once every year • **May be:** -Paper or electronic/digital -Pre-tabulated or aggregated data -Individual-level or raw data -Provisional or final data
Column B	**State Title V Program has Access to an Electronic Data Source (Column B, Rows 1-9)**	➢ **Item Response Choices:** • YES/NO ➢ **Definition: Column B, Rows 1-9; Access to an Electronic Data Source:** • **Must be:** -Data source contains individual-level or raw data in digital format -Data must be manipulable/analyzable with statistical software • **May be:** -Publicly available, private or protected, internal or external to the MCH program -Accessible via CD-ROM, flash drives, external hard drives, disks, other portable media, ftp or File Transfer Protocol, Internet or Intranet, web portal, host computer or server in a network or client-server architecture -Provisional or final data
Column C	**Describe Periodicity (Column C, Rows 1-9)**	➢ **Item Response Choices:** • Daily • More often than monthly • Monthly • Quarterly • Semi-Annually • Annually • Less Often than Annually • Never

ITEM	FIELD NAME	INSTRUCTIONS
Column D	**Indicate Lag Length for Most Timely Data Available in Number of Months (Column D, Rows 1-9)**	➢ **Item Response Choices:** • Enter an integer between 0-60 (number of months); or NA if Column C is "Never." ➢ **Definition: Column D, Rows 1-9; Lag Length** • **Must be:** -The amount of time in months between the end of the official data collection period to the time the data is received or accessed (e.g., quarterly or annual data for births ending on December 31st that are received on March 20th would be a lag of 3 months with rounding) -If provisional data can be accessed before the end of the official data collection period, lag is 0 months • **May be:** -Provisional or final data in any of the above formats
Column E	**Data Source Is Linked to Vital Records Birth (Column E, Rows 1-9)**	➢ **Item Response Choices:** • YES/NO ➢ **Explanation: Column E, Rows 1-9; Data Linkage** • Indicate if the data source (Rows 1-9) is linked to Vital Records Birth
Column F	**Data Source is Linked to Another Data Source (Optional Field)**	➢ **Item Response Choices:** • Indicate the name of the data source to which this data source is linked ➢ **Explanation: Column F, Rows 1-9; Data Linkage** • Indicate if the data source (Rows 1-9) is linked to another data source, other than Vital Records Birth
Row 9	**Other Data Source (Optional Field)**	➢ **Item Response Choices:** • Insert the name of the other data source, and complete the columns using the instructions provided above

Instructions Part 2: This section of Form 12 is optional. This section gives states the opportunity to share a list of products or publications addressing maternal and child health that have been published or produced with Title V Block Grant or SSDI grant support (either fully or partially) during the reporting year. Type of products may include peer-reviewed publications in scholarly journals; submission(s) of peer-reviewed publications to scholarly journals; books; book chapters; reports and monographs (including policy briefs and best practices reports); conference presentations and posters; digital or web-based products (blogs, podcasts, web-based video clips, wikis, social networking sites); press communications (TV/radio interviews, newspaper interviews, public service announcements, and editorial articles); newsletters (electronic or print); pamphlets, brochures, or fact sheets; training; doctoral dissertations/master's theses; dashboards; or other products.

PART FOUR: APPENDICES

Appendix 1: Reporting Definitions for the Forms

Forms 2 and 3 – Budget and Expenditures

Administrative Title V Funds - The amount of funds the state uses for the management of the Title V allocation. This amount is limited by statute to 10 percent of the Federal Title V allotment.

Capacity – Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the state need to achieve the results we want?"

Budget Period – Period of time for which funds are available for use by the state. For the MCH Block Grant, the budget period is 24 months, beginning on October 1 of the federal fiscal year in which the funds are awarded and ending on September 30 of the following federal fiscal year.

Children – A child from age one (1) through 21 years.

Federal Allocation – The funding provided to the states under the Federal Title V Block Grant in any given fiscal year; applies specifically to the Application Face Sheet (SF-424) and Form 2.

Federal Fiscal Year: The federal government's fiscal year begins on October 1 and ends on September 30 of the following year.

Infants – Children in their first year of life (<365 days).

Local – Funds derived from local health jurisdictions within the state, which are used for MCH program activities and reported on the Application Face Sheet (SF 424) and Form 2.

Maintenance of Effort – State will maintain the level of funds being provided solely by such state for maternal and child health programs at a level at least equal to the level provided in fiscal year 1989.

Others (Class of Individuals) – Women and men, over age 21.

Other Federal Funds – Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program and reported on the Application Face Sheet (SF 424) and Form 2. These funds may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC, MCH Education funds and Medicaid Federal Medical Assistance Percentage (FMAP).

Other Funds – Funds available from other private sources such as foundations, which are used for MCH program activities and reported on the Application Face Sheet (SF 424) and on Form 2, line 5.

Pregnant Woman – A person from the time of conception to 60 days after birth, delivery, or expulsion of fetus.

Program Income – Funds collected by State MCH agencies from sources generated by the State's MCH

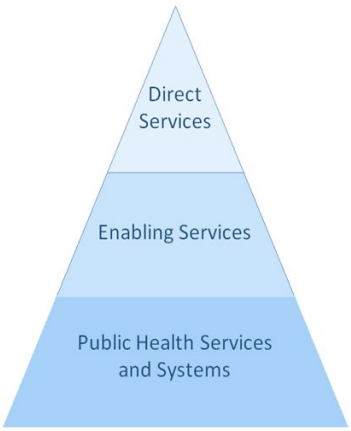
program to include insurance payments, Medicaid reimbursements, HMO payments, etc., as reported on the Application Face Sheet [SF 424] and Form 2.

State Funds – Non-federal funds derived from the state, as reported on the Application Face Sheet [SF 424] and Form 2, which are used for program activities and to meet the legislatively mandated match requirements (including overmatch, if applicable) for expenditure of the federal Title V MCH Block Grant allocation and the 1989 Maintenance of Effort, in any given year.

Total Federal-State Title V MCH Block Grant Partnership Funding – The total of the Federal Title V MCH Block Grant funds plus the state match. Included in this sum total are: 1) the *Federal* Title V Block grant allocation; 2) the *State's* dedicated funds towards meeting the required match for the federal Title V allocation (match and overmatch); 3) the *Local* funds, which are the total amount of MCH dedicated funds from local government within the state; 4) *Other* funds (funds available from other private sources such as foundations, which are used for MCH program activities and reported on the Application Face Sheet (SF 424) and on Form 2, line 5); and 5) *Program Income* (funds collected by State MCH agencies from insurance payments, Medicaid, HMO's, etc.). This total is reported on Form 2, line 8.

Total MCH Funding – All of the MCH funds administered by a State MCH program. Included in this sum total are the total of the Federal Title V MCH Block Grant funds plus the state match (as reported on Form 2, line 8), and *Other Federal* funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program and reported on Form 2, Lines 9 and 10). This total MCH funding is reported on Form 2, Line 11.

MCH Working Framework: MCH Pyramid of Services



Definitions are provided below for each level of service. In developing systems of care, states should assure that they are family- centered, community-based and culturally competent.

Direct Services – Direct services are preventive, primary, or specialty clinical services to pregnant women, infants and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. State reporting on direct services should not include the costs of clinical services which are delivered with Title V dollars but reimbursed by Medicaid, CHIP or other public or private payers. Examples include, but are not limited to, preventive, primary or specialty care visits, emergency department visits, inpatient services, outpatient and inpatient mental and behavioral health services, bereavement care, prescription drugs, occupational and physical therapy, speech therapy, durable medical equipment and medical supplies, medical foods, dental care, and vision care.

Enabling Services – Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Services Block Grant funds are used to finance these services. Enabling services include, but are not limited to: case management, care coordination, referrals, translation/interpretation, transportation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and outreach. State reporting on enabling services should not include the costs for enabling services that are reimbursed by Medicaid, CHIP, or other public and private payers. This category may include salary and operational support to a clinic that enable individuals to access health care or improve health outcomes. Examples include the salary of a public health nurse who provides prenatal care in a local clinic or compensation provided to a specialist pediatrician who provides services for children with special health care needs. In both cases the direct services might still be billed to Medicaid or other insurance, but providing for the availability of the provider enables individuals to access the services.

Public Health Services and Systems – Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns for services such as newborn screening, immunization, injury prevention, safe-sleep education, and anti-smoking.
State reporting on public health services and systems should not include costs for direct clinical preventive services, such as immunization, newborn screening tests, or smoking cessation.

Form 5 – Number of Individuals and Percentage of Populations Served by Title V

Form 5a, *Count of Individuals Served by Title V*, enables the state to track and report on the number of who received an individually-delivered service funded in part or in full by the Title V program within the top two levels of the MCH Pyramid (direct and enabling services). This includes individuals receiving services funded by total Federal and State dollars reported on line 8 of Form 2 and should align with the combined totals on Form 3a and 3b for direct and enabling services. Data sources are typically reimbursement or individual client records.
Pregnant women may also receive non-pregnancy related services and be counted in other participant categories (i.e., children ages one (1) through 21 and others). All remaining categories are mutually exclusive with CSHCN reported as a subset of all infants and children ages zero (0) through 21. Within each reporting category, the count of individuals served should be unduplicated to the fullest extent possible. Examples of direct and enabling services by participant category that Title V may fund in part or in full are provided below.

Pregnant women (through 60 days postpartum) – payment for prenatal, delivery, or postpartum care, case management, insurance eligibility assistance, hotline calls.

Infants (less than age one) – payment for well child visits, immunization, case management.

Children ages one (1) through 21– payment for well child visits, immunization, dental sealants, school-based health center services.

Children with special health care needs (ages 0 through 21) – specialty care services, care coordination.

Others (women and men over 21) – payment for well-woman visits, education or family- centered care provided to parents/guardians of children.

Form 5b, *Total Percentage of Populations Served by Title V*, enables the state to track and report on the total percentage who received a Title V-supported service within all levels of the MCH Pyramid (direct services, enabling services, and public health services and systems). The purpose of this form is to better capture the breadth of the State's Title V program and its reach in serving the MCH population. Included in this reporting are all individuals and populations served by the total Federal and State dollars, as reported on line 8 of Form 2, and the combined totals on Form 3a and 3b for all service levels. Non-Title V programs that provide direct and enabling services (e.g., WIC and Home Visiting) may be included if Title V funds or staff time are used to promote or enhance services. (Individual services that are Title V-funded may also be counted in Form 5a.) To avoid duplication, numerators for the percentage estimate should focus on the programs and services that have the largest reach for a given

population, which generally involves the public health services and systems level of the MCH Pyramid. Approximate denominators for each population group will be provided to facilitate percentage estimation. Within public health services and systems, only those reached by activities directly connected to promoting the access or quality of specific population-based services and systems should be counted, thus public health services such as needs assessment, surveillance, mortality review, and other data collection would be excluded. Examples of these public health services and systems activities, as well as direct/enabling service partnerships, are provided below by participant category.

Pregnant women (through 60 days postpartum)

- Develop and/or maintain a system of risk-appropriate perinatal care designations and transfer protocols (count 100%).
- Fund local health departments to engage provider groups and promote screening for perinatal depression, smoking or substance use (count number or percent of births in funded counties).
- Partner with Medicaid or other health plans to implement a policy/procedural change to reduce low- risk cesarean delivery or promote smoking cessation (count number or % served by Medicaid or other health plans).
- Outreach to hospitals to institute a safe sleep or baby friendly policy, distribute educational materials, or participate in a QI collaborative (count number or % of births in participating hospitals).
- Partner with WIC or home visiting programs to provide staff training or otherwise promote education, screening, or referrals on smoking cessation or preventive dental services (count number or % of pregnant/postpartum women served).
- Engage in a health promotion campaign that addresses areas, such as stillbirth prevention or postpartum depression.

Infants (less than age one)

- Administer, develop guidelines/standards/policies, or otherwise assure the newborn screening program (count 100%).
- Develop and/or maintain a system of risk-appropriate perinatal care designations and transfer protocols (count 100%).
- Outreach to hospitals to institute a safe sleep or baby friendly policy, distribute educational materials, or participate in a QI collaborative (count number or % of infants served).
- Partner with WIC or home visiting programs to provide staff training or otherwise promote education/counseling on safe sleep practices (count number or % of pregnant/postpartum women served).
- Implement a statewide campaign to promote safe sleep practices (count number of Web hits).

Children ages one (1) through 21

- Develop and maintain a statewide registry for developmental screening and follow-up (count number of children age one (1) through 5).
- Develop or promote school-based injury prevention, oral health, or physical activity programs (count number of children in participating schools).
- Partner with Medicaid, health plans, pediatric practices, or schools to implement a policy/procedural change, QI collaborative, or other campaign to promote the adolescent well

visit (count number of adolescents enrolled or served by plan/practice/school).
- Fund local health departments to promote and advance the medical home model among all pediatric providers (count number of children in local counties).

Children with special health care needs ages 0 through 21

Population-based approaches for the broader child population with CSHCN as a subset:

- See examples above and use the same percentage estimated for all children, assuming that CSHCN are served at the same rate since they are not excluded. CSHCN specific data can be used, if available, but it may underestimate reach if the definition does not match the MCHB definition of CSHCN used as a denominator.
- Train non-licensed health professionals, including CSHCN parent consultants, to address the social determinants of health (count estimated annual case-loads of those trained or % of professionals trained as a proxy for % of children potentially reached).

Population-based approaches for CSHCN specifically:

- Partner with state managed care organization to assess CSHCN quality of life measures for QI efforts (count number or % of CSHCN served by state managed care organization)
- Implement a pediatric sub-specialty telemedicine program to ensure access for rural CSHCN (count rural or all CSHCN if system is designed for overall access)

Population-based approaches for a subset of CSHCN:

- Partner with Medicaid to implement a Hispanic-focused care coordination program (count Hispanic CSHCN covered by Medicaid)
- Implement a QI project to promote transition to adult health care for medically complex CSHCN (count medically complex youth with special health care needs)

Others (women and men over age 21)

- Implement a statewide campaign to promote the well-woman visit (count number of web hits)
- Partner with WIC or Home Visiting to improve screening/counseling for smoking cessation (count number of women with a child age one (1) or more to avoid duplication with pregnant women)
- Partner to promote family engagement services (count number of parents over 21 served)

Form 6 – Deliveries and Infants Served by Title V and Eligible for Medicaid

- Title V of the Social Security Act – The authorizing legislation for the Maternal and Child Health Services Block Grant to States Program.

- Title V Reporting Form 6, Deliveries to Pregnant Women Served by Title V – Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

- Title V Reporting Form 6, Infants Served by Title V – The unduplicated count of infants provided services by the State's Title V program during the reporting period.

- Title XIX of the Social Security Act – The authorizing legislation for the Medicaid program.

- Title XIX Reporting on Form 6, Pregnant Women Eligible for Title XIX – The number of pregnant women who delivered during the reporting period and were eligible for the State's Title XIX (Medicaid) program.

- Title XIX Reporting on Form 6, Infants Eligible for Title XIX – The number of infants eligible for the State's Title XIX (Medicaid) program.

Form 10 – Performance Measurement

Evidence-based or –Informed Strategy Measure (ESM) –Developed by the state, ESMs assess the outputs of State Title V strategies and activities contained in the State Action Plan. The development of ESMs is guided through an examination of evidenced-based or evidence- informed strategies, and determining what components are meaningful, measurable, and achievable. The main criteria for ESMs are in being meaningfully related to the NPM through scientific evidence or theory and being measurable by the state with improvement achievable in multiple years of the five-year reporting cycle.

Evidence-based or –Informed Strategy Measure (ESM) Objectives – The objectives for activities and interventions that drive the achievement of higher-level objectives by the State Title V program.

Objectives – The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also Performance Objectives)

Outcome Measure – The ultimate focus and desired result of any set of public health program activities and interventions is an improved health and well-being outcome. Health and well- being outcomes are usually longer term and tied to the ultimate program goal. Morbidity and mortality statistics are indicators of achievement of health outcomes. For the Title V performance framework, other outcomes reflect commonly accepted indicators of a highly functioning system of care for children with special health care needs and their families, positive outcomes, outcomes which are legislatively mandated or are a legislative focus, and outcomes where the prevalence is increased.

Performance Indicator – The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure – An intermediate outcome on the path toward a longer-term outcome measure of health and well-being that is used to more directly assess the impact of a program. Positive health behaviors and access to quality health care are common intermediate outcomes that may lead to health, reduced morbidity and mortality, or highly functioning systems of care. For example, to reduce infant mortality, State Title V programs may work to promote safe sleep practices or access to quality well-woman care. The performance measure is phrased as a quantitative indicator, such as a rate or percentage. For example, "Percentage of infants placed to sleep on their backs."

Performance Measurement – The collection of data on, recording of, or tabulation of results or achievements, usually for comparison to a benchmark.

Performance Objectives – A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and the target populations. For example: "Increase the percentage of infants placed to sleep on their backs in State X by 10% over the next 5

years."

Risk Factors – Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving desired health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the state address this risk factor (i.e., what health outcome will this result support)?"

Risk Factor Objectives – Objectives that describe an improvement in risk factors (usually behavioral or physiological) that are associated with morbidity and mortality.

Targets – An aspired outcome that is explicitly stated, e.g., "Attain 90% of timeliness in reporting" or "Achieve 100% completeness of reporting," etc. In this Guidance, "Targets" is often used interchangeably with "Objectives."

Appendix 2: Assurances and Certifications

View Burden Statement

OMB Number: 4040-0007
Expiration Date: 02/28/2025

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

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