HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

NEW JERSEY

State Snapshot

FY2026 Application / FY2024 Annual Report

December 2025

Title V Federal-State Partnership - New Jersey

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY2026 Application / FY2024 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

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State Youth Leader
No Contact Information Provided

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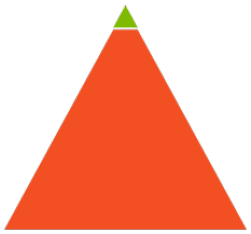
Funding by Source

Source	FY 2024 Expenditures
Federal Allocation	$11,321,093
State MCH Funds	$179,176,495
Local MCH Funds	$0
Other Funds	$0
Program Income	$0

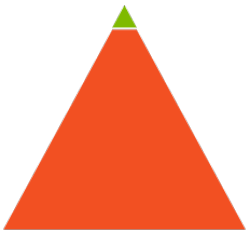
Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$0	$0
Enabling Services	$1,120,788	$17,738,473
Public Health Services and Systems	$10,200,305	$161,438,022

FY 2024 Expenditures Federal



FY 2024 Expenditures Non-Federal



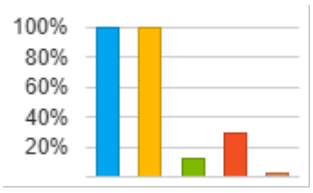
Percentage Served by Title V

Population Served	Percentage Served	FY 2024 Expenditures
Pregnant Women	100.0%	$39,365,052
Infants < 1 Year	100.0%	$1,617,257
Children 1 through 21 Years	11.6%	$19,776,326
CSHCN (Subset of all infants and children)	29.1%	$128,936,398
Others *	2.0%	$0

*Others– Women and men, over age 21.

FY 2024 Expenditures
Total: $189,695,033

FY 2024 Percentage Served



The Title V legislation directs States to conduct a comprehensive, statewide maternal and child Health (MCH) needs assessment every five years. Based on the findings of the needs assessment, states select seven to ten priority needs for programmatic focus over the five-year reporting cycle. The State Priorities and Associated Measures Table below lists the national and state measures the state chose in addressing its identified priorities for the 2025 Needs Assessment reporting cycle. All states are also reporting on two Universal National Performance Measures, Postpartum Visit and Medical Home.

State Priorities and Associated Measures

Priority Needs and Associated Measures	Priority Need Type	Reporting Domain(s)

Increase Healthy Births and Bridge Gaps in Birth Outcomes
 	
NPMs
• 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 - PPV
  ○ ESM PPV.1: Number of women enrolled in the Healthy Women, Healthy Families (HWHF) initiative that attended a postpartum visit.
• Percent of women who were screened for depression or anxiety following a recent live birth - MHS
  ○ ESM MHS.1: Number of women screened for postpartum depression through the New Jersey Postpartum Resource and Support Network (NJPRSN) Program.
• Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care - DSR
  ○ ESM DSR.1: Preventive medical visit
 	
SPMs
• SPM 2: Percentage of Black non-Hispanic preterm births in NJ
• SPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
  ○ SPM ESM 1.1: First trimester prenatal care rate
	New	Women/Maternal Health, Perinatal/Infant Health

Reduce Maternal and Infant Mortality and Expand & Strengthen Evidence Based Programs Addressing Mortality NPMs • 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 during sleep - SS ○ ESM SS.1: Complete Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding)	Revised	Perinatal/Infant Health

○ ESM SS.2: Rate of black infant mortality in NJ per 1,000 live births. ○ ESM SS.3: Number of trained doulas enrolled as NJ FamilyCare (Medicaid) providers.		
Reduce Differential Outcomes in Maternal Healthcare for Specific Populations NPMs ● 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 - PPV ○ ESM PPV.1: Number of women enrolled in the Healthy Women, Healthy Families (HWHF) initiative that attended a postpartum visit. ● Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care - DSR ○ ESM DSR.1: Preventive medical visit SPMs ● SPM 7: Rate of black infant mortality in NJ per 1,000 live births.	Revised	Women/Maternal Health, Perinatal/Infant Health
Improve Nutrition, Food Security & Increase Physical Activity NPMs ● Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS ○ ESM FS.1: Percent of children (<18 y/o) in food sufficient households SPMs ● SPM 10: Food sufficient households	Revised	Child Health
Improve Exclusive Breastfeeding Rates for the first six months after birth NPMs ● A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF ○ ESM BF.1: Percentage of Births in Baby Friendly Hospitals ○ ESM BF.2: Number of Individuals Trained to Become Community Doula and NJ FamilyCare (Medicaid) Providers	New	Perinatal/Infant Health

○ ESM BF.3: Percent of children in food-sufficient households.		
Promote Healthy Youth Development from Childhood Through Adolescence & Young Adulthood (AYA) NPMs • Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS ○ ESM DS.1: Parent-completed early childhood developmental screening using an ASQ screening tool. • Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child ○ ESM PDV-Child.1: Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416) • 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 - ADM ○ ESM ADM.1: The number of youth (ages 10-24) in CAHP sponsored programs who report having a non-parent/guardian mentor that they can talk to (Baseline to be collected in 2025) • Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH ○ ESM MH.1: Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC). • Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY ○ ESM BLY.1: Percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media). ○ ESM BLY.2: Reduce the percentage of high school students who are bullied on school property. ○ ESM BLY.3: Number of students (male and female) who completed at least 75% of an evidence-based Teen Pregnancy Prevention Model (Teen Outreach Program, Reducing the Risk or Teen PEP) SPMs • SPM 6: Percentage of students completing the TOP program, Reducing the Risk, Teen PEP and Lifelines per year. • SPM 9: Percent of children, ages 9 through 35 months, who received a developmental screening	Revised	Child Health, Adolescent Health, Cross-Cutting/Systems Building

using a parent-completed screening tool in the past year • SPM 11: Preventive Dental Visit		
Promote Healthy Youth Development & Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs) NPMs • 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 - ADM o ESM ADM.1: The number of youth (ages 10-24) in CAHP sponsored programs who report having a non-parent/guardian mentor that they can talk to (Baseline to be collected in 2025) SPMs • SPM 8: Rate of live births to adolescents (aged 10-19) in NJ per 1,000 females (aged 10-19).	Revised	Adolescent Health
Improve Access to Quality Care for CSHCN NPMs • 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 - TAHC o ESM TAHC.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service • Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY o ESM BLY.1: Percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media). o ESM BLY.2: Reduce the percentage of high school students who are bullied on school property. o ESM BLY.3: Number of students (male and female) who completed at least 75% of an evidence-based Teen Pregnancy Prevention Model (Teen Outreach Program, Reducing the Risk or Teen PEP) SPMs • SPM 3: Percentage of NJ resident newborns discharged from NJ hospitals who did not pass their newborn hearing screening and have a documented outpatient audiological follow-up visit. • SPM 4: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS)	Continued	Children with Special Health Care Needs

who have been referred to NJ's Special Child Health Services Case Management who are receiving services.		
Promote Healthy Youth Development for CSHCN over the course of Childhood, Adolescence and Young Adulthood NPMs • Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH o ESM MH.1: Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC). SPMs • SPM 5: Average age (in years) of initial diagnosis for children with an ASD	Revised	Children with Special Health Care Needs

Executive Summary

Program Overview

The Title V Program (TVP) in New Jersey (NJ) funds important initiatives which reach almost every resident in the state. The Title V funding for these programs, aimed at mothers, children and their families, endeavor to reduce infant deaths, provide better access to quality care services, deliver family-centered, community-based coordinated care for children and youth with special healthcare needs (CSHCN), and increase family access to NJ FamilyCare (State Medicaid). Working closely with community-based organizations, licensed implementing agencies and state partners, our TVP responds to the needs of pregnant and parenting women and their families by funding, creating, implementing and evaluating programs that get to the root causes of the health care and access issues that many NJ residents face.

Title V Block Grant Needs Assessment: Framework
The Title V Maternal and Child Health Block Grant Needs Assessment (T5NA) was a systematic process to collect information about the State's public health system. The information collected during the needs assessment process has been used to guide future efforts to address the varied needs of pregnant women, mothers, infants, children, adolescents, and CSHCN.

The goal of the statewide needs assessment was to improve MCH outcomes and to strengthen partnerships for ensuring the effective implementation of strategies designed to address the needs of the MCH population. The needs assessment was influenced by the theoretical framework of the Socio-Ecological Model (SEM). There is a complex interplay between a person and the environment in which they live, and that health and education outcomes are correlated with the impact of these complex systems on an individual and community. The SEM is a conceptual model-turned theoretical model as it illustrates the various and complicated aspects of context which impact a person's well-being, and, ultimately, their health outcomes.

The below stages highlight the timeline of activities facilitated during the needs assessment process in NJ (January 2024 – June 2025).

Title V Block Grant: Needs Assessment Planning
Phase I: Idea Generation--- Workgroup/Steering Committee led

A. Review data related to 2023 priorities and performance measures
B. Conduct SWOT analysis to assess current situation related to priorities
C. Attend stakeholder meeting, conduct key informant interviews and focus groups
    a. Stakeholder meetings with groups who were already addressing MCH population issues
        i. Ask about current priorities for stakeholder's group of focus
        ii. How they anticipate priorities changing over the next five years
        iii. Suggestions for improving services
        iv. Emerging issues for their populations

Phase II: Review, Evaluate and Narrow Points

A. Review
B. Evaluate
    a. Magnitude/Severity/Trend/Feasibility/Degree of gaps/Opportunities
C. Community Evaluator Model
    a. People with lived experience
    b. Trained and hired as community evaluators
D. Title V Public Input Survey

Phase III: Action Planning

A. State Action Plans Review
B. Select meaningful performance measures to monitor progress on each priority
C. Develop Objectives
D. Identify key strategies for the five-year state action plans
    a. Specific focus on implications and unintended consequences of each action plan

Needs Assessment Findings

The needs assessment is regularly conducted in concert with the NJDOH's strategic plan, the State's Health Improvement Plan, and Healthy NJ 2030, which augments the collaborative process with other MCH partners and helps to inform all the activities implemented throughout the state. One of the needs assessment processes working in tandem is that of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. The MIECHV Needs Assessment is a process used to identify and document communities with a high concentration of at-risk families, particularly those facing challenges related to MCH. This assessment helps guide the allocation of resources and ensures that home visiting services are targeted to areas with the greatest need. It also

supports the development of strategies to enhance the quality and reach of early childhood home visiting programs.

While some of the T5NA findings revealed new needs of the population since the last needs assessment process, many of the responses from both professional stakeholders and service recipients included expressed desires for an enhanced focus on breastfeeding endeavors, perinatal care and postpartum follow-up connection to care, the promotion of healthy youth development with a more precise focus on teen pregnancy and sexually transmitted infections (STIs) as well as improving overall nutrition by considering food security as an important variable.

The T5NA findings corroborated our current understanding of the ongoing needs of certain populations. Within the population of CSHCN, “coordination of care” and “transition to adult services” are themes that were iterated numerous times during the process. Additionally, for maternal and women’s health, “increased accessibility” and “communication support”, including interpretation services, were revealed as areas for consideration. In the perinatal health domain, "breastfeeding education and resources” and “workplace flexibility” were mentioned as necessities, while the needs of children and adolescents in the state iterate the need for “timely developmental screening”, “opportunities for physical education” and “connection to appropriate and timely care.”

While the specific data gathered for each individual health domain spoke to population-level needs and voids within the state, multiple themes emerged that transcend population health domain. These themes include “transportation and mobility help”, “linguistic accessibility of providers”, “better mental health services” and the “streamlining and simplifying of application processes.” These overarching primary themes are considered priority areas for our TVP and are examined in tandem with the ongoing efforts to address the state priority areas that will remain the same.

TVP Role

The Division of Family Health Services (FHS) within NJDOH works to promote and protect the health of mothers, children, adolescents, and those with greater healthcare needs such CSHCN and their families. The MCH Block Grant (MCHBG) Application and Annual Report that FHS submits annually to the Maternal Child Health Bureau (MCHB) provides an overview of innovative initiatives, state-supported programs, and other state-based responses to the needs of pregnant and parenting women and their families. These initiatives and programs are strategically designed to address NJ's MCH needs.

MCH priorities continue to be a focus for the NJDOH. FHS, the TVP in NJ, has identified, 1) improving access to health services thru partnerships and collaboration, 2) reducing gaps in health outcomes across the lifespan, and 3) increasing knowledge of services, as three priority goals for the MCH population. These goals are consistent with the Life Course Perspective (LCP), which proposes that an interrelated web of social, economic, environmental, and physiological factors contribute, to varying degrees through the course of a person’s life and across generations, to good health and well-being. Community Health Factors (CHF) the conditions in which people live, learn, work, play, worship, and age significantly affect health, functioning, and quality of life.

To ensure access to enabling services and population-based preventive services, consistent with the findings of the Five-Year Needs Assessment, the goals and SPNs selected by FHS are built upon the work of prior MCH Block Grant Applications/Annual Reports and in alignment with NJDOH's and FHS' goals and objectives.

The NJ SPNs:

SPN 1- Increase Healthy Births and Bridge Gaps in Birth Outcomes
SPN 2 - Reduce Maternal and Infant Mortality and Expand & Strengthen Evidence-Based Programs Addressing Black Infant Mortality
SPN 3 - Reducing Differential Outcomes in Maternal Healthcare for Specific Populations
SPN 4 - Improving Nutrition, Food Security & Increase Physical Activity
SPN 5 - Improve Exclusive Breastfeeding Rates for the first Six Months after Birth
SPN 6 - Promoting Healthy Youth Development from Childhood Through Adolescence & Young Adulthood (AYA)
SPN 7 - Promoting Healthy Youth Development & Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs)
SPN 8 - Improving Access to Quality Care for CSHCN,
SPN 9 - Promoting Healthy Youth Development over the course of Childhood, Adolescence and Young Adulthood

NJ has selected the following National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

NPM 1-Postpartum Visit
NPM 3-Postpartum Mental Health Screening
NPM 5-Perinatal Care Discrimination
NPM 8-Breastfeeding
NPM 9-Safe Sleep
NPM 11- Medical Home for CSHCN & Child Health
NPM 13-Developmental Screening
NPM 14-Preventive Dental Visit
NPM 19-Transition to Adult Healthcare
NPM 20-Bullying
NPM 21-Adult Mentor
NPM 22- Food Sufficiency

State Performance Measures (SPMs) have been reassessed through the needs assessment process. The existing SPMs which will be continued are:

SPM 2 Black Non-Hispanic Preterm Infants in NJ,
SPM 3 Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening, and who have outpatient audiological follow-up documented.
SPM 4- Referral from Birth Defects and Autism Registry System (BDARS) to Case Management Unit,
SPM 5- Age of Initial Autism Diagnosis,
SPM 6- Teen Outreach Program (TOP), Get Real, Love Notes, Teen Prevention Education Program (PEP) and Lifelines completion
SPM 7- Black, NH Infant Mortality in NJ.
SPM 8 – Rate of live births to adolescents (ages 10-19 y/o) per 1,000 families in New Jersey
SPM 9 – Percent of children, ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool in the past year
SPM 10 – Food sufficient households
SPM 11 – Preventive dental visit

The Affordable Care Act (ACA) transformed the health insurance landscape in the United States, with coverage (2014) further extending essential benefits to categorical populations such as women, pregnant women, children, homeless individuals, undocumented residents, and CSHCN. However, health differences burden marginal populations the most as pervasive issues lead to worse health outcomes over time. Nationally, the persistence of these hardships proliferates as there remains a focus on the provision of sick care in place of creating and elevating a system that prioritizes complete wellness to mitigate the potential for disease manifestation. However, in NJ an orientation toward addressing the CHF have prompted greater emphasis on prevention efforts to endorse wellness. This is evidenced by NJ's commitment to expansion of Medicaid benefits for adults without disabled or pregnancy-status, and postpartum coverage for up to 365 days postpartum, beyond the federally mandated two months.

The expansion of Medicaid helps ensure continuous insurance coverage for low-income pregnant women. This type of comprehensive service coverage improves the health of those covered those impoverished, who tend to have higher rates of smoking, preeclampsia and diabetes, and lower rates of prenatal visits and breastfeeding initiation (Anstey et al., 2017; Ross et al., 2019). Speaking to the Medical Home NPM, the expansion of Medicaid to populations that existed in the space between "too resourced" to receive Medicaid support and yet "not resourced enough" to connect with medical care at the frequency clinically indicated, leads to morbidities over time that could have been avoided with insurance coverage.

Furthermore, charity care monies were able to be diverted into other fountains of care once Medicaid expansion occurred. One clear demonstration of the benefit of this diversion was in the arena of hemophilia grants, which paid for important interventions that moderated future emergency room visits and intensive care episodes. Those enrolled in Medicaid were able to get coverage and stay out of the hospital emergency room for ambulatory sensitive conditions, attending to their primary care appointments and getting treatment early and often.

Hearing from people with lived experience is paramount to achieving person-centered care programming and correlated positive health outcomes for families in NJ. For this reason, the TVP and state agencies that serve pregnant women, caregivers, children and CSHCN closely with grantees to center the voices of people with lived experience while programming is crafted and implemented. This occurs via focus group engagement, quarterly, biannual and annual feedback opportunities and regular parent meetings, hosted by our statewide parent advocacy partners, or SPAN. People with lived experience are also integrated into the MCH workforce through our community health worker program, providing opportunities for professionals with first-hand experience to offer their perspective on programmatic functionality and efficiency.

Evaluation efforts are being created and solidified for programs throughout the MCH Unit. Broad program evaluation efforts have been instituted and are collaborative in nature as NJDOH works closely with Rutgers University, The College of New Jersey and Johns Hopkins University to evaluate program implementation efforts and outcome measures utilizing standardized procedures and evidence-based evaluation metrics to ensure aims are met and modifications are made when necessary. On a mezzo level, evaluation and quality improvement efforts are growing to enhance communication and standardize follow-up on quantitative efforts on a monthly and quarterly basis.

One of the ongoing challenges in quality assurance and improvement efforts is the systematizing of efforts across the MCH Unit. Engaging in quality improvement initiatives takes time and person power. These efforts are becoming a more established part of the DOH as a newly created performance management unit.

The NJDOH established the Performance and Grant Management Unit (PMU) in August 2024 to enhance health outcomes through improved program evaluation, quality improvement, data integration, grant management and grant acquisition, and strategic alignment. Collaborating with department leaders, the PMU is developing mechanisms that fully captures and set performance standards, and align all programs, whether related to public health surveillance, grants, policy implementation, or other services, ensuring that they contribute to the Department's strategic goals and strengthens NJDOH's impact on public health.

How Federal Title V Funds Complement State-Supported MCH Efforts

Title V Funds are essential in supporting NJ's MCH efforts and complement existing contracts that the NJDOH maintains with public and private partners throughout the state, including local health systems, education and outreach programs. Moreover,

Title V bolsters the work of various divisions and helps to align efforts across funding sources. FHS uses Title V MCH funding as the primary source for multiple public health interventions for NJ's pregnant women and women of childbearing age. In the past few years, a greater emphasis has been on decreasing gaps in health outcomes across the varied populations in the state, and in healthcare service delivery in NJ. The TVP has worked cross-divisionally, cross-state agency and cross-public/private sector to find creative solutions to the issues that NJ residents face. Below are ways in which the Title V funds complement state-supported efforts:

NJ's TVP:

1) Serves as the main funding source used by the NJ TVP to support MCH populations in accordance with Title V and other federal and state guidelines to protect and promote the health and well-being of women, children, and families and children with special health care needs.
2) Supports NJ's state-priority MCH efforts throughout all 21 counties
3) Supports the infrastructure needed to sustain Special Child Health Services including but not limited to evaluation and treatment centers.
4) Supports specialized pediatric services across the state to ensure access to comprehensive, coordinated pediatric specialty and sub-specialty services.
5) Supports the Birth Defects and Autism Registries, NBS activities, and county-based free case management services to children birth through age 21 who have special health care needs. Supports Home Visiting with braided MIECHV funding
6) Supports school health programming and works compatibly with CDC funding to reach impoverished and underserved communities.
7) Supports the capacity for developing data-informed strategies to prevent maternal mortality and morbidity, and any gaps that exist.
8) NJ Fetal Infant Mortality Review (FIMR) - to fund grantees to conduct FIMR-related activities (e.g., Chart review, family interview); these activities that seek to identify ways to strengthen the systems of care and resources available to families to prevent future deaths.
9) School Health NJ- to fund grantees working with underserved school districts in NJ to create school nurse led school health teams and implement evidence based social-emotional learning programming aligned with the CDC Whole School, Whole Community, Whole Child framework.

Title V funds are used to support NJ's state-priority MCH efforts, including increasing healthy births, reducing BIM, improving nutrition and physical activity, promoting youth development, improving access to quality care for CSHCN, improving breastfeeding rates and reducing teen pregnancy and sexually transmitted infections, and reducing differences in service delivery. Therefore, Title V funds are necessary to improve the health of pregnant women and their families in NJ.

MCH Success Story

CHWs

CHW's are at the heart of public health. They bridge the gap between health care providers and the communities they serve. As trusted members within their neighborhoods, CHWs play a pivotal role in promoting health, preventing diseases, and fostering well-being. The Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI) empowers CHWs to become change-makers in public health. The CLGI launched its first bilingual Spanish cohort in the fall of 2024 in partnership with Union College of Union County. The cohort was facilitated without a textbook by Deryan Coba, MPH and supported by DOH staff Jocelyn Rodriguez who provided technical assistance and translation. On March 3rd the CLGI graduated 14 CHWs, now equipped to bridge the gap between healthcare providers and their communities. The next Spanish cohort will launch in April 2025.

HWHF (CHW)

Through the HWHF Program, our grantee, the Partnership of Maternal and Child Health of Northern NJ, reported that one of their Community Health Worker (CHW) sub-grantees, Women's Rising, provided support to a family with nine children (with one being a newborn), that was impacted by domestic violence (DV), living in a motel. This CHW assisted with linking the family to obtain financial assistance, a Section 8 voucher, and the family was able to reclaim their property. The CHW from Women Rising was also able to assist with necessary baby pantry items for the newborn. Women's Rising also connected a client to Northeast Legal Services for assistance with a bullying claim not being addressed in the child's school, which resulted in successfully getting the child transferred. Consequently, the school started taking other bullying cases seriously.

Maternal and Child Health Bureau (MCHB) Discretionary Investments - New Jersey

The largest funding component (approximately 85%) of the MCH Block Grant is awarded to state health agencies based on a legislative formula. The remaining two funding components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including children with special needs, and their families. In addition, MCHB supports a range of other discretionary grants to help ensure that quality health care is available to the MCH population nationwide.

Provided below is a link to a web page that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2024.

List of MCHB Discretionary Grants

Please note: If you would like to view a list of more recently awarded MCHB discretionary investments, please refer to the Find Grants page that displays all HRSA awarded grants where you may filter by Maternal and Child Health.