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New York State Department of Health
Center for Community Health
Division of Family Health
Bureau of Maternal and Child Health

Request for Applications

Maternal and Infant Health Initiative

KEY DATES

RFA Release Date:	**October 17, 2012**
Registration for Applicant Call:	**October 25, 2012**
Written Questions Due:	**October 25, 2012**
Applicant Conference Call:	**October 29, 2012**
Letter of Intent to Apply:	**November 9, 2012**
Additional Written Questions Due:	**November 9, 2012**
Q&As Posted on or about:	**November 28, 2012**
Applications Due:	**December 18, 2012**
Projected Contract Start Date:	**July 1, 2013**

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I. Introduction

The New York State Department of Health (NYSDOH), Bureau of Maternal and Child Health (BMCH), announces the availability of funds to support community-based programs to improve maternal and infant health outcomes for high-need women and families in targeted communities. The overarching goal of the Maternal and Infant Health RFA is to improve maternal and infant health outcomes for high-need women and to reduce racial, ethnic and economic disparities in those outcomes. Funded programs will work to improve specific maternal and infant health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality rates through implementation of evidence-based and/or best practice strategies across the reproductive life course.

This Request for Applications (RFA) consists of two components, each requiring a separate application:

Component A: Maternal and Infant Community Health Collaboratives (MICHC) - $13.79 million will support 20 to 25 projects to support collaborative development, implementation and coordination of evidence-based and/or best practice strategies designed to achieve a set of performance standards that include:

- High-need women and infants are enrolled in health insurance;
- High-need women and infants are engaged in health care and other supportive services appropriate to their needs;
- The medical, behavioral and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up; and
- Within the community there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors.

The MICHC initiative integrates and replaces NYSDOH's current community-based perinatal health programs - including the **Comprehensive Prenatal - Perinatal Services Networks (CPPSN)**, the **Community Health Worker Program (CHWP)** and the **Healthy Mom - Health Baby Prenatal and Postpartum Home Visiting (HMHB)** initiative - to develop multi-dimensional community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes. Preference will be given to applicants serving the highest need Tier 1 counties described on page 12.

Component B: Maternal, Infant and Early Childhood Home Visiting (MIECHV) - $1.18 million will support 2 to 6 projects for expansion, enhancement and/or establishment of specific evidence-based home visiting programs that have been shown to positively impact maternal health, child health and child maltreatment outcomes, i.e. Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). This component serves to implement New York State's (NYS) MIECHV federal grant funding and approved MIECHV State Plan. Component B

grantees will be required to implement local home visiting programs with fidelity to the selected evidence-based model, and to coordinate with other community providers, including MIH Component A grantees, to assure that home visiting services are coordinated with, and embedded within, larger community maternal, infant and child health systems. Preference will be given to applicants serving the highest need Tier 1 counties described on page 12.

As a companion to this RFA, a Request for Proposals (RFP) is being issued to establish a new **Maternal and Infant Health Center of Excellence (MIH-COE)** that supports funded grantees for both Components A and B, including training of community health workers and coordination of specific data management and evaluation activities required as part of the federal MIECHV program.

In addition, it is anticipated that grantees funded through this RFA may be eligible to receive supplemental funding to support the use of health information technology (HIT) to coordinate the delivery of services among health care providers, health plans, and community-based organizations. The effective use of HIT to share information on health risks among health care and human services providers can significantly reduce poor health outcomes and impact life span consequences for women and infants. Based on recommendations from the Medicaid Redesign Team's Health Disparities Work Group, the enacted state budget for 2012-13 includes new funding to support initiatives to demonstrate effective and efficient use of HIT to improve coordination of care for maternal and child health. It is anticipated that funding will be awarded separately from this RFA as a targeted enhancement to Component A of the MIH initiative.

Background:

The goal of the MIH initiative is to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes. High-need women include those who are low-income or uninsured; racial, ethnic and linguistic minorities; women with multiple social or economic stressors; underserved immigrants; victims of domestic violence; individuals impacted by mental health issues, alcoholism and/or substance abuse; women with unintended or unwanted pregnancies; and women with disabilities. These women on average attend fewer prenatal visits and are more likely to experience poorer pregnancy outcomes. Their families are more likely to be without a medical home and are less likely to access consistent, comprehensive preventive and primary care services.[1] [2] [3] [4] [5] [6] [7] [8]

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[1] Perloff J and Jaffee K, Late Entry into Prenatal Care: The Neighborhood Context,Social Work (1999) 44 (2): 116-128. doi: 10.1093/sw/44.2.116)

[2] Kropp F et al, Increasing Prenatal Care and Healthy Behaviors in Pregnant Substance Users, J Psychoactive Drugs. 2010 March; 42(1): 73–81.

[3] Roberts SC, Pies C,Complex calculations: how drug use during pregnancy becomes a barrier to prenatal care. Matern Child Health 2011 Apr;15(3):333-41.

[4] Marcus SM,Depression during pregnancy: rates, risks and consequences--Motherisk Update 2008., Can J Clin Pharmacol. 2009 Winter;16(1):e15-22. Epub 2009 Jan 22.

Improving maternal and infant health is a key priority within the NYSDOH Prevention Agenda, Title V/Maternal Child Health Services Block Grant, and state Medicaid program. Of great concern, key population maternal and child health indicators - including use of early prenatal care, low birth weight, prematurity and maternal mortality - have not improved significantly over the last decade in NYS, and in some instances have actually worsened. Even in measures where trends are improving - such as reductions in adolescent pregnancy and birth rates and infant mortality - there are significant racial, ethnic and economic disparities. See **Attachments 1a and 1b, Birth Data by Zip Code.** Preterm birth, low birth weight, infant mortality and maternal mortality are among the most pressing maternal and child health problems nationally and in NYS.

The causes of adverse pregnancy outcomes, and effective strategies to improve those outcomes, are not completely understood. Perinatal health is a complex interrelationship of individual, family, community and societal factors, making it difficult to identify a single program or policy intervention that will improve outcomes. There is a solid knowledge base regarding the relationship between birth outcomes and specific individual behaviors (e.g., smoking, breastfeeding) and ecologic factors (e.g., certain clinical practices, poverty and other community level factors). In contrast, with a few notable exceptions (e.g., home visiting), there is little published literature highlighting specific evidence-based public health interventions that can be implemented to effectively change these individual behaviors or ecologic factors, and in turn improve health outcomes. Moreover, there is evidence that interventions during the prenatal period may be too late to have an impact on many adverse outcomes, and events or exposures that occur long before a woman becomes pregnant may play a more important role on the woman's later birth outcomes.[9] For additional information on the current scientific knowledge base in this area, see the bibliography in **Attachment 2**.

Specific key population health outcomes for the MIH initiative include:

Preterm Birth: Preterm birth is defined as any birth occurring before 37 weeks gestation. In NYS in 2010, 12.1% of all births were preterm.[10] The Healthy People 2020 national goal is to reduce the rate of preterm births to 11.4%,[11] and the NYSDOH has joined the National March of Dimes in calling for an 8% reduction in preterm births by 2014. There are persistent and

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[5] Chambliss LR, Intimate partner violence and its implication for pregnancy, Clin Obstet Gynecol. 2008 Jun;51(2):385-97.

[6] Maupin R et al, Characteristics of women who delivery with no prenatal care, J Matern Fetal Neonatal Med. 2004 Jul;16(1):45-50.)

[7] Phillippi J, Women's perceptions of access to prenatal care in the United States: a literature review, J Midwifery Womens Health. 2009 May-Jun;54(3):219-25.

[8] McConnell D, Mayes R and Llewellyn G, Women with Intellectual Disability at Risk of Adverse Pregnancy and Birth Outcomes, *J Intellectual Disability Res.* June 2008;52(Pt 6);529-35.

[9] Atrash, Hani et al. "Preconception Care for Improving Perinatal Outcomes: The Time to Act". Maternal and Child Health Journal. No 10. 2006. Pp S3-S11.

[10] New York State Vital Statistics, 2010 figures. New York State Dept of Health

[11] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26, accessed 25 March 2012.

dramatic racial disparities in preterm birth rates. The percentage of African-American women delivering at less than 37 weeks gestation was 15.8% in 2010, 58% higher than the 10.0% rate among white women. Preterm infants are vulnerable to many health and disabling complications including respiratory, gastrointestinal, immune system, central nervous system, hearing and vision problems, and often require care in a neonatal intensive care unit after birth.[12] Longer term problems may include cerebral palsy, mental retardation, visual and hearing impairments, behavior and social-emotional concerns, learning difficulties and poor health and growth.[13] Individuals who are born premature or at low birth weight are more likely to have significant health problems, including disabling impairments, in the future as compared to children who are born at full term at a normal weight. Unfortunately the causes of preterm birth are not fully understood, which makes it challenging to plan and implement interventions to address this issue. Risk factors for preterm birth include late or no prenatal care, smoking, alcohol use, drug use, domestic violence, lack of social support, stress, long working hours, exposure to environmental pollutants, infections, high blood pressure, diabetes, being underweight before pregnancy, obesity and short inter-pregnancy interval.[14] [15] The occurrence of a previous preterm birth is the greatest predictor of subsequent preterm birth.[16]

Low Birth Weight: Low birth weight is defined as an infant weighing less than 2,500 grams at birth. In NYS, 8.2% of babies are born at a low birth weight.[17] The Healthy People 2020 Objectives call for a reduction in low birth weight rates to 7.8%.[18] Additionally, in NYS 1.5% of babies are born at a very low birth weight (<1,500g).[19] The Healthy People 2020 Objective for very low birth weight is a reduction to 1.4%.[10] There are persistent and striking racial disparities in low birth weight rates. In 2010 the NYS rate for African-American infants was 12.5% while the rate for white infants was 7.0%.[20] Babies born at low birth weight can develop a variety of serious health problems as infants, often requiring stays in the neonatal intensive care unit.[21] Being a low birth weight baby often goes hand in hand with being born premature. The two main predictors for low birth weight are prematurity and intrauterine growth restriction.[22] Low birth weight babies due to prematurity tend to have additional health problems including disability impairments.

Infant Mortality: Infant mortality is used as a measure for the overall health of a country. As of

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[12] Institute of Medicine, 2006.
[13] Institute of Medicine, Preterm Birth: Causes, Consequences, and Prevention, 2006.
[14] Lang, Janet M. et al. "A Comparison of Risk Factors for Preterm Labor and Term Small-for-Gestational-Age Birth. Epidemiology. Vol. 7, No. 4, July 1996. Pp. 369-376.
[15] Centers for Disease Control. "Prematurity." Available online through www.cdc.gov
[16] Adams, Melissa M. et Al. "Rates of and Factors Associated with Recurrence of Preterm Delivery. Journal of the American Medical Association. March 22/29, 2000. Vol 283, No. 12. Pp 1591-1596
[17] New York State Vital Statistics, 2010.
[18] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26, accessed 25 March 2012.
[19] New York State Vital Statistics, 2010.
[20] New York State Vital Statistics, 2010.
[21] McCormick, Marie. "The Contribution of Low Birth Weight to Infant Mortality and Childhood Morbidity." New England Journal of Medicine. 1985. 312: pp82-90.
[22] Stevens, Lise et al. JAMA Patient Page: Low Birth Weight. Journal of the American Medical Association.

2008, the United States ranked 29th in the world for infant mortality.[23] Infant mortality is defined as death from the time of birth until the day of the infant's first birthday. In NYS in 2010, 1,227 infants died before age one, giving an infant mortality rate in NYS of 5.1 infant deaths per 1,000 live births.[24] The most frequent causes of infant death are congenital malformation, prematurity and low birth weight, and sudden infant death syndrome. Healthy People 2020 calls for a reduction in the infant mortality rate to 6.0 infant deaths per 1,000 live births.[25] While NYS has achieved this goal, there are persistent and striking racial disparities in infant mortality. The infant mortality rate among African-Americans was 10.2 per 1,000 births in 2010, compared to 3.8 per 1,000 births for white women.

Maternal Mortality: Maternal death is defined by the World Health Organization as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." In 2010, there were 56 maternal deaths in NYS for a rate of 23.1 per 100,000 live births. Significant disparities exist, with the rate per 100,000 live births for African Americans of 58.2, compared to 15 per 100,000 live births for white women. The racial disparity in maternal mortality in NYS is dramatic and exceeds the differences seen in infant mortality and low birth weight rates. Healthy People 2020 calls for a reduction in the maternal mortality rate to 11.4 maternal deaths per 100,000 live births. A review of 93 maternal death cases occurring from 2006-2008 in NYS and reported through the New York Patient Occurrence Reporting and Tracking System (NYPORTS) revealed the leading causes of death as: Hemorrhage (23%), Pregnancy-induced Hypertension (16%), Cardiac arrest (16%), and Embolism (15%). Cesarean deliveries, induced preterm births and obesity are known to increase the risk for medical complications during delivery. The association of underlying maternal health and chronic medical conditions with maternal mortality highlights the importance of addressing preconception and interconception health of high-risk women, as well as prenatal and intrapartum health and care.

Through the MIH RFA, the NYSDOH seeks to improve these key outcomes, reduce associated disparities and maximize the use of limited public health resources through a critical re-structuring of current community-based maternal and infant health public health programs. The NYSDOH endeavors to use these funds to drive and support innovation to ultimately build a practice base of evidence that is implemented and tested through continuous quality improvement. The NYSDOH is committed to targeting limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. To accomplish this, the MIH RFA incorporates the following key guiding models, principles and approaches within a comprehensive public health framework:

- A **performance management approach** to measuring, monitoring and improving health

[23] Centers for Disease Control and Prevention
[24] New York State Vital Statistics, 2010 figures. New York State Dept of Health
[25] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26, accessed 25 March 2012.

outcomes**.** Performance management is the practice of actively using performance data to improve the public's health.[26] The performance management framework centers on a clear and focused aim and the strategic use of performance standards to guide the development and implementation of specific improvement strategies. Applicants will be asked to show how chosen improvement strategies align with core set of performance standards and the needs of their community, and will work with DOH to develop relevant performance measures used to monitor the effectiveness of those strategies. It is expected that grantees will continuously monitor progress in improving defined short- and longer-term outcomes, and refining strategies to improve effectiveness.

- A **life course model** promotes optimal women's health throughout the reproductive lifespan. The life course model looks at health as an integrated continuum and suggests a complex interplay of multiple determinants, considering the impact of social, environmental, biological, behavioral and psychological factors on individuals throughout their lives. It builds on recent social science and public health literature that posits that each life stage influences the next and that social, economic and physical environments interacting across the life course impact individual and community health. A life course perspective recognizes that as many as half of all pregnancies are unintended, underscores the importance of promoting a woman's health regardless of her pregnancy plans, and expands the focus on improving pregnancy outcomes from prenatal care alone to include preconception and interconception care and wellness.[27]

- A **social ecological model** approach recognizes health as a function of individuals and the environments in which they live – including family, peer, neighborhood, work place, community and societal influences. A social ecological model identifies and addresses health determinants at multiple ecologic levels to strengthen individual knowledge and skills; enhance social networks and supports; change organizational practices; mobilize communities; and influence policy.[28]

Collaboration and Shared Deliverables: The MIH initiative is intended to function as a comprehensive initiative with two discrete but integrated components. While applications for **Components A-Maternal and Infant Community Health Collaboratives (MICHC)** and **B-Maternal, Infant and Early Childhood Home Visiting (MIECHV)** will be reviewed and scored separately, once funded it is an expectation that all funded grantees serving common target areas will actively collaborate to achieve the shared goals of the larger initiative, including: the coordination or integration of planning strategies (such as community advisory

[26] Turning Point Performance Management Collaborative, http://www.turningpointprogram.org/Pages/perfmgt.html last accessed April 9, 2012.
[27] U.S. Department of Health and Human Services Health Resources and Services Administration, Maternal and Child Health Bureau, "Rethinking MCH: The Life Course Model as an Organizing Framework, Concept Paper," November, 2010 Version 1.1
[28] Centers for Disease Control and Prevention, "The Social-Ecological Model: A Framework for Prevention," http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html, last accessed April 10, 2012

groups and annual community assessments); the development of improvement strategies; and the ongoing coordination of outreach, screening and referral, service delivery and other systems-building strategies. Should the same applicant organization be selected to receive funding for more than one RFA component (A or B), awards may be integrated into a single grant award and administered as a single contract.

Community Assessment: A comprehensive assessment and prioritization of community needs and strengths will serve as the fundamental basis for both Component A and B projects. Improvement strategies will be designed to address specific priority needs and gaps – and build on specific strengths – identified through community assessments. Assessment is viewed as an ongoing activity, not a stand-alone "planning" phase of funded projects. In addition to the initial assessments described in their applications, funded grantees will be expected to integrate ongoing community assessment activities in their MIH initiatives to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. An updated community assessment will be an annual grant deliverable for grantees of both Components A and B.

Both initial and ongoing/updated community assessments should reflect collaboration with multiple and diverse partners. Community assessments should build upon previous local and state community assessment and planning efforts, including those conducted in association with other DOH-funded initiatives (e.g., CPPSN, CHWP and HMHB), as well as the state's MIECHV Needs Assessment. The statewide MIECHV needs assessment is available at: http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/

Target Communities: The MIH initiative targets high-need women, infants and their families, with a particular focus on Medicaid-eligible individuals and populations, residing in the highest need communities statewide. Given limited public health resources, it is necessary to target activities to areas of highest need with consideration for where impact will be greatest, particularly with regard to racial, ethnic and economic disparities in priority outcomes. To accomplish this, a targeting methodology for the MIH RFA has been adopted based on the methodology developed for the NYS MIECHV Needs Assessment and Updated State Plan. [29] Based on this methodology and additional updated vital statistics birth data, the RFA establishes two "tiers" of target areas:

- **Tier 1**– the 14 highest-need counties: *Albany, Bronx, Erie, Kings, Monroe, Nassau, New York, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, and Westchester.*

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[29] This methodology incorporated a set of 23 community-level indicators that encompass multiple domains of infant, maternal and family health and well-being to calculate standardized metrics called "Z-scores". A Z-score is a standardized score that indicates number of standard deviations above or below the mean; positive Z-scores (>0) are above the mean and negative Z-scores (<0) are below the mean. Z-scores were calculated for both the number of cases (burden) and rates for each indicator. An average Z-score was then calculated for all indicators combined, thus creating two composite index measures of relative risk (one for burden, one for rate) for each county in the state.

- **Tier 2** – all remaining counties. Within Tier 2, counties have been further designated into two sub-groups:
  - **Tier 2a** – counties that have an annual average of 500 or more births for which Medicaid is the payor ("Medicaid births"), based on 2008-10 vital statistics data. This includes the following counties: *Broome, Chautauqua, Chemung, Dutchess, Niagara, Oswego, Rockland, St. Lawrence, Ulster*
  - **Tier 2b** – counties that have an annual average less than 500 Medicaid births, based on 2008-10 vital statistics data

For both Components A and B, preference will be given to funding projects targeting Tier 1 counties, with remaining funding to support a smaller number of targeted projects in Tier 2. For Component A, within Tier 2, preference will be given to funding projects targeting Tier 2a counties. Separate applications are required for Component A and Component B that will be reviewed and scored separately.

For both Components A and B, within the targeted Tier 1 and Tier 2 counties selected by the applicant, grant activities should primarily target more specific high-need geographic areas and populations identified by applicants based on their community assessments**.** In order to be considered for funding, an application **must** propose to serve a target area that accounts for an average of 100 or more Medicaid births annually, based on 2008-10 vital statistics data. **Applications that do not meet this criteria will not be considered for funding**. Applicants may wish to refer to the ZIP code level data provided in **Attachments 1a, 1b** and **1c** to assist in identifying high need geographic areas.

Note: In order to optimize coverage of high-need areas across the state, funded grantees may be required to make adjustments to their proposed target areas, in consultation with NYSDOH.

II. Component A: Maternal and Infant Community Health Collaboratives

A. Who May Apply

Minimum Eligibility Requirements:

- Applications will be accepted from Article 28 facilities, community-based not-for-profit health and human service organizations, and local government agencies. Organizations applying for funding through Component B also may submit applications for funding through Component A.
- Each application must propose a target area that accounts for an average of 100 or more Medicaid births annually, based on 2008-10 vital statistics data.

Preferred Eligibility Requirements:

Preference will be given to:

- Projects targeting Tier 1 counties and Tier 2a counties
- Applications demonstrating strong collaboration, including subcontracts, with other partner agencies/organizations that provide health, educational and supportive services to high-need preconception, prenatal/postpartum and interconception women, infants and families, particularly those partner agencies/organizations with demonstrated experience and capacity serving high-need populations in the high-need neighborhoods identified in the community needs assessment.
  - Because of the multi-dimensional nature of maternal and infant health and the strategies needed to address it, collaboration is a strong expectation of this RFA. The lead agency needs to have a substantial coordinating role and cannot simply be a pass-through for funding to other organizations.
- Organizations, including lead applicants and/or subcontractors, who have a history of serving and/or are representative of diverse target populations, including: those most impacted by racial, ethnic and economic disparities; those in need of linguistically and culturally appropriate programs and services; and individuals with disabilities.
- Applications that demonstrate strong in-kind support from both the lead agency and partners, including successful public-private partnerships.

Applicants may propose to target more than one county. However, a separate application must be submitted, and will be reviewed and scored separately, for each Tier 1 county an applicant proposes to serve. A single application may be submitted to target multiple Tier 2 counties if the applicant proposes to serve those counties as part of a coordinated regional/multi-county project. If the same lead organization proposes to target both Tier 1 and Tier 2 counties, separate applications must be submitted for Tier 1 and Tier 2. The same lead organization may submit multiple applications targeting Tier 1 counties, but may submit no more than one application for Tier 2.

Applicant proposes to serve counties in Tier:	Application Requirement
1: *counties of Albany, Bronx, Erie, Kings, Monroe, Nassau, New York, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, Westchester*	Separate application required to serve each of these counties
2: *all remaining counties in New York State*	Single application proposing to serve multiple counties as part of a coordinated regional/multi-county project
1 and 2	Separate applications for each Tier 1 county **and** a single application for single or multiple Tier 2 county(ies)

For example:

- An applicant that proposes to target areas in Bronx and Queens counties, must submit separate applications for each of those counties, since both of these are designated as Tier 1 counties.
- An applicant that proposes to target areas in Albany, Greene and Columbia Counties must submit one application for Albany (Tier 1) and a second application for Greene and Columbia (Tier 2).
- An applicant that is proposing to serve Broome, Tioga and Chenango counties must submit a single Tier 2 application that addresses all three counties as part of a single coordinated project. Separate Tier 2 applications from the same applicant organization for each of these counties individually will not be accepted.

Note that for Component A, with the exception of four specific counties (Bronx, Kings, New York, Queens), only **one** award will be made for each county; In Bronx, Kings, New York and Queens counties, no more than **two** awards will be made per county (see **Selection and Funding Methodology** below for further detail). As noted above, collaboration is a strong expectation of this RFA and initiative. The NYSDOH encourages collaborative applications from multiple community agencies and organizations working together to respond to and implement this initiative, with coordination and leadership from a strong applicant lead agency. To help facilitate this, NYSDOH has attached a list of current DOH grantees for the CPPSN, CHWP and HMHB initiatives (see **Attachment 3**) as well as current Healthy Families NY (**Attachment 4**), Nurse Family Partnership (**Attachment 5**), Healthy Start **(Attachment 6**), Family Planning (**Attachment 7**) Comprehensive Adolescent Pregnancy Prevention **(Attachment 8),** and Rural Health Network **(Attachment 9)** programs in the state. In addition, as part of the published Questions and Answers for this RFA, we will include a list of organizations that have submitted letters of intent to apply for MIH funding.

B. Description of the Program

Overview

The overall goal of **Component A**: **Maternal and Infant Community Health Collaboratives (MICHC)** is to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. Specific priority outcomes for this initiative include **Preterm births**, **Low Birth Weight**, **Infant Mortality** and **Maternal Mortality**. To positively impact these four key outcomes, MICHC activities will seek to address maternal and infant health behaviors, supports and service systems across three key life course stages: **preconception, prenatal/postpartum and interconception**.

Strategies will focus on improving: outreach to find and engage high-need women and their families in health insurance, health care and other needed community services; timely identification of needs and risk factors and coordinated follow-up to address risks identified; the integration and coordination of services within larger community systems; and, the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan.

MICHC grantees will work collaboratively with other community partners to assess and prioritize specific community needs and strengths, and to select and implement specific improvement strategies to address those needs. Based on their community assessments, grantees will select and implement relevant evidence-based or best practice activities, and/or develop and implement innovative strategies based upon sound empirical and theoretical frameworks. Using a structured performance management framework, grantees will regularly assess their progress in implementing strategies and achieving desired outcomes, and will continually refine improvement strategies to enhance or expand effective strategies and revise or discontinue those that are less effective. NYSDOH and the new Maternal and Infant Health Center of Excellence (MIH-COE) will provide additional guidance and technical support to grantees on performance measure development, data collection and reporting systems, and quality improvement methodology. **Figure 1** presents a summary overview of the conceptual framework for the MICHC initiative.

Figure 1: Component A: Maternal and Infant Community Health Collaboratives (MICHC)

AIM: To improve health outcomes for women of childbearing age and their families while reducing persistent racial/ethnic and economic disparities related to those outcomes.

Strong Collaboration & Partnerships

Preconception

Prenatal/ Postpartum

Interconception

Improvement Strategies

- Directly responsive to community assessment
- Address relevant factors at community, organizational, family & individual social ecologic levels
- Targeted to one or more clearly-defined groups or organizations
- Clearly articulated rationale based on established or emerging evidence base or other empirical or theoretical framework(s)
- Builds on strengths and capacity of applicant and collaborating partners

Performance Standards

- **PS1:** High-need women and infants are enrolled in health insurance
- **PS2:** High-need women and infants are engaged in health care and other supportive services appropriate to their needs
- **PS3:** The medical, behavioral, and psychological risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral, and follow-up
- **PS4:** Within the community there are supports and opportunities in place that help high-need women engage in and maintain healthy behaviors and reduce or eliminate risky behaviors

Performance Measures

- **To be developed in Year 1:**
  - Process measures to monitor the implementation of improvement strategies as planned
  - Outcome measures to monitor the extent to which performance standards have been accomplished and which health outcomes improved
  - Tools and processes for ongoing critical review of progress and performance, with adjustments to improvement strategies as needed

Improved Outcomes

Pre term birth

Low Birth Weight

Infant Mortality

Maternal Mortality

Assessment of Community Needs & Resources

Medicaid funding is a key source of support for Component A, and MICHC activities will primarily target Medicaid-eligible populations and individuals. **Throughout Component A of this RFA, the term "high-need" populations or individuals includes Medicaid-eligible women and their families**. Additionally, the specific improvement strategies chosen will be grounded in a comprehensive, multi-dimensional assessment of community needs and resources that identifies more specific target geographic areas and subpopulations (e.g., women with disabilities, specific racial and ethnic minority groups, women with depression, addiction or other psychosocial risk factors).

As a specific requirement to assure conditions for federal Medicaid matching funds dedicated to this initiative are met, all MICHC grantees will conduct activities to increase awareness, accessibility and utilization of family planning services among Medicaid-eligible preconception and interconception women, hereafter referred to in this RFA as "Offering and Arranging." In order to assure adequate continued funding for this program, a minimum of 25% of each grantee's award amount should be used to support the Offering and Arranging of family planning services. Offering and Arranging activities may be incorporated in community, organizational and/or individual/family level strategies. Please refer to **Attachment 10** for additional detailed guidance on Offering and Arranging of family planning services, and to the ***MICHC Improvement Strategies*** section below for examples of Offering and Arranging activities at each ecologic level.

Organizational Capacity and Experience
(20 points, 4 page limit in Attachment 11 Application Template)

Collaboration and partnerships are a central focus of MICHC. Lead applicants are strongly encouraged to work in close collaboration with other community partners to develop and implement their improvement plans. Lead applicants are encouraged to develop subcontracts or other partnership agreements with other community organizations and agencies to expand collective capacity, experience and expertise for designing and implementing effective improvement strategies. Applicants targeting high-need populations in multiple neighborhoods should engage partners in each of those neighborhoods, particularly applicants serving counties with large metropolitan areas with distinct neighborhoods and distinct service providers in each of those neighborhoods. Key recommended partners include local health departments, health care providers (including prenatal care, pediatric and women's primary care, family planning), mental health and substance abuse services providers, community-based organizations, home visiting programs (including Healthy Families New York [**Attachment 4**], Nurse Family Partnership [**Attachment 5**]), WIC programs, Healthy Start programs (**Attachment 6**), Rural Health Networks (**Attachment 9**), faith-based organizations, business, philanthropic and economic development partners, and other key leaders or organizations serving the community. Because only one (or for selected New York City counties, up to two) Component A grants will be awarded for each target county, collaborative applications that engage multiple key community partners are strongly encouraged. Applicants should include evidence of commitment from collaborating partners such as memoranda or letters of agreement, and sub-contractual relationships reflected in the budget. Services may be provided by the applicant

organization and/or through subcontracts with other partner organizations. For joint applications, one organization should be designated as the lead organization and is responsible for submitting the application and administering the grant. The lead agency needs to have a substantial coordinating and/or implementation role and cannot simply be a pass-through for funding to other organizations.

Funded grantees may be required to collaborate with other key community initiatives or projects with common target areas and goals identified by the NYSDOH during the course of the grant period.

Assessment of Community Needs and Strengths
(20 points, 8 page limit in Attachment 11 Application Template)

As described in ***Section I. Introduction***, MICHC projects will be based on comprehensive community assessments. Component A applications will include a preliminary community assessment that incorporates:

- Identification of specific target populations and geographic communities including target ZIP codes;
- A critical analysis of community-level data, needs and strengths related to each of the Performance Standards (described in more detail below): enrollment in health insurance; engagement in health care and other supportive services; coordination of risk identification, referral to appropriate services and follow-up; and promotion of healthy behaviors and elimination of risky behaviors;
- A description of the availability and capacity of existing maternal, infant and child health programs and resources to serve the target community, including the specific target populations and neighborhoods identified, and assessment of key gaps in services.

Community assessment is viewed as an ongoing activity, not a stand-alone "planning" phase of funded projects. In addition to the initial assessments described in their applications, funded grantees will be expected to integrate ongoing community assessment activities to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. Both initial and ongoing/updated community assessments should reflect collaboration with multiple and diverse partners. Community assessments should build upon previous local and state community assessment and planning efforts, including those conducted in association with other NYSDOH-funded initiatives (e.g., CPPSN, CHWP and HMHB), as well as the state's MIECHV Needs Assessment. The statewide MIECHV needs assessment is available at:
http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/

An updated community assessment will be an annual grant deliverable for grantees of both Components A and B. Component A grantees' annual community assessment will monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. They will be expected to contribute to the development of the annual updated community assessments and improvement plans required for Component B

MIECHV grantees serving the same target communities, and in turn draw on those assessments to inform larger community assessments for Component A. The format for these annual community assessments will be provided as part of Year 1 implementation for funded grantees.

Performance Standards

The centerpiece of the MICHC performance management framework is the set of four **performance standards**. A performance standard is a generally accepted, objective standard of measurement against which a grantee's level of performance can be compared; it establishes the level of performance expected. Collectively, these performance standards serve to describe specific, tangible processes and outcomes that need to be accomplished through this particular initiative. They contribute to the achievement of the overarching goals of improved key population health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality.

Performance standards provide a framework to guide applicants and funded grantees in their ongoing community assessment work. For each performance standard, a community assessment should help answer questions such as:

- *What is the current status of this standard within our community? How do we know that?*
- *For which specific populations and geographic areas are we falling short in meeting this standard, and why?*
- *What specific individual, family, organizational and/or community-level factors most significantly influence the achievement of this standard within our target group(s)?*
- *What existing strengths within our organization(s) and community can we build on to effectively address those factors? Who are key individuals within the community who can help advance those efforts?*

Performance Standard 1: High-need women and infants are enrolled in health insurance
Uninsured people receive less timely medical care, less medical care overall and have worse health outcomes.[30] Lack of health insurance may result in delayed diagnosis and treatment of chronic diseases and failure to identify and address medical and psychosocial risk factors, and creates a financial burden on uninsured families and the health care system. Reducing uninsurance among children increases their access to and use of medical care, reduces preventable hospitalizations, and reduces families' financial burdens from health care.[31]

National studies have reported low family incomes and inability to afford health insurance as the primary reasons for the relative lack of health insurance among African Americans and among uninsured children generally.[32] [33] Nationally, uninsured children are disproportionately

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[30] Bovbjerg R and Hadley J. Why Health Insurance is Important. The Urban Institute Health Policy Briefs. DC-SPG no 1, Nov 2007.
[31] Hudson JL and Selden TM, Children's Eligibility And Coverage: Recent Trends And A Look Ahead, *Health Aff September 2007 vol. 26 no. 5 w618-w629*
[32] Lu MC, Kotelchuck M, Hogan V, Jones L, Wright K, and Halfon N, Closing the Black-White Gap in Birth Outcomes: A Life-course Approach, *Ethn Dis,* Winter 2010 vol. 20 (1 Suppl 2):S2-62-76

Hispanic, from single-parent (or no-parent) families and from families in which all parents are unemployed.[34] [35] Other documented reasons for being uninsured include the perception of a difficult enrollment process, uncertainty about income eligibility requirements and where to apply, concerns about quality and access, actual or perceived requirements related to documentation of citizenship status, and limited English language proficiency.[36] [37]

NYS has expanded eligibility requirements for Medicaid coverage for pregnant women and children, and for individuals in need of family planning services. Pregnant women and infants (up to age one year) with family incomes up to 200% Federal Poverty Level (FPL), and children age one to eighteen years with family incomes up to 133% FPL, are eligible for Medicaid. Men and women of childbearing age who have household incomes up to 200% FPL and are not otherwise enrolled in Medicaid are eligible for Medicaid coverage for family planning services through the state's Family Planning Benefit Program (FPBP). Following a historic expansion of the state's Child Health Plus (CHPlus) program in 2008, subsidized CHPlus coverage is available for children with family incomes up to 400% of the FPL, and children with family household incomes over 400% FPL can buy into the program, making NYS the only state that offers subsidized public health insurance to children with family incomes up to 400% FPL, and one of only 12 states that allow families with incomes above the state's established eligibility levels to buy into public health insurance.[38] [39]

A large proportion of NYS's maternal and child health population is covered under public health insurance programs (i.e., Medicaid, Family Health Plus and Child Health Plus). In 2010, Medicaid and Family Health Plus provided coverage for 45.8% of births (See Table 1). When broken down by race and ethnicity, Medicaid is the payor for 70.9% of births to mothers who identified as Hispanic and to 64.6% of women who identified as Black, compared to 38.4% of births to mothers who identified as white.[40] A recent review of Medicaid prenatal care records illustrated that a significant proportion of Medicaid-eligible women were uninsured prior to pregnancy, highlighting the importance of improving outreach and enrollment in health insurance among high-need preconception and interconception women, including insurance coverage for family planning services to promote planned pregnancies and adequate birth spacing.

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[33] U.S Dept of Health and Human Services, Centers for Medicare and Medicaid Services, Informing CHIP and Medicaid Outreach and Education – Topline Report: Key findings from a National Survey of Low-Income Parents. Nov 2011

[34] Hudson and Selden 2007.

[35] DeVoe JE et al,Uninsured Children and Adolescents With Insured Parents, *JAMA. 2008;300(16):1904-1913. doi:10.1001/jama.2008.51*

[36] Informing CHIP and Medicaid Outreach and Education, 11/11

[37] Sommers B,Enrolling Eligible Children In Medicaid And CHIP: A Research Update *Health Aff (Millwood) July 2010 29:71350-1355*

[38] Henry J. Kaiser Family Health Foundation, Statehealthfacts.org, www.statehealthfacts.org/comparecat.jsp?cat=4 , accessed April 16, 2012.

[39] *Feinberg E et al,* Language Proficiency and the Enrollment of Medicaid-Eligible Children in Publicly Funded Health Insurance Programs , Maternal and Child Health Journal, Volume 6, Number 1, 5-18, DOI: 10.1023/A:1014308031534,

[40] Source: 2010 NYS Vital Statistics, Table 4. NYS DOH

Financial Coverage of Live Births in NYS 2010[41]
Table 1

Payor	# of Births	% of Statewide Total
New York State Total	***242,914***	
Medicaid/ Family Health +	111,144	45.8%
Private Insurance	116,374	47.9%
Self-Pay	4,055	1.7%
Other Insurance	8,571	3.5%
Not Stated	2,770	1.1%

NYS specific data from the 2007 National Survey of Children's Health indicate that the significant disparities in health insurance coverage for children reported nationally also exist in NYS. While 13.1% of children overall were uninsured at some time during the 12 months prior to the survey, Hispanic and Black children were about twice as likely to report being uninsured as White children, and were about two to three times more likely than White children to have public health insurance at the time of the survey (See Table 2).

2007 National Survey of Children's Health-NYS Results
Table 2

		% of Children Ages 0-17			
Measure		**Overall**	**Hispanic**	**Black**	**White**
Children who currently have health insurance coverage		**94.4**	**90.1**	**94.7**	**96.1**
Children who are currently uninsured or were uninsured at some time during the previous 12 months		**13.1**	**20.5**	**19.1**	**9.1**
Children who currently have public health insurance coverage		**31.8**	**54.6**	**45.2**	**17.3**

Notably, the majority of currently uninsured children are eligible for public health insurance, emphasizing the importance of effective outreach and enrollment strategies to improve insured status.[42]

Increasing enrollment in public health insurance is a major strategic priority in NYS. Facilitated enrollment services are currently available statewide through 41 community-based agencies and 14 health plans that provide application assistance to families applying for Medicaid (including FPBP), CHPlus or Family Health Plus. Assistance is available in community-based locations at

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[41] Source: 2010 NYS Vital Statistics, Table 13. NYS DOH.
[42] Kenny GM et al, Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?*Health Aff October 2010 vol. 29 no. 10 1920-1929*

convenient times, including evenings and weekends, from staff speaking 60 different languages. Facilitated enrollers form relationships with families, helping them retain continuous coverage once initially enrolled. Facilitated enroller organizations account for over 430,000 applications submitted annually, and have been successful in reaching immigrant and rural communities that previously had minimal access to the public health insurance system. Barriers to enrollment have been further reduced through the implementation of Presumptive Eligibility for both pregnant women and children, expanding Medicaid eligibility for children age six to eighteen to 133% of the FPL, the elimination of a previous requirement for a face-to-face interviews, and the launch of a Web-based eligibility screening tool and "fill and print" application, with the addition of a Spanish version of the Web-based eligibility screening tool in mid-2012. As an outcome of the state's Medicaid Redesign Team (MRT) process, presumptive eligibility and other steps to streamline enrollment for FPBP are slated for implementation later in 2012. The NYSDOH "Connections to Coverage" statewide campaign builds and sustains relationships with sister state agencies, schools, community- and faith- based organizations and other strategic partners to connect children and families to enrollment in public health insurance programs. Through the campaign, local partners can help institute practices to routinely assess client families for insurance status, help connect families directly to facilitated enrollers and provide education to both families and other community organizations through presentations, trainings, workshops, dissemination of printed information and outreach at a variety of community events.

Through their community assessments, MICHC applicants and grantees will identify specific factors and barriers to enrollment in health insurance among high-need populations within their selected targeted communities – including factors at the community systems, organizational and individual/family levels. Improvement strategies should be designed to address these specific factors to reach, inform, enroll and retain high-need, hard to reach populations in health insurance across the life course stages (preconception, prenatal/postpartum, interconception). Strategies for preconception and interconception stages should include a specific focus on increasing enrollment of eligible women in Medicaid Family Planning Benefit Program as part of required Offering and Arranging activities.

Performance Standard 2: High-need women and infants are engaged in health care and other supportive services appropriate to their needs

Health insurance alone is not sufficient to assure that women and their families engage in needed health care and other supportive services. Access to health care requires gaining entry into the health care system; having an adequate supply of service providers to meet community needs; getting access to sites of care where patients can receive needed services; and finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.[43]

[43] Ketchum, & Lake Research Partners. (2011). *Informing CHIP and Medicaid Outreach and Education...* Conducted for Centers for Medicare & Medicaid Services. Washington DC: U.S. Department of Health and Human Services. Retrieved March 30, 2012 from http://www.insurekidsnow.gov/professionals/CHIP-Medicaid-Survey-Topline.pdf

For many high-need women, prenatal care may be their first experience with the health care system as an adult. Several studies suggest that women who obtain adequate prenatal care may establish positive care-seeking behavior that increases the likelihood they will practice healthier behaviors after delivery and seek more preventive care for their babies.[44] [45] At the same time, there is increasing recognition that achieving further improvement in birth outcomes requires that women be engaged in health care before conception, including between subsequent pregnancies. A number of key medical, behavioral, psychosocial and environmental risk factors for adverse birth outcomes are modifiable through clinical interventions before pregnancy occurs, and in some instances are amenable to intervention only before conception. Preconception health status is believed to be an important factor in persistent and widening racial, ethnic and economic disparities in birth outcomes, further emphasizing the need to strengthen preconception and interconception health care for high-need populations.[46] At least one study has demonstrated that utilization of preconception care can increase pregnancy planning and intention,[47] which in turn is associated with more timely and adequate use of prenatal care services.[48] Across all life periods, women with identified risk factors may need ancillary services such as mental health, substance abuse/addiction services, nutritional counseling services, domestic violence intervention supports, home visiting or other supportive services.

High-need women and families face a variety of personal, social and structural barriers to utilizing care, including: low income; lack of health insurance and the cost of services; low motivation for preventive care or a belief that preventive or prenatal care is not necessary; fear of medical procedures; fear of revealing undocumented immigrant status; distance and access to transportation; lack of child care or difficulty taking time off from work; location and hours of services and limited English proficiency or literacy and other language and cultural barriers.[49] [50] Additionally, women suffering depression or other mental health issues, alcoholism or substance use or intimate partner violence are less likely to seek timely and adequate care.[51] [52] [53] [54] [55] [56] [57]

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[44] Kogan, M.D., G. R. Alexander, B. W. Jack et al. (1998). The Association Between Adequacy of Prenatal Care Utilization and Subsequent Pediatric Care Utilization in the United States. *Pediatrics* 102 (1 Pt 1): 2530.

[45] Reichman, N, Corman, H., Noonan, K., Schwartz-Soicher, O. (2010). Effects of Prenatal Care on Maternal Postpartum Behaviors. *Review of Economics of the Household* 8 (2): 171-197

[46] Atrash, Hani et al. "Preconception Care for Improving Perinatal Outcomes: The Time to Act". Maternal and Child Health Journal. No 10. 2006. Pp S3-S11.

[47] Moos MK et al, The impact of a preconceptional health promotion program on intendedness of pregnancy. Am J Perinatol 1996;13:103-8.

[48] McComb Hulsey T,Association Between Early Prenatal Care and Mother's Intention of and Desire for the Pregnancy, Journal of Obstetric, Gynecologic, & Neonatal Nursing, Volume 30, Issue 3, pages 275–282, May 2001

[49] Phillippi J, Women's perceptions of access to prenatal care in the United States: a literature review,J Midwifery Womens Health. 2009 May-Jun;54(3):219-25.

[50] York P et al,Maternal Factors That Influence Inadequate Prenatal Care,Public Health Nursing, Volume 10, Issue 4, pages 241–244, December 1993

[51] York P et al, 1993

[52] Kropp F et al, Increasing Prenatal Care and Healthy Behaviors in Pregnant Substance Users, J Psychoactive Drugs. 2010 March; 42(1): 73–81

[53] Roberts SC, Pies C,Complex calculations: how drug use during pregnancy becomes a barrier to prenatal care. Matern Child Health 2011 Apr;15(3):333-41.

[54] Marcus SM,Depression during pregnancy: rates, risks and consequences--Motherisk Update 2008., Can J Clin Pharmacol. 2009 Winter;16(1):e15-22. Epub 2009 Jan 22.

As shown in **Table 3** below, there are economic disparities in utilization of primary health care services. Women enrolled in Medicaid are less likely to enroll in early prenatal care and to receive postpartum visits, and young children enrolled in Medicaid are less likely to receive required well-child visits than their counterparts enrolled in Commercial HMOs.[58]

NYS Managed Care Plan Performance Reports: 2009
Table 3

Measure	Medicaid	Commercial HMO
The percentage of women, continuously enrolled for 10 or more months, who delivered a live birth and had their first prenatal care visit in the first trimester of pregnancy.	71%	86%
The percentage of women who had a postpartum care visit between 21 and 56 days after they gave birth.	73%	76%
The percentage of children who had five or more well-child and preventive health visits in their first 15 months of life.	77%	89%

Through their community assessments, MICHC applicants and grantees will identify specific factors and barriers to accessing and utilizing health and other needed supportive services among high-need populations within their selected targeted communities – including factors at the community systems, organizational and individual/family levels. Improvement strategies should be designed to address these specific factors to engage and retain high-need, hard to reach populations in timely and ongoing health and other needed supportive services across the life course stages (preconception, prenatal/postpartum, interconception). Strategies for preconception, postpartum and interconception women should include a specific focus on increasing awareness and utilization of family planning services as part of required Offering and Arranging activities.

Performance Standard 3: The medical, behavioral and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up.

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[55] Chambliss LR, Intimate partner violence and its implications for pregnancy, Clin Obstet Gynecol. 2008 Jun;51(2):385-97.
[56] Maupin R et al, Characteristics of women who deliver with no prenatal care, J Matern Fetal Neonatal Med. 2004 Jul;16(1):45-50
[57] Phillippi, 2009.
[58] 2011 New York State Managed Care Plan Performance. New York State Dept of Health.

Comprehensive, high quality health care addresses medical, behavioral and psychosocial factors that in turn influence health status and outcomes, using approaches that are safe, timely, patient centered, efficient, and equitable.[59] Building on work to enroll high-need women and families in health insurance (Performance Standard 1) and engage them in health and supportive services (Performance Standard 2), Performance Standard 3 focuses on additional strategic efforts to assure that the specific needs of individuals and families are identified and addressed effectively within community-wide service systems.

Over the last century, the concept of prenatal health care has evolved significantly, from an initial focus on reducing maternal morbidity due to toxemia, to current models that link traditional obstetrical care to a wide range of other ancillary public health and social support services.[60] While the scientific evidence base for prenatal care remains equivocal, proposed mechanisms for the potential benefits of prenatal care on both maternal and infant health outcomes include: early and comprehensive screening to identify risk factors; preventive counseling to promote and reinforce healthy behaviors and reduce risky behaviors; management of chronic or emergent medical conditions such as diabetes and hypertension; and, linking high-risk individuals to key supportive services such as WIC, home visiting and smoking cessation programs.[61] [62] Postpartum care visits provide an additional opportunity to assess maternal medical, behavioral and psychosocial risks, provide information on infant care and birth spacing, and assure ongoing health care and management plans are in place for preexisting or developing chronic conditions.

Researchers have also suggested that **systems-level** approaches to improve the accessibility and appropriateness of prenatal health care services, and to coordinate the provision of health and ancillary supportive services, may further augment benefits of prenatal care.[63] In NYS, significant emphasis has been placed on building and strengthening these types of systems to assure that risk factors are systematically and routinely identified, documented and addressed. These efforts focus both on improving systems <u>within</u> health care practices and on building reciprocal linkages <u>between</u> health care and other community providers that serve high-need families, including WIC, home visiting, early care and education, mental health and substance abuse, domestic violence, income assistance and many other services. With support from NYSDOH and other sources, several communities have implemented innovative approaches to build community systems for prenatal risk assessment, referral and follow-up, including: standardized prenatal risk screening and communication forms; structured referral processes between clinical practices, health plans, local health departments and other community service providers; Web-based data systems (e.g., PeerPlace®) that support centralized risk assessments,

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[59] Ketchum, & Lake Research Partners, 2011.
[60] Alexander GR and Kotelchuck M, Assessing the role and effectiveness of prenatal care: history, challenges and directions for future research. Public Health Reports, July-August 2001, 116:306-16.
[61] Alexander GR and Korenbrot CC, The role of prenatal care in preventing low birth weight, Future Child 1995 Spring;5(1):103-20.
[62] Marie C. McCormick, Joanna E. Siegel, Recent Evidence on the Effectiveness of Prenatal Care, Ambulatory Pediatrics, Volume 1, Issue 6, November–December 2001, Pages 321-325, ISSN 1530-1567, 10.1367/1539-4409(2001)001<0321:REOTEO>2.0.CO;2. (http://www.sciencedirect.com/science/article/pii/S1530156705600676)
[63] Alexander and Korenbrot, 1995.

referrals and coordinated follow-up services across multiple participating health and human service providers within a community; and, integration of community health workers/peer health advisors into health care practice teams to provide ongoing reinforcement, follow-up and systems navigation support for high-need patients. As a companion to these efforts, there has been significant work in NYS over the past decade to integrate and expand home visiting as a particularly effective intervention and support for high-need families within larger prenatal, postpartum and early childhood service systems.[64]

Prenatal care standards were established for NYS's Medicaid program over two decades ago, initially in response to the creation of the Prenatal Care Assistance Program (PCAP). In 2009, updated prenatal care standards went into effect for all NYS Medicaid providers, the result of a collaborative process that included the NYSDOH Office of Health Insurance Programs, Division of Family Health, Island Peer Review Organization (IPRO) and a statewide advisory stakeholder workgroup. In addition to requirements for comprehensive clinical diagnostic and treatment services, these standards address: accessibility and timeliness of care; comprehensive medical, psychosocial and nutritional risk assessment, screening, counseling and referral; health education; mechanisms for consultation and referral; and, development of a plan of care and care coordination.[65] NYSDOH recently partnered with IPRO to conduct a review of year 2009 medical records to assess key aspects of prenatal care delivery and establish a baseline for implementation of the revised standards. Preliminary results of this study identify numerous areas in which further improvements are needed, including risk screening and referral and follow-up for identified risks.[66] It is anticipated that multi-dimensional efforts that involve a number of community partners – both within health plans and health care practices and in larger community service systems – are needed to fully achieve these comprehensive standards.

As described under Performance Standard 2 in the previous section, there is increasing recognition that preconception and interconception health care are critical to identifying and addressing medical, behavioral, psychosocial and environmental risk factors for adverse birth outcomes before pregnancy occurs. The Centers for Disease Control and Prevention (CDC) has issued a set of comprehensive recommendations to improve preconception health and health care in the United States. These recommendations emphasize the integration of preconception care in all primary, preventive and specialty health services for women of reproductive age, including in particular family planning services. Recommendations for the content of preconception care include: risk assessment, screening, health promotion education and counseling; interventions for identified risks, focusing on those with evidence of effectiveness and the greatest potential impact; and, linking postpartum women with an adverse pregnancy outcome to interconception care.[67] Several national professional health organizations have issued clinical practice guidelines for preconception care for women with specific chronic health conditions, including diabetes,

[64] www.scaany.org/initiatives/HomeVisiting.php
[65] www.health.ny.gov/health_care/medicaid/standards/prenatal_care/
[66] NYSDOH, unpublished data 2011
[67] Johnson K et al. Recommendations to improve preconception health and health care - United states. A Report of the CDC/ATSDR preconception Care work group and the select panel on preconception care. CDC MMWR April 21 2006;55(RR06):1-23.

hypothyroidism and conditions requiring teratogenic medications.[68] Building on the models described above for prenatal care systems, additional systems-building work is needed to achieve these recommendations and to build strong, reciprocal linkages between health care and other community supportive services for high-need women and their families in preconception and interconception periods.

Through their community assessments, MICHC applicants and grantees will identify specific factors and barriers to identifying and addressing medical, behavioral and psychosocial risk factors of women and infants among high-need populations within their selected targeted communities – including factors at the community systems, organizational and individual/family levels. Improvement strategies should be designed to address these specific factors to improve timely risk identification, follow-up and coordination of interventions and supportive services across the reproductive life course. Strategies for preconception, postpartum and interconception women should include a specific focus on identifying, counseling and referring individuals who may benefit from family planning services as part of required Offering and Arranging activities.

Performance Standard 4: Within the community there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors.

In its landmark publication *The Future of Public Health*, the Institute of Medicine stated that the mission of public health is "creating conditions in which people can be healthy" - and highlighted the importance of partnerships between public health and numerous other community partners to accomplish this mission.[69] This requires partners to identify and address the broader "upstream" determinants of health, many of which may appear to be outside the traditional scope of public health and health care sectors.[70]

Many social and economic features of communities have been linked with mortality, general health status, disability, birth outcomes, chronic conditions, utilization of health care services, health behaviors and other risk factors for chronic disease, as well as with mental health, injuries, violence and other important health indicators.[71] [72] The health of individuals and populations can be affected positively or negatively by structural and environmental factors such as poor air and water quality, substandard housing conditions including exposure to lead paint or mold, lack of access to fresh fruits and vegetables, unsafe walking environment and concentrations of fast food restaurants and liquor stores.

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[68] Johnson et al 2006.

[69] The Institute of Medicine, National Academy of Sciences. The future of public health. Washington D.C.:National Academies Press, 1988.

[70] Schutchfield, F.D. and Howard, A.F. Moving on Upstream: The Role of Health Departments in Addressing Sociocologic Determinants of Disease. Am Journal of Prev Medicine 2011;40(1s1):S80-83.

[71] Robert Wood Johnson Foundation, Commission to Build a Healthier America, Where we live matters for our health, Issue Brief 2: Housing and Health, September 2008.

[72] Perloff J and Jaffee K, Late Entry into Prenatal Care: The Neighborhood Context,Social Work (1999) 44 (2): 116-128. doi: 10.1093/sw/44.2.116

Health behaviors are also powerfully influenced by social norms - the expectations or rules for behavior held by a social group. A property of a community, social norms are transmitted to individuals through life long socialization processes, both within families and through larger community institutions such as schools, churches or membership associations.[73]

In 2010-11, as part of its efforts to better understand and promote preconception health, the NYSDOH Bureau of Maternal and Child Health conducted a total of 35 focus groups across the state with adolescents and young adults, to determine attitudes toward health and supports needed to be healthy. Participants emphasized: the need for opportunities to engage in prevention behaviors in community settings that are accessible, affordable, and safe; the need to raise awareness and understanding of the importance of health and healthy behaviors; and the need to raise critical awareness of health disparities impacting racial and ethnic minority communities.[74]

Through their community assessments, MICHC applicants and grantees will identify specific needs and strengths within target communities and populations that influence the availability of structural, environmental and social supports and opportunities for health-promoting behaviors across the life course. Grantees may propose a variety of strategies commensurate with their experience and capacity to create change to address these factors. As emphasized above, meaningful partnerships with a diverse set of community organizations and actors – including those not traditionally involved in the public health and health care sectors – to plan, develop and implement collaborative community and system level solutions will be critical to achieving these changes. Community-based participatory research offers a relevant model for ways to engage citizens and community partners in identifying, prioritizing and developing collective solutions to health issues within their own community.[75] Strategies for preconception, prenatal, postpartum and interconception women should include a specific focus on promoting family planning, birth spacing, prevention of unintended pregnancy, and utilization of family planning services as part of required Offering and Arranging activities.

MICHC Improvement Strategies
(30 points, 30 page limit in Attachment 11 Application Template)

Applicants have the flexibility to propose specific strategies that they determine will be most effective in addressing their identified needs, in the context of the strengths and capacity of their target community, within the performance management framework presented in **Figure 1**. All MICHC grantees are required to design and implement strategies to address factors at multiple ecological levels. At a minimum, for each of the four MICHC performance standards, and within each standard for each of the three respective life course stages, applicants should propose at least one specific strategy to address factors at the community and/or organizational level and at least one specific strategy to address factors at the individual/family level, as described in more detail below.

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[73] Bartholomew et al 2006.
[74] New York State Department of Health, unpublished data.
[75] Schutchfield and Howard, 2011.

Improvement plans will be developed using a structured format provided in **Attachment 11: Component A - Application Template** of this RFA. Within their improvement plans, applicants need to demonstrate how each proposed strategy meets the following criteria:

- The strategy is clearly linked to specific findings and priorities identified in the community needs assessment;
- There is a clearly defined target group(s) and geographic area including target ZIP code(s) for each strategy. The MIH RFA is intended to primarily target low-income, Medicaid-eligible populations or the providers/organizations that serve those populations;
- There is a clear demonstrated rationale for how the strategy will improve one or more of the performance standards and associated targeted outcomes, based on established or emerging evidence base or other well-defined and relevant empirical and/or theoretical framework(s); *and*
- The applicant has (or describes a specific plan to develop) the capacity to effectively implement the strategy, directly and/or in collaboration with other partners. Lead organizations are strongly encouraged to partner with other organizations, including through formal sub-contracting arrangements, to augment or complement their own capacity to carry out effective local improvement work. Applicants in counties with multiple high-need neighborhoods and/or communities should include partners that are well positioned to address the needs of the target populations in those areas.

As noted, a minimum of 25% of each grantee's award amount should be used to support the Offering and Arranging of family planning services for Medicaid-eligible preconception and interconception women. Offering and Arranging activities should be incorporated within strategies targeting preconception and interconception women at all ecologic levels.

As part of Year 1 implementation, funded grantees will work with NYSDOH and the new MIH-COE to develop a set of performance measures to monitor the effectiveness of their proposed strategies.

Note: It is anticipated that over the course of the 5-year initiative, the MIH-COE will identify additional evidence-based/best practice strategies of relevance for this initiative. It is an expectation of grantees that they participate in ongoing training and technical assistance opportunities provided by DOH through the COE, and that modifications to improvement plans may be required to incorporate additional evidence-based or promising strategies and/or to discontinue strategies that are deemed not to be effective.

Community and Organizational Systems Level Strategies:

Achieving and sustaining changes at higher ecologic levels requires a focus on **systems**: the organizations, institutions, structures, processes and resources that collectively are intended to support and improve – or may indirectly influence – the health of individuals and populations. Systems that are accessible, effective and functionally coordinated or integrated can enable

service providers to deliver quality services and enable consumers to practice healthy behaviors and utilize health-supporting services.

All applicants need to develop strategies to address community and/or organizational level factors that influence the MICHC performance standards and measures. Based on their community assessments and grantee capacity, applicants may propose strategies to achieve community-level changes, organizational-level changes, or a combination of the two.

Strategies to Influence Community Level Change:

Within the social ecologic model, the community environment encompasses an array of factors, determinants and conditions that affect the health of populations. Community-level factors may impact health directly or indirectly through their influence on health behaviors. Relevant community-level factors may include aspects of the physical environment (e.g., quality of housing or safe and accessible places for recreation and physical activity), the availability and accessibility of resources and services (e.g., health care, mental health, substance abuse services, home visiting, family support resources), social norms (e.g. related to use of prenatal care services, breastfeeding, or personal health behaviors), and community capacity to effectively identify and address community problems.[76] The fundamental importance - and significant conceptual and practical challenges - of addressing these social determinants of health to improve the health of populations, and especially to improve racial, ethnic and economic disparities in health outcomes, has received increasing recognition in the public health community.[77]

Based on their community assessments and the capacity of their own and partner organizations, MIH applicants may propose to implement strategies to influence changes at the community level. Community-level strategies may focus on: influencing social norms related to health and health behaviors; creating and strengthening opportunities and supports that help high-need individuals practice healthy behaviors; and/or strategies for empowering high-need individuals and populations to change their personal, social and community environments. It is anticipated that successful strategies to address community-level factors will require active collaboration with multiple sectors of the community, including those not traditionally included in discussions of health and health promotion. Grantees should identify and engage key “gate-keepers” or other influential individuals who serve and/or represent the target community to participate fully in the selection/design and implementation of community change strategies. A working understanding of health promotion theories and models related to social norms, social capital/community capacity, community organization and community development may help grantees develop more

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[76] Bartholomew, L.K., Parcel, G.S., Gerjo, Kl, Gottlieb, N.H. (2006). *Planning Health Promotion Programs: An Intervention Mapping Approach (1st Ed)*. San Francisco: John Wiley and Sons, Inc.
[77] Scutchfield, F.D., Howard A.F. (2011). Moving on Upstream: The Role of health Departments in Addressing Socioecologic Determinants of Disease. *American Journal of Preventive Medicine*, 40(1S1), S80-S83.

effective strategies to influence these inherently challenging issues.

Potential examples of strategies that grantees may undertake to influence change at the community level may include:

- As part of ongoing community assessment activities, conduct focus groups, surveys, interviews or other methods to assess knowledge, attitudes, norms, behaviors, perceived barriers or other relevant factors among community members;
- Conduct community mapping to systematically assess the availability and gaps in health and social services or other key resources within the community;
- Develop or expand existing community coalitions, advisory boards or other forums for convening partners representing diverse segments of the community to identify and address community issues;
- Conduct community-based participatory problem-solving to engage members of the community in raising awareness of health disparities and identifying specific community health issues and solutions;
- Engage community health workers to link individuals and groups from within target communities to voluntary community organizations (such as social groups, neighborhood associations, faith-based institutions, community advisory boards), in which they can associate with others to collectively address issues of concern to their community;
- Implement public awareness campaigns to increase awareness and knowledge of specific community resources, the use of health care services and/or health promoting behaviors, including enrollment in FPBP and utilization of family planning services;
- Conduct community education regarding Medicaid eligibility, enrollment criteria, affordability and where to apply through targeted outreach strategies;
- Provide community education and outreach in high-need areas to raise awareness of the importance of planning pregnancies and birth spacing and the availability of family planning methods and services within the community;
- Adopt/disseminate or develop new media materials and vehicles utilizing methods that may be effective in changing social norms related to health promoting behaviors (e.g., role-modeling, entertainment-education, behavioral journalism); and
- Work with the MIH Center of Excellence to arrange for training of staff within grantee or partner organization(s) to increase capacity for above strategies.

Strategies to Influence Organizational Level Change:

Organizations are groups of people intentionally and systematically structured to pursue collective goals or address specific needs on an ongoing basis. Within a social-ecologic model, organizations can play a key role in influencing – and in turn may be influenced by - both the community and individuals within it. Examples of organizations that may be targeted for changes through the MIH initiative include health care provider practices, family planning service providers and other community service agencies that serve high-need target populations. There are many potential organizational-level factors that may be identified through community assessments related to the MICHC performance standards.

To help guide their thinking about organizational-level factors and strategies, applicants may find it helpful to first ask themselves and their partners: *What specifically do we want to see change within a target organization?* Possible examples of specific practices or characteristics that may be targeted for change within community organizations may include:

- Routine assessments of preconception and interconception Medicaid-eligible women within primary care practices or family planning clinics for: medical and psychosocial risk factors, health promoting/health risk behaviors, and management of chronic conditions, with appropriate follow-up for factors identified;
- Development of outreach strategies to increase consumer knowledge of Medicaid eligibility, reduce negative perceptions of or perceived barriers to Medicaid enrollment, and increase demand for health insurance coverage by testing messages with adults in the target communities;
- Incorporation of practices to determine and process presumptive eligibility for Medicaid for pregnant women and Medicaid FPBP for preconception and interconception women;
- Development and implementation of specific protocols within prenatal care clinics to provide and document clinical care in accordance with Medicaid Prenatal Care Standards;
- Adoption and integration of National Standards on Culturally and Linguistically Appropriate Services (CLAS Standards) into organizational practices to make services more culturally and linguistically accessible, including delivery of culturally competent care, availability of language access services and organizational supports for cultural competency;[78]
- Changes in facilities or policies to make community services more accessible and welcoming for families with infants and young children, such as easy access for strollers, private areas for breastfeeding, or age-appropriate toys in waiting areas;
- Adoption and implementation of specific innovative or evidence-based clinical care models (such as *Centering Pregnancy*) or practices (such as administration of 17 alpha hydroxyprogesterone caproate to women at risk of preterm delivery) within a prenatal care practice;
- Promotion and support for breastfeeding mothers, including education on rights and ongoing support for breastfeeding in the workplace and utilization of interventions outlined in the *CDC's Guide to Breastfeeding Interventions;*[79]
- Use of Web-based data systems (such as *Peer Place®*) within multiple community organizations (i.e., primary care practices, family planning clinics, home visiting programs, and other local service agencies) to document patient/client risk factors and needs, make referrals to other available community services, and communicate/coordinate ongoing follow-up care across community health and human service providers;
- Establishment and implementation of protocols across multiple community organizations for uniform screening and cross-referral of high-need women to assure a "no wrong

[78] www.minorityhealth.hhs.gov
[79] Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. "The CDC Guide to Breastfeeding Interventions." Atlanta: Center for Disease Control and Prevention, 2005.

door" community-wide approach so that individuals can access care and services regardless of where they enter the system; and

- Development of coordinated outreach, intake and referral processes across community health and social service programs, to assure cross-systems communication, collaboration and coordination.

Once the desired organizational changes such as those above have been identified and clearly defined, grantees may find it helpful to then ask a second guiding question: *What can we (directly or in collaboration with other partners) do to help make this change happen?* In effect, this requires additional improvement activities that can be directed to the target organization(s) to achieve the kinds of changes within those organizations that are described above. Examples of methods and strategies that MICHC grantees may find useful to support or facilitate changes within their own or other targeted community organizations may include:

- As part of ongoing community assessment activities, conduct focus groups, surveys or other methods to assess learning needs, current practices, barriers to change or other relevant issues within community organizations;
- Work with targeted organizations, or groups of organizations, to implement changes in a specific area of practice identified through needs assessment, using an evidence-based quality improvement methodology (See **Attachment 12** for overview of evidence-based QI models commonly used in health care/public health practice);
- Conduct "public health detailing"[80] [81]visits to health care provider practices, family planning clinics or other service agencies to increase awareness and provide ready-to-use resources or tools that support desired organizational changes;
- Conduct or facilitate training and/or technical assistance for community partner organizations to support adoption or implementation of organizational changes;
- Facilitate specific linkages between community health and human service providers to support improved cross-referrals;
- Convene community advisory groups or coalitions to facilitate the identification of common interests and needs and strategies to address them across community organizations; and
- Work with the MIH-COE to arrange for training of staff within grantee or sub-contractor organization(s) to increase capacity for supporting above strategies.

Note: It is anticipated that supplemental funding may be available to grantees funded through Component A of this RFA to support the use of health information technology (HIT) to communicate and coordinate the delivery of services among multiple community organizations. The use of HIT to share information on health risks among health care and human services providers is considered an effective strategy to significantly reduce poor health outcomes among women and infants. Information about this potential opportunity will be provided separately when available.

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[80] Kisuule F, Wright S, Barreto J, Zenilman J. (2008). Improving Antibiotic Utilization among Hospitalists: A Pilot Academic Detailing Project with a Public Health Approach. *Journal of Hospital Medicine*, 3(1), 64-70.
[81] Larson K, Levy J, Rome MG, Matte TD, Silver LD, Frieden TR. (2006). Public Health Detailing: A Strategy to Improve the Delivery of Clinical Preventive Services in New York City. *Public Health Reports*, 121, 228-234.

Individual/Family Level Strategies:

All applicants need to propose strategies to find, engage and provide social support to high-need **individuals and families** within the target communities.

The core individual/family level strategy required for this initiative is the use of **community health workers (CHWs)**. Also known as *lay health advisors*, *natural helpers, indigenous helpers* or *promotoras*, CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports.[82] Based on social support and social network theories of health promotion, CHWs have been used across a variety of public health initiatives to enhance multiple aspects of individuals' social networks and supports, which in turn can improve health outcomes by modeling and reinforcing positive health behaviors and practices, buffering the impact of stress, and facilitating access to and utilization of resources, including health care and other community services.[83] For example, peer support has been shown to critically influence breastfeeding, with demonstrated positive impact on intention to breastfeed and improvement in breastfeeding rates among high-need populations.[84] [85]

Well-designed CHW initiatives have the potential to provide multiple dimensions of social support, including informational, tangible, emotional and appraisal support.[86] At a community/systems level, CHWs also can be effective in mobilizing and coordinating community resources.[87] Research studies demonstrate that CHWs can improve health outcomes,

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[82] Bartholomew, L.K., Parcel, G.S., Gerjo, Kl, Gottlieb, N.H. (2006). *Planning Health Promotion Programs: An Intervention Mapping Approach (1st Ed)*. San Francisco: John Wiley and Sons, Inc.

[83] Berkman, L.S., & Glass, T.G. (2000). Social integration, social networks, social support and health. In L.S. Berkman & I. Kawachi (eds.), *Social epidermiology* (pp. 137-173). New York: Oxford University Press. ;Heaney, C. A., & Isreal, B.A. (2002). Social networks and social support. In K. Glanz, F.M. Lewis, & B. K. Rimer (Eds.), *Health behavior and health education: Theory, research and practice* (3rd ed., pp. 185-209). San Francisco: Jossey-Bass. ;Eng, E., & Parker, E. (2002). Natural helper models to enhance a community's health and competence. In R. J. DiClemente, R.A. Crosby, & M.C. Kegler (Eds.), *Emerging theories in health promotion practice and research: Strategies for improving public health* (1st ed). San Francisco: Jossey-Bass. ;Hogan, B.E., Linden, W., & Najarian , B. (2002) . Social support interventions: Do they work?*Clinical Psychology Review*, 22, 381-440. ;Lewin S.A. , Dick,J., Pond, P., Zwarenstein, M., Aja, G., van Wyk , B., et al. (2003). Lay health workers In primary and community health care: Cochrane Review Retrieved March 3, 2005, from http://www.chchrane.org/cochrane/revabstr /ab004015.htm.; House, J.S., Umberson, D., & Landis, K. R. (1988). Structures and process of social support. *Annual review of sociology,* 14,293-318.; Isreal, B.A., & Rounds, K.A. (1987). Social networks and social support: A synthesis of health educators. *Advances in Health Education and Promotion*, 2, 311-351.

[84] Humphreys, A.S., N.J. Thompson and K.R. Miner. "Intention to breastfeed in low-income pregnant women: The role of social support and previous experience." Birth (1998): 169-174.

[85] Mitra, A.K., et al. "Predictors of breastfeeding intention among low-income women." Maternal and Child Health Journal (2004): 65-70.

[86] Heaney, C. A., & Isreal, B.A. (2002). Social networks and social support. In K. Glanz, F.M. Lewis, & B. K. Rimer (Eds.), *Health behavior and health education: Theory, research and practice* (3rd ed., pp. 185-209). San Francisco: Jossey-Bass. ;McLeroy,K.R., Gottlieb, N.H., & Heaney, C.A. (2001). Social health in the work place. In M.P.O'Donnell (Ed.), *Health promotion in the workplace* (3rd ed., pp. 459-486). Albany, NY: Delmar.

[87] Eng, E., & Parker, E. (2002). Natural helper models to enhance a community's health and competence. In R. J. DiClemente, R.A. Crosby, & M.C. Kegler (Eds.), *Emerging theories in health promotion practice and research:*

address disparities, improve the utilization of preventive and primary care services and reduce the need for intensive services among high-need populations. A randomized controlled trial of a CHW intervention to increase insurance coverage among Latino children in Boston found that children in the CHW intervention group were significantly more likely to be insured and to be insured continuously compared to children in the control group.[88] In addition to improved health outcomes, CHWs contribute to reducing health care costs by decreasing unnecessary or avoidable emergency department utilization and hospitalizations.[89]

For the purpose of this RFA, CHWs are further defined as trained paraprofessionals working under the direction and supervision of a licensed professional (a public health nurse or licensed social worker with clinical experience) in accordance with standards and practices defined by NYSDOH Bureau of Maternal and Child Health (BMCH) (see Attachment 13). CHWs will perform a combination of community outreach, home visits, group activities /workshops, and community-based supportive services to provide a source of enhanced social support and create a bridge between under-served and hard-to-reach populations and formal providers of health, social and other community services.

Additionally, this RFA provides an important opportunity to expand the role of CHWs, consistent with the commitment to life course and social-ecological models. While the role of BMCH's CHW Program traditionally has focused on working with women and infants during **prenatal and postpartum** periods, through the new MIH initiative the scope of CHWs will be broadened to provide ongoing support during **preconception** and **interconception** periods to promote healthy behaviors, including initial and continuous engagement with health and community services, for high-need women of reproductive age within target communities.

To incorporate CHW-led strategies within their programs, MICHC grantees will be required to recruit, train and supervise/mentor CHWs in accordance with BMCH requirements (See **Attachment 13).** CHW services should be available across all geographic areas targeted by the applicant. Specific required activities related to administration and oversight of local CHW work include:

- Recruit, engage and support individuals to serve as CHWs, with an emphasis on engaging lay individuals from within the identified target communities and who are themselves representative of the target population(s);
- Recruit, engage and support individuals with appropriate professional licensure and experience to serve as CHW coordinators/supervisors;
- Facilitate participation in training for CHWs, in coordination with the new MIH- COE;
- Provide professional supervision for CHWs; and
- Participate in data collection and evaluation activities established for this initiative, in coordination with the new MIH-COE.

Strategies for improving public health (1st ed). San Francisco: Jossey-Bass.

[88] Flores G, et al, 2005.

[89] Michelen, W, et al 2006.

Lead applicants that do not have experience and expertise administering CHW programs are strongly encouraged to subcontract or otherwise partner directly with other community organizations that have that experience and capacity. See **Attachment 3** for list of current NYSDOH-funded CHW programs.

In turn, CHWs supported through this initiative will implement a range of local strategies to find and engage high-need individuals in health insurance, health care and other supportive services; to identify specific needs and risk factors of clients; and, to improve the practice of health-promoting behaviors among target populations. CHWs may target preconception, prenatal/ postpartum, and interconception women and their families, with a strong focus on high-need women who are not currently engaged in health care or other supportive community services. CHW services should be tailored to the needs of clients and the community, and be coordinated with and integrated in larger community-wide health and community service systems. For example, CHW services are part of a continuum of maternal, infant and child health home visiting services (including Component B MIECHV grantees), serving as a safety net for those high-risk clients that may not be eligible for other programs because of eligibility criteria, capacity issues or who may graduate out of those programs. CHW activities targeting preconception and interconception women should incorporate activities related to Offering and Arranging of family planning services.

Examples of potential strategies that may be implemented through CHWs include:

- Conduct neighborhood "on the ground" outreach and networking to find and connect with high-need individuals, with particular emphasis on those not yet engaged in mainstream service systems;
- Use client-centered approaches to identify individual client and family needs, goals, strengths and challenges. Where available and appropriate to level of training, this should incorporate the use of validated screening or assessment tools to identify client risks or needs;
- For clients that are not enrolled in other home visiting programs, offer and provide regular home visits that include client-centered provision of health information, modeling and demonstrating skills, and reinforcing positive health choices and behaviors;
- Refer and provide direct 1:1 assistance to help clients obtain and consistently utilize health insurance (including FPBP), primary care and/or prenatal care services, family planning services and other needed community services such as WIC, substance abuse, domestic violence, mental health, etc. Examples of activities may include: assistance in completing applications, finding service providers or scheduling appointments; helping clients arrange child care or transportation; and accompanying clients to visits;
- Provide and disseminate written and oral information about available family planning health services in the community to prevent unintended pregnancies and promote spacing of subsequent pregnancies. This could include assisting individuals with arranging visits to family planning providers;
- Provide individualized social support to encourage and reinforce health promoting behaviors by clients, including personal and family health behaviors, consistent use of effective contraception to prevent unintended pregnancy or support birth spacing,

utilization of needed health and supportive services, and communicating their questions and needs to service providers;
- Establish relationships with other health and human service providers in the community to identify and refer individuals who may benefit from CHW support services;
- Link families to other family resources within the community such as libraries, museums, Family Resource Centers (**Attachment 14**), Child Care Resource and Referral agencies (**Attachment 15**), play groups, breastfeeding support groups, etc; and/or
- In collaboration with CHW coordinators, convene or arrange group educational sessions for expectant and new families.

Within this framework, grantees have the flexibility to propose specific local approaches to implement these core required strategies.

Note: While the above examples focus on individual/family level activities, CHWs also may be integrated in strategies targeting change at community or organizational levels, such as:

- Development of community coalitions;
- Establishment of reciprocal referral networks;
- Integration of CHWs within multi-disciplinary health care teams to serve as liaisons between the medical home and the patient/family;
- Linking high-need individuals to larger community development activities that utilize participatory problem-solving or other empowerment methods; and/or
- Introducing media materials designed to influence social norms related to health and health behaviors to members of target communities.

See **Community and Organizational Systems Level Strategies** above for further information on these potential approaches.

Selection of high need populations should be guided by an initial and ongoing community needs assessment. CHW services should primarily target low-income, Medicaid-eligible women and families, with particular emphasis given to reaching individuals and sub-groups who are traditionally underserved and/or disconnected from mainstream services, as identified through the community needs assessment. Strategies targeting preconception and interconception women should incorporate activities related to Offering and Arranging of family planning services.

Performance Measurement, Monitoring and Reporting
(10 points, 2 page limit in Attachment 11 Application Template)

Performance management is the practice of actively using performance data to improve the public's health. Continuous measurement and monitoring of improvement is a critical element of any performance-based organization. Each MICHC performance standard will have one or more associated **performance measures** that capture the degree to which an initiative has accomplished what was intended.

Performance may be monitored by process and/or outcome measures. **Process measures** describe ways in which interventions are implemented or services delivered, such as the adoption of new screening protocols within a clinical practice or group of practices, the reach of a social marketing campaign among the target population, or the extent to which an evidence-based intervention has been replicated with fidelity to the original model. **Outcome measures** describe the results achieved through those interventions or services. Outcomes may be "short-term" (e.g., changes in knowledge, attitudes, or skills) "intermediate-term" (e.g., changes in personal health behaviors, utilization of health or other services, consistent use of effective contraception and spacing of pregnancies, organizational practices, community norms) or "long-term" (e.g., health status outcomes – preterm birth, low birth weight, infant mortality). Outcomes may be measured at the individual, organizational and/or population/community level.

All MICHC grantees will be expected to collect, review and report a set of defined performance measures to monitor and assess the implementation and effectiveness of MICHC improvement strategies. The specific performance measures will be developed as part of Year 1 implementation in close consultation with NYSDOH and the new MIH-COE. Where relevant, performance measures will be based on other existing validated measures such as those summarized in **Attachment 16 Measures for Monitoring Quality.** It is anticipated that performance measures will include a set of uniform core performance measures for the entire MICHC initiative that will be reported by all grantees, as well as additional process and outcome measures specific to each MICHC project. Data sources for performance measures likely will include a combination of data collected and reported directly by grantees to DOH (e.g., client-level data from community health worker activities) and data analyzed and reported to grantees by DOH (e.g., community-level vital statistics or Medicaid enrollment/utilization data).

All grantees will be expected to incorporate Quality Improvement (QI) activities to critically review the effectiveness of chosen strategies. Once performance measures and accompanying data sources have been defined, data should be reviewed on a "real-time" basis to provide rapid-cycle feedback about performance to promote continuous quality improvement. These QI activities should lead to adjustment of improvement strategies as needed to optimize their effectiveness. Grantees will be required to submit quarterly reports that reflect critical review of progress and performance data and any resulting changes to improvement plans. Improvement plans will be formally updated annually as a condition of continued grant funding. MICHC partners should be fully engaged in these activities. Improvement plans should reflect engagement of the target population in development of strategies and assessment of progress. Through these activities, the MICHC initiative will help develop a body of "practice-based evidence" related to improving maternal and infant health outcomes among high-need populations and communities.

The MIH-COE will be charged with developing and implementing an evaluation of the MICHC initiative, including assessment of the implementation and effectiveness/ impact of specific required strategies on performance standards and associated performance measures. As a condition of funding, grantees will be required to participate in any evaluation activities directed by the NYSDOH. It is anticipated that these evaluation activities will build directly upon the

performance management activities described above.

Budget and Funding Restrictions
(20 points, 3 page narrative limit, exclusive of budget tables and forms in Attachment 11 Application Template)

Funds awarded through this RFA may be used to support activities of this grant and their associated costs. Specific costs that are allowable under this grant include but are not limited to personnel costs, consultant or subcontracting costs, staff training, basic infrastructure/overhead costs (e.g., rent, utilities, telephone), supplies and equipment. All funds requested for this grant need to be included in the justification and show support for the proposed improvement strategies. As noted, a minimum of 25% of each grantee's award amount should be used to support the Offering and Arranging of family planning services for Medicaid-eligible preconception and interconception women. Offering and Arranging activities should be incorporated within strategies targeting preconception and interconception women at all ecologic levels.

Funds awarded under Component A of this RFA are not intended to support the direct delivery of evidence-based home visiting program services described in Component B of this RFA. Applicants seeking funding to support direct delivery of evidence-based home visiting services should apply under Component B. Component A funds may be appropriate for community-wide systems-building or coordination work that includes integration of home visiting services.

The initiative will **not** fund direct clinical/medical/laboratory services and supplies, case management, mental health counseling, crisis intervention, transportation, educational preparation (such as GED), job placement, child care or services or any other services that are available/funded through other resources.

MICHC grant funds may not be used to supplant existing funds for currently existing staff or organization activities, and allocation of costs to grant funds should be proportionate across revenue streams.

Projected Number of Awards and Funding Range

Approximately $13.79 million will be available to fund approximately 20-25 Component A projects, with annual funding per project ranging from a maximum of $200,000 to $1,200,000. The actual amount of funding awarded for a selected project will be based on the level of need in the geographic target area, the scope of the proposed project, and the relative proportion of need within the selected county or counties that will be targeted for MICHC activities by the proposed project.

Applicants may propose to target more than one county. A separate application must be submitted, and will be reviewed and scored separately, for each Tier 1 county an applicant proposes to serve. A single application may be submitted to serve multiple Tier 2 counties, if the

applicant proposes to serve those as part of a coordinated regional/multi-county project. If the same organization proposes to target both Tier 1 and Tier 2 counties, separate applications must be submitted for Tier 1 and Tier 2. The same lead organization may submit multiple applications targeting Tier 1 counties, but may submit no more than one application for Tier 2, regardless of the number of Tier 2 counties targeted for the proposed project.

Applicant proposes to serve counties in:	**Application Requirement:**
Tier 1: *Counties of Albany, Bronx, Erie, Kings, Monroe, Nassau, New York, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, Westchester*	Separate application required to serve each of these counties
Tier 2: *all remaining counties in New York State*	Single application proposing to serve multiple counties as part of a coordinated regional/multi-county project
Tiers 1 and 2	Separate applications for each Tier 1 county **and** a single application for single or multiple Tier 2 county(ies)

For example:

- An applicant that proposes to target areas in Bronx and Queens counties must submit separate applications for each of those counties, since both of these are designated as Tier 1 counties.
- An applicant that proposes to target areas in Albany, Greene and Columbia Counties must submit one application for Albany (Tier 1) and a second application for Greene and Columbia (Tier 2).
- An applicant that is proposing to serve Broome, Tioga and Chenango counties must submit a single Tier 2 application that addresses all three counties as part of a single coordinated project. Separate Tier 2 applications from the same applicant organization for each of these counties individually will not be accepted.

Selection and Funding Methodology

Applications will be screened to verify that minimum eligibility criteria as defined in the RFA are met:

- Application is received by the deadline posted on the cover page of this RFA.
- Application is only for Component A.
- Eligible Organization (Article 28 facilities, community-based not-for-profit health and human service organizations, and local government agencies).
- Target area consists of 100 or more Medicaid births annually (Attachment 1c).
- Application proposes to serve a single Tier 1county <u>or</u> one or more Tier 2 county(ies).
- Applicant organization submitted only one application for Tier 2 counties.

Applications that are determined not to meet minimum criteria will be rejected and not considered for funding. Eligible applications will be reviewed and scored by teams of trained reviewers using a structured, pre-approved review tool. Applications that achieve a minimum passing score of 65 (out of 100) points or higher will be designated as "passing" and considered for funding. Applications will be sorted into designated Tiers 1 or 2, and within Tier 2 to subgroup 2a or 2b, based on the county or counties they propose to target, and ranked from highest to lowest score within each of these respective groups. Highest preference will be given to funding applications that propose to serve Tier 1 counties, next to applications that propose to serve Tier 2a counties, and finally applications that propose to serve Tier 2b counties. For both Tiers 1 and 2, no more than one project will be funded to target the same county, except that up to two projects may be funded for Bronx, Kings, New York and Queens Counties only if the two projects have distinct (non-overlapping) target areas within the county. Passing applications that are not selected for funding will be designated as "approved but not funded".

For applications that are selected for funding, a maximum annual funding level has been established for each area, as shown in Table 4 below. For applications targeting Tier 2 counties, the maximum funding level corresponds to the "index county" in the highest subgroup. *For example,* an application that is selected for funding that targets activities to counties in both Tier 2a and Tier 2b would be eligible for up to a maximum of $400,000 per year. An application that is selected for funding that targets activities to multiple counties all of which are designated as Tier 2b would be eligible for up to a maximum of $200,000 per year.

Within these maximum award levels, the actual level of funding will depend on the scope of the proposed project, with specific consideration for the proportion of annual Medicaid births (i.e., births for which Medicaid is the payor) for the target county or counties that fall within the specific ZIP codes targeted by the applicant for the proposed project. *For example*, a project that proposes to serve a set of ZIP codes within a county that account for 90% of all annual Medicaid births within that county would be eligible to receive a higher level of funding than a project that proposes to serve a set of ZIP codes that account for 50% of all annual Medicaid births within that same county. Note that awards cannot be higher than the amount requested by the applicant.

Table 4. Component A Maximum Annual Award Amount by County

	County	Maximum Award per Project	Maximum Number of Awards per County
Tier 1	Bronx, Kings	$1,200,000[1]	2
	New York, Queens	$1,000,000[1]	2
	Erie, Monroe	$850,000	1
	Nassau, Onondaga, Suffolk, Westchester	$750,000	1
	Albany, Oneida, Orange, Richmond	$500,000	1
Tier 2a	Broome, Chautauqua, Chemung, Dutchess, Niagara, Oswego, Rockland, St. Lawrence, Ulster	$400,000[2]	1
Tier 2b	Remaining 39 counties	$200,000[2]	1

[1] *– Maximum award shown is based on one award for the county. If a second award is made in these four counties, available funding would be allocated proportionately based on base target areas of respective projects.*

[2] *- Maximum award for Tier 2 projects applies regardless of number of target counties included in proposal. If an application is selected that targets both Tier 2a and 2b counties, maximum funding level is based on Tier 2a, i.e. $400,000.*

Should the same applicant organization be selected to receive funding for more than one application (including multiple Component A applications and/or an award for Component B), the awards may be rolled up into a single award and administered as a single contract. It is anticipated that funds will be awarded as a multi-year (5-year) contract.

C. Completing an Application

This section provides instructions to applicants on how to complete their applications, and identifies the specific criteria and parameters on which the applications will be competitively evaluated.

To apply for Component A funding, applicants should complete the Component A Application Template provided in Attachment 11. Separate applications are required for Component A and Component B that will be reviewed and scored separately.

Applicants should respond to each category and criteria described in full. In particular, applicants should note carefully items that are required in order for the proposal to be eligible for review.

ALL APPLICATIONS SHOULD CONFORM TO THE FORMAT PRESCRIBED IN **ATTACHMENT 11**.

Point value and page limit for each section are as follows:

Application Section	Maximum Score	Page Limit
Applicant Cover Page	**0**	**n/a**
Attestation of Eligibility	**0**	**n/a**
Executive Summary	**0**	**1**
Organizational Experience and Capacity	**20**	**4**
Assessment of Community Needs and Strengths	**20**	**8**
Improvement Plan	**30**	**30**
Performance Measurement, Monitoring and Reporting	**10**	**2**
Budget and Staffing Plan	**20**	3 page narrative limit, exclusive of budget tables and forms

III. Component B: Maternal, Infant and Early Childhood Home Visiting

A. Who May Apply

Minimum Eligibility Requirements:

- Eligible applicants include Article 28 facilities, Article 36 facilities, community-based not-for-profit organizations, local health departments, local departments of social services, or other local government agencies.
- Each application must propose a target area that accounts for an average of 100 or more Medicaid births annually, based on 2008-10 vital statistics data.
- Applicants must propose to implement Nurse Family Partnership (NFP) or Healthy Families New York (HFNY) Home Visiting program models. Funds may be requested to establish new NFP or HFNY programs, or to expand and/or enhance established programs.
  - If home visiting is provided by nurses, home visiting services must be provided by agencies that are Certified Home Health Agencies (CHHAs) or Licensed Home Care Service Agencies (LHCSAs) approved to provide services pursuant to Article 36 of the Public Health Law. Therefore, in order to receive funds for Component B for implementation of Nurse Family Partnership, the applicant needs to either be an approved Article 36 provider or subcontract the delivery of home visiting services to an approved Article 36 provider.
- All applicants **must** include a letter from the national program developer(s) for their respective model(s) documenting agreement by the model developer to work with the applicant to establish and/or expand and implement the evidence-based home visiting program as proposed. For those applicants proposing implementation of the HFNY model, a letter from the NYS Office of Children and Family Services is required as the program developer. **Applications that do not include a letter of agreement will not be reviewed.**
  - Continuation of any funding awarded through this RFA for the establishment and/or expansion of home visiting programs will be conditional on receiving a final letter of approval for a new or expanded program from the national program developer within six months of notification of funding from NYSDOH, and on initiation of services for new clients within 12 months of notification of funding.
  - National program developers may have additional eligibility requirements associated with a particular program model beyond those specified in this RFA.
- Organizations that currently receive funding through NYSDOH and/or the NYS Office of Children and Family Services (NYSOCFS) for evidence-based home visiting services, including MIECHV (**Attachment 17**) funding, are eligible to apply for additional funding through this RFA, as well as organizations that do not currently receive such funding. Initial preference for funding through this RFA will be given to

projects that have not already been awarded MIECHV funding outside of this RFA. See ***Selection and Funding Methodology*** below for additional detail.

Applicants may propose to serve more than one county. A separate Component B application must be submitted, and will be reviewed and scored separately, for each Tier 1 county that an applicant proposes to serve. A single application may be submitted to serve multiple Tier 2 counties, alone or in combination with up to one Tier 1 county, if the applicant proposes to serve those as part of a coordinated regional/multi-county initiative.

Preferred Eligibility Requirements:

Preference will be given to:

- Projects serving "Tier 1" counties.
- Applications demonstrating strong collaboration with other health, education and human service partner agencies and organizations, including but not limited to: applicants for Component A, prenatal care providers, community-based organizations, local health departments, local departments of social services, health plans, and other home visiting service providers.
- Applications that demonstrate strong in-kind support from both the lead agency and partners, including public-private partnerships.
- Organizations, including lead applicants and/or sub-contractors, that have a history of serving and/or are representative of diverse target populations including: those most impacted by racial, ethnic and economic disparities, utilizing linguistically and culturally appropriate programs and services; and individuals with disabilities.

B. Description of the Program

Overview

The national **Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program** was authorized by the federal Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148) to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. At the federal level, MIECHV is administered jointly by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). MIECHV funds have been made available to states through annual formula-based allocations, with the opportunity for states to apply for additional grant funding on a competitive basis.

The New York State Department of Health (NYSDOH) has been designated as the lead entity to accept and administer New York's MIECHV federal grant funding. In close partnership with the New York State Office of Children and Family Services (OCFS), a core group of other state agency partners, and many external stakeholders, NYSDOH has completed a series of key required steps and deliverables to secure MIECHV funding for the state. In September 2010, a

comprehensive statewide MIECHV Needs Assessment was completed and subsequently approved by HRSA/ACF. Based on a rigorous multi-dimensional analysis of over 20 data indicators, 14 NYS counties were designated as primary target communities for NYS's MIECHV initiative. In June 2011, a comprehensive MIECHV State Plan was submitted and subsequently approved by HRSA/ACF. NYS's State Plan targeted initial MIECHV funding (based on the state's FY10 formula-based grant allocation) to Bronx, Erie, and Monroe counties, to support the expansion/enhancement of the two specific established evidence-based program models that have demonstrated positive outcomes in maternal health, child health and child maltreatment**: Nurse Family Partnership (NFP)** and **Healthy Families America/Healthy Families New York (HFNY).** The plan also allocated grant funds to support a new Center of Excellence for maternal and infant health, and noted that potential future increases in federal MIECHV grant funding for NYS would be awarded to support further expansion of NFP and/or HFNY programs in target communities through a competitive Request for Applications (RFA) process. Component B of this MIH RFA implements that aspect of our MIECHV State Plan, to award additional MIECHV grant funds made available to NYS through our FY11 formula-based grant allocation, as well as other potential increases in federal funding awards for this initiative.

Within the larger MIH initiative described in this RFA, **Component B MIECHV** focuses on **implementation of evidence-based home visiting programs** as a specific effective strategy for improving outcomes for high-need women and families. This component aligns directly with the state's MIECHV initiative described above, and is driven by three overarching goals:

- Improve pregnancy outcomes for high-need women and babies.
- Improve children's health and development.
- Strengthen family functioning and life course.

To contribute to these goals, all NYS MIECHV grantees will focus on the dual priorities of **implementing home visiting program services with fidelity to the evidence-based model(s)** and **integrating home visiting programs/services within a comprehensive, coordinated system of maternal, infant and early childhood services.**

Component B MIECHV grant funding will support the establishment, expansion and/or enhancement of specific evidence-based home visiting programs to serve targeted high-need populations and communities across the state. Component B grant funds may be requested to establish new home visiting programs or to expand or enhance existing home visiting programs. As noted above, Component B projects must include one of the two specific evidence based program models that have demonstrated positive outcomes in maternal health, child health and child maltreatment**: Nurse Family Partnership (NFP)** or **Healthy Families America/Healthy Families New York (HFNY).**

The **NFP** is a nurse-led evidence-based home visiting program targeted to low-income first-time mothers designed to improve maternal and child health, pregnancy outcomes, children's subsequent health and development, and economic self-sufficiency of the family. It includes one-on-one home visits by trained public health nurses to participating clients. Visits begin early in the woman's pregnancy with program enrollment no later than 28th week of gestation, and

conclude when the woman's child turns two years old. During visits, nurses work to reinforce maternal behaviors that are consistent with program goals and that encourage positive behaviors and accomplishments. The national model developer for NFP is the Nurse Family Partnership National Service Office. The contact person for organizations seeking to establish and/or expand NFP programs within New York State is:

Renee Nogales, Program Developer Northeast Region
Nurse-Family Partnership National Service Office
Renee.Nogales@nursefamilypartnership.org

The Healthy Families America (HFA) – operated in New York State by the Office of Children and Family Services (OCFS) as **Healthy Families New York (HFNY)** - is a national program model which utilizes highly trained paraprofessionals who are hired from and represent the language and culture of the community served, to deliver home visiting services to expectant mothers and parents with infants less than three months of age considered at high-risk for child abuse and neglect. Once enrolled, services are provided to families until the child enters kindergarten or Head Start. The program aims to reduce child maltreatment, increase use of prenatal care, improve parent-child interactions and school readiness, ensure healthy child development, promote positive parenting, promote family self-sufficiency and decrease dependency on public assistance and other social services. The national model developer for HFNY is Healthy Families America. The contact person for organizations seeking to establish and/or expand HFNY programs within NYS is:

Bernadette Johnson, Program Coordinator
Healthy Families New York
NYS Office of Children and Family Services
Bernadette.Johnson@ocfs.state.ny.us

In addition to the above two models, applicants may propose to utilize a portion of their MIECHV grant (up to 10% of the amount requested) to support additional HRSA-designated evidence-based programs if they will be implemented in collaboration with a NFP or HFNY program as part of a coordinated community-wide systems approach. Other HRSA-designated evidence-based home visiting programs currently include: Early Head Start, Family Check Up, Healthy Steps, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY), The Public Health Nursing Early Intervention Program for Adolescent Mothers, and Child First. See http://homvee.acf.hhs.gov/ for further information on these models, and **Attachment 18** for a list of NYS contacts for programs currently operating in NYS.

Assessment of Community Needs and Resources

MIECHV projects will be based on comprehensive community assessments, as described in Section I. Introduction. Component B applications will include a preliminary community assessment that incorporates:

- Identification of specific target populations and geographic communities for home

visiting services;
- A critical analysis of community-level data, needs and strengths related to each of the six MIECHV benchmark areas (see below); and
- A description of the availability and capacity of existing home visiting programs to serve the target community, and identification of key gaps in services.

The community assessments presented in Component B applications should build upon prior assessments conducted within the community, as well as the statewide MIECHV Needs Assessment, which is available at:
http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/

Assessment is viewed as an ongoing activity, not a stand-alone "planning" phase of funded projects. Funded Component B grantees will be expected to conduct ongoing assessment of community needs and strengths to identify persistent and emerging issues and opportunities. Component B grantees will be expected to contribute to and build upon the development of annual updated community assessments and improvement plans required for Component A MICHC grantees described under Component A, **Assessment of Community Needs and Resources**.

Performance Standards and Improvement Strategies

Five **performance standards** have been established for Component B. As described for Component A above, a performance standard is a generally accepted, objective standard of measurement against which a grantee's level of performance can be compared; it establishes the level of performance expected.

Performance Standard 1: Home visitors are recruited, trained and deployed consistent with model-specific requirements

The selection, training and on-going support of staff members hired to work with women and their families in their homes requires careful consideration of the unique needs of the program and communities being served. The characteristics, qualifications and training of home visitors are important elements of evidence-based home visiting program models and may represent unique strengths of a particular model. For example, the **HFA-HFNY** program utilizes home visitors who are trained paraprofessionals recruited from the targeted community who share the same language and cultural background as program participants. Personal attributes such as warmth, the ability to establish trusting relationships, the ability to work effectively with children and families, and non-judgmental attitudes are the primary selection criteria. The **NFP** program utilizes registered nurses as home visitors, based on nurses' unique professional knowledge and experience that is appealing to first-time mothers during the critical life transition of pregnancy and new parenthood. They have the ability to answer questions and concerns that a pregnant woman may have regarding their health and their baby's health. Registered nurses have an educational background that teaches them to listen, assess, plan, teach, refer, and support, thus

preparing them to conduct the strengths-focused assessments and deliver the individualized interventions that are part of the NFP program model.

To meet this performance standard, Component B grantees will develop and carry out plans to: recruit and hire staff that meet minimum and preferred qualifications for program management supervision and home visiting positions as required by the model developer of the home visiting model selected; facilitate provision of core training of home visiting staff as required by the model developer, as well as additional training to be provided in conjunction with the new MIH-COE; and provide professional supervision of home visitor staff in accordance with model developer requirements. To promote staff retention, plans should address opportunities for staff development; recognition of achievement; diversification of caseloads to avoid burnout; and supportive supervision.

Performance Standard 2: High-need families are identified, screened for eligibility and enrolled in evidence-based home visiting program services

Finding, engaging and retaining families are critical to the success of home visiting programs. All programs need to develop and implement plans to conduct outreach to identify high-need women and families who may be eligible for program participation. Outreach and recruitment efforts should include a strong emphasis on engaging pregnant women who are not yet receiving prenatal care, and women and families who may avoid health services for such reasons as substance abuse, domestic violence, disabling impairment, lack of trust or other factors. Home visiting programs should partner with a variety of community organizations and service providers, including local hospitals, prenatal care providers, schools, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics, community- and faith-based organizations and other agencies serving high-need pregnant and newly parenting families, to promote referrals of potential home visiting clients. Non-traditional partners that may interact with high-need individuals or populations, particularly those that may be less likely to seek support through traditional service systems, should be engaged to improve outreach and referral for home visiting services. Special emphasis should be placed on identifying and engaging pregnant women who may be at especially high risk for late or inadequate use of prenatal care, including women experiencing depression or other mental health issues, alcohol or substance abuse, domestic violence and/or unintended or unwanted pregnancies. Programs also will need to develop and implement engagement strategies to improve the acceptance rate for home visiting program enrollment among families who are eligible for services, and to improve retention in services/minimize attrition among clients once enrolled in services, with particular emphasis on any sub-groups that typically have lower acceptance rates.

Performance Standard 3: Home Visiting services are provided to enrolled clients with fidelity to the evidence-based program model selected

Fidelity is a key emphasis of the federal and NYS MIECHV initiatives. The national MIECHV initiative places emphasis on building states' capacity to assess the fidelity and quality of the replication and expansion of evidence-based home visiting models. Fidelity includes adhering to

a model's staffing, training, certification and supervision requirements; delivering family-level services at the specified intensity (dosage); and covering the prescribed content. "Fidelity is the extent to which an intervention is implemented as intended by its designers (the model developer). It refers not only to whether or not all the intervention components and activities were actually implemented, but also to whether they were implemented properly".[90] Applicants proposing implementation of the HFNY model are required to implement the 12 Healthy Families America critical elements in a way that meet the needs of the community served and to adhere to the policies and procedures set forth in the HFNY policy manual and accreditation standards (available at www.healthyfamiliesnewyork.org). Applicants proposing implementation of the NFP model are required to adhere to the 18 required model elements, use NFP-specific implementation tools, and adhere to NFP Implementation Plan and Guidance documents (available at www.nursefamilypartnership.org).

In accordance with national MIECHV requirements, applicants wishing to adapt the model chosen need prior approval by the respective model developer. An acceptable adaptation includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts. Continued approval of the program model developer will be a condition of ongoing grant funding. See **Attachment 19** for specific model elements for NFP and **Attachment 20** for specific model elements for HFA.

Performance Standard 4: Measurable improvements across key benchmark areas will be achieved for families participating in home visiting services.

Consistent with the authorizing legislation and federal guidance, NYS's MIECHV initiative is expected to promote specific outcomes within each of the following six required **MIECHV benchmark** areas:

1. Improved maternal and newborn health;
2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
3. Improvement in school readiness and achievement;
4. Reduction in crime or domestic violence;
5. Improvements in family economic self-sufficiency; and
6. Improvements in the coordination and referrals for other community resources and supports.

Each benchmark area includes multiple constructs. Each respective evidence-based home visiting program model incorporates a variety of strategies to assess, address and document services and outcomes in these areas. Funded grantees will be required to fully participate in data collection, reporting and monitoring activities as described further under ***Performance Measurement, Monitoring and Reporting*** below. A minimum set of performance measures for

[90] Daro, Deborah. "Replicating Evidence-Based Home Visiting Models: A Framework for Assessing Fidelity." HRSA Brief. Brief 3. December 2010.

the constructs within each benchmark area has been drafted (see **Attachment 21**). Additional measures may be added during the grant implementation period. Funded grantees will also be required to comply with model specific data collection, reporting and monitoring requirements.

Performance Standard 5: Home visiting programs will be coordinated and integrated with larger community maternal, infant and early childhood service systems.

The full positive impact of evidence-based home visiting services cannot be achieved unless those services are integrated within broader community efforts to improve population health outcomes. For any intervention to realize a notable and sustained reduction in a participant's risk factors or improvements in key protective factors, the planning process should consider the complementary changes that need to occur in the major institutions and norms that influence a parent's actions and shape a child's social environment. [91] High-need women and families should receive assistance from a system of support and services that promotes optimal health, mental health, family functioning and self-sufficiency. Such a system of services would include outreach and engagement of high-need women and families; assessment of parent, child and family health, mental health, development, social and other service needs; and early intervention and referrals to an array of coordinated supports and services including home visiting services as needed.[92]

Home visiting is a key component of this system of care. Component B grantees will be expected to work collaboratively with other community partners, including MIH Component A grantees, to coordinate outreach, referral, assessment and intake processes with other home visiting programs (see **Attachments 4, 5 and 17** for list of current HFNY, NFP and MIECHV grantees respectively) and other service providers within the target community (see **Attachments 3, 6, 7, 8, 9, 14, and 15**). Grantees should establish reciprocal referral agreements with other formal service providers such as prenatal care, family planning, substance abuse, mental health, domestic violence, nutrition services, child protective services, and other health and social services agencies. Grantees are also encouraged to promote and facilitate partnerships with informal family support resources within the community, such as Family Resource Centers (**Attachment 14**), Child Care Resource and Referral agencies (**Attachment 15),** libraries, parks and recreational activities, child care resource and referral agencies, parent support groups, etc., to support families' engagement and participation in these resources. Ultimately, through these broader systems-building and integration efforts, it is expected that home visiting programs will contribute to improvements in population-level outcomes, including reduction of racial, ethnic and economic disparities.

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[91] Daro D, Home Visitation: Assessing Progress, Managing Expectations, published by the Ounce of Prevention Fund and Chapin Hall Center for Children.

[92] Schuyler Center for Analysis and Advocacy, "Universal Prenatal/Postpartum Care and Home Visitation: The Plan for an Ideal System in New York State. October 2007.

Performance Measurement, Monitoring and Reporting

As described for Component A above, performance management is the practice of actively using performance data to improve the public's health. Continuous measurement and monitoring of performance is a critical element of performance management. Please refer to **Section B, Performance Measurement, Monitoring and Reporting o**f Component A of this RFA above for a general overview and information about different types of performance measures.

With guidance and technical assistance from NYSDOH and the MIH-COE, as well as the respective home visiting program model developer, all Component B grantees will be expected to collect, review and report on a set of defined performance measures to monitor and assess their progress and performance in implementing MIECHV programs and improving outcomes among home visiting client families. In turn, a subset of these measures will be reported to the federal Health Services and Resources Administration (HRSA) to fulfill federal requirements for MIECHV benchmark reporting. Final NYS measures, data collection and reporting tools and requirements will be provided and/or developed as part of the contracting process for funded grantees, and reporting requirements and/or tools may be modified over time. (See Attachment 21 MIECHV Benchmarks.)

All Component B grantees will be expected to incorporate activities to critically review their own data on a "real-time" basis to provide rapid-cycle feedback about performance and to promote continuous quality improvement. Grantees will be required to submit quarterly reports that reflect critical review of progress and performance data and any resulting changes to improvement program activities.

As a condition of funding, Component B grantees will be expected to participate in all DOH-designated data collection, reporting and evaluation activities. Additional NYS-specific evaluation activities may be established over the course of the initiative in consultation with the new MIH-COE. Currently there is no individual grantee-specific evaluation required. The federal grantor, HRSA, will carry out a national evaluation of the national MIECHV program. The NYSDOH will participate in activities of the national evaluation as requested by HRSA and may request participation of MIECHV grantees.

Budget and Funding Restrictions

Funds awarded through this RFA may be used to support activities of this grant and their associated costs. Specific costs that are allowable under this grant include but are not limited to personnel costs, consultant or subcontracting costs, staff training, basic infrastructure/overhead costs (e.g., rent, utilities, telephone), supplies, equipment, and limited incentives for target population participation. All funds requested for this grant should be included in the justification and show support for the proposed improvement strategies.

MIECHV grant funds may not be used to supplant funds for currently existing staff or organization activities, and allocation of program costs to MIECHV grant funds should be

proportionate across revenue and funding streams, including other grants, Medicaid or other reimbursement or funding for home visiting services.

Applicants that are currently operating either NFP or HFNY programs need to demonstrate that they have, or will develop, the capacity to serve additional clients with funding awarded through this RFA.

Projected Number of Awards and Funding Range

Funding to support Component B of the RFA is federal MIECHV grant funding awarded to NYS. Based on FY11 funding levels for NYS, approximately $1.18 million annually is available to fund 2 to 6 projects in the range of $200,000 to $750,000 annually. Within this funding range, the projected caseload and typical per-client costs for the selected model will be considered in determining the size of each award.

There is potential that additional funding will become available for Component B as a result of future increases in federal MIECHV grant funds for NYS. Should this occur, the NYSDOH reserves the right to increase the number of awards to be made through this RFA. See **Selection and Funding Methodology** below for additional detail.

Selection and Funding Methodology

1. Component B applications will be reviewed and scored by inter-agency teams of trained reviewers using a structured, pre-approved review tool. A minimum passing score of 65 (out of 100) points must be achieved to be considered for funding.
2. Applications will be sorted into two Tiers, based on the county they propose to serve, as described in *Target Communities* in **Section I** of this RFA.
   - Applicants may propose to serve more than one county.
   - A separate application must be submitted, and will be reviewed and scored separately, for each Tier 1 county.
   - A single application may be submitted to serve multiple Tier 2 counties, alone or in combination with up to one Tier 1 county, if the applicant proposes to serve those as part of a coordinated regional/multi-county initiative.

Applicant proposes to serve counties in Tier:	Application Requirement
1: *counties of Albany, Bronx, Erie, Kings, Monroe, Nassau, New York, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, Westchester*	Separate application required to serve each of these counties
2: *all remaining counties in New York State*	Single application proposing to serve multiple counties as part of a coordinated regional/multi-county project
1 and 2	Single application to serve one or multiple Tier 2 county(ies), alone or in combination with up to one Tier 1 county.

For example:

- ➢ An applicant that proposes to target areas in Bronx and Queens counties must submit separate applications for each of those counties, since both of these are designated as Tier 1 counties.
- ➢ An applicant that proposes to target areas in Albany, Greene and Columbia counties as part of a coordinated regional/multi-county initiative must submit one application for Albany (Tier 1), Greene (Tier 2) and Columbia (Tier 2).
- ➢ An applicant that is proposing to serve Broome, Tioga and Chenango counties must submit a single Tier 2 application that addresses all three counties as part of a single coordinated project. Separate Tier 2 applications from the same applicant organization for each of these counties individually will not be accepted.

3. Awards will be made in the following order, until all funding allocated for Component B has been distributed:
    a. Within Tier 1, awards will be made in order from highest to lowest score, except that in this initial step (i.e., step #3a), no more than one award will be made within any Tier 1 county and no additional funding will be awarded to the specific projects previously awarded MIECHV funding outside of this RFA (i.e., NFP in the Bronx, NFP in Monroe County, HFNY in the Bronx, and HFNY in Erie County) pursuant to NYS' MIECHV State Plan.
    b. All remaining passing applications from both Tiers 1 and 2 will then be combined, re-sorted into New York City (5 boroughs) vs. Rest of State, and ranked in order of decreasing score within each of these two regional groups.
    c. Awards will then be made in descending order by score, alternating between Rest of State and New York City, until all available funding has been awarded.
    d. In the case of an exact tie in score, the application with the proposed target area that accounts for the higher number of annual Medicaid births (2008-10) will be ranked higher.
4. Any applications that have received a score at or above the minimum passing score of 65, but that are not selected to receive an award through this RFA, will be designated as "approved but not funded" (ANF). Should additional funding become available to support MIECHV activities, additional awards will be made to fund these ANF applications in accordance with the funding methodology Steps #3a-c above.
5. Should this process result in awarding funds to multiple organizations to serve the same target area, the Department reserves the right to negotiate with funded applicants to adjust their target area to optimize the distribution and coordination of services across grantees.
6. Should the same applicant organization be selected to receive funding for more than one application, including multiple applications for Component B applications and/or an award for Component A, the awards may be integrated into a single award and administered as a single contract.
7. Funds will be awarded as a multi-year (3.25 -year) contract.

Note: Any funds awarded through the RFA to support HFNY programs will be sub-allocated to NYSOCFS to administer as an expansion of the NYSOCFS HFNY program.

C. Completing an Application

This section provides instructions to applicants on how to complete their applications, and identifies the specific criteria and parameters on which the applications will be competitively evaluated.

To apply for Component B funding, applicants should complete the Component B Application Template provided in Attachment 22. Separate applications are required for Component A and Component B that will be reviewed and scored separately.

Applicants should respond to each category and criteria described in full. In particular, applicants should note carefully items that are required in order for the proposal to be eligible for review.

ALL APPLICATIONS SHOULD CONFORM TO THE FORMAT PRESCRIBED **IN ATTACHMENT 22**.

Point value and page limit for each section are as follows:

Application Section	Maximum Score	Page Limit
Applicant Cover Page	**0**	**n/a**
Attestation of Eligibility	**0**	**n/a**
Executive Summary	**0**	**1**
Organizational Experience and Capacity	**20**	**7**
Assessment of Community Needs and Strengths	**20**	**7**
Improvement Plan	**30**	**20**
Performance Measurement, Monitoring and Reporting	**10**	**2**
Budget and Staffing Plan	**20**	3 page narrative limit, exclusive of budget tables and forms

IV. Administrative Requirements

A. Issuing Agency

This RFA is issued by the New York State Department of Health, Center for Community Health, Division of Family Health, Bureau of Maternal and Child Health. The NYSDOH is responsible for the requirements specified herein and, in conjunction with partnering state agencies, for the evaluation of all applications.

B. Question and Answer Phase

All substantive questions must be submitted in writing to:

Fran Mazzariello
Bureau of Maternal and Child Health
New York State Department of Health
Empire State Plaza
Corning Tower Building, Room 831
Albany, New York 12237-0621

Telephone: (518) 474-1911
Email: bmchph@health.state.ny.us Fax: (518) 474-7054

To the degree possible, each inquiry should cite the RFA section and paragraph to which it refers. Written questions received by October 25, 2012 will be addressed in the applicant webinar/conference call on October 29, 2012. All substantive questions must be received by November 9, 2012, and will be addressed in the written response to all questions to be posted on the Department's website.

Questions of a technical nature can be addressed in writing or via telephone to Fran Mazzariello. **Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.**

Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

This RFA has been posted on the Department's public website at: http://www.health.ny.gov/funding/. Questions and answers, as well as any updates and/or modifications, will also be posted on the Department's website. All such updates will be posted on or about the date identified on the cover sheet of this RFA.

C. Applicant Conference Call and Letter of Intent to Apply

A non-mandatory applicant conference webinar will be held on the date indicated on the cover page of the RFA. The Department requests that potential applicants register for the conference call by returning the attached form "Registration for Applicant Conference Webinar" (**Attachment 23**) by the date indicated on the cover page of the RFA. This will help ensure availability of sufficient telephone lines. Responses to questions raised in the Applicant Conference Call will be posted on the Department's website at www.health.ny.gov/funding/#rfa. The telephone number and participant code will be emailed to those submitting a registration form.

A **letter of intent to apply** is not mandatory but is strongly encouraged. A list of potential applicants (i.e., those who submit a letter of intent to apply) will be posted on the Department's website by RFA component to facilitate collaborative applications. Please complete and submit a letter of intent to apply using the template provided in **Attachment 24**.

Any updates/modifications to this RFA (including responses to written questions, responses to questions raised at the applicant conference webinar, list of potential applicants from letters of intent received), will be posted on the Department's website at www.health.ny.gov/funding/#rfa.

D. How to file an application

A completed application must be **received** at the following address by the date and time posted on the cover sheet of this RFA. Late applications will not be accepted*.

Fran Mazzariello
Bureau of Maternal and Child Health
New York State Department of Health
Empire State Plaza
Corning Tower Building, Room 831
Albany, New York 12237-0621

If an applicant is applying for more than one component of this RFA, a separate application must be submitted for each component. Applicants shall submit 1 original, signed application and 5 copies. Application packages should be clearly labeled with the name and number of the RFA as listed on the cover of this RFA document. **Applications will not be accepted via fax or e-mail.**

It is the applicant's responsibility to see that applications are delivered to the address above prior to the date and time specified.

*Late applications due to a documentable delay by the carrier may be considered at the Nw York State Department of Health's discretion.
Applications meeting the guidelines set forth above and in the application template in Attachment 11 for Component A and Attachment 22 for Component B, will be reviewed and

evaluated competitively by trained review teams convened by the *NYSDOH Division of Family Health, Bureau of Maternal and Child Health* in collaboration with partnering state agencies.

Applications failing to provide all response requirements or failing to follow the prescribed format may be removed from consideration or points may be deducted.

If changes in funding amounts are necessary for this initiative, funding will be modified and awarded in the same manner as outlined in the award process described above.

Following the award of grants from this RFA, unsuccessful applicants may request a debriefing from the NYSDOH, Division of Family Health, Bureau Maternal and Child Health no later than 10 business days from the date of the award(s) announcement. This debriefing will be limited to the positive and negative aspects of the subject application. In the event that unsuccessful applicants wish to protest awards, please follow the procedures established by the New York State Comptroller found at: www.osc.state.ny.us.

E. The Department's Reserved Rights

THE DEPARTMENT OF HEALTH RESERVES THE RIGHT TO:

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at the Department's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications.
6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Conduct contract negotiations with the next responsible applicant, should the Department be unsuccessful in negotiating with the selected applicant.
13. Utilize any and all ideas submitted with the applications received.
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.

15. Waive or modify minor irregularities in applications received after prior notification to the applicant.
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of the RFA.
17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State.
18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.
19. Award grants based on geographic or regional considerations to serve the best interests of the state.

F. Term of Contract

Any contract resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller.

It is expected that contracts resulting from this RFA will be multi-year and have the following terms contingent on contractor performance and availability of funds:

- Component A: July 1, 2013 to June 30, 2018
- Component B: July 1, 2013 to September 29, 2016

G. Payment Methods & Reporting Requirements of Grant Awardees

1. The Department may, at its discretion, make an advance payment to not for profit grant contractors in an amount not to exceed 25 percent of the annualized award amount.

2. The grant contractor will be required to submit quarterly vouchers and required reports of expenditures to the State's designated payment office:

DESIGNATED PAYMENT OFFICE
All reports and claims for reimbursement, or reports and claims to account for the advance payment should be sent through the contract management system to:

For Component A and Component B NFP contracts:
BMCH Fiscal Unit
NYS Department of Health
Corning Tower, Room 878
Empire State Plaza
Albany, NY 12237

For Component B HFNY contracts:
N.Y.S. Office of Children & Family Services
52 Washington Street
Rensselaer, New York 12144-2796

Grant contractors shall provide complete and accurate billing vouchers to the Department's designated payment office in order to receive payment. Billing vouchers submitted to the Department must contain all information and supporting documentation required by the Contract, the Department and the State Comptroller. Payment for vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.
Payment of such vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be: *Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Workplan".*

3. The grant contractor will be required to submit the following periodic reports on a timely basis (within 30 days of the end of the quarter): substantive quarterly progress reports, an annual report, and a cumulative end of contract period report addressing all objectives and process implementation activities and outcomes per the approved workplan and budget. All reports should identify in-kind and other sources of income of the agency.

All payment and reporting requirements will be detailed in Appendix C of the final grant contract.

H. Vendor Identification Number

Effective January 1, 2012, in order to do business with New York State, you must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller's Bureau of State Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award and in order to initiate a contract with the New York State Department of Health, vendors must be registered in the New York State Vendor File and have a valid New York State Vendor ID.

If already enrolled in the Vendor File, please include the Vendor Identification number on the application cover sheet. If not enrolled, to request assignment of a Vendor Identification number, please submit a New York State Office of the State Comptroller Substitute Form W-9,

which can be found on-line at: http://www.osc.state.ny.us/vendors/substitute_formw9.pdf or by referencing Attachment 29 (Statewide Vendor File Registration SFS Portal Format).

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855-233-8363 or by emailing at helpdesk@sfs.ny.gov.

I. Vendor Responsibility Questionnaire

The New York State Department of Health recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us.

Vendors must provide their New York State Vendor Identification Number when enrolling.To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

Applicants should complete and submit the Vendor Responsibility Attestation (**Attachment 11**).

J. General Specifications

1. By signing the "Application Form" each applicant attests to its express authority to sign on behalf of the applicant.

2. Contractors will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by the Department during the Question and Answer Phase (Section IV.B.) must be clearly noted in a cover letter attached to the application.

4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ,

has previously failed to perform satisfactorily in connection with public bidding or contracts.

5. Provisions Upon Default

   a. The services to be performed by the Applicant shall be at all times subject to the direction and control of the Department as to all matters arising in connection with or relating to the contract resulting from this RFA.
   b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, the Department acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.
   c. If, in the judgment of the Department, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

K. Appendices Included in DOH Grant Contracts

The following will be incorporated as appendices into any contract(s) resulting from this Request for Application. Copies of the NYSDOH standard contract and appendices and the NYSOCFS standard contract and appendices are found in **Attachments 26a and 26b** respectively.

APPENDIX A -	Standard Clauses for All New York State Contracts
APPENDIX A-1	Agency Specific Clauses
APPENDIX A-2	Program Specific Clauses
APPENDIX B -	Detailed Budget
APPENDIX C -	Payment and Reporting Schedule
APPENDIX D -	Workplan
APPENDIX G -	Notifications

APPENDIX H - Federal Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement

APPENDIX E - Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:

Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:

- **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR

- **C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR

- **SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:

- **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR

- **DB-120.1** -- Certificate of Disability Benefits Insurance OR

- **DB-155** -- Certificate of Disability Benefits Self-Insurance

NOTE: Do not include the Workers' Compensation and Disability Benefits forms with your application. These documents will be requested as a part of the contracting process should you receive an award.

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
ALBANY	12009	179	4	2.2	17	10.7	5	3.2	19	10.6	21.4
ALBANY	12023	69	6	8.7	4	6.1	3	4.8	13	18.8	26.0
ALBANY	12047	698	59	8.5	78	12.1	23	3.7	165	23.7	60.7
ALBANY	12054	452	35	7.7	43	10.4	4	1.0	33	7.3	9.8
ALBANY	12059	36	5	13.9	4	12.1	2	6.5	11	30.6	11.7
ALBANY	12067	46	4	8.7	4	9.5	0	0.0	4	8.7	7.8
ALBANY	12077	147	10	6.8	16	11.8	4	2.9	14	9.5	7.7
ALBANY	12084	184	18	9.8	21	12.1	5	3.0	7	3.8	9.8
ALBANY	12110	460	23	5.0	34	7.8	14	3.3	45	9.8	18.9
ALBANY	12143	206	13	6.3	22	11.5	8	4.3	59	28.6	22.5
ALBANY	12158	227	14	6.2	16	7.8	3	1.5	39	17.2	15.6
ALBANY	12159	134	3	2.2	9	7.1	3	2.5	11	8.2	11.5
ALBANY	12183	116	8	6.9	7	6.9	3	3.0	28	24.1	62.8
ALBANY	12186	134	11	8.2	7	5.9	1	0.9	9	6.7	14.7
ALBANY	12189	618	44	7.1	66	11.3	21	3.7	134	21.7	28.0
ALBANY	12193	52	3	5.8	5	10.0	3	6.3	11	21.2	30.7
ALBANY	12202	508	64	12.6	65	14.4	20	4.7	295	58.1	107.4
ALBANY	12203	667	41	6.1	42	7.0	28	4.8	150	22.5	8.0
ALBANY	12204	275	29	10.5	26	10.3	7	2.8	89	32.5	77.2
ALBANY	12205	766	57	7.4	77	10.9	19	2.7	135	17.6	33.1
ALBANY	12206	913	106	11.6	117	14.6	63	8.2	473	51.8	118.7
ALBANY	12207	88	15	17.0	12	15.4	5	6.9	56	63.6	142.9
ALBANY	12208	753	81	10.8	78	11.2	27	4.0	161	21.4	31.9
ALBANY	12209	466	44	9.4	53	12.4	17	4.1	150	32.3	61.3
ALBANY	12210	453	60	13.2	46	11.6	23	6.0	224	49.6	153.7
ALBANY	12211	205	15	7.3	26	13.4	4	2.1	19	9.3	8.5
ALBANY	12303	1,010	90	8.9	102	10.7	41	4.7	273	27.1	59.8

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
ALLEGANY	14709	53	3	5.7	3	6.0	4	8.2	20	37.7	7.1
ALLEGANY	14711	79	4	5.1	10	13.5	11	14.9	22	27.8	34.5
ALLEGANY	14715	108	10	9.3	13	12.9	6	5.9	47	43.5	52.3
ALLEGANY	14727	167	7	4.2	20	12.3	3	1.9	60	35.9	67.1
ALLEGANY	14735	128	15	11.7	13	11.2	19	16.4	36	28.6	44.9
ALLEGANY	14739	121	8	6.6	12	10.4	5	4.3	58	47.9	83.3
ALLEGANY	14744	41	3	7.3	3	7.9	3	7.9	9	22.0	1.4
ALLEGANY	14770	90	5	5.6	7	8.1	2	2.4	28	31.1	36.7
ALLEGANY	14804	46	4	8.7	3	6.7	2	4.4	8	17.4	32.8
ALLEGANY	14806	98	6	6.1	11	11.6	2	2.1	31	31.6	31.1
ALLEGANY	14813	64	4	6.3	8	12.7	4	6.3	29	45.3	23.8
ALLEGANY	14822	35	3	8.6	4	11.8	1	2.9	11	31.4	68.4
ALLEGANY	14880	56	5	8.9	10	19.2	0	0.0	17	30.4	70.2
ALLEGANY	14895	322	25	7.8	38	12.8	4	1.4	141	43.8	53.5
ALLEGANY	14897	39	3	7.7	3	9.4	3	9.4	16	41.0	32.3

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
BROOME	13744	33	3	9.1	4	12.1	1	3.2	8	24.2	53.8
BROOME	13746	72	5	6.9	5	7.0	1	1.4	18	25.0	39.7
BROOME	13748	86	8	9.3	9	10.5	1	1.2	27	31.4	56.0
BROOME	13754	122	11	9.0	21	17.2	4	3.4	48	39.3	76.5
BROOME	13760	1,459	96	6.6	135	9.3	44	3.1	340	23.3	40.5
BROOME	13787	92	7	7.6	8	8.7	3	3.3	33	35.9	46.9
BROOME	13790	656	65	9.9	91	14.0	28	4.5	190	29.0	70.7
BROOME	13795	105	12	11.4	16	15.7	0	0.0	26	24.8	42.1
BROOME	13797	85	11	12.9	9	11.5	6	7.9	19	22.4	54.9
BROOME	13833	126	11	8.7	13	10.4	2	1.6	36	28.6	57.7
BROOME	13850	489	32	6.5	45	9.3	11	2.4	50	10.2	3.2
BROOME	13862	140	5	3.6	10	7.3	2	1.5	36	25.7	34.5
BROOME	13865	161	7	4.3	9	5.6	2	1.3	42	26.1	35.4
BROOME	13901	702	77	11.0	86	12.4	26	3.8	229	32.7	74.1
BROOME	13903	646	43	6.7	72	11.3	18	2.9	180	28.0	64.4
BROOME	13904	286	23	8.0	30	10.6	14	5.0	73	25.5	70.2
BROOME	13905	941	65	6.9	104	11.2	38	4.2	338	35.9	88.3

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
CATTARAUGUS	14042	172	11	6.4	16	9.6	7	4.3	43	25.0	59.0
CATTARAUGUS	14065	83	5	6.0	5	6.9	6	8.6	21	25.9	48.4
CATTARAUGUS	14070	171	11	6.4	21	12.9	6	3.7	47	27.6	65.0
CATTARAUGUS	14101	67	7	10.4	11	16.9	1	1.5	21	31.3	63.8
CATTARAUGUS	14129	64	2	3.1	9	15.0	2	3.3	27	42.2	134.9
CATTARAUGUS	14138	93	29	31.2	8	12.7	9	14.5	18	22.8	44.1
CATTARAUGUS	14171	58	4	6.9	1	1.9	1	2.0	7	12.1	33.3
CATTARAUGUS	14706	154	6	3.9	14	9.2	5	3.3	32	20.8	16.8
CATTARAUGUS	14719	137	50	36.5	17	17.9	7	7.4	17	15.2	38.3
CATTARAUGUS	14726	195	147	75.4	2	4.9	12	29.3	12	11.3	18.3
CATTARAUGUS	14737	154	6	3.9	23	15.9	4	2.8	51	33.1	45.1
CATTARAUGUS	14738	79	2	2.5	1	1.3	2	2.6	38	48.1	34.3
CATTARAUGUS	14741	57	5	8.8	7	12.5	3	5.5	9	15.8	43.0
CATTARAUGUS	14743	56	7	12.5	8	14.8	0	0.0	14	25.0	47.6
CATTARAUGUS	14753	37	3	8.1	7	19.4	4	11.1	11	29.7	29.8
CATTARAUGUS	14755	89	13	14.6	9	12.2	5	6.8	19	22.9	14.7
CATTARAUGUS	14760	716	45	6.3	92	13.3	20	2.9	262	36.6	72.0
CATTARAUGUS	14772	218	57	26.1	24	14.6	4	2.4	55	29.3	47.9
CATTARAUGUS	14779	319	26	8.2	43	13.7	12	3.9	163	51.1	87.6

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
CAYUGA	13021	1,367	91	6.7	157	11.6	41	3.0	637	46.6	45.4
CAYUGA	13026	41	4	9.8	3	7.5	0	0.0	13	31.7	18.4
CAYUGA	13033	124	3	2.4	6	4.8	4	3.3	51	41.1	33.1
CAYUGA	13034	51	2	3.9	2	3.9	0	0.0	20	39.2	26.0
CAYUGA	13081	31	4	12.9	4	13.8	0	0.0	12	38.7	30.3
CAYUGA	13092	80	8	10.0	10	13.9	6	8.3	27	34.2	19.0
CAYUGA	13111	45	1	2.2	5	11.6	3	7.1	26	57.8	21.2
CAYUGA	13118	178	9	5.1	9	5.6	4	2.5	77	43.5	42.9
CAYUGA	13140	142	16	11.3	23	16.4	3	2.2	56	39.4	48.5
CAYUGA	13147	38	7	18.4	5	13.2	2	5.7	16	42.1	42.6
CAYUGA	13156	54	1	1.9	1	1.9	3	5.7	22	40.7	39.8
CAYUGA	13160	34	1	2.9	5	15.2	0	0.0	13	38.2	11.5
CAYUGA	13166	157	6	3.8	14	9.1	5	3.2	66	42.0	35.4

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

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CHAUTAUQUA	14048	599	62	10.4	77	13.2	35	6.0	349	58.3	102.2
CHAUTAUQUA	14062	94	11	11.7	9	10.1	6	7.0	28	30.1	35.9
CHAUTAUQUA	14063	278	21	7.6	34	13.0	11	4.2	90	32.6	11.5
CHAUTAUQUA	14136	165	13	7.9	18	11.3	8	5.1	46	27.9	59.5
CHAUTAUQUA	14701	1,546	123	8.0	169	11.4	81	5.5	891	57.7	83.8
CHAUTAUQUA	14710	92	7	7.6	5	6.0	3	3.6	26	29.2	33.9
CHAUTAUQUA	14712	54	10	18.5	8	16.3	4	8.3	16	29.6	34.7
CHAUTAUQUA	14716	71	9	12.7	12	16.9	2	2.9	32	45.1	15.5
CHAUTAUQUA	14718	47	7	14.9	8	18.2	3	7.0	14	29.8	20.4
CHAUTAUQUA	14723	44	10	22.7	4	11.8	2	5.9	11	28.9	42.4
CHAUTAUQUA	14724	99	7	7.1	10	10.9	19	20.9	23	23.2	29.0
CHAUTAUQUA	14728	43	14	32.6	2	6.7	5	16.7	6	16.7	18.0
CHAUTAUQUA	14733	107	11	10.3	13	12.9	4	4.0	35	32.7	74.8
CHAUTAUQUA	14740	36	8	22.2	0	0.0	2	7.1	11	34.4	33.3
CHAUTAUQUA	14747	68	11	16.2	8	12.9	4	6.5	23	35.4	43.9
CHAUTAUQUA	14750	96	13	13.5	11	11.7	2	2.2	25	26.0	33.1
CHAUTAUQUA	14757	92	13	14.1	14	17.7	6	7.7	28	32.6	40.1
CHAUTAUQUA	14767	82	12	14.6	6	9.0	17	27.0	18	23.1	8.3
CHAUTAUQUA	14775	67	10	14.9	6	9.2	6	9.2	35	52.2	49.4
CHAUTAUQUA	14781	83	7	8.4	10	12.5	14	17.7	18	22.0	78.4
CHAUTAUQUA	14782	79	7	8.9	12	15.4	6	7.8	33	41.8	73.3
CHAUTAUQUA	14784	42	11	26.2	7	21.2	1	3.1	17	43.6	40.7
CHAUTAUQUA	14787	164	12	7.3	19	12.2	6	4.0	65	39.9	43.4

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CHEMUNG	14814	56	3	5.4	5	9.6	1	1.9	3	5.4	9.5
CHEMUNG	14838	47	3	6.4	8	17.4	1	2.2	25	53.2	30.3
CHEMUNG	14845	503	38	7.6	52	10.7	7	1.4	152	30.3	23.3
CHEMUNG	14861	46	3	6.5	6	14.3	1	2.4	22	47.8	58.8
CHEMUNG	14871	117	15	12.8	25	21.9	0	0.0	31	26.5	18.4
CHEMUNG	14889	44	2	4.5	0	0.0	0	0.0	19	43.2	26.7
CHEMUNG	14894	47	4	8.5	5	11.6	1	2.3	30	63.8	63.5
CHEMUNG	14901	699	74	10.6	90	13.2	19	2.8	537	76.8	110.0
CHEMUNG	14903	236	22	9.3	26	11.3	7	3.0	110	46.6	64.0
CHEMUNG	14904	697	63	9.0	75	11.1	9	1.3	456	65.6	74.3
CHEMUNG	14905	312	27	8.7	31	10.2	4	1.3	120	38.5	41.0

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CHENANGO	13411	104	4	3.8	7	6.9	5	5.0	62	59.6	29.8
CHENANGO	13460	128	4	3.1	4	3.1	3	2.4	62	48.4	50.6
CHENANGO	13464	31	3	9.7	7	22.6	2	6.5	15	48.4	43.2
CHENANGO	13730	85	3	3.5	5	6.0	3	3.6	41	48.2	28.1
CHENANGO	13733	157	12	7.6	15	9.8	2	1.3	69	44.2	38.1
CHENANGO	13778	143	6	4.2	11	7.7	3	2.2	57	39.9	38.3
CHENANGO	13801	51	7	13.7	10	21.3	1	2.2	27	54.0	29.0
CHENANGO	13809	43	4	9.3	3	7.1	1	2.4	19	46.3	24.9
CHENANGO	13815	489	36	7.4	44	9.1	3	0.6	265	54.2	55.8
CHENANGO	13830	146	15	10.3	15	10.4	2	1.4	59	40.7	29.9

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CLINTON	12901	951	70	7.4	88	9.3	11	1.2	482	50.7	36.4
CLINTON	12910	76	4	5.3	8	10.7	1	1.4	39	51.3	56.5
CLINTON	12912	71	4	5.6	4	5.6	1	1.4	25	35.2	52.6
CLINTON	12918	75	3	4.0	7	9.3	1	1.3	21	28.0	17.1
CLINTON	12919	84	6	7.1	12	14.3	0	0.0	35	41.7	21.6
CLINTON	12921	74	2	2.7	6	8.2	0	0.0	30	40.5	34.5
CLINTON	12934	38	1	2.6	1	2.7	3	8.1	22	57.9	46.3
CLINTON	12935	54	11	20.4	10	19.2	0	0.0	19	35.2	68.4
CLINTON	12958	60	2	3.3	1	1.7	0	0.0	23	38.3	46.5
CLINTON	12959	40	1	2.5	5	12.5	1	2.5	22	55.0	57.1
CLINTON	12962	163	9	5.5	10	6.2	5	3.1	52	31.9	32.8
CLINTON	12972	186	14	7.5	25	13.4	1	0.5	61	32.8	40.9
CLINTON	12979	65	7	10.8	9	14.3	1	1.6	24	36.9	54.2
CLINTON	12981	128	5	3.9	10	7.9	1	0.8	56	43.8	39.8
CLINTON	12985	36	1	2.8	3	8.3	1	2.8	26	72.2	66.7
CLINTON	12992	174	14	8.0	20	11.8	3	1.8	69	39.7	62.6

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COLUMBIA	12037	82	5	6.1	7	8.8	3	4.0	13	16.9	32.0
COLUMBIA	12075	85	7	8.2	5	6.1	0	0.0	9	11.3	24.1
COLUMBIA	12106	65	8	12.3	8	12.5	0	0.0	6	9.2	21.5
COLUMBIA	12125	32	3	9.4	3	11.5	0	0.0	9	36.0	38.1
COLUMBIA	12173	64	3	4.7	5	8.2	4	6.5	8	12.5	30.7
COLUMBIA	12184	187	15	8.0	23	12.9	4	2.3	25	13.5	22.5
COLUMBIA	12513	48	2	4.2	7	14.6	3	6.3	6	12.5	36.5
COLUMBIA	12516	44	2	4.5	3	7.1	2	7.1	5	16.7	37.9
COLUMBIA	12521	44	7	15.9	8	19.5	1	2.6	8	20.0	36.2
COLUMBIA	12523	66	6	9.1	8	12.5	2	3.2	7	10.6	31.7
COLUMBIA	12526	97	4	4.1	5	5.4	6	6.7	11	11.5	27.8
COLUMBIA	12529	63	8	12.7	10	17.5	1	2.2	7	13.7	42.2
COLUMBIA	12534	610	53	8.7	68	11.5	34	5.9	107	17.7	47.4

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CORTLAND	13040	89	2	2.2	5	6.6	0	0.0	48	53.9	51.8
CORTLAND	13045	965	78	8.1	90	10.7	15	1.8	495	51.3	28.1
CORTLAND	13077	209	22	10.5	23	12.1	2	1.0	87	41.6	43.5
CORTLAND	13101	96	7	7.3	11	12.9	0	0.0	47	49.0	21.5
CORTLAND	13158	49	4	8.2	7	17.1	0	0.0	25	52.1	65.5
CORTLAND	13803	118	6	5.1	5	4.8	4	3.9	51	43.2	28.6

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DELAWARE	12167	87	5	5.7	8	9.3	3	3.5	51	58.6	52.6
DELAWARE	12430	39	4	10.3	5	14.7	2	7.4	17	43.6	30.3
DELAWARE	12455	36	2	5.6	2	6.1	0	0.0	10	28.6	30.3
DELAWARE	12776	73	10	13.7	6	8.8	4	5.8	28	38.4	19.0
DELAWARE	13739	39	1	2.6	5	12.8	1	2.6	17	43.6	10.6
DELAWARE	13753	101	3	3.0	5	5.1	6	6.5	38	37.6	12.5
DELAWARE	13755	32	3	9.4	5	15.6	2	6.5	16	50.0	9.8
DELAWARE	13757	32	1	3.1	2	6.5	0	0.0	12	37.5	41.7
DELAWARE	13775	47	4	8.5	4	8.5	0	0.0	12	25.5	46.5
DELAWARE	13783	81	8	9.9	9	11.3	2	2.6	38	46.9	62.2
DELAWARE	13838	166	15	9.0	27	16.3	9	5.7	78	47.0	58.0
DELAWARE	13839	45	1	2.2	2	4.5	2	4.5	16	35.6	14.2
DELAWARE	13849	156	9	5.8	8	5.1	6	3.9	68	43.6	45.5
DELAWARE	13856	230	18	7.8	15	6.7	5	2.3	126	54.8	39.3

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DUTCHESS	12501	61	2	3.3	2	3.4	0	0.0	3	10.3	16.9
DUTCHESS	12508	630	27	4.3	48	8.1	19	3.3	166	26.6	35.2
DUTCHESS	12514	65	2	3.1	7	10.9	0	0.0	8	12.3	15.5
DUTCHESS	12522	173	15	8.7	20	13.0	1	1.7	18	17.0	35.0
DUTCHESS	12524	455	25	5.5	35	8.2	8	1.9	45	10.0	20.1
DUTCHESS	12531	87	7	8.0	8	9.5	1	1.3	9	11.0	9.8
DUTCHESS	12533	666	49	7.4	81	12.5	14	2.2	63	9.5	10.9
DUTCHESS	12538	390	26	6.7	40	10.6	7	1.9	72	18.5	30.9
DUTCHESS	12540	154	12	7.8	17	11.7	3	2.1	17	11.1	19.8
DUTCHESS	12545	96	5	5.2	7	7.9	2	3.1	11	14.5	13.4
DUTCHESS	12546	81	9	11.1	7	9.7	2	22.2	1	3.1	35.1
DUTCHESS	12564	185	16	8.6	22	12.2	2	1.4	33	20.4	7.2
DUTCHESS	12567	87	8	9.2	11	13.3	0	0.0	8	13.1	12.7
DUTCHESS	12569	276	15	5.4	19	7.1	4	1.6	43	15.8	21.6
DUTCHESS	12570	178	7	3.9	13	7.5	3	1.8	9	5.1	13.7
DUTCHESS	12571	210	17	8.1	19	9.4	5	2.5	19	9.2	13.5
DUTCHESS	12572	175	14	8.0	17	9.9	1	0.6	20	11.5	13.5
DUTCHESS	12578	39	1	2.6	4	10.8	0	0.0	6	15.8	19.6
DUTCHESS	12580	99	6	6.1	11	11.5	3	3.1	22	22.2	15.0
DUTCHESS	12581	63	3	4.8	6	9.8	2	3.7	8	14.0	29.4
DUTCHESS	12582	119	4	3.4	10	8.5	0	0.0	12	10.9	11.0
DUTCHESS	12583	54	7	13.0	6	11.8	2	4.0	13	24.1	8.1
DUTCHESS	12590	1,070	63	5.9	87	8.5	24	2.4	220	20.7	21.3
DUTCHESS	12592	35	1	2.9	1	3.1	0	0.0	1	7.1	75.3
DUTCHESS	12594	123	11	8.9	13	11.7	2	2.9	20	22.0	19.0
DUTCHESS	12601	1,860	177	9.5	219	12.6	65	3.8	835	44.9	59.7
DUTCHESS	12603	1,284	94	7.3	131	10.7	21	1.7	269	21.0	21.5

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ERIE	14001	250	12	4.8	25	10.4	6	2.5	38	15.2	20.9
ERIE	14004	257	14	5.4	32	12.9	6	2.5	35	13.7	24.1
ERIE	14006	258	16	6.2	30	11.9	6	2.4	37	14.3	39.7
ERIE	14025	83	4	4.8	7	8.4	0	0.0	4	4.8	18.5
ERIE	14030	52	5	9.6	4	8.0	1	2.0	7	13.5	40.8
ERIE	14031	170	12	7.1	21	12.7	2	1.2	20	11.8	11.7
ERIE	14032	187	15	8.0	22	11.9	4	2.2	7	3.7	1.2
ERIE	14033	47	4	8.5	4	8.5	1	2.2	1	2.1	14.5
ERIE	14034	58	2	3.4	3	5.2	1	1.8	9	15.5	29.6
ERIE	14043	663	41	6.2	67	10.4	21	3.4	94	14.2	21.5
ERIE	14047	182	15	8.2	19	10.7	7	4.1	18	9.9	33.5
ERIE	14051	448	30	6.7	38	8.8	11	2.6	17	3.8	5.8
ERIE	14052	359	24	6.7	28	8.0	9	2.6	23	6.4	11.8
ERIE	14057	154	14	9.1	18	12.2	3	2.1	8	5.2	13.9
ERIE	14059	175	7	4.0	18	10.4	7	4.2	9	5.2	12.8
ERIE	14068	152	10	6.6	18	11.8	6	4.1	17	11.2	9.0
ERIE	14072	530	32	6.0	43	8.4	12	2.5	72	13.6	20.9
ERIE	14075	1,115	58	5.2	96	8.8	23	2.2	69	6.2	27.9
ERIE	14080	127	5	3.9	15	12.1	4	3.4	13	10.2	28.0
ERIE	14081	123	7	5.7	13	10.9	7	5.9	64	52.0	77.4
ERIE	14085	289	30	10.4	30	10.5	3	1.1	14	4.9	19.3
ERIE	14086	869	50	5.8	90	10.5	16	1.9	57	6.6	15.3
ERIE	14091	44	6	13.6	11	25.0	1	2.4	18	40.9	58.8
ERIE	14102	40	0	0.0	1	2.6	3	7.9	7	17.9	51.3
ERIE	14111	129	10	7.8	16	12.6	7	5.9	20	15.5	33.3
ERIE	14127	725	51	7.0	75	10.6	18	2.7	24	3.3	11.4
ERIE	14139	77	7	9.1	5	6.7	2	2.8	11	14.7	58.0
ERIE	14141	254	24	9.4	29	11.8	4	1.7	30	11.9	37.4
ERIE	14150	1,175	66	5.6	111	9.8	32	3.0	268	22.8	43.3
ERIE	14170	49	4	8.2	5	10.4	0	0.0	6	12.2	0.0

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ERIE	14201	586	48	8.2	65	12.4	17	3.6	164	28.1	120.3
ERIE	14202	113	7	6.2	6	5.8	0	0.0	34	30.1	48.6
ERIE	14204	349	35	10.0	53	16.6	20	6.9	106	30.5	140.7
ERIE	14206	760	68	8.9	84	11.8	36	5.4	186	24.5	92.7
ERIE	14207	1,265	130	10.3	150	12.7	67	6.1	576	45.6	124.8
ERIE	14208	385	41	10.6	60	17.0	24	7.8	150	39.0	74.1
ERIE	14209	243	29	11.9	28	12.7	12	6.6	68	28.1	157.4
ERIE	14210	655	47	7.2	69	10.8	25	4.2	142	21.7	84.0
ERIE	14211	1,073	142	13.2	160	16.3	76	8.7	413	38.6	148.1
ERIE	14212	522	66	12.6	60	12.7	35	8.4	209	40.1	110.1
ERIE	14213	1,392	135	9.7	176	14.1	94	8.5	468	33.7	105.9
ERIE	14214	670	69	10.3	83	13.0	33	5.6	220	32.9	58.7
ERIE	14215	1,866	241	12.9	297	17.1	113	7.2	732	39.2	140.3
ERIE	14216	861	51	5.9	81	9.9	23	3.1	163	18.9	50.3
ERIE	14217	730	47	6.4	67	9.4	26	3.7	116	15.9	40.4
ERIE	14218	792	73	9.2	79	10.3	46	6.3	141	17.8	85.9
ERIE	14219	347	29	8.4	41	12.1	10	3.1	39	11.2	40.8
ERIE	14220	978	75	7.7	97	10.1	35	3.8	122	12.5	59.4
ERIE	14221	1,163	65	5.6	101	8.8	31	2.8	64	5.5	13.5
ERIE	14222	287	16	5.6	18	6.5	7	2.8	35	12.2	53.6
ERIE	14223	647	40	6.2	53	8.4	15	2.5	97	15.0	24.9
ERIE	14224	959	65	6.8	106	11.2	20	2.2	61	6.4	20.4
ERIE	14225	1,111	89	8.0	132	12.3	38	3.7	215	19.4	61.1
ERIE	14226	1,017	79	7.8	109	10.9	29	3.0	132	13.0	27.7
ERIE	14227	629	54	8.6	60	9.8	17	2.9	64	10.2	23.8
ERIE	14228	636	51	8.0	54	8.7	25	4.2	101	15.9	37.8

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
ESSEX	12870	49	2	4.1	3	6.4	1	2.2	4	8.2	49.6
ESSEX	12883	178	15	8.4	15	8.7	10	5.8	86	48.3	64.0
ESSEX	12928	62	0	0.0	2	3.3	3	4.9	29	46.8	34.5
ESSEX	12944	127	12	9.4	14	11.2	1	0.8	63	49.6	57.7
ESSEX	12946	138	11	8.0	11	8.2	4	3.0	40	29.0	13.1
ESSEX	12956	61	14	23.0	10	16.7	2	3.3	33	55.9	62.5
ESSEX	12974	37	5	13.5	5	14.7	1	3.2	15	40.5	50.7
ESSEX	12996	49	10	20.4	9	18.4	0	0.0	18	36.7	63.5
ESSEX	12997	41	2	4.9	3	7.7	1	2.6	16	39.0	37.9

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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FRANKLIN	12916	75	2	2.7	6	8.5	6	8.5	30	40.5	42.3
FRANKLIN	12917	67	6	9.0	6	9.1	14	21.9	22	32.8	21.3
FRANKLIN	12920	66	5	7.6	10	15.2	2	3.1	18	27.3	29.9
FRANKLIN	12926	85	6	7.1	11	13.4	2	2.4	30	35.3	30.7
FRANKLIN	12937	47	0	0.0	3	6.5	3	6.5	20	42.6	15.2
FRANKLIN	12953	401	28	7.0	42	10.7	16	4.1	209	52.1	56.3
FRANKLIN	12957	59	5	8.5	4	7.3	3	5.5	35	60.3	54.4
FRANKLIN	12966	95	7	7.4	11	11.6	4	4.2	42	44.2	52.8
FRANKLIN	12983	248	17	6.9	25	10.3	3	1.2	64	25.8	41.7
FRANKLIN	12986	178	23	12.9	20	11.5	2	1.1	56	31.6	57.0
FRANKLIN	12989	38	1	2.6	4	10.8	0	0.0	10	26.3	16.9
FRANKLIN	13655	120	4	3.3	19	16.0	5	4.2	91	75.8	59.7

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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FULTON	12025	137	13	9.5	16	12.3	3	2.3	32	23.4	46.3
FULTON	12078	826	68	8.2	80	10.7	28	3.7	360	43.6	70.6
FULTON	12095	361	30	8.3	27	8.1	12	3.7	112	31.0	44.8
FULTON	12117	98	5	5.1	7	7.6	0	0.0	29	29.6	44.2
FULTON	13329	124	11	8.9	20	16.5	3	2.5	46	37.1	77.9
FULTON	13452	173	11	6.4	18	11.0	7	4.3	58	33.5	38.5

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

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GENESEE	14005	57	4	7.0	5	10.0	2	4.2	15	26.3	14.9
GENESEE	14013	76	5	6.6	12	16.9	4	5.9	28	36.8	49.0
GENESEE	14020	779	56	7.2	73	10.3	21	3.0	270	34.7	50.0
GENESEE	14036	123	9	7.3	13	10.9	2	1.7	16	13.0	21.5
GENESEE	14040	56	4	7.1	6	11.3	0	0.0	11	19.6	26.5
GENESEE	14054	57	4	7.0	6	11.8	0	0.0	11	19.3	40.7
GENESEE	14058	95	3	3.2	8	9.0	3	3.4	25	26.3	56.3
GENESEE	14125	121	10	8.3	16	14.3	3	2.7	37	30.6	39.9
GENESEE	14143	38	1	2.6	5	15.2	0	0.0	9	23.7	55.6
GENESEE	14416	99	7	7.1	7	8.0	3	3.5	16	16.3	36.5
GENESEE	14422	81	4	4.9	7	8.9	0	0.0	18	22.2	35.9
GENESEE	14482	303	13	4.3	21	7.5	6	2.2	73	24.1	53.8
GENESEE	14525	81	3	3.7	6	8.0	1	1.4	23	28.4	33.3

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
GREENE	12015	92	6	6.5	10	11.0	0	0.0	8	8.7	13.2
GREENE	12051	131	10	7.6	12	10.1	6	5.4	17	13.0	7.9
GREENE	12058	39	3	7.7	4	10.5	1	2.7	7	17.9	45.8
GREENE	12083	104	8	7.7	12	12.0	4	4.1	26	25.0	38.7
GREENE	12087	36	5	13.9	6	17.6	0	0.0	9	25.0	13.9
GREENE	12192	50	3	6.0	0	0.0	1	2.1	16	32.0	13.7
GREENE	12413	131	12	9.2	13	10.4	4	3.3	27	20.6	81.6
GREENE	12414	346	34	9.8	53	15.8	19	5.8	55	15.9	31.3
GREENE	12431	36	3	8.3	6	18.2	0	0.0	3	8.3	12.1
GREENE	12451	39	3	7.7	7	18.4	0	0.0	4	10.3	18.5
GREENE	12463	38	1	2.6	2	5.3	2	5.4	8	21.1	49.6

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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HAMILTON	12134	111	5	4.5	11	10.9	5	5.0	25	22.5	30.0

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

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HERKIMER	13322	38	2	5.3	9	23.7	2	5.3	14	36.8	48.8
HERKIMER	13324	53	2	3.8	6	11.8	2	3.9	30	56.6	54.1
HERKIMER	13338	42	4	9.5	3	7.3	3	7.1	17	40.5	45.0
HERKIMER	13340	215	10	4.7	17	7.9	1	0.5	102	47.4	36.0
HERKIMER	13350	305	21	6.9	31	10.2	4	1.3	159	52.1	89.0
HERKIMER	13357	399	34	8.5	37	9.4	2	0.5	177	44.5	65.4
HERKIMER	13365	291	27	9.3	29	10.2	15	5.3	117	40.5	65.6
HERKIMER	13407	166	11	6.6	20	12.1	2	1.2	72	43.4	48.2
HERKIMER	13416	65	8	12.3	8	12.5	3	4.6	28	43.1	8.4
HERKIMER	13431	63	7	11.1	12	20.0	4	6.7	19	30.2	30.8

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JEFFERSON	13601	2,165	159	7.3	233	11.6	85	4.4	783	36.3	58.5
JEFFERSON	13602	58	7	12.1	10	19.2	5	10.2	1	1.8	19.3
JEFFERSON	13603	1,195	78	6.5	108	9.4	48	4.3	15	1.3	104.7
JEFFERSON	13605	189	11	5.8	20	11.0	6	3.3	68	36.0	44.3
JEFFERSON	13606	100	4	4.0	9	10.1	0	0.0	42	42.4	28.8
JEFFERSON	13607	59	9	15.3	12	21.1	2	3.8	24	40.7	55.6
JEFFERSON	13608	74	6	8.1	8	11.8	2	2.9	30	40.5	47.6
JEFFERSON	13612	128	8	6.3	16	13.0	4	3.3	37	29.1	46.2
JEFFERSON	13616	155	18	11.6	19	12.9	7	5.0	16	10.3	64.8
JEFFERSON	13618	52	4	7.7	5	10.4	1	2.1	17	32.7	8.8
JEFFERSON	13622	80	6	7.5	11	14.9	1	1.4	27	33.8	87.0
JEFFERSON	13624	142	9	6.3	15	11.0	4	3.0	45	31.7	16.6
JEFFERSON	13634	128	8	6.3	6	5.3	0	0.0	48	37.5	47.3
JEFFERSON	13637	399	25	6.3	29	7.7	21	5.7	37	9.4	104.0
JEFFERSON	13650	35	0	0.0	0	0.0	0	0.0	15	42.9	44.4
JEFFERSON	13656	126	11	8.7	6	5.6	3	2.9	47	39.2	30.3
JEFFERSON	13661	56	0	0.0	7	13.2	1	1.9	21	37.5	33.8
JEFFERSON	13673	140	9	6.4	13	10.5	3	2.5	41	29.9	39.0
JEFFERSON	13679	66	6	9.1	9	14.5	0	0.0	22	33.3	57.7
JEFFERSON	13685	73	8	11.0	5	7.4	5	7.5	18	24.7	24.9
JEFFERSON	13691	117	8	6.8	13	11.5	2	1.8	45	39.1	39.9

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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LEWIS	13327	88	11	12.5	8	10.1	1	1.3	30	34.9	29.9
LEWIS	13343	57	8	14.0	5	10.0	0	0.0	23	41.8	16.7
LEWIS	13367	336	29	8.6	33	11.2	9	3.1	118	36.6	39.7
LEWIS	13368	44	3	6.8	2	5.1	0	0.0	15	34.1	62.5
LEWIS	13433	75	4	5.3	6	8.8	0	0.0	44	58.7	121.2
LEWIS	13619	531	34	6.4	55	10.8	22	4.4	178	33.6	58.3
LEWIS	13620	113	7	6.2	6	5.8	4	3.8	29	26.1	61.5
LEWIS	13626	94	4	4.3	12	14.0	3	3.7	23	24.7	69.9
LEWIS	13648	56	4	7.1	3	5.6	2	3.7	25	44.6	9.1

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LIVINGSTON	14414	218	7	3.2	15	7.2	2	1.0	49	22.5	21.9
LIVINGSTON	14423	132	4	3.0	14	10.9	2	1.6	36	27.3	24.4
LIVINGSTON	14435	71	1	1.4	4	5.8	4	5.8	15	21.4	22.2
LIVINGSTON	14437	288	22	7.6	28	10.0	5	1.8	129	44.8	45.8
LIVINGSTON	14454	144	5	3.5	10	7.4	3	2.3	47	32.6	4.1
LIVINGSTON	14481	45	2	4.4	4	9.1	0	0.0	12	26.7	31.0
LIVINGSTON	14485	128	6	4.7	11	8.9	5	4.1	38	29.7	30.0
LIVINGSTON	14487	165	8	4.8	14	8.9	6	3.9	35	21.2	29.0
LIVINGSTON	14510	187	17	9.1	28	15.6	11	6.3	89	47.8	66.7
LIVINGSTON	14517	106	6	5.7	7	6.9	3	3.0	43	40.6	50.2
LIVINGSTON	14533	70	6	8.6	10	15.6	0	0.0	21	30.0	54.7

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MADISON	13030	92	3	3.3	7	7.6	4	4.3	30	32.6	39.9
MADISON	13032	384	27	7.0	44	11.6	15	3.9	164	42.7	36.8
MADISON	13035	150	11	7.3	13	8.7	1	0.7	32	21.3	10.3
MADISON	13037	265	16	6.0	30	11.4	7	2.7	83	31.3	31.4
MADISON	13052	63	3	4.8	5	8.9	2	3.6	27	42.9	12.3
MADISON	13082	100	3	3.0	7	7.1	2	2.0	33	33.0	31.9
MADISON	13122	34	5	14.7	5	14.7	2	5.9	12	35.3	41.7
MADISON	13332	98	5	5.1	8	8.3	12	12.5	47	48.0	24.7
MADISON	13334	58	1	1.7	7	12.1	5	8.6	29	50.0	42.1
MADISON	13346	103	10	9.7	12	11.8	9	8.8	32	31.1	3.6
MADISON	13402	47	5	10.6	8	17.4	4	8.9	23	48.9	76.0
MADISON	13408	88	8	9.1	10	11.4	2	2.3	35	39.8	16.9
MADISON	13409	75	2	2.7	6	8.0	3	4.1	32	42.7	28.4
MADISON	13421	494	34	6.9	47	9.6	26	5.3	215	43.5	59.4
MADISON	13485	32	2	6.3	1	3.2	0	0.0	16	50.0	49.4

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MONROE	14420	509	28	5.5	44	9.3	5	1.1	158	31.0	19.2
MONROE	14428	237	13	5.5	20	8.8	2	0.9	37	15.6	30.1
MONROE	14445	283	20	7.1	27	10.7	6	2.5	88	31.1	22.8
MONROE	14450	1,112	67	6.0	96	9.3	16	1.6	122	11.0	15.7
MONROE	14464	215	19	8.8	22	11.1	3	1.5	69	32.1	35.3
MONROE	14467	282	15	5.3	18	6.7	1	0.4	79	28.0	24.0
MONROE	14468	516	33	6.4	43	9.0	8	1.7	95	18.4	21.6
MONROE	14472	174	7	4.0	10	5.9	4	2.5	30	17.2	11.6
MONROE	14514	249	19	7.6	20	8.5	3	1.3	25	10.1	11.3
MONROE	14526	543	38	7.0	47	9.5	3	0.6	42	7.7	10.5
MONROE	14534	657	51	7.8	52	8.4	11	1.8	39	5.9	8.2
MONROE	14543	55	6	10.9	11	20.8	1	2.0	3	5.5	1.5
MONROE	14546	153	11	7.2	12	8.3	2	1.4	31	20.3	21.5
MONROE	14559	471	32	6.8	38	8.7	7	1.6	100	21.2	27.4
MONROE	14580	1,433	89	6.2	110	8.4	18	1.4	176	12.3	16.6
MONROE	14586	387	33	8.5	41	11.6	7	2.0	43	11.1	20.7
MONROE	14604	40	2	5.0	1	2.9	3	9.1	27	67.5	51.6
MONROE	14605	731	93	12.7	101	15.6	40	6.4	537	73.5	165.2
MONROE	14606	1,165	112	9.6	115	10.8	55	5.3	592	50.8	118.7
MONROE	14607	351	35	10.0	35	11.0	5	1.6	144	41.0	126.2
MONROE	14608	728	91	12.5	81	12.3	24	3.8	539	74.0	179.9
MONROE	14609	2,215	236	10.7	260	13.1	58	3.0	1093	49.4	123.4
MONROE	14610	425	30	7.1	35	9.1	8	2.2	61	14.4	29.1
MONROE	14611	961	145	15.1	122	14.4	40	4.8	738	76.8	177.7
MONROE	14612	1,026	57	5.6	69	7.3	20	2.1	234	22.9	36.0
MONROE	14613	851	79	9.3	93	12.3	47	6.5	596	70.0	178.8
MONROE	14615	768	86	11.2	82	11.8	23	3.4	372	48.4	103.4
MONROE	14616	1,102	73	6.6	75	7.5	20	2.0	349	31.7	59.4
MONROE	14617	736	38	5.2	57	8.4	11	1.7	96	13.1	30.1
MONROE	14618	582	43	7.4	49	8.8	7	1.3	44	7.6	5.4

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

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MONROE	14619	662	62	9.4	78	13.2	26	4.5	410	61.9	158.8
MONROE	14620	843	70	8.3	80	10.3	21	2.8	293	34.8	63.4
MONROE	14621	1,847	210	11.4	227	13.7	84	5.2	1247	67.5	190.8
MONROE	14622	390	21	5.4	19	5.4	6	1.8	73	18.7	40.4
MONROE	14623	731	45	6.2	46	6.7	13	2.0	150	20.5	14.2
MONROE	14624	1,160	85	7.3	96	8.9	20	1.9	229	19.7	36.4
MONROE	14625	282	19	6.7	18	6.9	10	3.9	41	14.5	18.6
MONROE	14626	900	60	6.7	74	8.9	19	2.3	166	18.4	31.7

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MONTGOMERY	12010	1,018	78	7.7	112	12.2	19	2.1	408	40.2	59.9
MONTGOMERY	12066	64	4	6.3	8	13.6	2	3.7	26	40.6	21.9
MONTGOMERY	12068	118	5	4.2	8	7.2	10	9.3	33	28.0	37.0
MONTGOMERY	12070	32	3	9.4	6	20.7	1	3.4	9	28.1	26.5
MONTGOMERY	12072	107	3	2.8	9	9.1	15	15.6	27	25.5	34.6
MONTGOMERY	12166	46	6	13.0	4	10.0	3	7.9	10	21.7	79.7
MONTGOMERY	13317	110	11	10.0	9	8.9	4	4.1	46	41.8	59.8
MONTGOMERY	13339	314	26	8.3	35	12.6	65	24.5	90	28.8	62.9
MONTGOMERY	13428	76	5	6.6	4	5.6	19	27.5	20	26.3	56.5

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NASSAU	11001	774	55	7.1	67	8.7	14	2.5	130	16.8	8.7
NASSAU	11003	1,446	142	9.8	202	14.2	73	7.4	578	40.0	32.2
NASSAU	11010	647	39	6.0	66	10.3	10	1.9	80	12.4	11.9
NASSAU	11020	137	5	3.6	9	6.7	5	5.0	42	30.7	9.6
NASSAU	11021	675	53	7.9	59	9.0	12	2.4	28	4.1	3.0
NASSAU	11023	343	22	6.4	32	9.6	4	1.4	29	8.5	2.4
NASSAU	11024	257	24	9.3	16	6.3	5	2.3	44	17.1	9.0
NASSAU	11030	467	40	8.6	50	11.0	10	2.8	19	4.1	2.4
NASSAU	11040	1,065	72	6.8	108	10.2	17	2.2	123	11.6	8.2
NASSAU	11050	986	82	8.3	110	11.3	27	3.7	183	18.6	8.1
NASSAU	11096	330	24	7.3	54	16.9	19	8.6	208	63.2	49.0
NASSAU	11501	722	53	7.3	73	10.2	7	1.1	128	17.8	16.5
NASSAU	11507	163	13	8.0	16	9.9	6	4.9	24	14.7	2.6
NASSAU	11509	53	2	3.8	6	11.5	0	0.0	3	5.7	10.3
NASSAU	11510	1,038	89	8.6	133	13.0	32	3.5	262	25.3	22.9
NASSAU	11514	129	11	8.5	18	14.0	2	1.7	16	12.4	6.5
NASSAU	11516	357	21	5.9	24	7.0	10	4.0	58	16.2	10.2
NASSAU	11518	291	23	7.9	39	13.5	5	1.9	29	10.0	2.9
NASSAU	11520	1,974	167	8.5	259	13.6	95	5.4	1063	53.9	62.6
NASSAU	11530	645	38	5.9	66	10.3	6	1.1	18	2.8	4.1
NASSAU	11542	996	83	8.3	128	13.2	21	2.6	432	43.5	26.8
NASSAU	11545	288	28	9.7	44	15.3	7	3.1	24	8.3	4.6
NASSAU	11548	33	3	9.1	4	12.5	1	3.4	8	24.2	5.6
NASSAU	11550	3,414	350	10.3	521	15.9	175	5.8	2285	66.9	58.9
NASSAU	11552	770	61	7.9	82	10.9	22	3.5	193	25.1	18.2
NASSAU	11553	1,311	114	8.7	167	13.2	76	6.5	760	58.0	72.7
NASSAU	11554	1,074	85	7.9	115	10.9	16	1.7	181	16.9	9.2
NASSAU	11557	200	24	12.0	26	13.1	4	2.5	18	9.0	2.6
NASSAU	11558	259	16	6.2	23	9.1	7	3.0	75	29.0	23.8
NASSAU	11559	312	26	8.3	24	7.8	15	6.6	40	12.9	7.6

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NASSAU	11560	176	13	7.4	19	11.0	2	1.4	38	21.6	5.1
NASSAU	11561	1,175	97	8.3	132	11.5	27	2.7	240	20.5	19.9
NASSAU	11563	659	50	7.6	59	9.1	13	2.3	77	11.7	8.9
NASSAU	11565	260	14	5.4	20	7.8	5	2.3	19	7.3	4.4
NASSAU	11566	1,058	96	9.1	116	11.2	18	2.0	70	6.6	7.4
NASSAU	11568	47	2	4.3	1	2.4	0	0.0	4	8.5	6.3
NASSAU	11570	787	56	7.1	84	10.9	9	1.3	104	13.2	15.1
NASSAU	11572	869	68	7.8	92	10.8	13	1.7	88	10.1	10.3
NASSAU	11575	967	96	9.9	136	14.8	61	7.2	653	67.5	109.1
NASSAU	11576	278	19	6.8	20	7.3	4	2.0	47	16.9	3.0
NASSAU	11577	323	24	7.4	36	11.2	9	3.5	37	11.5	7.4
NASSAU	11579	108	7	6.5	16	15.0	0	0.0	8	7.4	2.1
NASSAU	11580	1,257	121	9.6	162	13.1	43	4.7	382	30.4	20.3
NASSAU	11581	617	53	8.6	75	12.3	14	3.0	99	16.0	11.9
NASSAU	11590	2,217	171	7.7	276	12.9	87	4.5	1219	55.0	51.1
NASSAU	11596	287	24	8.4	27	9.5	2	0.9	16	5.6	7.2
NASSAU	11598	535	39	7.3	46	8.7	11	2.7	52	9.7	3.9
NASSAU	11702	471	27	5.7	51	11.1	11	2.5	46	9.8	16.4
NASSAU	11709	166	20	12.0	25	15.2	3	2.1	23	13.9	17.0
NASSAU	11710	1,029	73	7.1	91	8.9	12	1.3	80	7.8	8.0
NASSAU	11714	690	53	7.7	90	13.1	9	1.4	60	8.7	8.0
NASSAU	11732	107	16	15.0	19	17.9	0	0.0	5	4.7	2.6
NASSAU	11753	233	16	6.9	14	6.2	6	3.1	17	7.3	2.5
NASSAU	11756	1,278	89	7.0	147	11.7	30	2.7	182	14.3	10.0
NASSAU	11758	1,562	124	7.9	176	11.5	37	2.7	163	10.4	11.5
NASSAU	11762	673	45	6.7	63	9.5	3	0.5	19	2.8	8.9
NASSAU	11771	252	21	8.3	28	11.2	2	1.0	45	17.9	16.3
NASSAU	11783	627	49	7.8	75	12.1	6	1.0	25	4.0	6.1
NASSAU	11791	560	32	5.7	39	7.0	9	2.0	22	3.9	1.5
NASSAU	11793	946	75	7.9	102	10.9	6	0.7	34	3.6	5.8

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NASSAU	11797	168	17	10.1	12	7.2	6	4.4	3	1.8	1.0
NASSAU	11801	1,264	95	7.5	152	12.2	27	2.5	344	27.3	15.3
NASSAU	11803	760	60	7.9	82	10.9	7	1.1	27	3.6	2.9
NASSAU	11804	106	12	11.3	14	14.3	0	0.0	3	2.8	2.0

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NIAGARA	14008	41	3	7.3	2	5.1	0	0.0	15	36.6	58.5
NIAGARA	14012	74	3	4.1	7	9.6	1	1.4	21	28.4	45.8
NIAGARA	14028	57	3	5.3	4	7.0	2	3.5	14	24.6	86.2
NIAGARA	14067	132	7	5.3	14	10.6	1	0.8	29	22.1	23.5
NIAGARA	14092	258	16	6.2	24	9.6	2	0.8	19	7.4	18.5
NIAGARA	14094	1,780	146	8.2	196	11.2	67	3.9	474	26.6	46.3
NIAGARA	14105	109	5	4.6	10	9.3	7	6.7	32	29.4	60.0
NIAGARA	14108	128	13	10.2	19	15.0	3	2.4	28	21.9	21.4
NIAGARA	14120	1,319	94	7.1	133	10.3	33	2.6	216	16.4	35.1
NIAGARA	14131	133	9	6.8	15	11.5	4	3.1	25	18.8	54.1
NIAGARA	14132	150	4	2.7	9	6.2	8	5.5	17	11.3	36.1
NIAGARA	14172	76	6	7.9	10	13.2	1	1.3	11	14.5	38.2
NIAGARA	14174	132	13	9.8	21	16.3	0	0.0	10	7.6	37.5
NIAGARA	14301	600	67	11.2	75	14.1	25	4.9	296	49.3	135.3
NIAGARA	14303	243	29	11.9	41	18.8	12	5.7	136	56.0	146.7
NIAGARA	14304	892	58	6.5	91	10.7	28	3.4	200	22.4	49.4
NIAGARA	14305	640	75	11.7	99	16.4	26	4.4	263	41.1	112.1

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ONEIDA	13042	75	4	5.3	9	12.0	0	0.0	33	44.0	59.9
ONEIDA	13054	58	3	5.2	5	8.8	2	3.5	16	27.6	58.8
ONEIDA	13303	34	3	8.8	2	6.3	1	3.1	13	38.2	43.5
ONEIDA	13308	150	8	5.3	16	10.9	5	3.4	64	42.7	59.8
ONEIDA	13309	205	12	5.9	19	9.5	3	1.5	60	29.3	50.1
ONEIDA	13316	225	13	5.8	28	12.7	8	3.6	91	40.4	42.0
ONEIDA	13318	56	5	8.9	7	12.7	2	3.6	32	58.2	47.6
ONEIDA	13323	243	16	6.6	29	12.0	7	2.9	54	22.3	6.2
ONEIDA	13328	32	3	9.4	5	15.6	1	3.1	5	15.6	13.9
ONEIDA	13354	86	7	8.1	7	8.1	2	2.3	22	25.6	34.8
ONEIDA	13363	52	6	11.5	8	15.7	2	3.9	23	44.2	30.3
ONEIDA	13403	107	4	3.7	10	9.4	1	0.9	22	20.6	12.8
ONEIDA	13413	357	25	7.0	32	9.0	8	2.3	57	16.0	23.4
ONEIDA	13417	96	6	6.3	13	13.5	4	4.2	37	38.5	32.5
ONEIDA	13424	55	1	1.8	2	3.8	1	1.9	22	40.7	32.1
ONEIDA	13425	77	5	6.5	6	8.0	7	9.5	26	33.8	48.9
ONEIDA	13438	126	6	4.8	11	9.2	7	5.7	42	33.3	38.9
ONEIDA	13440	1,492	104	7.0	157	10.9	59	4.1	677	45.4	59.6
ONEIDA	13456	92	5	5.4	12	13.0	1	1.1	22	23.9	31.3
ONEIDA	13461	67	2	3.0	11	16.4	2	3.0	9	13.4	17.4
ONEIDA	13471	114	10	8.8	17	15.2	4	3.6	62	54.4	34.0
ONEIDA	13476	92	2	2.2	7	7.7	0	0.0	23	25.0	38.7
ONEIDA	13477	38	0	0.0	2	5.3	1	2.6	11	28.9	27.2
ONEIDA	13478	98	5	5.1	7	7.4	4	4.2	36	36.7	36.7
ONEIDA	13480	96	3	3.1	11	11.5	4	4.2	38	39.6	26.1
ONEIDA	13490	36	1	2.8	7	19.4	0	0.0	8	22.2	18.0
ONEIDA	13492	314	19	6.1	31	10.1	5	1.6	65	20.7	28.9
ONEIDA	13495	66	2	3.0	5	7.7	0	0.0	26	39.4	41.7
ONEIDA	13501	1,905	191	10.0	284	15.1	137	7.3	1416	74.4	111.0
ONEIDA	13502	1,316	122	9.3	162	12.5	66	5.1	802	60.9	72.9

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ONONDAGA	13027	930	49	5.3	84	9.1	6	0.6	225	24.2	20.5
ONONDAGA	13029	294	18	6.1	33	11.3	2	0.7	86	29.4	44.9
ONONDAGA	13031	410	25	6.1	30	7.4	5	1.2	89	21.7	27.7
ONONDAGA	13039	602	47	7.8	82	13.7	7	1.2	107	17.8	22.2
ONONDAGA	13041	391	37	9.5	44	11.4	6	1.5	62	15.9	23.7
ONONDAGA	13057	449	28	6.2	53	11.8	4	0.9	128	28.6	33.7
ONONDAGA	13060	103	10	9.7	15	14.9	1	1.0	33	32.0	30.0
ONONDAGA	13063	67	1	1.5	6	9.0	1	1.5	20	29.9	16.9
ONONDAGA	13066	289	18	6.2	26	9.0	4	1.4	26	9.0	5.6
ONONDAGA	13078	243	16	6.6	29	12.0	2	0.8	32	13.2	13.1
ONONDAGA	13080	102	3	2.9	4	3.9	0	0.0	33	32.4	44.4
ONONDAGA	13084	119	5	4.2	13	10.9	4	3.4	33	27.7	19.3
ONONDAGA	13088	715	54	7.6	82	11.5	12	1.7	203	28.4	30.7
ONONDAGA	13090	1,060	63	5.9	86	8.2	13	1.2	242	22.8	26.2
ONONDAGA	13104	377	27	7.2	45	12.0	6	1.6	54	14.3	12.9
ONONDAGA	13108	153	9	5.9	18	11.8	4	2.6	34	22.2	15.8
ONONDAGA	13110	44	6	13.6	7	15.9	1	2.3	17	38.6	29.2
ONONDAGA	13112	56	4	7.1	6	10.7	0	0.0	17	30.4	29.2
ONONDAGA	13116	119	9	7.6	9	7.6	4	3.4	26	21.8	33.0
ONONDAGA	13120	87	7	8.0	5	5.8	1	1.2	48	55.2	33.9
ONONDAGA	13152	163	4	2.5	10	6.2	0	0.0	15	9.2	4.1
ONONDAGA	13159	129	12	9.3	18	14.6	0	0.0	30	23.3	13.7
ONONDAGA	13164	96	3	3.1	2	2.1	0	0.0	16	16.7	30.3
ONONDAGA	13202	318	33	10.4	42	13.3	14	4.4	274	86.2	149.9
ONONDAGA	13203	796	75	9.4	95	12.1	45	5.7	557	70.0	115.7
ONONDAGA	13204	1,257	122	9.7	129	10.6	78	6.5	1003	79.8	175.6
ONONDAGA	13205	934	114	12.2	102	11.1	60	6.6	700	75.0	176.1
ONONDAGA	13206	715	59	8.3	77	10.9	18	2.5	369	51.6	94.0
ONONDAGA	13207	661	69	10.4	78	12.1	23	3.6	413	62.5	137.7
ONONDAGA	13208	1,296	104	8.0	145	11.3	83	6.5	932	71.9	140.7

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ONONDAGA	13209	393	21	5.3	41	10.5	12	3.1	167	42.7	38.8
ONONDAGA	13210	648	66	10.2	68	10.7	23	3.6	331	51.1	24.0
ONONDAGA	13211	261	23	8.8	31	11.9	3	1.2	116	44.4	64.0
ONONDAGA	13212	647	54	8.3	69	10.8	11	1.7	208	32.1	42.6
ONONDAGA	13214	236	20	8.5	27	11.6	5	2.2	55	23.3	6.5
ONONDAGA	13215	306	18	5.9	30	9.9	5	1.6	41	13.4	16.9
ONONDAGA	13219	447	32	7.2	55	12.4	4	0.9	92	20.6	17.9
ONONDAGA	13224	338	32	9.5	39	11.7	11	3.3	174	51.5	88.5

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Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
ONTARIO	14424	755	44	5.8	75	10.5	26	3.7	243	32.2	36.6
ONTARIO	14425	405	17	4.2	35	9.0	8	2.1	88	21.7	24.9
ONTARIO	14432	159	6	3.8	18	12.0	6	4.1	60	37.7	36.6
ONTARIO	14456	634	38	6.0	69	11.4	34	5.7	315	49.8	47.8
ONTARIO	14466	42	3	7.1	2	5.0	3	7.5	17	40.5	47.6
ONTARIO	14469	181	14	7.7	18	10.5	3	1.9	48	26.5	28.7
ONTARIO	14471	52	7	13.5	13	25.5	1	2.0	15	28.8	12.8
ONTARIO	14504	54	3	5.6	4	8.0	0	0.0	22	40.7	39.7
ONTARIO	14512	144	7	4.9	15	11.1	2	1.5	55	38.5	51.1
ONTARIO	14532	140	14	10.0	12	8.9	6	4.5	40	28.6	37.3
ONTARIO	14548	124	13	10.5	13	11.2	6	5.4	46	37.1	36.5
ONTARIO	14560	81	5	6.2	7	8.9	5	6.3	36	44.4	26.5
ONTARIO	14561	114	6	5.3	10	9.1	4	3.8	23	20.2	26.7
ONTARIO	14564	375	28	7.5	38	11.2	7	2.2	47	12.5	8.6

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
ORANGE	10916	99	7	7.1	5	5.6	1	1.2	7	7.4	14.6
ORANGE	10917	69	6	8.7	4	6.7	2	3.8	22	32.8	31.3
ORANGE	10918	356	31	8.7	37	11.1	3	1.0	56	16.5	22.9
ORANGE	10921	128	9	7.0	10	8.4	0	0.0	19	15.3	17.8
ORANGE	10924	306	21	6.9	21	7.4	10	3.7	65	22.1	18.2
ORANGE	10925	138	15	10.9	14	11.3	2	2.0	16	12.4	16.6
ORANGE	10926	122	3	2.5	11	10.8	3	3.6	22	18.8	10.2
ORANGE	10928	190	12	6.3	22	12.6	9	5.8	42	22.7	44.3
ORANGE	10930	280	18	6.4	28	11.8	6	3.1	40	15.6	16.8
ORANGE	10940	2,171	179	8.2	232	10.9	112	5.4	1149	53.2	78.3
ORANGE	10941	441	30	6.8	38	8.8	18	4.4	115	26.3	48.1
ORANGE	10950	3,685	209	5.7	241	7.8	105	4.7	2153	61.0	20.8
ORANGE	10958	100	12	12.0	14	14.7	6	6.8	22	22.0	23.0
ORANGE	10963	71	2	2.8	5	7.1	2	2.9	14	19.7	26.7
ORANGE	10973	61	2	3.3	4	6.8	2	3.7	7	12.1	25.9
ORANGE	10987	78	7	9.0	10	14.1	1	2.0	7	11.1	9.1
ORANGE	10990	450	29	6.4	48	11.2	12	3.1	39	9.2	18.2
ORANGE	10992	256	16	6.3	26	11.1	5	2.3	26	10.4	15.1
ORANGE	10996	282	13	4.6	31	12.1	6	3.4	2	0.7	1.5
ORANGE	10998	121	8	6.6	12	10.1	3	2.8	13	10.9	23.8
ORANGE	12518	150	12	8.0	14	10.1	1	0.8	15	10.1	16.2
ORANGE	12520	81	3	3.7	7	9.1	2	2.7	10	12.5	12.1
ORANGE	12543	125	9	7.2	13	10.7	5	4.2	34	27.6	45.3
ORANGE	12549	307	28	9.1	35	11.9	7	2.4	62	20.5	21.6
ORANGE	12550	2,798	215	7.7	340	13.1	187	7.3	1621	58.1	82.8
ORANGE	12553	886	49	5.5	79	9.6	24	3.2	202	23.0	32.2
ORANGE	12575	58	3	5.2	8	15.1	2	4.3	4	7.0	26.2
ORANGE	12577	61	7	11.5	6	11.1	2	3.8	5	8.2	18.8
ORANGE	12586	486	43	8.8	52	11.4	28	6.3	143	29.5	45.5
ORANGE	12729	110	7	6.4	10	9.1	6	5.5	47	43.1	51.5

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(CUMULATIVE 3 Year Total)

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ORANGE	12771	561	40	7.1	45	8.4	31	5.9	262	47.0	66.4
ORANGE	12780	65	9	13.8	9	14.3	5	8.3	23	35.4	32.9

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ORLEANS	14098	96	6	6.3	7	8.0	2	2.4	27	28.4	54.3
ORLEANS	14103	359	24	6.7	54	15.3	19	5.5	161	45.1	39.2
ORLEANS	14411	408	37	9.1	42	11.1	8	2.1	181	44.5	64.1
ORLEANS	14470	241	15	6.2	21	9.6	6	2.8	89	36.9	29.9
ORLEANS	14476	65	5	7.7	4	7.1	0	0.0	20	30.8	29.9
ORLEANS	14477	51	5	9.8	9	18.0	0	0.0	19	37.3	9.4
ORLEANS	14571	36	2	5.6	3	8.6	1	2.9	13	36.1	35.1

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OSWEGO	13028	48	3	6.3	5	10.4	0	0.0	23	48.9	45.8
OSWEGO	13036	260	14	5.4	17	6.6	7	2.7	106	40.8	42.8
OSWEGO	13044	86	3	3.5	3	3.6	4	4.7	29	33.7	57.5
OSWEGO	13069	1,025	62	6.0	101	10.0	37	3.7	581	56.7	64.4
OSWEGO	13074	150	12	8.0	18	12.3	6	4.1	83	55.3	36.7
OSWEGO	13076	73	3	4.1	10	13.7	0	0.0	34	46.6	46.9
OSWEGO	13083	77	2	2.6	6	8.2	1	1.4	34	44.2	34.8
OSWEGO	13114	222	15	6.8	23	10.4	5	2.3	101	45.5	37.5
OSWEGO	13126	1,078	73	6.8	106	9.9	36	3.4	582	54.1	30.1
OSWEGO	13131	133	10	7.5	21	16.2	6	4.7	55	41.7	44.4
OSWEGO	13132	122	10	8.2	15	12.3	2	1.6	52	42.6	38.4
OSWEGO	13135	225	12	5.3	26	11.7	5	2.3	89	39.7	59.5
OSWEGO	13142	228	18	7.9	18	8.2	7	3.2	110	48.5	43.8
OSWEGO	13144	64	2	3.1	2	3.2	1	1.6	36	56.3	41.7
OSWEGO	13145	52	4	7.7	5	9.8	1	1.9	22	42.3	31.7
OSWEGO	13167	86	3	3.5	6	7.1	6	7.1	48	55.8	47.6
OSWEGO	13302	53	6	11.3	5	9.4	1	1.9	30	56.6	43.5
OSWEGO	13493	88	12	13.6	4	5.3	3	3.9	42	50.0	39.9

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OTSEGO	12116	52	4	7.7	6	11.8	0	0.0	20	38.5	32.5
OTSEGO	12155	42	4	9.5	5	11.9	0	0.0	13	31.0	12.1
OTSEGO	12197	50	4	8.0	4	8.2	1	2.1	18	36.0	29.0
OTSEGO	13315	36	3	8.3	5	14.3	0	0.0	14	38.9	19.0
OTSEGO	13320	53	2	3.8	1	1.9	1	1.9	15	28.3	31.4
OTSEGO	13326	128	6	4.7	6	4.7	1	0.8	35	27.3	22.2
OTSEGO	13335	43	3	7.0	3	7.0	3	7.0	15	34.9	36.4
OTSEGO	13348	51	4	7.8	4	7.8	1	2.0	15	29.4	23.8
OTSEGO	13439	119	8	6.7	16	13.6	5	4.2	39	33.6	65.4
OTSEGO	13491	97	9	9.3	10	10.3	1	1.0	38	39.2	13.0
OTSEGO	13808	41	1	2.4	2	5.0	0	0.0	15	36.6	31.4
OTSEGO	13820	461	34	7.4	46	10.1	14	3.1	178	38.6	10.3
OTSEGO	13825	90	4	4.4	7	8.0	1	1.1	35	38.9	26.3
OTSEGO	13843	47	3	6.4	4	8.5	1	2.1	19	40.4	23.8

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PUTNAM	10509	566	49	8.7	65	11.8	11	2.3	156	29.3	9.8
PUTNAM	10512	763	56	7.3	80	10.7	19	2.7	129	17.4	10.4
PUTNAM	10516	153	8	5.2	14	9.7	3	2.3	17	11.3	1.9
PUTNAM	10524	105	7	6.7	13	13.1	1	1.1	7	6.7	6.6
PUTNAM	10537	93	5	5.4	9	10.8	3	3.8	19	20.7	0.0
PUTNAM	10541	698	69	9.9	84	12.4	11	1.7	95	13.9	9.3
PUTNAM	10579	246	25	10.2	23	9.5	2	0.9	17	7.0	15.6
PUTNAM	12563	195	13	6.7	19	10.1	2	1.2	31	17.2	9.3

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RENSSELAER	12018	175	6	3.4	8	5.0	3	1.9	23	13.1	23.6
RENSSELAER	12033	231	12	5.2	18	8.5	1	0.5	25	10.8	19.3
RENSSELAER	12052	47	3	6.4	7	15.6	1	2.2	8	17.0	39.7
RENSSELAER	12061	264	22	8.3	24	9.7	3	1.2	20	7.6	10.3
RENSSELAER	12062	46	7	15.2	9	23.1	3	8.3	4	9.3	26.5
RENSSELAER	12090	185	4	2.2	14	7.9	7	4.0	59	32.6	23.9
RENSSELAER	12094	75	5	6.7	5	6.9	0	0.0	18	24.0	25.9
RENSSELAER	12121	36	0	0.0	1	2.9	1	3.1	4	11.1	10.9
RENSSELAER	12123	169	9	5.3	16	10.3	2	1.4	23	13.8	30.8
RENSSELAER	12138	62	3	4.8	5	8.8	4	7.4	7	11.7	12.6
RENSSELAER	12140	46	2	4.3	3	7.9	0	0.0	4	8.7	39.7
RENSSELAER	12144	713	41	5.8	61	9.6	15	2.4	150	21.1	44.7
RENSSELAER	12154	89	8	9.0	11	13.3	4	4.8	5	5.6	25.9
RENSSELAER	12168	46	1	2.2	8	18.2	1	3.3	7	19.4	14.7
RENSSELAER	12180	1,981	193	9.7	231	12.8	82	4.6	393	19.9	62.1
RENSSELAER	12182	528	40	7.6	46	9.6	22	4.6	96	18.2	61.3
RENSSELAER	12185	51	1	2.0	1	2.1	0	0.0	5	9.8	26.0
RENSSELAER	12196	78	6	7.7	10	13.3	3	4.1	12	15.4	3.3
RENSSELAER	12198	247	6	2.4	13	5.6	4	1.7	18	7.3	18.5

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ROCKLAND	10901	632	33	5.2	46	9.5	18	4.8	136	24.3	7.2
ROCKLAND	10913	112	5	4.5	7	7.6	2	3.1	13	13.4	3.0
ROCKLAND	10920	242	26	10.7	20	10.0	5	2.9	44	19.6	19.3
ROCKLAND	10923	325	28	8.6	34	12.6	12	4.9	117	36.7	36.6
ROCKLAND	10927	610	46	7.5	55	10.5	40	8.0	407	67.4	64.1
ROCKLAND	10952	3,559	164	4.6	181	6.5	88	4.1	2084	61.3	23.4
ROCKLAND	10954	728	64	8.8	71	12.0	21	4.3	214	32.9	16.7
ROCKLAND	10956	732	60	8.2	71	11.4	18	3.4	134	19.6	11.2
ROCKLAND	10960	496	38	7.7	50	11.6	24	6.2	181	38.3	30.8
ROCKLAND	10962	118	10	8.5	11	10.5	1	1.4	19	20.4	14.2
ROCKLAND	10965	384	25	6.5	38	11.7	8	3.3	64	19.5	8.9
ROCKLAND	10968	58	1	1.7	0	0.0	3	8.6	20	40.0	16.3
ROCKLAND	10970	348	29	8.3	29	10.1	16	6.5	114	33.9	24.2
ROCKLAND	10974	81	4	4.9	7	10.6	1	1.9	17	24.3	22.4
ROCKLAND	10976	42	3	7.1	2	5.9	2	6.7	19	51.4	6.2
ROCKLAND	10977	4,316	283	6.6	356	10.2	248	9.1	3068	72.9	46.0
ROCKLAND	10980	334	26	7.8	37	13.9	5	2.2	62	19.3	14.4
ROCKLAND	10983	147	7	4.8	12	9.2	2	2.2	23	18.3	7.0
ROCKLAND	10984	72	11	15.3	10	16.4	3	5.5	11	15.7	8.5
ROCKLAND	10986	61	5	8.2	6	11.8	1	2.3	12	20.0	18.9
ROCKLAND	10989	256	15	5.9	23	10.9	4	2.4	23	9.8	7.6
ROCKLAND	10993	169	19	11.2	18	12.6	8	6.1	71	42.8	28.6
ROCKLAND	10994	164	12	7.3	18	12.9	0	0.0	24	16.2	6.7

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SARATOGA	12019	409	27	6.6	32	8.2	6	1.6	23	5.6	11.3
SARATOGA	12020	1,118	59	5.3	108	9.9	35	3.3	144	12.9	35.9
SARATOGA	12027	77	5	6.5	11	14.5	4	5.2	3	3.9	11.8
SARATOGA	12065	1,263	76	6.0	112	9.3	34	3.0	130	10.3	22.4
SARATOGA	12074	70	3	4.3	8	12.1	3	4.6	13	18.6	33.7
SARATOGA	12086	42	3	7.1	4	10.8	1	2.9	7	16.7	25.0
SARATOGA	12118	526	45	8.6	55	11.0	8	1.7	77	14.6	37.1
SARATOGA	12148	122	11	9.0	10	8.9	1	0.9	5	4.1	13.7
SARATOGA	12170	137	16	11.7	22	16.7	1	0.8	24	17.5	51.1
SARATOGA	12188	347	23	6.6	37	11.5	9	2.9	34	9.8	30.1
SARATOGA	12803	384	25	6.5	41	11.5	16	4.5	73	19.0	59.0
SARATOGA	12822	243	19	7.8	24	10.7	13	5.9	43	17.7	91.1
SARATOGA	12831	438	37	8.4	61	14.5	17	4.1	42	9.6	17.1
SARATOGA	12833	128	11	8.6	11	9.2	8	6.8	20	15.6	24.8
SARATOGA	12835	75	7	9.3	9	12.7	5	7.4	16	21.3	62.5
SARATOGA	12850	83	5	6.0	7	8.9	3	3.9	20	24.1	37.0
SARATOGA	12859	83	4	4.8	11	14.3	0	0.0	21	25.3	34.8
SARATOGA	12866	1,027	70	6.8	104	10.6	44	4.6	101	9.9	18.3
SARATOGA	12871	189	19	10.1	21	11.7	6	3.4	34	18.0	42.8

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SCHENECTADY	12053	111	7	6.3	8	7.6	2	2.1	20	18.2	21.1
SCHENECTADY	12056	61	7	11.5	8	13.6	1	1.7	6	9.8	30.3
SCHENECTADY	12137	47	1	2.1	5	11.6	2	5.0	16	34.0	67.9
SCHENECTADY	12302	782	57	7.3	68	9.2	17	2.4	74	9.5	24.1
SCHENECTADY	12304	903	83	9.2	96	11.2	29	3.8	305	33.8	96.5
SCHENECTADY	12305	137	11	8.0	9	6.9	5	4.7	58	42.3	23.5
SCHENECTADY	12306	775	60	7.7	74	10.0	21	3.0	141	18.2	55.4
SCHENECTADY	12307	532	74	13.9	73	14.7	34	8.3	257	48.3	225.4
SCHENECTADY	12308	689	53	7.7	58	8.7	21	3.5	244	35.5	119.1
SCHENECTADY	12309	799	57	7.1	82	10.6	16	2.2	48	6.0	17.1

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
SCHOHARIE	12043	202	21	10.4	23	11.6	5	2.6	94	46.5	22.7
SCHOHARIE	12076	35	1	2.9	1	2.9	1	3.1	11	32.4	13.1
SCHOHARIE	12093	52	5	9.6	4	7.7	2	3.9	25	48.1	23.3
SCHOHARIE	12122	111	8	7.2	9	8.5	3	3.0	44	39.6	56.4
SCHOHARIE	12149	69	2	2.9	7	10.3	0	0.0	31	44.9	41.7
SCHOHARIE	12157	109	6	5.5	16	14.7	1	1.0	35	32.1	55.9
SCHOHARIE	12160	31	3	9.7	7	23.3	1	3.6	13	41.9	75.3
SCHOHARIE	13459	70	6	8.6	4	6.0	0	0.0	25	35.7	39.5

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

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SCHUYLER	14805	34	2	5.9	3	9.4	1	3.0	15	44.1	71.4
SCHUYLER	14812	117	12	10.3	14	12.6	3	2.7	54	46.2	21.3
SCHUYLER	14818	54	2	3.7	3	5.7	0	0.0	19	35.2	50.3
SCHUYLER	14865	57	4	7.0	5	9.1	0	0.0	34	59.6	36.0
SCHUYLER	14869	40	2	5.0	2	5.3	1	2.7	23	57.5	44.9
SCHUYLER	14891	113	8	7.1	16	15.0	0	0.0	64	57.7	37.6

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

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SENECA	13148	353	16	4.5	26	7.7	10	3.0	132	37.6	37.4
SENECA	13165	375	21	5.6	36	10.3	13	3.8	134	35.7	62.9
SENECA	14521	120	4	3.3	6	5.3	13	11.4	38	31.7	17.0
SENECA	14541	112	1	0.9	6	5.5	10	9.3	27	24.1	39.5
SENECA	14847	79	1	1.3	2	2.7	11	14.7	16	20.8	64.5

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ZIP Code Level Birth Data 2008-2010
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ST. LAWRENCE	12967	68	15	22.1	5	9.6	5	9.8	23	37.1	98.0
ST. LAWRENCE	13613	97	11	11.3	16	17.0	5	5.4	47	48.5	66.7
ST. LAWRENCE	13617	259	15	5.8	22	8.8	8	3.2	121	47.3	17.1
ST. LAWRENCE	13625	47	4	8.5	8	17.4	1	2.2	17	36.2	11.7
ST. LAWRENCE	13630	64	17	26.6	4	9.1	2	4.7	19	37.3	50.0
ST. LAWRENCE	13635	40	7	17.5	7	17.9	1	2.6	27	67.5	21.7
ST. LAWRENCE	13642	402	26	6.5	42	11.0	8	2.1	190	47.7	61.2
ST. LAWRENCE	13646	69	9	13.0	9	15.0	2	3.3	26	39.4	22.8
ST. LAWRENCE	13652	65	5	7.7	3	4.6	0	0.0	36	55.4	32.8
ST. LAWRENCE	13654	96	32	33.3	2	4.4	12	26.7	14	18.2	3.8
ST. LAWRENCE	13658	137	15	10.9	11	9.1	10	8.2	42	32.6	48.9
ST. LAWRENCE	13660	76	8	10.5	9	12.2	3	4.1	28	37.3	26.0
ST. LAWRENCE	13662	565	51	9.0	78	14.2	18	3.2	288	51.0	50.6
ST. LAWRENCE	13667	151	14	9.3	10	6.8	3	2.1	90	59.6	67.3
ST. LAWRENCE	13668	105	11	10.5	10	10.2	4	4.1	50	47.6	38.1
ST. LAWRENCE	13669	528	56	10.6	48	9.6	10	2.0	278	53.7	56.9
ST. LAWRENCE	13676	388	35	9.0	36	9.4	8	2.1	168	43.4	11.8
ST. LAWRENCE	13680	52	11	21.2	6	17.6	3	8.8	7	15.2	27.8
ST. LAWRENCE	13681	53	4	7.5	8	15.7	4	8.2	19	37.3	72.9
ST. LAWRENCE	13684	36	7	19.4	8	22.2	0	0.0	20	55.6	43.9
ST. LAWRENCE	13694	39	2	5.1	3	7.7	1	2.6	17	43.6	35.1
ST. LAWRENCE	13697	82	9	11.0	14	17.5	0	0.0	49	59.8	70.0

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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(CUMULATIVE 3 Year Total)

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STEUBEN	14572	138	8	5.8	9	7.0	7	5.5	59	42.8	31.1
STEUBEN	14801	198	14	7.1	26	14.0	16	8.8	82	41.8	50.7
STEUBEN	14807	74	2	2.7	3	4.2	3	4.2	23	31.1	32.6
STEUBEN	14809	87	7	8.0	7	8.4	6	7.2	32	37.2	58.6
STEUBEN	14810	348	25	7.2	31	9.4	10	3.0	169	48.6	49.1
STEUBEN	14820	32	3	9.4	3	9.7	0	0.0	11	34.4	0.0
STEUBEN	14821	102	9	8.8	13	13.4	3	3.1	45	44.1	68.5
STEUBEN	14823	126	5	4.0	13	10.7	1	0.8	57	45.2	38.8
STEUBEN	14826	57	2	3.5	3	5.6	3	5.7	24	42.1	16.3
STEUBEN	14830	701	52	7.4	61	9.2	13	2.0	297	42.4	38.9
STEUBEN	14840	55	3	5.5	4	7.5	1	1.9	23	41.8	25.0
STEUBEN	14843	491	39	7.9	51	10.8	9	1.9	252	51.3	63.7
STEUBEN	14855	69	4	5.8	6	9.2	22	34.4	11	15.9	57.1
STEUBEN	14858	60	2	3.3	5	8.5	2	3.4	30	50.0	38.6
STEUBEN	14870	314	16	5.1	23	7.7	2	0.7	90	28.7	28.2
STEUBEN	14873	78	2	2.6	6	8.3	7	9.7	34	43.6	40.0
STEUBEN	14879	95	7	7.4	12	13.3	3	3.4	44	46.3	73.5
STEUBEN	14885	43	1	2.3	3	7.3	9	22.5	9	20.9	31.7
STEUBEN	14898	88	4	4.5	5	6.5	37	48.1	15	17.2	55.6

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SUFFOLK	11701	1,159	110	9.5	182	16.2	69	6.6	585	50.5	53.3
SUFFOLK	11703	641	61	9.5	92	14.8	27	4.6	123	19.2	27.7
SUFFOLK	11704	1,279	118	9.2	183	14.9	55	4.7	305	23.9	19.4
SUFFOLK	11705	232	18	7.8	29	13.8	7	3.5	14	6.0	11.7
SUFFOLK	11706	2,760	211	7.6	371	14.0	193	7.6	1255	45.5	53.1
SUFFOLK	11713	495	36	7.3	53	11.8	24	6.1	180	36.4	63.1
SUFFOLK	11715	151	16	10.6	15	10.7	2	1.5	17	11.3	25.5
SUFFOLK	11716	296	25	8.4	36	12.8	5	1.9	39	13.2	16.2
SUFFOLK	11717	3,590	260	7.2	415	11.9	261	7.8	2277	63.4	84.7
SUFFOLK	11718	78	2	2.6	8	10.7	1	1.4	4	5.1	6.3
SUFFOLK	11719	85	6	7.1	7	8.9	0	0.0	10	11.8	24.0
SUFFOLK	11720	954	67	7.0	102	11.5	19	2.4	158	16.6	23.5
SUFFOLK	11721	162	14	8.6	19	11.9	3	2.1	5	3.1	6.0
SUFFOLK	11722	2,055	180	8.8	271	13.7	138	7.4	1153	56.2	79.0
SUFFOLK	11724	58	7	12.1	7	12.3	1	2.0	0	0.0	5.4
SUFFOLK	11725	710	50	7.0	72	10.4	1	0.2	36	5.1	7.3
SUFFOLK	11726	919	94	10.2	137	15.4	65	7.7	495	54.0	61.1
SUFFOLK	11727	1,130	101	8.9	125	12.3	26	2.8	203	18.0	30.9
SUFFOLK	11729	887	76	8.6	118	13.9	47	5.9	192	21.6	24.1
SUFFOLK	11730	458	31	6.8	53	11.8	8	1.8	35	7.6	12.3
SUFFOLK	11731	837	53	6.3	90	10.9	17	2.2	77	9.2	10.0
SUFFOLK	11733	395	23	5.8	33	9.2	4	1.3	13	3.3	8.5
SUFFOLK	11735	1,044	84	8.0	129	12.5	20	2.1	190	18.2	12.8
SUFFOLK	11738	599	54	9.0	71	12.6	8	1.6	103	17.2	16.8
SUFFOLK	11740	233	21	9.0	34	14.7	5	2.3	40	17.2	10.8
SUFFOLK	11741	882	75	8.5	93	11.3	22	2.8	82	9.3	12.6
SUFFOLK	11742	451	24	5.3	33	7.8	7	1.8	44	9.8	13.8
SUFFOLK	11743	1,211	71	5.9	135	11.3	27	2.5	200	16.5	12.3
SUFFOLK	11746	2,478	198	8.0	270	11.1	107	4.8	975	39.4	36.2
SUFFOLK	11747	446	33	7.4	48	11.1	6	1.5	32	7.2	6.6

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SUFFOLK	11749	142	22	15.5	24	17.9	12	9.9	52	36.9	21.9
SUFFOLK	11751	439	34	7.7	62	14.6	8	2.0	52	11.9	19.1
SUFFOLK	11752	313	25	8.0	36	11.8	12	4.1	42	13.4	18.2
SUFFOLK	11754	494	33	6.7	55	11.4	5	1.1	38	7.7	10.5
SUFFOLK	11755	382	40	10.5	43	12.1	7	2.1	29	7.6	14.1
SUFFOLK	11757	1,504	111	7.4	191	13.0	55	4.0	338	22.5	20.4
SUFFOLK	11763	1,092	69	6.3	87	8.8	43	4.8	267	24.5	38.6
SUFFOLK	11764	359	22	6.1	32	9.6	5	1.6	17	4.7	9.7
SUFFOLK	11766	347	23	6.6	37	11.6	6	2.0	19	5.5	7.5
SUFFOLK	11767	447	27	6.0	34	8.0	8	2.0	43	9.6	7.9
SUFFOLK	11768	465	27	5.8	36	7.9	6	1.4	32	6.9	5.0
SUFFOLK	11769	214	11	5.1	12	5.8	4	2.0	9	4.2	4.6
SUFFOLK	11772	1,874	130	6.9	191	11.0	74	4.7	607	32.4	39.8
SUFFOLK	11776	860	61	7.1	80	10.2	20	2.8	147	17.1	19.5
SUFFOLK	11777	238	12	5.0	23	10.6	5	2.6	21	8.8	18.8
SUFFOLK	11778	494	42	8.5	46	10.5	9	2.3	67	13.6	27.0
SUFFOLK	11779	1,330	86	6.5	112	8.9	37	3.2	213	16.0	22.7
SUFFOLK	11780	343	30	8.7	45	13.8	3	1.0	18	5.2	7.9
SUFFOLK	11782	438	27	6.2	47	11.3	9	2.3	35	8.0	14.2
SUFFOLK	11784	897	62	6.9	89	10.9	19	2.6	175	19.5	31.8
SUFFOLK	11786	175	13	7.4	12	7.4	0	0.0	12	6.9	15.1
SUFFOLK	11787	939	60	6.4	78	8.5	10	1.2	47	5.0	12.9
SUFFOLK	11788	460	29	6.3	55	12.4	5	1.2	36	7.8	19.5
SUFFOLK	11789	284	20	7.0	32	12.4	5	2.1	20	7.0	19.9
SUFFOLK	11790	353	20	5.7	25	7.5	6	2.1	14	4.0	5.6
SUFFOLK	11792	237	16	6.8	28	13.1	3	1.5	14	5.9	9.5
SUFFOLK	11795	739	50	6.8	100	14.1	19	2.8	46	6.2	10.2
SUFFOLK	11796	106	3	2.8	8	7.5	3	2.9	3	2.8	10.1
SUFFOLK	11798	921	130	14.1	162	18.6	80	10.2	542	58.8	90.4
SUFFOLK	11901	1,154	88	7.6	143	13.1	65	6.2	615	53.3	55.6

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SUFFOLK	11933	162	5	3.1	8	5.3	5	3.4	36	22.2	12.8
SUFFOLK	11934	284	23	8.1	26	10.1	5	2.1	45	15.8	11.7
SUFFOLK	11935	71	4	5.6	12	17.4	0	0.0	9	12.7	13.1
SUFFOLK	11937	656	33	5.0	63	10.1	27	4.5	314	47.9	22.0
SUFFOLK	11940	134	10	7.5	11	8.8	4	3.4	21	15.7	24.9
SUFFOLK	11941	132	6	4.5	11	8.8	3	2.6	36	27.5	25.9
SUFFOLK	11942	172	7	4.1	14	9.1	4	2.9	38	22.1	17.5
SUFFOLK	11944	182	14	7.7	20	12.2	8	5.4	71	39.2	37.3
SUFFOLK	11946	583	33	5.7	62	11.3	22	4.1	307	52.7	38.5
SUFFOLK	11949	404	25	6.2	48	12.6	5	1.4	36	8.9	14.3
SUFFOLK	11950	745	63	8.5	79	12.1	25	4.3	287	38.5	62.5
SUFFOLK	11951	596	60	10.1	68	13.0	20	4.2	197	33.1	57.2
SUFFOLK	11952	95	6	6.3	9	10.3	3	3.7	27	28.4	25.4
SUFFOLK	11953	505	38	7.5	56	12.3	16	4.0	104	20.6	26.1
SUFFOLK	11954	115	6	5.2	8	7.1	4	3.6	35	30.4	15.0
SUFFOLK	11955	106	5	4.7	9	9.0	3	3.2	15	14.2	40.0
SUFFOLK	11961	351	27	7.7	37	11.7	7	2.4	56	16.0	22.8
SUFFOLK	11963	220	12	5.5	23	11.1	3	1.5	65	29.5	15.0
SUFFOLK	11964	47	3	6.4	3	6.5	2	4.9	5	10.6	12.8
SUFFOLK	11967	1,035	72	7.0	97	10.6	38	4.6	305	29.5	43.3
SUFFOLK	11968	435	27	6.2	46	11.1	19	4.8	202	46.5	13.9
SUFFOLK	11971	129	14	10.9	21	17.8	3	2.7	18	14.0	11.6
SUFFOLK	11976	30	0	0.0	2	6.9	1	4.2	9	30.0	10.1
SUFFOLK	11977	55	3	5.5	8	15.7	1	2.3	10	18.2	6.3
SUFFOLK	11978	132	8	6.1	16	12.8	5	4.2	52	39.4	21.8
SUFFOLK	11980	178	12	6.7	15	9.3	1	0.7	21	11.8	12.2

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SULLIVAN	12701	492	60	12.2	72	15.7	27	5.9	286	58.4	80.1
SULLIVAN	12719	30	0	0.0	3	10.7	4	14.8	13	43.3	50.5
SULLIVAN	12721	258	22	8.5	24	9.6	8	3.3	77	30.0	62.5
SULLIVAN	12734	33	5	15.2	5	16.1	1	3.3	16	48.5	60.6
SULLIVAN	12737	54	3	5.6	6	11.3	0	0.0	13	24.5	37.6
SULLIVAN	12747	66	4	6.1	10	16.1	2	3.3	29	43.9	36.5
SULLIVAN	12748	54	5	9.3	5	10.2	4	8.2	17	31.5	20.8
SULLIVAN	12754	309	40	12.9	45	15.7	19	6.7	189	61.2	71.9
SULLIVAN	12758	110	8	7.3	15	14.2	0	0.0	45	41.3	44.2
SULLIVAN	12759	60	5	8.3	6	10.7	4	7.3	35	58.3	100.8
SULLIVAN	12764	36	3	8.3	4	11.4	2	5.9	11	30.6	21.7
SULLIVAN	12775	75	10	13.3	7	10.3	7	10.6	18	24.0	63.7
SULLIVAN	12779	136	18	13.2	25	19.4	4	3.1	94	69.6	151.5
SULLIVAN	12783	53	8	15.1	6	11.8	3	6.1	33	62.3	56.7
SULLIVAN	12788	61	4	6.6	6	10.5	2	3.7	29	48.3	35.1
SULLIVAN	12789	79	6	7.6	7	9.3	3	4.0	37	46.8	50.9
SULLIVAN	12790	159	11	6.9	13	8.4	5	3.4	42	26.8	24.5

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Attachment 1a

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
TIOGA	13732	222	9	4.1	21	9.7	2	0.9	42	18.9	19.5
TIOGA	13734	58	3	5.2	4	7.8	2	4.1	19	33.3	24.3
TIOGA	13736	89	7	7.9	7	8.3	3	3.7	35	39.3	36.1
TIOGA	13743	113	12	10.6	12	11.0	3	2.9	43	38.1	34.1
TIOGA	13811	106	6	5.7	15	14.9	6	6.2	38	35.8	35.7
TIOGA	13812	55	2	3.6	1	2.3	1	2.3	24	43.6	47.6
TIOGA	13827	315	28	8.9	31	10.5	8	2.8	125	39.8	56.1
TIOGA	13835	65	5	7.7	8	13.6	5	8.6	32	49.2	69.8
TIOGA	14883	108	8	7.4	15	16.9	3	3.4	44	41.1	31.3
TIOGA	14892	213	22	10.3	19	12.4	5	3.3	88	41.5	41.8

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
ZIP Codes w/ <30 births withheld

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1a

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500g) (08-10)	% Low Birth Weight	# Premature (<37 Weeks) (08-10)	% Premature	# Late/ No PNC (08-10)	%Late/No PNC	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
TOMPKINS	13053	121	9	7.4	13	11.7	3	2.8	39	32.2	39.4
TOMPKINS	13068	180	13	7.2	20	11.8	0	0.0	64	35.6	23.1
TOMPKINS	13073	227	18	7.9	20	9.7	3	1.5	91	40.3	45.3
TOMPKINS	14817	78	4	5.1	12	16.0	2	2.6	28	35.9	31.6
TOMPKINS	14850	1,564	109	7.0	139	9.3	52	3.5	484	31.0	9.8
TOMPKINS	14867	197	13	6.6	13	7.2	3	1.7	74	38.1	44.4
TOMPKINS	14882	109	10	9.2	8	7.7	4	3.8	30	27.5	11.9
TOMPKINS	14886	185	11	5.9	13	7.3	5	2.8	56	30.6	51.4

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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(CUMULATIVE 3 Year Total)

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ULSTER	12401	1,279	105	8.2	100	9.0	29	2.9	569	44.5	82.7
ULSTER	12404	92	8	8.7	5	6.0	1	1.4	35	38.0	75.6
ULSTER	12428	262	26	9.9	31	12.9	11	5.2	141	54.0	66.7
ULSTER	12443	90	5	5.6	6	7.0	1	1.2	13	14.4	35.7
ULSTER	12446	177	7	4.0	12	7.9	7	4.9	64	36.2	86.6
ULSTER	12449	78	5	6.4	6	8.5	1	1.6	30	39.0	56.5
ULSTER	12458	50	6	12.0	6	13.6	0	0.0	24	48.0	54.5
ULSTER	12461	34	0	0.0	1	3.1	2	6.3	3	8.8	20.4
ULSTER	12466	112	4	3.6	12	11.4	3	3.0	25	22.3	68.0
ULSTER	12472	39	3	7.7	3	8.6	0	0.0	7	17.9	16.1
ULSTER	12477	558	35	6.3	44	8.7	11	2.3	151	27.1	34.3
ULSTER	12484	76	5	6.6	6	8.2	1	1.4	16	21.1	16.5
ULSTER	12486	48	2	4.2	2	4.3	2	4.8	2	4.2	6.8
ULSTER	12487	144	7	4.9	8	6.0	1	0.8	24	16.8	37.0
ULSTER	12491	32	1	3.1	2	7.4	2	7.4	2	6.3	42.6
ULSTER	12498	80	11	13.8	12	16.0	4	5.7	23	28.8	25.2
ULSTER	12515	40	4	10.0	3	9.7	2	6.3	15	37.5	31.4
ULSTER	12525	105	7	6.7	7	7.2	1	1.1	18	17.3	26.3
ULSTER	12528	465	26	5.6	37	8.3	10	2.3	82	17.7	16.2
ULSTER	12542	189	17	9.0	20	10.9	7	3.8	51	27.0	45.5
ULSTER	12547	92	10	10.9	11	12.8	1	1.2	25	27.2	29.9
ULSTER	12548	48	3	6.3	6	14.0	1	2.4	17	35.4	35.5
ULSTER	12561	323	20	6.2	29	9.5	7	2.4	54	16.7	12.9
ULSTER	12566	298	20	6.7	29	10.2	9	3.2	78	26.2	38.7
ULSTER	12589	440	45	10.2	55	13.5	7	1.8	123	28.1	33.9
ULSTER	12740	31	3	9.7	5	17.9	1	3.7	6	20.0	21.4

Teen Pregnancy Rate: # pregnancies/ 1000 females aged 15-19
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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

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WARREN	12801	595	44	7.4	65	11.7	13	2.4	208	35.0	86.8
WARREN	12804	702	57	8.1	66	10.0	20	3.1	183	26.1	45.0
WARREN	12817	74	3	4.1	5	7.2	6	8.6	18	24.7	37.9
WARREN	12843	45	2	4.4	4	9.1	0	0.0	16	35.6	46.5
WARREN	12845	92	4	4.3	9	10.1	5	5.7	32	34.8	22.4
WARREN	12846	88	6	6.8	12	14.6	4	4.9	29	33.0	45.1
WARREN	12853	31	3	9.7	2	6.9	0	0.0	10	32.3	12.0
WARREN	12885	140	12	8.6	15	11.4	2	1.6	56	40.0	33.8

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(CUMULATIVE 3 Year Total)

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WASHINGTON	12057	53	3	5.7	5	9.8	3	6.0	6	11.3	10.8
WASHINGTON	12809	96	9	9.4	11	11.7	3	3.3	15	15.6	43.8
WASHINGTON	12816	136	13	9.6	11	8.5	6	4.6	29	21.5	54.8
WASHINGTON	12827	109	7	6.4	8	7.5	2	1.9	19	17.4	24.8
WASHINGTON	12828	253	19	7.5	24	10.0	8	3.3	58	22.9	68.2
WASHINGTON	12832	188	15	8.0	15	8.7	2	1.2	52	27.7	50.4
WASHINGTON	12834	166	8	4.8	14	9.1	6	3.9	30	18.3	34.1
WASHINGTON	12839	535	46	8.6	53	10.6	22	4.5	105	19.7	62.5
WASHINGTON	12865	94	8	8.5	11	12.0	2	2.2	21	22.3	33.3
WASHINGTON	12887	148	10	6.8	12	8.5	4	2.9	38	25.9	71.6

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WAYNE	13143	119	6	5.0	6	5.5	5	4.6	64	53.8	61.2
WAYNE	13146	102	8	7.8	14	14.4	6	6.3	28	27.7	60.6
WAYNE	14433	193	17	8.8	16	8.8	10	5.6	83	43.2	82.8
WAYNE	14489	256	21	8.2	24	10.2	6	2.6	137	53.5	74.8
WAYNE	14502	375	27	7.2	35	9.9	11	3.2	68	18.1	27.7
WAYNE	14505	161	11	6.8	18	12.2	3	2.1	41	25.5	27.2
WAYNE	14513	491	43	8.8	56	12.6	23	5.2	231	47.0	57.0
WAYNE	14516	79	4	5.1	10	13.7	1	1.4	31	39.2	47.6
WAYNE	14519	326	26	8.0	22	7.3	11	3.8	77	23.6	36.7
WAYNE	14522	275	12	4.4	24	9.5	6	2.5	111	40.4	31.5
WAYNE	14551	199	16	8.0	20	11.4	10	5.8	108	54.3	80.4
WAYNE	14568	191	18	9.4	16	9.8	3	1.9	17	8.9	33.5
WAYNE	14589	247	11	4.5	13	5.6	4	1.8	75	30.4	46.4
WAYNE	14590	182	8	4.4	14	8.3	11	6.7	83	45.9	57.0

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WESTCHESTER	10502	121	9	7.4	21	17.6	0	0.0	11	9.5	5.9
WESTCHESTER	10504	167	16	9.6	19	12.2	3	2.7	9	6.3	1.9
WESTCHESTER	10506	127	10	7.9	16	13.2	2	2.4	5	4.8	2.8
WESTCHESTER	10507	262	25	9.5	26	10.3	10	4.5	112	44.1	15.2
WESTCHESTER	10510	205	18	8.8	20	10.1	7	4.2	8	4.1	3.8
WESTCHESTER	10511	78	4	5.1	7	9.6	0	0.0	24	31.2	38.1
WESTCHESTER	10514	292	25	8.6	36	12.7	5	2.2	7	2.6	0.6
WESTCHESTER	10518	32	2	6.3	3	9.7	0	0.0	3	10.3	8.8
WESTCHESTER	10520	338	20	5.9	29	8.9	6	2.0	42	12.6	9.3
WESTCHESTER	10522	274	27	9.9	38	14.3	5	2.4	37	13.8	8.7
WESTCHESTER	10523	292	23	7.9	39	13.9	16	6.4	117	41.6	31.0
WESTCHESTER	10526	39	1	2.6	6	16.2	0	0.0	4	10.8	4.1
WESTCHESTER	10528	385	26	6.8	38	10.7	12	6.5	53	19.5	9.0
WESTCHESTER	10530	421	34	8.1	56	13.6	9	2.7	30	7.4	6.7
WESTCHESTER	10532	125	8	6.4	17	13.9	4	4.0	10	8.5	6.5
WESTCHESTER	10533	181	12	6.6	21	12.2	4	3.1	11	6.2	6.4
WESTCHESTER	10536	237	28	11.8	32	13.7	1	0.5	29	13.0	0.6
WESTCHESTER	10538	597	41	6.9	60	10.7	7	3.7	25	5.9	3.6
WESTCHESTER	10543	654	45	6.9	93	15.0	22	6.1	197	38.2	21.1
WESTCHESTER	10546	31	1	3.2	3	9.7	1	3.4	4	12.9	13.1
WESTCHESTER	10547	294	27	9.2	32	11.7	10	3.9	64	22.0	13.7
WESTCHESTER	10548	121	13	10.7	24	21.1	0	0.0	23	19.0	42.7
WESTCHESTER	10549	658	61	9.3	79	12.1	9	1.5	260	40.0	17.4
WESTCHESTER	10550	1,869	233	12.5	301	16.9	122	8.0	1169	63.2	80.9
WESTCHESTER	10552	670	64	9.6	83	12.9	24	4.8	185	28.7	21.2
WESTCHESTER	10553	400	55	13.8	58	15.3	25	7.9	187	48.1	58.9
WESTCHESTER	10560	109	10	9.2	10	9.5	0	0.0	12	12.1	7.0
WESTCHESTER	10562	1,262	88	7.0	142	11.5	36	3.0	602	48.2	34.0
WESTCHESTER	10566	1,140	102	8.9	117	11.2	23	2.3	615	54.0	55.9
WESTCHESTER	10567	491	50	10.2	60	12.8	12	2.8	67	13.9	11.3

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WESTCHESTER	10570	299	25	8.4	42	14.5	4	1.6	34	11.9	10.2
WESTCHESTER	10573	1,586	101	6.4	171	11.3	38	3.6	859	67.2	32.5
WESTCHESTER	10576	99	13	13.1	7	7.5	1	2.0	6	8.2	6.8
WESTCHESTER	10577	56	5	8.9	5	9.6	1	4.0	1	2.6	5.8
WESTCHESTER	10580	480	41	8.5	59	13.3	3	2.9	10	3.5	2.4
WESTCHESTER	10583	988	81	8.2	119	12.4	29	4.3	35	3.8	1.4
WESTCHESTER	10588	69	2	2.9	9	13.4	1	1.6	12	17.9	26.4
WESTCHESTER	10589	143	13	9.1	15	10.9	0	0.0	7	5.2	4.1
WESTCHESTER	10590	139	15	10.8	13	9.8	1	1.5	7	6.9	2.5
WESTCHESTER	10591	965	64	6.6	114	12.0	23	2.7	311	33.2	27.0
WESTCHESTER	10594	130	15	11.5	19	15.0	3	2.8	11	9.2	5.3
WESTCHESTER	10595	153	9	5.9	13	8.7	3	2.3	16	11.3	4.6
WESTCHESTER	10598	708	51	7.2	78	11.4	8	1.2	50	7.1	4.8
WESTCHESTER	10601	450	55	12.2	71	16.5	21	5.9	157	37.1	47.0
WESTCHESTER	10603	755	83	11.0	99	13.6	34	5.4	273	38.5	41.4
WESTCHESTER	10604	337	24	7.1	44	13.3	15	5.4	111	35.8	17.2
WESTCHESTER	10605	690	45	6.5	79	11.8	24	4.5	140	22.5	15.5
WESTCHESTER	10606	778	38	4.9	97	12.8	37	5.4	412	54.6	55.2
WESTCHESTER	10607	283	28	9.9	47	17.3	17	7.0	114	42.4	42.6
WESTCHESTER	10701	3,190	350	11.0	474	16.5	185	7.5	2160	68.1	80.0
WESTCHESTER	10703	808	78	9.7	117	15.8	32	4.8	397	49.4	46.3
WESTCHESTER	10704	1,182	103	8.7	135	12.1	48	5.4	296	25.3	15.8
WESTCHESTER	10705	1,928	205	10.6	263	15.1	133	9.2	1317	68.6	70.5
WESTCHESTER	10706	151	13	8.6	20	13.8	5	4.4	17	11.3	11.0
WESTCHESTER	10707	355	33	9.3	43	12.6	11	3.9	40	11.6	11.2
WESTCHESTER	10708	768	59	7.7	91	12.5	16	3.0	36	4.9	4.3
WESTCHESTER	10709	266	16	6.0	37	15.2	6	3.3	11	4.4	8.2
WESTCHESTER	10710	797	56	7.0	84	11.1	18	2.9	160	20.6	10.1
WESTCHESTER	10801	1,804	135	7.5	231	13.1	92	6.5	914	54.9	51.3
WESTCHESTER	10803	327	25	7.6	24	7.8	11	5.9	28	9.4	8.4

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(CUMULATIVE 3 Year Total)

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WESTCHESTER	10804	373	21	5.6	55	15.3	6	3.2	12	3.8	3.8
WESTCHESTER	10805	625	56	9.0	67	11.2	23	5.0	236	41.8	25.5

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WYOMING	14009	189	15	7.9	21	11.8	3	1.7	60	31.7	36.0
WYOMING	14011	164	6	3.7	12	7.7	1	0.7	47	28.7	21.4
WYOMING	14024	67	3	4.5	5	8.2	2	3.3	15	22.7	38.9
WYOMING	14066	43	4	9.3	5	12.5	3	7.7	15	34.9	40.8
WYOMING	14145	38	1	2.6	4	10.8	1	2.7	5	13.2	0.0
WYOMING	14167	40	0	0.0	0	0.0	1	2.7	14	35.0	28.4
WYOMING	14427	62	4	6.5	6	9.7	0	0.0	21	33.9	53.6
WYOMING	14530	202	9	4.5	12	6.5	3	1.6	72	35.6	46.5
WYOMING	14550	60	3	5.0	4	7.0	3	5.3	17	28.3	52.3
WYOMING	14569	200	10	5.0	24	13.0	4	2.2	78	39.0	25.2
WYOMING	14591	49	4	8.2	5	10.4	2	4.3	11	22.4	5.6

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YATES	14418	36	2	5.6	3	8.6	2	5.7	15	41.7	46.5
YATES	14507	48	1	2.1	0	0.0	4	8.7	26	54.2	66.7
YATES	14527	512	25	4.9	36	7.3	21	4.3	160	31.3	35.3
YATES	14544	54	0	0.0	2	3.9	5	10.2	16	29.6	27.4
YATES	14837	219	19	8.7	23	10.8	10	4.8	92	42.2	38.3
YATES	14842	43	2	4.7	3	7.3	7	17.1	13	30.2	8.3

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ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

Attachment 1b

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BRONX	10451	2,291	233	10.2	314	13.9	1842	80.4	117.0
BRONX	10452	4,510	452	10.0	599	13.5	3687	81.8	107.3
BRONX	10453	4,420	401	9.1	565	13.1	3597	81.4	114.8
BRONX	10454	2,255	236	10.5	330	14.9	1955	86.7	117.6
BRONX	10455	2,268	201	8.9	308	13.8	1950	86.0	109.8
BRONX	10456	5,002	530	10.6	691	14.1	4164	83.2	131.2
BRONX	10457	4,254	431	10.1	559	13.5	3524	82.8	119.8
BRONX	10458	4,424	431	9.7	607	14.0	3608	81.6	87.3
BRONX	10459	2,552	259	10.1	368	14.6	2109	82.6	118.5
BRONX	10460	3,035	328	10.8	416	14.0	2495	82.2	125.5
BRONX	10461	1,869	160	8.6	215	11.7	909	48.7	59.4
BRONX	10462	3,537	351	9.9	459	13.1	2240	63.3	64.5
BRONX	10463	2,878	222	7.7	306	10.9	1331	46.3	50.2
BRONX	10464	111	*	*	14	13.0	32	28.8	40.0
BRONX	10465	1,426	142	10.0	183	13.0	557	39.1	40.8
BRONX	10466	3,113	364	11.7	464	15.1	2188	70.4	93.9
BRONX	10467	4,957	482	9.7	676	13.8	3679	74.2	89.7
BRONX	10468	3,943	359	9.1	504	13.0	3167	80.4	112.6
BRONX	10469	2,626	263	10.0	335	12.9	1660	63.2	75.2
BRONX	10470	650	48	7.4	67	10.7	349	53.7	68.8
BRONX	10471	652	53	8.1	62	9.9	143	21.9	15.6
BRONX	10472	3,749	370	9.9	510	13.8	3161	84.4	120.2
BRONX	10473	2,396	283	11.8	333	14.1	1658	69.2	88.8
BRONX	10474	711	62	8.7	83	11.9	615	86.5	27.1
BRONX	10475	997	117	11.7	135	13.7	499	50.1	63.4
KINGS	11201	2,464	209	8.5	307	12.7	388	15.7	51.3
KINGS	11203	3,126	380	12.2	488	16.1	2201	70.4	83.8

Late/No Prenatal Care Data withheld due to incomplete reporting
Teen Pregnancy Rate: # pregnancies/1000 females aged 15-19
ZIP Codes w/<30 births withheld
*Indicates <3 cases

Source: NYC Dept of Health and Mental Hygiene
Office of Vital Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
KINGS	11204	4,138	283	6.8	394	9.6	2769	66.9	24.8
KINGS	11205	2,415	151	6.3	244	10.2	1427	59.1	67.3
KINGS	11206	4,556	336	7.4	476	10.7	3472	76.2	95.7
KINGS	11207	4,540	550	12.1	767	17.4	3515	77.4	113.4
KINGS	11208	4,636	487	10.5	696	15.3	3136	67.6	105.2
KINGS	11209	2,733	231	8.5	351	12.9	1208	44.2	28.0
KINGS	11210	3,099	284	9.2	407	13.4	1697	54.8	46.4
KINGS	11211	6,142	340	5.5	562	9.3	3984	64.9	39.3
KINGS	11212	4,348	552	12.7	771	18.0	3469	79.8	118.8
KINGS	11213	3,533	357	10.1	494	14.3	2640	74.7	79.4
KINGS	11214	3,418	220	6.4	343	10.1	2225	65.1	34.0
KINGS	11215	2,968	193	6.5	328	11.2	535	18.0	26.6
KINGS	11216	2,092	244	11.7	322	15.7	1443	69.0	89.2
KINGS	11217	1,653	125	7.6	171	10.5	442	26.7	65.7
KINGS	11218	4,121	269	6.5	412	10.1	2835	68.8	34.7
KINGS	11219	8,184	420	5.1	612	7.6	6593	80.6	35.2
KINGS	11220	8,780	513	5.8	830	9.6	7895	89.9	71.6
KINGS	11221	3,810	448	11.8	603	16.3	2997	78.7	108.2
KINGS	11222	1,086	68	6.3	110	10.3	427	39.3	30.7
KINGS	11223	3,488	258	7.4	364	10.5	2123	60.9	45.6
KINGS	11224	1,574	157	10.0	214	13.7	1176	74.7	83.8
KINGS	11225	2,743	269	9.8	355	13.2	1859	67.8	79.2
KINGS	11226	5,021	552	11.0	822	16.7	3780	75.3	94.3
KINGS	11228	1,392	89	6.4	163	11.8	687	49.4	18.9
KINGS	11229	2,900	235	8.1	327	11.4	1551	53.5	30.6
KINGS	11230	4,678	350	7.5	473	10.2	2655	56.8	25.7
KINGS	11231	1,704	125	7.3	185	11.0	453	26.6	57.3

Late/No Prenatal Care Data withheld due to incomplete reporting
Teen Pregnancy Rate: # pregnancies/1000 females aged 15-19
ZIP Codes w/<30 births withheld
*Indicates <3 cases

Source: NYC Dept of Health and Mental Hygiene
Office of Vital Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
KINGS	11232	1,564	97	6.2	161	10.4	1284	82.1	85.6
KINGS	11233	3,066	423	13.8	543	18.0	2296	74.9	107.9
KINGS	11234	3,241	316	9.8	447	13.9	1555	48.0	43.7
KINGS	11235	2,857	239	8.4	317	11.2	1742	61.0	37.4
KINGS	11236	3,989	462	11.6	700	17.8	2466	61.8	76.0
KINGS	11237	2,766	168	6.1	363	13.4	2374	85.8	92.1
KINGS	11238	2,103	200	9.5	268	13.0	750	35.7	59.2
KINGS	11239	448	44	9.8	63	14.1	250	55.8	74.9

Late/No Prenatal Care Data withheld due to incomplete reporting
Teen Pregnancy Rate: # pregnancies/1000 females aged 15-19
ZIP Codes w/<30 births withheld
*Indicates <3 cases

Source: NYC Dept of Health and Mental Hygiene
Office of Vital Statistics

Attachment 1b

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
NEW YORK	10001	517	42	8.1	54	10.7	154	29.8	50.5
NEW YORK	10002	4,012	258	6.4	385	10.2	3079	76.8	53.1
NEW YORK	10003	1,252	86	6.9	152	12.4	106	8.5	10.5
NEW YORK	10005	243	29	11.9	28	11.8	11	4.5	43.9
NEW YORK	10007	953	79	8.3	130	13.9	15	1.6	12.0
NEW YORK	10009	1,559	128	8.2	200	13.0	662	42.5	68.9
NEW YORK	10010	912	71	7.8	102	11.5	64	7.0	11.3
NEW YORK	10011	1,464	127	8.7	190	13.2	151	10.3	34.3
NEW YORK	10012	646	53	8.2	71	11.2	95	14.7	45.6
NEW YORK	10013	1,259	93	7.4	128	10.5	336	26.7	10.0
NEW YORK	10014	899	71	7.9	109	12.4	37	4.1	8.9
NEW YORK	10016	1,620	137	8.5	177	11.1	128	7.9	26.0
NEW YORK	10017	448	36	8.0	60	13.5	17	3.8	42.8
NEW YORK	10018	121	7	5.8	16	13.4	39	32.2	69.1
NEW YORK	10019	1,334	118	8.8	171	13.1	247	18.5	47.8
NEW YORK	10021	2,041	179	8.8	310	15.5	56	2.8	12.6
NEW YORK	10022	1,083	104	9.6	145	13.8	46	4.3	11.0
NEW YORK	10023	3,070	269	8.8	419	14.0	171	5.6	18.1
NEW YORK	10024	2,453	189	7.7	285	12.0	185	7.5	20.1
NEW YORK	10025	3,235	262	8.1	375	11.9	764	23.6	39.1
NEW YORK	10026	1,625	167	10.3	222	14.2	901	55.5	85.0
NEW YORK	10027	2,269	241	10.6	310	14.1	1305	57.5	59.5
NEW YORK	10028	1,549	128	8.3	218	14.5	106	6.9	21.9
NEW YORK	10029	3,265	345	10.6	476	15.3	2431	74.5	104.7
NEW YORK	10030	1,148	122	10.6	154	13.9	819	71.3	113.7
NEW YORK	10031	2,421	227	9.4	296	12.5	1830	75.6	107.3
NEW YORK	10032	2,431	185	7.6	271	11.3	1806	74.3	100.5

Late/No Prenatal Care Data withheld due to incomplete reporting
Teen Pregnancy Rate: # pregnancies/1000 females aged 15-19
ZIP Codes w/<30 births withheld
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Source: NYC Dept of Health and Mental Hygiene
Office of Vital Statistics

Attachment 1b

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
NEW YORK	10033	2,274	166	7.3	239	10.7	1454	63.9	91.8
NEW YORK	10034	1,694	124	7.3	171	10.2	1142	67.5	85.3
NEW YORK	10035	1,464	162	11.1	205	14.8	1121	76.6	107.4
NEW YORK	10036	582	53	9.1	81	14.3	165	28.4	79.6
NEW YORK	10037	656	94	14.3	101	16.1	415	63.4	127.5
NEW YORK	10038	672	52	7.7	68	10.8	292	43.5	31.3
NEW YORK	10039	1,146	152	13.3	197	17.7	837	73.0	133.8
NEW YORK	10040	1,845	152	8.2	204	11.2	1220	66.1	87.2
NEW YORK	10044	410	35	8.5	69	17.1	73	17.8	20.2
NEW YORK	10128	2,278	212	9.3	295	13.3	181	8.0	12.3
NEW YORK	10280	413	43	10.4	55	13.6	18	4.4	11.4

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Office of Vital Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
QUEENS	11004	419	44	10.5	64	15.4	101	24.1	10.2
QUEENS	11101	1,077	112	10.4	162	15.3	605	56.2	64.8
QUEENS	11102	1,374	107	7.8	195	14.4	825	60.0	56.0
QUEENS	11103	1,259	84	6.7	153	12.4	683	54.3	27.5
QUEENS	11104	1,095	81	7.4	122	11.2	567	51.8	28.6
QUEENS	11105	1,154	96	8.3	132	11.6	465	40.3	20.5
QUEENS	11106	1,342	104	7.7	199	15.0	774	57.7	36.1
QUEENS	11354	1,889	121	6.4	188	10.0	1190	63.0	27.1
QUEENS	11355	3,615	196	5.4	326	9.1	2742	75.9	26.2
QUEENS	11356	1,025	70	6.8	104	10.3	585	57.1	47.9
QUEENS	11357	1,191	69	5.8	96	8.1	250	21.0	11.0
QUEENS	11358	1,270	82	6.5	118	9.4	539	42.5	20.1
QUEENS	11360	515	35	6.8	46	9.0	86	16.7	9.2
QUEENS	11361	881	52	5.9	71	8.2	263	29.9	11.5
QUEENS	11362	488	27	5.5	43	9.0	90	18.4	9.7
QUEENS	11363	164	12	7.3	12	7.4	36	22.0	4.9
QUEENS	11364	919	61	6.6	88	9.7	254	27.8	14.9
QUEENS	11365	1,511	101	6.7	154	10.3	647	42.8	24.7
QUEENS	11366	479	45	9.4	70	14.7	207	43.2	13.7
QUEENS	11367	2,442	189	7.7	225	9.3	915	37.5	27.6
QUEENS	11368	6,859	433	6.3	853	12.5	6039	88.1	106.6
QUEENS	11369	1,626	107	6.6	194	12.0	1287	79.2	78.6
QUEENS	11370	1,164	114	9.8	154	13.3	781	67.1	36.6
QUEENS	11372	3,069	207	6.7	384	12.6	2213	72.1	65.4
QUEENS	11373	4,846	334	6.9	544	11.4	3919	80.9	54.3
QUEENS	11374	1,658	113	6.8	155	9.4	640	38.6	22.6
QUEENS	11375	2,647	188	7.1	264	10.1	530	20.0	15.8

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Office of Vital Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
QUEENS	11377	3,624	226	6.2	398	11.1	2557	70.6	43.9
QUEENS	11378	1,402	94	6.7	145	10.4	710	50.7	33.1
QUEENS	11379	1,103	52	4.7	99	9.1	325	29.5	21.4
QUEENS	11385	4,374	309	7.1	487	11.3	2728	62.4	51.1
QUEENS	11411	646	95	14.7	125	19.7	281	43.5	60.5
QUEENS	11412	1,384	139	10.0	212	15.5	737	53.3	89.7
QUEENS	11413	1,392	177	12.7	212	15.4	673	48.4	80.6
QUEENS	11414	813	74	9.1	93	11.5	177	21.8	24.6
QUEENS	11415	846	73	8.6	80	9.5	245	29.0	28.2
QUEENS	11416	1,089	103	9.5	145	13.4	557	51.2	66.0
QUEENS	11417	1,214	87	7.2	138	11.5	585	48.2	53.7
QUEENS	11418	1,618	132	8.2	191	11.9	714	44.2	68.4
QUEENS	11419	1,981	257	13.0	276	14.1	1028	51.9	56.6
QUEENS	11420	1,849	222	12.0	259	14.1	919	49.7	56.3
QUEENS	11421	1,700	121	7.1	195	11.6	918	54.0	82.0
QUEENS	11422	1,199	130	10.8	183	15.4	574	47.9	65.6
QUEENS	11423	1,143	126	11.0	147	13.0	589	51.5	63.0
QUEENS	11426	541	47	8.7	49	9.1	195	36.0	17.9
QUEENS	11427	824	79	9.6	115	14.0	356	43.3	30.3
QUEENS	11428	723	70	9.7	84	11.7	354	49.0	44.8
QUEENS	11429	953	110	11.5	120	12.7	493	51.7	67.9
QUEENS	11432	2,640	271	10.3	339	12.9	1553	58.9	57.6
QUEENS	11433	1,464	156	10.7	227	15.7	853	58.3	95.8
QUEENS	11434	2,356	310	13.2	376	16.2	1220	51.8	83.9
QUEENS	11435	2,630	286	10.9	354	13.6	1309	49.8	68.1
QUEENS	11436	800	98	12.3	129	16.3	418	52.3	80.4
QUEENS	11691	3,381	288	8.5	406	12.2	1996	59.1	89.3

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Office of Vital Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
QUEENS	11692	935	120	12.8	160	17.2	609	65.1	120.6
QUEENS	11693	457	51	11.2	65	14.3	229	50.1	64.0
QUEENS	11694	583	42	7.2	80	13.8	161	27.6	24.7
QUEENS	11697	100	5	5.0	10	10.1	11	11.1	7.7

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Source: NYC Dept of Health and Mental Hygiene
Office of Vital Statistics

ZIP Code Level Birth Data 2008-2010
(CUMULATIVE 3 Year Total)

County	ZIP	Total # Births (08-10)	# Low Birth Weight (<2500 Gms) (08-10)	% Low Birth Weight	# Premature (<37 weeks) (08-10)	% Premature	# Medicaid Payor (08-10)	% Medicaid Payor	Teen Pregnancy Rate
RICHMOND	10301	1,534	142	9.3	193	12.8	820	53.5	63.9
RICHMOND	10302	996	104	10.4	151	15.3	663	66.6	95.8
RICHMOND	10303	1,225	116	9.5	179	14.7	752	61.4	88.8
RICHMOND	10304	1,906	185	9.7	248	13.1	1136	59.6	72.2
RICHMOND	10305	1,520	111	7.3	181	12.0	660	43.4	35.3
RICHMOND	10306	1,703	156	9.2	221	13.1	503	29.5	24.8
RICHMOND	10307	420	30	7.1	44	10.5	86	20.5	15.8
RICHMOND	10308	828	64	7.7	90	10.9	161	19.4	10.2
RICHMOND	10309	1,039	80	7.7	112	10.8	207	19.9	10.7
RICHMOND	10310	1,116	83	7.4	131	11.8	612	54.8	90.0
RICHMOND	10312	1,804	141	7.8	196	10.9	352	19.5	13.6
RICHMOND	10314	2,981	217	7.3	304	10.3	1017	34.1	25.3

Late/No Prenatal Care Data withheld due to incomplete reporting
Teen Pregnancy Rate: # pregnancies/1000 females aged 15-19
ZIP Codes w/<30 births withheld
*Indicates <3 cases

Source: NYC Dept of Health and Mental Hygiene
Office of Vital Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

Attachment 1c

County	ZIP	Average # Annual Medicaid births (2008-2010)
ALBANY	12009	6.3
ALBANY	12023	4.3
ALBANY	12047	55.0
ALBANY	12054	11.0
ALBANY	12059	3.7
ALBANY	12067	1.3
ALBANY	12077	4.7
ALBANY	12084	2.3
ALBANY	12110	15.0
ALBANY	12143	19.7
ALBANY	12158	13.0
ALBANY	12159	3.7
ALBANY	12183	9.3
ALBANY	12186	3.0
ALBANY	12189	44.7
ALBANY	12193	3.7
ALBANY	12202	98.3
ALBANY	12203	50.0
ALBANY	12204	29.7
ALBANY	12205	45.0
ALBANY	12206	157.7
ALBANY	12207	18.7
ALBANY	12208	53.7
ALBANY	12209	50.0
ALBANY	12210	74.7
ALBANY	12211	6.3
ALBANY	12303	91.0
ALLEGANY	14709	6.7
ALLEGANY	14711	7.3
ALLEGANY	14715	15.7
ALLEGANY	14727	20.0
ALLEGANY	14735	12.0
ALLEGANY	14739	19.3
ALLEGANY	14744	3.0
ALLEGANY	14770	9.3
ALLEGANY	14804	2.7
ALLEGANY	14806	10.3
ALLEGANY	14813	9.7
ALLEGANY	14822	3.7
ALLEGANY	14880	5.7
ALLEGANY	14895	47.0
ALLEGANY	14897	5.3

County	ZIP	Average # Annual Medicaid births (2008-2010)
BROOME	13744	2.7
BROOME	13746	6.0
BROOME	13748	9.0
BROOME	13754	16.0
BROOME	13760	113.3
BROOME	13787	11.0
BROOME	13790	63.3
BROOME	13795	8.7
BROOME	13797	6.3
BROOME	13833	12.0
BROOME	13850	16.7
BROOME	13862	12.0
BROOME	13865	14.0
BROOME	13901	76.3
BROOME	13903	60.0
BROOME	13904	24.3
BROOME	13905	112.7
CATTARAUGUS	14042	14.3
CATTARAUGUS	14065	7.0
CATTARAUGUS	14070	15.7
CATTARAUGUS	14101	7.0
CATTARAUGUS	14129	9.0
CATTARAUGUS	14138	6.0
CATTARAUGUS	14171	2.3
CATTARAUGUS	14706	10.7
CATTARAUGUS	14719	5.7
CATTARAUGUS	14726	4.0
CATTARAUGUS	14737	17.0
CATTARAUGUS	14738	12.7
CATTARAUGUS	14741	3.0
CATTARAUGUS	14743	4.7
CATTARAUGUS	14753	3.7
CATTARAUGUS	14755	6.3
CATTARAUGUS	14760	87.3
CATTARAUGUS	14772	18.3
CATTARAUGUS	14779	54.3
CAYUGA	13021	212.3
CAYUGA	13026	4.3
CAYUGA	13033	17.0
CAYUGA	13034	6.7
CAYUGA	13081	4.0
CAYUGA	13092	9.0

*Zip Codes w/ <30 births total from 2008-2010 withheld.
** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)
CAYUGA	13111	8.7
CAYUGA	13118	25.7
CAYUGA	13140	18.7
CAYUGA	13147	5.3
CAYUGA	13156	7.3
CAYUGA	13160	4.3
CAYUGA	13166	22.0
CHAUTAUQUA	14048	116.3
CHAUTAUQUA	14062	9.3
CHAUTAUQUA	14063	30.0
CHAUTAUQUA	14136	15.3
CHAUTAUQUA	14701	297.0
CHAUTAUQUA	14710	8.7
CHAUTAUQUA	14712	5.3
CHAUTAUQUA	14716	10.7
CHAUTAUQUA	14718	4.7
CHAUTAUQUA	14723	3.7
CHAUTAUQUA	14724	7.7
CHAUTAUQUA	14728	2.0
CHAUTAUQUA	14733	11.7
CHAUTAUQUA	14740	3.7
CHAUTAUQUA	14747	7.7
CHAUTAUQUA	14750	8.3
CHAUTAUQUA	14757	9.3
CHAUTAUQUA	14767	6.0
CHAUTAUQUA	14775	11.7
CHAUTAUQUA	14781	6.0
CHAUTAUQUA	14782	11.0
CHAUTAUQUA	14784	5.7
CHAUTAUQUA	14787	21.7
CHEMUNG	14814	1.0
CHEMUNG	14838	8.3
CHEMUNG	14845	50.7
CHEMUNG	14861	7.3
CHEMUNG	14871	10.3
CHEMUNG	14889	6.3
CHEMUNG	14894	10.0
CHEMUNG	14901	179.0
CHEMUNG	14903	36.7
CHEMUNG	14904	152.0
CHEMUNG	14905	40.0
CHENANGO	13411	20.7
CHENANGO	13460	20.7
CHENANGO	13464	5.0
CHENANGO	13730	13.7
CHENANGO	13733	23.0
CHENANGO	13778	19.0
CHENANGO	13801	9.0
CHENANGO	13809	6.3
CHENANGO	13815	88.3
CHENANGO	13830	19.7
CLINTON	12901	160.7
CLINTON	12910	13.0
CLINTON	12912	8.3
CLINTON	12918	7.0
CLINTON	12919	11.7
CLINTON	12921	10.0
CLINTON	12934	7.3
CLINTON	12935	6.3
CLINTON	12958	7.7
CLINTON	12959	7.3
CLINTON	12962	17.3
CLINTON	12972	20.3
CLINTON	12979	8.0
CLINTON	12981	18.7
CLINTON	12985	8.7
CLINTON	12992	23.0
COLUMBIA	12037	4.3
COLUMBIA	12075	3.0
COLUMBIA	12106	2.0
COLUMBIA	12125	3.0
COLUMBIA	12173	2.7
COLUMBIA	12184	8.3
COLUMBIA	12513	2.0
COLUMBIA	12516	1.7
COLUMBIA	12521	2.7
COLUMBIA	12523	2.3
COLUMBIA	12526	3.7
COLUMBIA	12529	2.3
COLUMBIA	12534	35.7
CORTLAND	13040	16.0
CORTLAND	13045	165.0
CORTLAND	13077	29.0
CORTLAND	13101	15.7

*Zip Codes w/ <30 births total from 2008-2010 withheld.
** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

Attachment 1c

County	ZIP	Average # Annual Medicaid births (2008-2010)
CORTLAND	13158	8.3
CORTLAND	13803	17.0
DELAWARE	12167	17.0
DELAWARE	12430	5.7
DELAWARE	12455	3.3
DELAWARE	12776	9.3
DELAWARE	13739	5.7
DELAWARE	13753	12.7
DELAWARE	13755	5.3
DELAWARE	13757	4.0
DELAWARE	13775	4.0
DELAWARE	13783	12.7
DELAWARE	13838	26.0
DELAWARE	13839	5.3
DELAWARE	13849	22.7
DELAWARE	13856	42.0
DUTCHESS	12501	1.0
DUTCHESS	12508	55.3
DUTCHESS	12514	2.7
DUTCHESS	12522	6.0
DUTCHESS	12524	15.0
DUTCHESS	12531	3.0
DUTCHESS	12533	21.0
DUTCHESS	12538	24.0
DUTCHESS	12540	5.7
DUTCHESS	12545	3.7
DUTCHESS	12546	0.3
DUTCHESS	12564	11.0
DUTCHESS	12567	2.7
DUTCHESS	12569	14.3
DUTCHESS	12570	3.0
DUTCHESS	12571	6.3
DUTCHESS	12572	6.7
DUTCHESS	12578	2.0
DUTCHESS	12580	7.3
DUTCHESS	12581	2.7
DUTCHESS	12582	4.0
DUTCHESS	12583	4.3
DUTCHESS	12590	73.3
DUTCHESS	12592	0.3
DUTCHESS	12594	6.7
DUTCHESS	12601	278.3
DUTCHESS	12603	89.7
ERIE	14001	12.7
ERIE	14004	11.7
ERIE	14006	12.3
ERIE	14025	1.3
ERIE	14030	2.3
ERIE	14031	6.7
ERIE	14032	2.3
ERIE	14033	0.3
ERIE	14034	3.0
ERIE	14043	31.3
ERIE	14047	6.0
ERIE	14051	5.7
ERIE	14052	7.7
ERIE	14057	2.7
ERIE	14059	3.0
ERIE	14068	5.7
ERIE	14072	24.0
ERIE	14075	23.0
ERIE	14080	4.3
ERIE	14081	21.3
ERIE	14085	4.7
ERIE	14086	19.0
ERIE	14091	6.0
ERIE	14102	2.3
ERIE	14111	6.7
ERIE	14127	8.0
ERIE	14139	3.7
ERIE	14141	10.0
ERIE	14150	89.3
ERIE	14170	2.0
ERIE	14201	54.7
ERIE	14202	11.3
ERIE	14204	35.3
ERIE	14206	62.0
ERIE	14207	192.0
ERIE	14208	50.0
ERIE	14209	22.7
ERIE	14210	47.3
ERIE	14211	137.7
ERIE	14212	69.7
ERIE	14213	156.0

*Zip Codes w/ <30 births total from 2008-2010 withheld.
** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)		County	ZIP	Average # Annual Medicaid births (2008-2010)
ERIE	14214	73.3		GENESEE	14005	5.0
ERIE	14215	244.0		GENESEE	14013	9.3
ERIE	14216	54.3		GENESEE	14020	90.0
ERIE	14217	38.7		GENESEE	14036	5.3
ERIE	14218	47.0		GENESEE	14040	3.7
ERIE	14219	13.0		GENESEE	14054	3.7
ERIE	14220	40.7		GENESEE	14058	8.3
ERIE	14221	21.3		GENESEE	14125	12.3
ERIE	14222	11.7		GENESEE	14143	3.0
ERIE	14223	32.3		GENESEE	14416	5.3
ERIE	14224	20.3		GENESEE	14422	6.0
ERIE	14225	71.7		GENESEE	14482	24.3
ERIE	14226	44.0		GENESEE	14525	7.7
ERIE	14227	21.3		GREENE	12015	2.7
ERIE	14228	33.7		GREENE	12051	5.7
ESSEX	12870	1.3		GREENE	12058	2.3
ESSEX	12883	28.7		GREENE	12083	8.7
ESSEX	12928	9.7		GREENE	12087	3.0
ESSEX	12944	21.0		GREENE	12192	5.3
ESSEX	12946	13.3		GREENE	12413	9.0
ESSEX	12956	11.0		GREENE	12414	18.3
ESSEX	12974	5.0		GREENE	12431	1.0
ESSEX	12996	6.0		GREENE	12451	1.3
ESSEX	12997	5.3		GREENE	12463	2.7
FRANKLIN	12916	10.0		HAMILTON	12134	8.3
FRANKLIN	12917	7.3		HERKIMER	13322	4.7
FRANKLIN	12920	6.0		HERKIMER	13324	10.0
FRANKLIN	12926	10.0		HERKIMER	13338	5.7
FRANKLIN	12937	6.7		HERKIMER	13340	34.0
FRANKLIN	12953	69.7		HERKIMER	13350	53.0
FRANKLIN	12957	11.7		HERKIMER	13357	59.0
FRANKLIN	12966	14.0		HERKIMER	13365	39.0
FRANKLIN	12983	21.3		HERKIMER	13407	24.0
FRANKLIN	12986	18.7		HERKIMER	13416	9.3
FRANKLIN	12989	3.3		HERKIMER	13431	6.3
FRANKLIN	13655	30.3		JEFFERSON	13601	261.0
FULTON	12025	10.7		JEFFERSON	13602	0.3
FULTON	12078	120.0		JEFFERSON	13603	5.0
FULTON	12095	37.3		JEFFERSON	13605	22.7
FULTON	12117	9.7		JEFFERSON	13606	14.0
FULTON	13329	15.3		JEFFERSON	13607	8.0
FULTON	13452	19.3		JEFFERSON	13608	10.0

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** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)
JEFFERSON	13612	12.3
JEFFERSON	13616	5.3
JEFFERSON	13618	5.7
JEFFERSON	13622	9.0
JEFFERSON	13624	15.0
JEFFERSON	13634	16.0
JEFFERSON	13637	12.3
JEFFERSON	13650	5.0
JEFFERSON	13656	15.7
JEFFERSON	13661	7.0
JEFFERSON	13673	13.7
JEFFERSON	13679	7.3
JEFFERSON	13685	6.0
JEFFERSON	13691	15.0
LEWIS	13327	10.0
LEWIS	13343	7.7
LEWIS	13367	39.3
LEWIS	13368	5.0
LEWIS	13433	14.7
LEWIS	13619	59.3
LEWIS	13620	9.7
LEWIS	13626	7.7
LEWIS	13648	8.3
LIVINGSTON	14414	16.3
LIVINGSTON	14423	12.0
LIVINGSTON	14435	5.0
LIVINGSTON	14437	43.0
LIVINGSTON	14454	15.7
LIVINGSTON	14481	4.0
LIVINGSTON	14485	12.7
LIVINGSTON	14487	11.7
LIVINGSTON	14510	29.7
LIVINGSTON	14517	14.3
LIVINGSTON	14533	7.0
MADISON	13030	10.0
MADISON	13032	54.7
MADISON	13035	10.7
MADISON	13037	27.7
MADISON	13052	9.0
MADISON	13082	11.0
MADISON	13122	4.0
MADISON	13332	15.7

County	ZIP	Average # Annual Medicaid births (2008-2010)
MADISON	13334	9.7
MADISON	13346	10.7
MADISON	13402	7.7
MADISON	13408	11.7
MADISON	13409	10.7
MADISON	13421	71.7
MADISON	13485	5.3
MONROE	14420	52.7
MONROE	14428	12.3
MONROE	14445	29.3
MONROE	14450	40.7
MONROE	14464	23.0
MONROE	14467	26.3
MONROE	14468	31.7
MONROE	14472	10.0
MONROE	14514	8.3
MONROE	14526	14.0
MONROE	14534	13.0
MONROE	14543	1.0
MONROE	14546	10.3
MONROE	14559	33.3
MONROE	14580	58.7
MONROE	14586	14.3
MONROE	14604	9.0
MONROE	14605	179.0
MONROE	14606	197.3
MONROE	14607	48.0
MONROE	14608	179.7
MONROE	14609	364.3
MONROE	14610	20.3
MONROE	14611	246.0
MONROE	14612	78.0
MONROE	14613	198.7
MONROE	14615	124.0
MONROE	14616	116.3
MONROE	14617	32.0
MONROE	14618	14.7
MONROE	14619	136.7
MONROE	14620	97.7
MONROE	14621	415.7
MONROE	14622	24.3
MONROE	14623	50.0

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Source: NYS Dept of Health
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NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

Attachment 1c

County	ZIP	Average # Annual Medicaid births (2008-2010)		County	ZIP	Average # Annual Medicaid births (2008-2010)
MONROE	14624	76.3		NASSAU	11560	12.7
MONROE	14625	13.7		NASSAU	11561	80.0
MONROE	14626	55.3		NASSAU	11563	25.7
MONTGOMERY	12010	136.0		NASSAU	11565	6.3
MONTGOMERY	12066	8.7		NASSAU	11566	23.3
MONTGOMERY	12068	11.0		NASSAU	11568	1.3
MONTGOMERY	12070	3.0		NASSAU	11570	34.7
MONTGOMERY	12072	9.0		NASSAU	11572	29.3
MONTGOMERY	12166	3.3		NASSAU	11575	217.7
MONTGOMERY	13317	15.3		NASSAU	11576	15.7
MONTGOMERY	13339	30.0		NASSAU	11577	12.3
MONTGOMERY	13428	6.7		NASSAU	11579	2.7
NASSAU	11001	43.3		NASSAU	11580	127.3
NASSAU	11003	192.7		NASSAU	11581	33.0
NASSAU	11010	26.7		NASSAU	11590	406.3
NASSAU	11020	14.0		NASSAU	11596	5.3
NASSAU	11021	9.3		NASSAU	11598	17.3
NASSAU	11023	9.7		NASSAU	11702	15.3
NASSAU	11024	14.7		NASSAU	11709	7.7
NASSAU	11030	6.3		NASSAU	11710	26.7
NASSAU	11040	41.0		NASSAU	11714	20.0
NASSAU	11050	61.0		NASSAU	11732	1.7
NASSAU	11096	69.3		NASSAU	11753	5.7
NASSAU	11501	42.7		NASSAU	11756	60.7
NASSAU	11507	8.0		NASSAU	11758	54.3
NASSAU	11509	1.0		NASSAU	11762	6.3
NASSAU	11510	87.3		NASSAU	11771	15.0
NASSAU	11514	5.3		NASSAU	11783	8.3
NASSAU	11516	19.3		NASSAU	11791	7.3
NASSAU	11518	9.7		NASSAU	11793	11.3
NASSAU	11520	354.3		NASSAU	11797	1.0
NASSAU	11530	6.0		NASSAU	11801	114.7
NASSAU	11542	144.0		NASSAU	11803	9.0
NASSAU	11545	8.0		NASSAU	11804	1.0
NASSAU	11548	2.7		NIAGARA	14008	5.0
NASSAU	11550	761.7		NIAGARA	14012	7.0
NASSAU	11552	64.3		NIAGARA	14028	4.7
NASSAU	11553	253.3		NIAGARA	14067	9.7
NASSAU	11554	60.3		NIAGARA	14092	6.3
NASSAU	11557	6.0		NIAGARA	14094	158.0
NASSAU	11558	25.0		NIAGARA	14105	10.7
NASSAU	11559	13.3		NIAGARA	14108	9.3

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Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

Attachment 1c

County	ZIP	Average # Annual Medicaid births (2008-2010)		County	ZIP	Average # Annual Medicaid births (2008-2010)
NIAGARA	14120	72.0		ONONDAGA	13039	35.7
NIAGARA	14131	8.3		ONONDAGA	13041	20.7
NIAGARA	14132	5.7		ONONDAGA	13057	42.7
NIAGARA	14172	3.7		ONONDAGA	13060	11.0
NIAGARA	14174	3.3		ONONDAGA	13063	6.7
NIAGARA	14301	98.7		ONONDAGA	13066	8.7
NIAGARA	14303	45.3		ONONDAGA	13078	10.7
NIAGARA	14304	66.7		ONONDAGA	13080	11.0
NIAGARA	14305	87.7		ONONDAGA	13084	11.0
ONEIDA	13042	11.0		ONONDAGA	13088	67.7
ONEIDA	13054	5.3		ONONDAGA	13090	80.7
ONEIDA	13303	4.3		ONONDAGA	13104	18.0
ONEIDA	13308	21.3		ONONDAGA	13108	11.3
ONEIDA	13309	20.0		ONONDAGA	13110	5.7
ONEIDA	13316	30.3		ONONDAGA	13112	5.7
ONEIDA	13318	10.7		ONONDAGA	13116	8.7
ONEIDA	13323	18.0		ONONDAGA	13120	16.0
ONEIDA	13328	1.7		ONONDAGA	13152	5.0
ONEIDA	13354	7.3		ONONDAGA	13159	10.0
ONEIDA	13363	7.7		ONONDAGA	13164	5.3
ONEIDA	13403	7.3		ONONDAGA	13202	91.3
ONEIDA	13413	19.0		ONONDAGA	13203	185.7
ONEIDA	13417	12.3		ONONDAGA	13204	334.3
ONEIDA	13424	7.3		ONONDAGA	13205	233.3
ONEIDA	13425	8.7		ONONDAGA	13206	123.0
ONEIDA	13438	14.0		ONONDAGA	13207	137.7
ONEIDA	13440	225.7		ONONDAGA	13208	310.7
ONEIDA	13456	7.3		ONONDAGA	13209	55.7
ONEIDA	13461	3.0		ONONDAGA	13210	110.3
ONEIDA	13471	20.7		ONONDAGA	13211	38.7
ONEIDA	13476	7.7		ONONDAGA	13212	69.3
ONEIDA	13477	3.7		ONONDAGA	13214	18.3
ONEIDA	13478	12.0		ONONDAGA	13215	13.7
ONEIDA	13480	12.7		ONONDAGA	13219	30.7
ONEIDA	13490	2.7		ONONDAGA	13224	58.0
ONEIDA	13492	21.7		ONTARIO	14424	81.0
ONEIDA	13495	8.7		ONTARIO	14425	29.3
ONEIDA	13501	472.0		ONTARIO	14432	20.0
ONEIDA	13502	267.3		ONTARIO	14456	105.0
ONONDAGA	13027	75.0		ONTARIO	14466	5.7
ONONDAGA	13029	28.7		ONTARIO	14469	16.0
ONONDAGA	13031	29.7		ONTARIO	14471	5.0

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NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)		County	ZIP	Average # Annual Medicaid births (2008-2010)
ONTARIO	14504	7.3		ORLEANS	14470	29.7
ONTARIO	14512	18.3		ORLEANS	14476	6.7
ONTARIO	14532	13.3		ORLEANS	14477	6.3
ONTARIO	14548	15.3		ORLEANS	14571	4.3
ONTARIO	14560	12.0		OSWEGO	13028	7.7
ONTARIO	14561	7.7		OSWEGO	13036	35.3
ONTARIO	14564	15.7		OSWEGO	13044	9.7
ORANGE	10916	2.3		OSWEGO	13069	193.7
ORANGE	10917	7.3		OSWEGO	13074	27.7
ORANGE	10918	18.7		OSWEGO	13076	11.3
ORANGE	10921	6.3		OSWEGO	13083	11.3
ORANGE	10924	21.7		OSWEGO	13114	33.7
ORANGE	10925	5.3		OSWEGO	13126	194.0
ORANGE	10926	7.3		OSWEGO	13131	18.3
ORANGE	10928	14.0		OSWEGO	13132	17.3
ORANGE	10930	13.3		OSWEGO	13135	29.7
ORANGE	10940	383.0		OSWEGO	13142	36.7
ORANGE	10941	38.3		OSWEGO	13144	12.0
ORANGE	10950	717.7		OSWEGO	13145	7.3
ORANGE	10958	7.3		OSWEGO	13167	16.0
ORANGE	10963	4.7		OSWEGO	13302	10.0
ORANGE	10973	2.3		OSWEGO	13493	14.0
ORANGE	10987	2.3		OTSEGO	12116	6.7
ORANGE	10990	13.0		OTSEGO	12155	4.3
ORANGE	10992	8.7		OTSEGO	12197	6.0
ORANGE	10996	0.7		OTSEGO	13315	4.7
ORANGE	10998	4.3		OTSEGO	13320	5.0
ORANGE	12518	5.0		OTSEGO	13326	11.7
ORANGE	12520	3.3		OTSEGO	13335	5.0
ORANGE	12543	11.3		OTSEGO	13348	5.0
ORANGE	12549	20.7		OTSEGO	13439	13.0
ORANGE	12550	540.3		OTSEGO	13491	12.7
ORANGE	12553	67.3		OTSEGO	13808	5.0
ORANGE	12575	1.3		OTSEGO	13820	59.3
ORANGE	12577	1.7		OTSEGO	13825	11.7
ORANGE	12586	47.7		OTSEGO	13843	6.3
ORANGE	12729	15.7		PUTNAM	10509	52.0
ORANGE	12771	87.3		PUTNAM	10512	43.0
ORANGE	12780	7.7		PUTNAM	10516	5.7
ORLEANS	14098	9.0		PUTNAM	10524	2.3
ORLEANS	14103	53.7		PUTNAM	10537	6.3
ORLEANS	14411	60.3		PUTNAM	10541	31.7

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NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)		County	ZIP	Average # Annual Medicaid births (2008-2010)
PUTNAM	10579	5.7		ROCKLAND	10993	23.7
PUTNAM	12563	10.3		ROCKLAND	10994	8.0
RENSSELAER	12018	7.7		SARATOGA	12019	7.7
RENSSELAER	12033	8.3		SARATOGA	12020	48.0
RENSSELAER	12052	2.7		SARATOGA	12027	1.0
RENSSELAER	12061	6.7		SARATOGA	12065	43.3
RENSSELAER	12062	1.3		SARATOGA	12074	4.3
RENSSELAER	12090	19.7		SARATOGA	12086	2.3
RENSSELAER	12094	6.0		SARATOGA	12118	25.7
RENSSELAER	12121	1.3		SARATOGA	12148	1.7
RENSSELAER	12123	7.7		SARATOGA	12170	8.0
RENSSELAER	12138	2.3		SARATOGA	12188	11.3
RENSSELAER	12140	1.3		SARATOGA	12803	24.3
RENSSELAER	12144	50.0		SARATOGA	12822	14.3
RENSSELAER	12154	1.7		SARATOGA	12831	14.0
RENSSELAER	12168	2.3		SARATOGA	12833	6.7
RENSSELAER	12180	131.0		SARATOGA	12835	5.3
RENSSELAER	12182	32.0		SARATOGA	12850	6.7
RENSSELAER	12185	1.7		SARATOGA	12859	7.0
RENSSELAER	12196	4.0		SARATOGA	12866	33.7
RENSSELAER	12198	6.0		SARATOGA	12871	11.3
ROCKLAND	10901	45.3		SCHENECTADY	12053	6.7
ROCKLAND	10913	4.3		SCHENECTADY	12056	2.0
ROCKLAND	10920	14.7		SCHENECTADY	12137	5.3
ROCKLAND	10923	39.0		SCHENECTADY	12302	24.7
ROCKLAND	10927	135.7		SCHENECTADY	12304	101.7
ROCKLAND	10952	694.7		SCHENECTADY	12305	19.3
ROCKLAND	10954	71.3		SCHENECTADY	12306	47.0
ROCKLAND	10956	44.7		SCHENECTADY	12307	85.7
ROCKLAND	10960	60.3		SCHENECTADY	12308	81.3
ROCKLAND	10962	6.3		SCHENECTADY	12309	16.0
ROCKLAND	10965	21.3		SCHOHARIE	12043	31.3
ROCKLAND	10968	6.7		SCHOHARIE	12076	3.7
ROCKLAND	10970	38.0		SCHOHARIE	12093	8.3
ROCKLAND	10974	5.7		SCHOHARIE	12122	14.7
ROCKLAND	10976	6.3		SCHOHARIE	12149	10.3
ROCKLAND	10977	1022.7		SCHOHARIE	12157	11.7
ROCKLAND	10980	20.7		SCHOHARIE	12160	4.3
ROCKLAND	10983	7.7		SCHOHARIE	13459	8.3
ROCKLAND	10984	3.7		SCHUYLER	14805	5.0
ROCKLAND	10986	4.0		SCHUYLER	14812	18.0
ROCKLAND	10989	7.7		SCHUYLER	14818	6.3

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** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)	County	ZIP	Average # Annual Medicaid births (2008-2010)
SCHUYLER	14865	11.3	STEUBEN	14855	3.7
SCHUYLER	14869	7.7	STEUBEN	14858	10.0
SCHUYLER	14891	21.3	STEUBEN	14870	30.0
SENECA	13148	44.0	STEUBEN	14873	11.3
SENECA	13165	44.7	STEUBEN	14879	14.7
SENECA	14521	12.7	STEUBEN	14885	3.0
SENECA	14541	9.0	STEUBEN	14898	5.0
SENECA	14847	5.3	SUFFOLK	11701	195.0
ST. LAWRENCE	12967	7.7	SUFFOLK	11703	41.0
ST. LAWRENCE	13613	15.7	SUFFOLK	11704	101.7
ST. LAWRENCE	13617	40.3	SUFFOLK	11705	4.7
ST. LAWRENCE	13625	5.7	SUFFOLK	11706	418.3
ST. LAWRENCE	13630	6.3	SUFFOLK	11713	60.0
ST. LAWRENCE	13635	9.0	SUFFOLK	11715	5.7
ST. LAWRENCE	13642	63.3	SUFFOLK	11716	13.0
ST. LAWRENCE	13646	8.7	SUFFOLK	11717	759.0
ST. LAWRENCE	13652	12.0	SUFFOLK	11718	1.3
ST. LAWRENCE	13654	4.7	SUFFOLK	11719	3.3
ST. LAWRENCE	13658	14.0	SUFFOLK	11720	52.7
ST. LAWRENCE	13660	9.3	SUFFOLK	11721	1.7
ST. LAWRENCE	13662	96.0	SUFFOLK	11722	384.3
ST. LAWRENCE	13667	30.0	SUFFOLK	11724	0.0
ST. LAWRENCE	13668	16.7	SUFFOLK	11725	12.0
ST. LAWRENCE	13669	92.7	SUFFOLK	11726	165.0
ST. LAWRENCE	13676	56.0	SUFFOLK	11727	67.7
ST. LAWRENCE	13680	2.3	SUFFOLK	11729	64.0
ST. LAWRENCE	13681	6.3	SUFFOLK	11730	11.7
ST. LAWRENCE	13684	6.7	SUFFOLK	11731	25.7
ST. LAWRENCE	13694	5.7	SUFFOLK	11733	4.3
ST. LAWRENCE	13697	16.3	SUFFOLK	11735	63.3
STEUBEN	14572	19.7	SUFFOLK	11738	34.3
STEUBEN	14801	27.3	SUFFOLK	11740	13.3
STEUBEN	14807	7.7	SUFFOLK	11741	27.3
STEUBEN	14809	10.7	SUFFOLK	11742	14.7
STEUBEN	14810	56.3	SUFFOLK	11743	66.7
STEUBEN	14820	3.7	SUFFOLK	11746	325.0
STEUBEN	14821	15.0	SUFFOLK	11747	10.7
STEUBEN	14823	19.0	SUFFOLK	11749	17.3
STEUBEN	14826	8.0	SUFFOLK	11751	17.3
STEUBEN	14830	99.0	SUFFOLK	11752	14.0
STEUBEN	14840	7.7	SUFFOLK	11754	12.7
STEUBEN	14843	84.0	SUFFOLK	11755	9.7

*Zip Codes w/ <30 births total from 2008-2010 withheld.
** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

County	ZIP	Average # Annual Medicaid births (2008-2010)
SUFFOLK	11757	112.7
SUFFOLK	11763	89.0
SUFFOLK	11764	5.7
SUFFOLK	11766	6.3
SUFFOLK	11767	14.3
SUFFOLK	11768	10.7
SUFFOLK	11769	3.0
SUFFOLK	11772	202.3
SUFFOLK	11776	49.0
SUFFOLK	11777	7.0
SUFFOLK	11778	22.3
SUFFOLK	11779	71.0
SUFFOLK	11780	6.0
SUFFOLK	11782	11.7
SUFFOLK	11784	58.3
SUFFOLK	11786	4.0
SUFFOLK	11787	15.7
SUFFOLK	11788	12.0
SUFFOLK	11789	6.7
SUFFOLK	11790	4.7
SUFFOLK	11792	4.7
SUFFOLK	11795	15.3
SUFFOLK	11796	1.0
SUFFOLK	11798	180.7
SUFFOLK	11901	205.0
SUFFOLK	11933	12.0
SUFFOLK	11934	15.0
SUFFOLK	11935	3.0
SUFFOLK	11937	104.7
SUFFOLK	11940	7.0
SUFFOLK	11941	12.0
SUFFOLK	11942	12.7
SUFFOLK	11944	23.7
SUFFOLK	11946	102.3
SUFFOLK	11949	12.0
SUFFOLK	11950	95.7
SUFFOLK	11951	65.7
SUFFOLK	11952	9.0
SUFFOLK	11953	34.7
SUFFOLK	11954	11.7
SUFFOLK	11955	5.0
SUFFOLK	11961	18.7

County	ZIP	Average # Annual Medicaid births (2008-2010)
SUFFOLK	11963	21.7
SUFFOLK	11964	1.7
SUFFOLK	11967	101.7
SUFFOLK	11968	67.3
SUFFOLK	11971	6.0
SUFFOLK	11976	3.0
SUFFOLK	11977	3.3
SUFFOLK	11978	17.3
SUFFOLK	11980	7.0
SULLIVAN	12701	95.3
SULLIVAN	12719	4.3
SULLIVAN	12721	25.7
SULLIVAN	12734	5.3
SULLIVAN	12737	4.3
SULLIVAN	12747	9.7
SULLIVAN	12748	5.7
SULLIVAN	12754	63.0
SULLIVAN	12758	15.0
SULLIVAN	12759	11.7
SULLIVAN	12764	3.7
SULLIVAN	12775	6.0
SULLIVAN	12779	31.3
SULLIVAN	12783	11.0
SULLIVAN	12788	9.7
SULLIVAN	12789	12.3
SULLIVAN	12790	14.0
TIOGA	13732	14.0
TIOGA	13734	6.3
TIOGA	13736	11.7
TIOGA	13743	14.3
TIOGA	13811	12.7
TIOGA	13812	8.0
TIOGA	13827	41.7
TIOGA	13835	10.7
TIOGA	14883	14.7
TIOGA	14892	29.3
TOMPKINS	13053	13.0
TOMPKINS	13068	21.3
TOMPKINS	13073	30.3
TOMPKINS	14817	9.3
TOMPKINS	14850	161.3
TOMPKINS	14867	24.7

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Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

County	ZIP	Average # Annual Medicaid births (2008-2010)
TOMPKINS	14882	10.0
TOMPKINS	14886	18.7
ULSTER	12401	189.7
ULSTER	12404	11.7
ULSTER	12428	47.0
ULSTER	12443	4.3
ULSTER	12446	21.3
ULSTER	12449	10.0
ULSTER	12458	8.0
ULSTER	12461	1.0
ULSTER	12466	8.3
ULSTER	12472	2.3
ULSTER	12477	50.3
ULSTER	12484	5.3
ULSTER	12486	0.7
ULSTER	12487	8.0
ULSTER	12491	0.7
ULSTER	12498	7.7
ULSTER	12515	5.0
ULSTER	12525	6.0
ULSTER	12528	27.3
ULSTER	12542	17.0
ULSTER	12547	8.3
ULSTER	12548	5.7
ULSTER	12561	18.0
ULSTER	12566	26.0
ULSTER	12589	41.0
ULSTER	12740	2.0
WARREN	12801	69.3
WARREN	12804	61.0
WARREN	12817	6.0
WARREN	12843	5.3
WARREN	12845	10.7
WARREN	12846	9.7
WARREN	12853	3.3
WARREN	12885	18.7
WASHINGTON	12057	2.0
WASHINGTON	12809	5.0
WASHINGTON	12816	9.7
WASHINGTON	12827	6.3
WASHINGTON	12828	19.3
WASHINGTON	12832	17.3

County	ZIP	Average # Annual Medicaid births (2008-2010)
WASHINGTON	12834	10.0
WASHINGTON	12839	35.0
WASHINGTON	12865	7.0
WASHINGTON	12887	12.7
WAYNE	13143	21.3
WAYNE	13146	9.3
WAYNE	14433	27.7
WAYNE	14489	45.7
WAYNE	14502	22.7
WAYNE	14505	13.7
WAYNE	14513	77.0
WAYNE	14516	10.3
WAYNE	14519	25.7
WAYNE	14522	37.0
WAYNE	14551	36.0
WAYNE	14568	5.7
WAYNE	14589	25.0
WAYNE	14590	27.7
WESTCHESTER	10502	3.7
WESTCHESTER	10504	3.0
WESTCHESTER	10506	1.7
WESTCHESTER	10507	37.3
WESTCHESTER	10510	2.7
WESTCHESTER	10511	8.0
WESTCHESTER	10514	2.3
WESTCHESTER	10518	1.0
WESTCHESTER	10520	14.0
WESTCHESTER	10522	12.3
WESTCHESTER	10523	39.0
WESTCHESTER	10526	1.3
WESTCHESTER	10528	17.7
WESTCHESTER	10530	10.0
WESTCHESTER	10532	3.3
WESTCHESTER	10533	3.7
WESTCHESTER	10536	9.7
WESTCHESTER	10538	8.3
WESTCHESTER	10543	65.7
WESTCHESTER	10546	1.3
WESTCHESTER	10547	21.3
WESTCHESTER	10548	7.7
WESTCHESTER	10549	86.7
WESTCHESTER	10550	389.7

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Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

NYS ZIP Code Level Medicaid Birth Data
Average # Annual Medicaid Births (2008-2010)

Attachment 1c

County	ZIP	Average # Annual Medicaid births (2008-2010)
WESTCHESTER	10552	61.7
WESTCHESTER	10553	62.3
WESTCHESTER	10560	4.0
WESTCHESTER	10562	200.7
WESTCHESTER	10566	205.0
WESTCHESTER	10567	22.3
WESTCHESTER	10570	11.3
WESTCHESTER	10573	286.3
WESTCHESTER	10576	2.0
WESTCHESTER	10577	0.3
WESTCHESTER	10580	3.3
WESTCHESTER	10583	11.7
WESTCHESTER	10588	4.0
WESTCHESTER	10589	2.3
WESTCHESTER	10590	2.3
WESTCHESTER	10591	103.7
WESTCHESTER	10594	3.7
WESTCHESTER	10595	5.3
WESTCHESTER	10598	16.7
WESTCHESTER	10601	52.3
WESTCHESTER	10603	91.0
WESTCHESTER	10604	37.0
WESTCHESTER	10605	46.7
WESTCHESTER	10606	137.3
WESTCHESTER	10607	38.0
WESTCHESTER	10701	720.0
WESTCHESTER	10703	132.3
WESTCHESTER	10704	98.7
WESTCHESTER	10705	439.0
WESTCHESTER	10706	5.7
WESTCHESTER	10707	13.3
WESTCHESTER	10708	12.0
WESTCHESTER	10709	3.7
WESTCHESTER	10710	53.3
WESTCHESTER	10801	304.7
WESTCHESTER	10803	9.3
WESTCHESTER	10804	4.0
WESTCHESTER	10805	78.7
WYOMING	14009	20.0
WYOMING	14011	15.7
WYOMING	14024	5.0
WYOMING	14066	5.0

County	ZIP	Average # Annual Medicaid births (2008-2010)
WYOMING	14145	1.7
WYOMING	14167	4.7
WYOMING	14427	7.0
WYOMING	14530	24.0
WYOMING	14550	5.7
WYOMING	14569	26.0
WYOMING	14591	3.7
YATES	14418	5.0
YATES	14507	8.7
YATES	14527	53.3
YATES	14544	5.3
YATES	14837	30.7
YATES	14842	4.3

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** Data Based on 2008-2010 total births- 3 year average

Source: NYS Dept of Health
Bureau of Biometrics and Health Statistics

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NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
Albany	**Albany County Health Department**	**Community Cradle**	
	175 Green Street	2E Commerce Square	
	Albany, NY 12201	324 Broadway, 3rd Floor	
	(518) 447-4691	Albany, NY 12201	
		(518) 426-1153	
Bronx	**Morris Heights Health Center**	**Bronx Health Link**	**New York City Department of Health and Mental Hygiene**
	2306 Walton Avenue	851 Grand Concourse - Room 903	158 East 115th Street - Room 227
	Bronx, NY 10468	Bronx, NY 10451	New York, NY 10029
	(718) 483-1203	(718) 590-2648	(646) 672-2892
	Urban Health Plan		
	1070 Southern Blvd		
	Bronx, NY 10459		
	(718) 589-2440		
Broome		**Mothers and Babies Perinatal Network**	
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	
Cayuga		**Reach CNY**	
		1010 James Street	
		Syracuse, NY 13203	
		(315) 424-0009	
Chautauqua	**Chautauqua Opportunities**		
	17 West Courtney Street		
	Dunkirk, NY 14048		
	(716) 366-3333		
Chenango		**Mothers and Babies Perinatal Network**	

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	
Clinton		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	
		(518) 761-0300	
Cortland		**Mothers and Babies Perinatal Network**	
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	
Delaware		**Mothers and Babies Perinatal Network**	
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	
Dutchess	**Institute for Family Health**	**Lower Hudson Valley Perinatal Network**	
	347 Main Hall	100 Woods Road	
	Poughkeepsie, NY 12601	Valhalla, NY 10595	
	(212) 633-0800	(914) 493-6435	
Erie	**Buffalo Prenatal-Perinatal Services Network**	**Buffalo Prenatal-Perinatal Services Network**	**Erie County Department of Health**
	625 Delaware Avenue Suite 410	625 Delaware Avenue Suite 410	95 Franklin Street Room 957
	Buffalo, NY 14202	Buffalo, NY 14202	Buffalo, NY 14202
	(716) 884-6711	(716) 884-6711	(716) 821-0204
Essex		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
		(518) 761-0300	
Franklin		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	
		(518) 761-0300	
Hamilton		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	
		(518) 761-0300	
Herkimer		**Mohawk Valley Perinatal Network**	
		100 Cornelia Street 2nd Floor	
		Utica, NY 13502	
		(315) 732-4657	
Jefferson	**Planned Parenthood of North Country**	**North Country Prenatal-Perinatal Council**	
	160 Stone Street	200 Washington Street Suite 300	
	Watertown, NY 13601	Watertown, NY 13601	
	(315) 782-1818	(315) 788-8533	
Kings	**Brookdale University Hospital and Medical Center**	**Caribbean Women's Health Association**	
	One Brookdale Plaza	3512 Church Avenue	
	Brooklyn, NY 11212	Brooklyn, NY 11203	
	(718) 240-5212	(718) 826-2942	
	CAMBA		
	1720 Church Avenue 2nd Floor		
	Brooklyn, NY 11226		
	(718) 287-2600		
Lewis	**Planned Parenthood of North Country**	**North Country Prenatal-Perinatal Council**	

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
	160 Stone Street	200 Washington Street Suite 300	
	Watertown, NY 13601	Watertown, NY 13601	
	(315) 782-1818	(315) 788-8533	
Livingston	**Livingston County Department of Health**		
	2 Murray Hill Drive		
	Morris, NY 14510		
	(585) 243-7270		
Madison		**Reach CNY**	
		1010 James Street	
		Syracuse, NY 13203	
		(315) 424-0009	
Monroe		**Perinatal Network of Monroe County**	**Monroe County Department of Health**
		339 East Avenue Suite 203	691 Saint Paul Street 4th Floor
		Rochester, NY 14604	Rochester, NY 14605
		(585) 546-4930	(585) 753-5267
Nassau	**Nassau County Prenatal-Perinatal Services Network**	**Nassau County Prenatal-Perinatal Services Network**	
	106 Charles Lindbergh Blvd	106 Charles Lindbergh Blvd	
	Uniondale, NY 11553	Uniondale, NY 11553	
	(516) 227-9681	(516) 227-9681	
New York	**Northern Manhattan Perinatal Partnership**	**Northern Manhattan Perinatal Partnership**	
	127 West 127th Street 3rd Floor	127 West 127th Street 3rd Floor	
	New York, NY 10027	New York , NY 10027	
	(212) 665-2600	(212) 665-2600	
	Harlem Hospital		
	506 Lenox Avenue		
	New York, NY 10037		

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
	(212) 939-1340		
Niagara	**Niagara Falls Memorial Medical Center**		
	621 Tenth Street		
	Niagara Falls, NY 14302		
	(716) 278-4301		
Oneida	**Oneida County Department of Health**	**Mohawk Valley Perinatal Network**	
	800 Park Avenue 8th Floor	100 Cornelia Street 2nd Floor	
	Utica, NY 13501	Utica, NY 13502	
	(315) 798-6400	(315) 732-4657	
Onondaga	**Onondaga County Department of Health**	**Reach CNY**	**Onondaga County Department of Health**
	421 Montogmery Street	1010 James Street	501 Fayette Street Suite B
	Syracuse, NY 13202	Syracuse, NY 13203	Syracuse, NY 13202
	(315) 435-3155	(315) 424-0009	(315) 435-2000
Orange	**Orange County Department of Health**	**Maternal Infant Services Network**	**Orange County Department of Health**
	124 Main Street	200 Route 32 PO Box 548	130 Broadway
	Goshen, NY 10924	Central, NY 10917	Newburgh, NY 12550
	(845) 291-2332	(845) 928-7448	(845) 568-5240
Oswego		**Reach CNY**	
		1010 James Street	
		Syracuse, NY 13203	
		(315) 424-0009	
Ostego		**Mothers and Babies Perinatal Network**	
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
Putnam		**Lower Hudson Valley Perinatal Network**	
		100 Woods Road	
		Valhalla, NY 10595	
		(914) 493-6435	
Queens	**Safe Space**		
	89-74- 162nd Street Floor 5		
	Jamaica, NY 10052		
	(212) 226-3536		
Rensselaer		**Community Cradle**	
		2E Commerce Square	
		324 Broadway, 3rd Floor	
		Albany, NY 12207	
		(518) 426-1153	
Richmond			
Rockland		**Lower Hudson Valley Perinatal Network**	
		100 Woods Road	
		Valhalla, NY 10595	
		(914) 493-6435	
Saratoga		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	
		(518) 761-0300	
Schenectady		**Community Cradle**	
		2E Commerce Square	
		324 Broadway, 3rd Floor	

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
		Albany, NY 12207	
		(518) 426-1153	
St. Lawerence	**Planned Parenthood of North Country**	**North Country Prenatal-Perinatal Council**	
	160 Stone Street	200 Washington Street Suite 300	
	Watertown, NY 13601	Watertown, NY 13601	
	(315) 782-1818	(315) 788-8533	
Suffolk	**Suffolk County Department of Health**	**Suffolk Perinatal Coalition**	
	225 Rabro Drove	475 East Main Street Suite 207	
	East Happague, NY 11788	Patchogue, NY 11772	
	(631) 853-3005	(631) 475-5400	
Sullivan	**Sullivan County Public Health Services**	**Maternal Infant Services Network**	
	PO Box 590	200 Route 32 PO Box 548	
	50 Community Lane	Central, NY 10917	
	Liberty, NY 12754	(845) 928-7448	
	(845) 292-0100		
Tioga		**Mothers and Babies Perinatal Network**	
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	
Tompkins		**Mothers and Babies Perinatal Network**	
		457 State Street	
		Binghamton, NY 13901	
		(607) 772-0517	
Ulster	**Sullivan County Public Health Services**	**Maternal Infant Services Network**	

NYSDOH Community-Based Perinatal Health Grantees

COUNTY	COMMUNITY HEALTH WORKER PROGRAM	COMPREHENSIVE PRENATAL-PERINATAL SERVICES NETWORKS	HEALTHY MOM-HEALTHY BABY PRENATAL and POSTPARTUM HOME VISITING PROGRAM
	PO Box 590	200 Route 32 PO Box 548	
	50 Community Lane	Central, NY 10917	
	Liberty, NY 12754	(845) 928-7448	
	(845) 292-0100		
Warren		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	
		(518) 761-0300	
Washington		**Adirondack Health Institute**	
		9 Carey Road	
		Queensbury, NY 12804	
		(518) 761-0300	
Westchester	**Mt. Vernon Neighborhood Health**	**Lower Hudson Valley Perinatal Network**	**Westchester County Department of Health**
	107 West Fourth Street	100 Woods Road	145 Huguenot Street Floor 8
	Mt. Vernon, NY 10552	Valhalla, NY 10595	New Rochelle, NY 10801
	(914) 699-7200	(914) 493-6435	(914) 813-5229

County	Program and Addresses	Target area	Contact Area
Albany	Healthy Families Albany County Albany County Dept for Children, Youth, and Families with Parson's Child and Family Center 112 State St. Room #300 Albany, NY 12207	Albany County cities of Albany, Cohoes, Watervliet and Green Island only	518-447-7054
Bronx	Healthy Families Morris Heights Morris Heights Health Center, Inc. 85 West Burnside Ave. Bronx, NY 10453	Morris Heights	718-483-1253
Bronx	South Bronx Healthy Families Bronx Lebanon Hospital Center 1650 Selwyn Ave. Suite 5h Bronx, NY 10466	South Bronx	718-960-2084
Brooklyn	Bushwick Bright Start Healthy Families Public Health Solutions 1491 Broadway, 4th Floor Brooklyn, NY 11221	Bushwick	718-416-1442
Brooklyn	CAMBA's Healthy Families CAMBA 2103 Kenmore Terrace Brooklyn, NY 11226	Flatbush (11226 zip code)	718-826-2223
Brooklyn	Healthy Families Successful Start Bedford Stuyvesant Family Medical Health Center 1360 Fulton St. Room 402 Brooklyn, NY 11216	Bedford Stuyvesant	718-623-5966
Brooklyn	Healthy Families Brookdale Brookdale Hospital Medical Center One Brookdale Plaza Brooklyn, NY 11212	Brookdale (11212 zip code)	718-240-8340
Broome	Healthy Families Broome Broom County Health Department and Our Lady of Lourdes Hospital 225 Front St. Binghamton, NY 13905	Broome County outside the Binghamton City School District	607-778-3909
Cattaraugus	Healthy Families of Allegany and Cattaraugus Counties Parent Education Program 234 North Union St. Olean, NY 14760	Allegany and Cattaraugus Counties	716-372-5987
Cayuga	Healthy Families Cayuga/Seneca Cayuga/Seneca Community Action Agency, Inc. Metcalf Plaza 144 Genesse St. Suite 504 Auburn, NY 13021 and 23 Center St. Waterloo, NY 13165	Cayuga-Seneca cities of Auburn, Port Byron, Cato, Locke, Martville and Scipio Center	315-283-2030

Clinton	Early Advantages Healthy Families Behavioral Health Services North, Inc. 22 US OVAL Suite 218 Plattsburg, NY 12903	Clinton city of Plattsburg and 1st time parents in all of county	518-563-8206 x-134
Delaware	Healthy Families of Delaware County Delaware Opportunities 35430 State Highway 10 Hamden, NY 13782	Delaware	607-746-1730
Dutchess	Dutchess County Healthy Families Dutchess County Dept of Health with Institute for Family Health 347 Main St. Suite 101 Poughkeepsie, NY 12601	Dutchess cities of Poughkeepsie, Hyde Park, and Beacon (12601, 12602, 12508, 12538 zip codes)	845-452-3387
Erie	Buffalo Healthy Families Buffalo Prenatal-Perinatal Network 625 Delaware Ave. Suite 410 Buffalo, NY 14202	Erie County	716-884-6711
Chemung	Healthy Families Chemung County Comprehensive Interdisciplinary Developmental Services 161 Sullivan St. Elmira, NY 14901	Chemung County	607-733-6533
Herkimer	Herkimer County Healthy Families Herkimer County Public Health Nursing Service 301 North Washington St. Herkimer, NY 13350	Herkimer County	315-867-1440
Madison	Starting Together Healthy Families Community Action Program of Madison County 3 East Main St. P.O. Box 249 Morrisville, NY 13408	Madison County	315-697-3588
Manhattan	University Settlement's Healthy Families Program University Settlement Society of New York, Inc. 413 East 120th St. New York, NY 10035	East Harlem and Lower East Side (10035 and 10009 zip codes)	212-289-6594
Manhattan	Best Beginnings Healthy Families Alianza Dominicana, Inc. 2410 Amsterdam Ave. New York, NY 10033	Washington Heights	212-923-5440
Manhattan	Healthy Families Baby Steps Northern Manhattan Perinatal Partnership, Inc. 2280 7th Ave New York, NY 10030	Central Harlem	212-690-2229
Niagara	Healthy Families Niagara Niagara County DSS with Family & Children Services of Niagara, Inc. 1522 Main St. Niagara Falls, NY 14305	Niagara County	716-285-6984

Oneida	Healthy Families Oneida County Oneida County Health Department with Family Nurturing Center 209 Elizabeth St. 4th Floor Suite Utica, NY 13501	Oneida	305-738-9773 x-239
Ontario	Healthy Families Ontario County Ontario County DSS with Child and Family Resources 41 Lewis St. Suite 103 Geneva, NY 14456	Ontario city of Geneva and 14432, 14461, 14504, 14547, 14548, 14561, and part of 14424 zip codes	315-781-1491 x-211
Orange	Healthy Families Middletown Occupations, Inc. 16-24 Union St. Middletown, NY 10940	Orange County city of Middletown	845-562-7244 x-300
Orange	Healthy Families Newburgh Occupations, Inc. 21 Grand St. Newburgh, NY 12550	Orange County city of Newburgh	845-562-7244 x-300
Ostego	Building Healthy Families Otsego County Opportunities for Otsego 182 Roundhouse Rd. Oneonta, 13820	Otsego County	607-433-8047
Queens	Safe Space Healthy Families Jamaica Safe Space NYC, Inc. 89-74 162nd St. 5th Floor Jamaica, NY 11432	Queens-Jamaica	718-526-2400
Rensselaer	Healthy Families of Rensselaer County Samaritan Hospital 2215 Burdett Ave. Troy, NY 12180	Rensselaer County	518-271-3923
Richmond	Healthy Families Staten Island Vincent Fontana Center for Child Protection 119 Tompkins Ave. Staten Island, NY 10304	Staten Island North Shore zip codes 10301, 10302, 10303, and 10304	718-303-8965
Schenectady	Healthy Schenectady Families Schenectady County Public Health Services 107 Nott Terrace Suite 304 Schenectady, NY 12308	Schenectady County	518-386-2824
Steuben	Healthy Families Steuben Institute for Human Services with Kinship Family & Youth Services 6666 County Rd. 11 Bath, NY 14810	Steuben County	607-324-6027
Suffolk	Healthy Families Suffolk Family Service League of Suffolk County, Inc. Iovino South Shore Family Center 1444 Fifth Ave. Bayshore, NY 11706	Suffolk Communities of Bayshore and Brentwood	631-647-6635 x-409

Sullivan	Healthy Families Sullivan County Sullivan County Public Health Services 50 Community Lane Liberty, NY 12754	Sullivan County	845-292-0100
Tioga	Tioga PACT Healthy Families Our Lady of Lourdes Memorial Hospital Youth Services 1062 State Rt. 38 Owego, NY 13827	Tioga County	607-687-6145
Ulster	Ulster County Healthy Families Healthy Start Ulster County DSS with Institute for Family Health 400 Aaron Ct. Kingston, NY 12401	Ulster County	845-339-8551
Westchester	Healthy Families Parkchester Catholic Guardian Society and Home Bureau 1990 Westchester Ave. Bronx, NY 10462	Parkchester	718-828-0300 x-225
Westchester	Westchester County Healthy Families Julia Dyckman Andrus Memorial 30 South Broadway 7th Floor Yonkers, NY 10701	Westchester County	914-968-1663

Nurse Family Partnership Program	
COUNTY	**PROGRAM**
Monroe	Mike Dedee Monroe Nurse Family Partnership 691 Saint Paul Street 4th Floor Rochester, NY 14605 (585) 753-5267
New York **(All 5 boroughs)**	Roberta Holder-Mosley NYC Nurse Family Partnership 158 East 115th Street Room 227 New York, NY 10029 (646) 672-2892
Onondaga	Susan Serrao Onondaga Nurse Family Partnership 501 East Fayette Street Suite B Syracuse, NY 13202 (315) 435-2000

HRSA-Funded Healthy Start Grantees

PROGRAM AND ADDRESS	TARGET AREA	CONTACT NUMBER
Central Harlem Healthy Start 127 West 127th Street 3rd Floor New York, NY 10027	Central Harlem	212-665-2600
Downstate NY Healthy Start 722 West 168th Street 9th Floor New York, NY 10032	Nassau and Suffolk Counties, Queens	212-305-1937
Healthy Start Brooklyn 485 Throop Avenue Brooklyn, NY 11221	Brooklyn	646-253-5614
Healthy Start Rochester 339 East Avenue Suite 203 Rochester, NY 14604	Rochester	585-546-4930
Syracuse Healthy Start 501 East Fayette Street Syracuse, NY 13202	Syracuse	315-435-2920

Attachment 7

NYSDOH Comprehensive Family Planning Grantees

Albany			
Upper Hudson Planned Parenthood	Albany Clinic	855 Central Avenue , Albany 12206	518-434-5678
Allegany			
Allegany County Health Department	Wellsville Family Planning	21 E. State Street , Wellsville 14895	585-268-9250
Allegany County Health Department	Alfred Family Planning=	10 Church Street , Alfred 14802	585-268-9250
Allegany County Health Department	Belmont Family Planning	7 Court Street , Belmont 14813	585-268-9250
Bronx			
Community HealthCare Network	Bronx HealthCenter	975 Westchester Ave Bronx 10459	718-320-4466
Jacobi Medical Center	Women's Health Center	1400 Pelham Parkway South Bldg. 8, 3rd Floor , Bronx 10461	718-918-5442
Lincoln Medical and Mental Health Center	Lincoln Medical	234 East 149th Street , Bronx 10451	718-579-5000
Morris Heights Health Center	St. Ann's	625 East 137th Street , Bronx 10454	718-401-6578
Morris Heights Health Center	Health Center	85 W Burnside Avenue , Bronx 10453	718-716-4400
Morris Heights Health Center	Walton Ave	25 E 183rd St , Bronx 10453	718-839-8900
Morris Heights Health Center	Women's Birthing Pav.	70 W Burnside Ave , Bronx 10453	718-716-2229
North Central Bronx Hospital	North Central Bronx Hospital	3424 Kossuth Avenue Suite 3H-17 Bronx 10467	718-519-3537
Planned Parenthood NYC	Bronx Health Center	349 E 149th Street , Bronx 10451	212-965-7000
Public Health Solutions	Tremont	4215 3rd Avenue 2nd Fl , Bronx 10457	718-294-5891
Segundo Ruiz Belvis Diagnostic & Treatment Center		545 E 142nd Street , Bronx 10454	718-579-4000
The Children's Aid Society	Bronx Health Services	1515 Southern Boulevard , Bronx 10460	718-860-8595
Broome			
Planned Parenthood of South Central NY	Binghamton	117 Hawley Street , Binghamton 13901	607-723-8306
Cattaraugus			
Cattaraugus County Health Department	Salamanca Clinic	69 Iroquois Dr , Salamanca 14779	716-945-1246
Cattaraugus County Health Department	Machias	Box 188 9824 Route 16 , Machias 14101	716-353-8525
Cattaraugus County Health Department:	Olean Clinic	1 Leo Moss Dr Suite 4010 Olean 14760	716-701-3439
Cayuga			
East Hill Family Medical	Auburn,	144 Genesee Street Suite 201 Metcalf Plaza Auburn 13021	315-253-8477
Finger Lakes Community and Migrant Health Care	Port Byron Community Health	60 Main Street , Port Byron 13140	315-776-9700
Finger Lakes Community and Migrant Health Care	King Ferry Migrant Health,	982 Rte 34B , King Ferry 13081	315-364-8090

Attachment 7

Chautauqua			
Chautauqua County Health Department	Jamestown	110 East Fourth St , Jamestown 14701	716-661-8111
Chautauqua County Health Department	Dunkirk	319 Central Ave , Dunkirk 14048	716-363-3660
Chemung			
Planned Parenthood Southern Finger Lakes	Elmira Center,	755 East Church St , Elmira 14901	607-734-3313
Chenango			
Planned Parenthood South Central NY	Norwich	24-26 Conkey Avenue Box 126 Norwich 13815	607-334-6378
Clinton			
Planned Parenthood North Country NY	Plattsburgh,	66 Brinkerhoff St Plattsburgh 12901	518-561-4430
Columbia			
Upper Hudson Planned Parenthood	Hudson	190 Fairview Ave , Hudson 12534	518-434-5678
Cortland			
Jacobus Center Reproductive Health	Cortland County Health Dept	60 Central Ave , Cortland 13045	607-753-5027
Delaware			
Planned Parenthood South Central NY	Sidney	37 Pleasant St , Sidney 13838	607-563-4363
Planned Parenthood South Central NY	Walton	130 North St , Walton 13856	607-865-6579
Dutchess			
Hudson River HealthCare:	Beacon,	6 Henry St , Beacon 12508	845-831-0400
Hudson River HealthCare:	Poughkeepsie	29 N Hamilton St , Poughkeepsie 12601	845-454-8204
Planned Parenthood Mid-Hudson Valley	Poughkeepsie	17 Noxon St , Poughkeepsie 12601	845-471-1540
Erie			
Kaleida Health	Deaconess Center,	1001 Humboldt Pkwy , Buffalo 14208	716-887-8272
Planned Parenthood Western NY	Wimbeldon Plaza Med Center	240 Center Rd. West Seneca 14224	716-831-2200
Planned Parenthood Western NY	Main Street	2697 Main St. Buffalo 14214	716-831-2200
Essex			
Planned Parenthood Mohawk Hudson:	Ticonderoga,	171 Lake George Ave #103 PO Box 225 , Ticonderoga 12883	518-585-7622
Franklin			
Planned Parenthood North Country NY	Saranac Lake	41 St. Bernard St , Saranac Lake 12983	518-891-0046
Planned Parenthood North Country NY	Malone	246 W Main St Suite 1 , Malone 12953	518-483-7150
Fulton			
Planned Parenthood Mohawk Hudson:	Johnstown	400 North Perry Street Johnstown 12095	518-736-1911
Genesee			
Planned Parenthood Rochester/Syracuse:	Batavia	222 West Main Street , Batavia 14020	585-344-0516
Greene			
Greene County Family Planning:	Catskill	411 Main Street Suite 300 Catskill 12414	518-719-3580
Herkimer			
Planned Parenthood Mohawk Hudson:	Herkimer	401 E German St Ste 310 Herkimer 13350	315-866-3085

Jefferson

Planned Parenthood North Country NY	Watertown	160 Stone St Watertown 13601	315-788-8065

Kings

Community HealthCare Network	CABS Health Center	94-98 Manhattan Ave Brooklyn 11206	718-388-0390
Community HealthCare Network	Dr. Betty Shabazz Health Ctr	999 Blake Ave , Brooklyn 11208	718-277-8303
Community HealthCare Network	Caribbean House Health Center	1167 Nostrand Ave Brooklyn 11225	718-778-0198
Coney Island Hospital	Coney Island Hospital	2601 Ocean Parkway Rm 9E1 Brooklyn 11235	718-616-4337
Coney Island Hospital	Luna Park Pediatric Adolescent Health Care Ctr	2201 Neptune Ave. Brooklyn 11224	718-946-3400
Coney Island Hospital	Ida G Israel CHC	2201 Neptune Ave Brooklyn 11224	718-946-3400
Coney Island Hospital	Homecrest Pediatric & Adolescent HCC	1601 Ave S , Brooklyn 11229	718-339-6243
Kings County Hospital Center	Kings County Hosp.	541 Clarkson Avenue E Building, Suite D , Brooklyn 11203	718 245-5495
Planned Parenthood NYC	Boro Hall Health Center,	44 Court St , Brooklyn 11204	212-965-7000
Public Health Solutions	Ft Greene,	295 Flatbush Ave Ext 3rd Floor , Brooklyn 11201	718-522-1144
Public Health Solutions	Bushwick,	335 Central Ave 2nd Fl. Brooklyn 11221	718-443-9300
Public Health Solutions	Eastern Parkway,	1873 Eastern Pkwy Brooklyn 11233	718-498-1001

Lewis

Planned Parenthood North Country NY	Lowville	7398 Turin Rd , Lowville 13367	315-376-7421

Livingston

Livingston County Reproductive Health Center	Mt. Morris	2 Murray Hill Drive , Mt. Morris 14510	585-243-7540
Livingston County Reproductive Health Center	Dansville	3 Chestnut Avenue , Dansville 14437	585-335-8570
Livingston County Reproductive Health Center	Avon	470 Collins Street , Avon 14414	585-226-3888
Livingston County Reproductive Health Center	SUNY Geneseo Lauderdale Center for Student Health & Counseling	1 College Circle , Geneseo 14454-1495	585-243-5738

Madison

Planned Parenthood Mohawk Hudson	Oneida	603 Seneca St Suite 5 Oneida 13421	315-363-3950

Monroe

Highland Hospital	South Clinton	777 South Clinton Ave Rochester 14620	585-279-4890
Highland Hospital	East Ridge Family Medicine	809 East Ridge Road Rochester 14621	585-279-4890
Oak Orchard Health Center	Brockport	300 West Avenue Brockport 14420	585-637-5319
Planned Parenthood Rochester/Syracuse	Greece Center	2824 W Ridge Rd Rochester 14626	585-227-2440
Planned Parenthood Rochester/Syracuse	Rochester	114 University Ave Rochester 14605	585-546-2595
Threshold Center for Alternative Youth Services, Inc.	Threshold	145 Parsells Ave , Rochester 14609	585-454-7530

Attachment 7

Montgomery

Planned Parenthood Mohawk Hudson	Amsterdam	4803 Rte 30 Kem Plaza Amsterdam 12010	518-842-0285

Nassau

Nassau Health Care Corporation	Freeport-Roosevelt Family Hlth Ctr,	380 Nassau Road , Roosevelt 11575	516-571-8600
Nassau HealthCare Corporation	Elmont Family Health Center	161 Hempstead Trnpke Elmont 11003	516-571-8200
Nassau HealthCare Corporation	Nassau University Med Ctr.	2201 Hempstead Trnpke East Meadow 11554	516-572-6566
Nassau HealthCare Corporation	Hempstead Family Hlth Ctr	135 Main Street Hempstead 11550	516- 572-1300
Nassau HealthCare Corporation	New Cassel-Westbury Family Hlth Ctr,	682 Union Ave , Westbury 11590	516-571-9500
Planned Parenthood Nassau County	Glen Cove	110 School St , Glen Cove 11542	516-750-2500
Planned Parenthood Nassau County	Hempstead	540 Fulton Ave , Hempstead 11550	516-750-2500
Planned Parenthood Nassau County	Massapequa	35 Carmans Rd , Massapequa 11758	516-750-2500

New York

Community HealthCare Network	Community League Hlth Ctr	1996 Amsterdam Ave , New York 10032	212-781-7979
Community HealthCare Network	Helen B Atkinson Hlth Ctr.	81 W 115th St , New York 10026	212-426-0088
Community HealthCare Network	Downtown Health Center	150 Essex Street , New York 10002	212-477-1120
Gouverneur Healthcare Services	Gouverneur Healthcare	227 Madison Street , New York 10002	212-238-7273
Harlem Hospital	Harlem Hospital Center	506 Lenox Avenue RHB Room 2050 New York 10037	212-939-8232
Metropolitan Hospital Center	Youth Health Services,	1901 First Ave, 7th Fl , New York 10029	212-423-7408
Metropolitan Hospital Center	Family Planning/ Youth Health SVC	1901 First Ave OPD 7th Floor South , New York 10029	212-423-6603
Mount Sinai Adolescent Health Center:	Mt Sinai	312 East 94th Street New York 10128	212-423-3000
New York Presbyterian Hospital	Family Planning Center	21 Audubon Ave , New York 10032	212-342-3232
New York Presbyterian Hospital	Young Men's Clinic	21 Audubon Ave , New York 10032	212-342-3232
Planned Parenthood NYC	Margaret Sanger Center	26 Bleecker Street , New York 10012	212-965-7000
The Children's Aid Society	Milbank Medical Group	14-32 West 118th Street New York 10026	212-369-8339
The Door Adolescent Health Center	The Door	121 Ave of the Americas New York 10013	212-941-9090

Niagara

Community Health Center of Buffalo	Niagara	501 10th Street Niagara Falls 14301	716-278-4418
Planned Parenthood Western NY	Niagara Falls	750 Portage Rd Niagara Falls 14301	716-282-1221
Planned Parenthood Western NY	N. Tonawanda	15 Webster St , N. Tonawanda 14120	716-694-6454

Oneida

Planned Parenthood Mohawk Hudson	Utica	1424 Genesee St 1st Fl. Utica 13502	315-724-6146
Planned Parenthood Mohawk Hudson	Rome	111 E Chestnut St Ste 205 Rome 13440	315-337-8584

Attachment 7

Onondaga			
Planned Parenthood Rochester/Syracuse	Syracuse	1120 E Genesee St Syracuse 13210	315-475-5540
Syracuse Model Neighborhood/OCDOH	North Syracuse	113 E Taft Rd , N Syracuse 13212	315-435-3295
Syracuse Model Neighborhood/OCDOH	Civic Center Clinic	421 Montgomery St Rm 30 Syracuse 13202	315-435-3295
Syracuse Model Neighborhood/OCDOH	Dr William Harris Health Ctr	301 Slocum Ave Syracuse 13204	315-435-3295
Syracuse Model Neighborhood/OCDOH	Teen Clinic,	421 Montgomery St Rm 30 Syracuse 13202	315-435-3295
Ontario			
Finger Lakes Community and Migrant Health Care	Geneva Community Health	601B Washington Street , Geneva 14456	315-781-8448
Planned Parenthood Rochester/Syracuse	Canandaigua	15 LaFayette Ave Canandaigua 14424	585-396-9352
Orange			
Planned Parenthood Mid-Hudson Valley	Middletown	40 Grove St. PO Box 2167 Middletown 10940	845-343-4432
Planned Parenthood Mid-Hudson Valley	Goshen	7 Coates Drive Suite 4 Goshen 10924	845-294-8831
Planned Parenthood Mid-Hudson Valley	Newburgh	136 Lake St Suite 11 Newburgh 12550	845-562-7800
Orleans			
Oak Orchard Health Center	Albion	301 West Ave Albion 14411	585-589-5613
Oak Orchard Health Center	Lyndonville	77 N. Main St Lyndonville 14098	585-765-2060
Oswego			
Oswego County Opportunities	Mexico Health Center	5558 Scenic Dr Mexico 13114	315-598-4790
Oswego County Opportunities	SUNY Oswego Mary Walker Health Center,	SUNY Oswego, Oswego 13126	315-598-4790
Oswego County Opportunities	Oswego Health Center	10 George St , Oswego 13126	315-598-4790
Oswego County Opportunities,	Northern Oswego Co Health Services Inc	61 Delano St ,Pulaski 13142	315-598-4790
Oswego County Opportunities	Fulton Health Center	522 South Fourth St. Fulton 13069	315-598-4790
Otsego			
Planned Parenthood South Central NY	Oneonta	37 Dietz St Oneonta 13820	607-432-2250
Putnam			
Planned Parenthood Hudson Peconic	Brewster	2505 Carmel Avenue Brewster 10509	845-278-7313

Queens			
Community HealthCare Network	Queens Health Center	97-04 Sutphin Ave. Jamaica 11435	718-657-7088
Community HealthCare Network	Long Island City Health Center	36-11 21st Street Long Island City 11106	718-482-7772
North Shore/LIJ Medical Center	Long Island Jewish Med. Ctr. Div. of Adolescent Medicine	410 Lakeville Rd Suite 108 New Hyde Park 11040	516-465-5379
North Shore/LIJ Medical Center	Long Island Jewish Med Ctr. Ambulatory Care Unit	270-05 76th Ave New Hyde Park 11040	718-470-4400
Public Health Solutions	Jamaica	90-04 161st St 5th Floor Jamaica 11432	718-523-2124
Public Health Solutions	Astoria	12-26 31st Ave. Astoria 11106	718-626-8162
Queens Hospital Center	Parsons Health Center	90-37 Parsons Blvd Jamaica 11432	718-334-6400
Queens Hospital Center	South Queens Comm Hlth Ctr,	114-02 Guy R Brewer Blvd Suite 217 Jamaica 11434	718-883-6699
Rensselaer			
Upper Hudson Planned Parenthood	Troy Clinic	200 Broadway , Troy 12180	518-274-5640
Richmond			
Coney Island Hospital	Mariner's Harbor Family Health	2040 Forest Ave Staten Island 10303	718-761-2044
Coney Island Hospital	Stapleton Family Health	111 Canal St. Staten Island 10304	718-390-6401
Planned Parenthood NYC	Staten Island Center	25 Hyatt Street , Staten Island 10301	212-965-7000
Staten Island University Hospital	South Site Ambulatory Care	375 Seguine Ave. Staten Island 10309	718-226-2051
Staten Island University Hospital	Bay Street Health Center	57 Bay St Staten Island 10301	718-226-6700
Staten Island University Hospital	Bay Street - Adolescent	57 Bay St. Staten Island 10301	718-226-6262
Staten Island University Hospital	Center for Women's Health	440 Seaview Ave Staten Island 10305	718-226-6550
Staten Island University Hospital	Boody Medical Arts Pavilion	242 Mason Ave , Staten Island 10305	718-226-6262
Rockland			
Planned Parenthood Hudson Peconic	Spring Valley	25 Perlman Dr. Spring Valley 10977	845-426-7577
Rockland County Health Department	Spring Valley	14 S Main St , Spring Valley 10977	845-364-2531
Rockland County Health Department	Pomona	50 Sanatorium Road Bldg D Pomona 10970	845-364-2531
Saratoga			
Planned Parenthood Mohawk Hudson	Clifton Park	1673 Rte 9 Chaucer Sq. Clifton Park 12065	518-383-1783
Planned Parenthood Mohawk Hudson	Saratoga Springs	236 Washington Street PO Box 5029 Saratoga Springs 12866	518-584-0041
Schenectady			
Planned Parenthood Mohawk Hudson	Schenectady	1040 State St , Schenectady 12307	518-374-5353
Schoharie			
Planned Parenthood Mohawk Hudson	Cobleskill	109 Legion Dr. Cobleskill 12043	518-234-3325
Schuyler			
Planned Parenthood Southern Finger Lakes	Watkins Glen Center	106 W Fourth St. Watkins Glen 14891	607-535-0030

Attachment 7

Provider	Site	Address	Phone
Seneca			
East Hill Family Medical	Waterloo	367 E. Main St. Waterloo 13165	315-539-0580
St. Lawrence			
Planned Parenthood North Country NY	Ogdensburg	419 Ford St Ogdensburg 13669	315-393-6544
Planned Parenthood North Country NY	Canton	9 Miner St , Canton 13617	315-386-8821
Steuben			
Finger Lakes Community and Migrant Health Care	Bath	117 E. Steuben St. Bath 14810	617-776-3063
Planned Parenthood Southern Finger Lakes	Corning Center	135 Walnut St. Corning 14830	607-962-4686
Planned Parenthood Southern Finger Lakes	Hornell Center	111 Seneca St. Hornell 14843	607-324-1124
Suffolk			
Planned Parenthood Hudson Peconic	West Islip	180 Sunrise Hwy. W Islip 11795	631-893-0150
Planned Parenthood Hudson Peconic	Huntington	755 New York Ave Suite 333 Huntington 11743	631-427-7154
Planned Parenthood Hudson Peconic	Patchogue	450 Waverly Ave , Patchogue 11772	631-475-5705
Planned Parenthood Hudson Peconic	Riverhead	550 E Main St Ste 100 Riverhead 11901	631-369-0230
Planned Parenthood Hudson Peconic	Smithtown	70 Maple Ave Smithtown 11787	631-361-7526
Planned Parenthood Hudson Peconic	Amagansett	618 Montauk Highway PO Box 1806 Amagansett 11930	631-267-6818
Suffolk County Department of Health	Marilyn Shellabarger South, Brookhaven Family Hlth Ctr.	550 Montauk Hwy and Dorsett Pl. Shirley 11967	631-852-1141
Suffolk County Department of Health	The Maxine S. Postal, Tri-Community Health Ctr.	1080 Sunrise Highway , Amityville 11701	631-854-1097
Suffolk County Department of Health	Elsie Owens North Brookhaven Health Center	82 Middle Country Rd. Coram 11727	631-854-2278
Suffolk County Department of Health	S Brookhaven Hlth Ctr West	265 E Main St , Patchogue 11772	631-854-1209
Suffolk County Department of Health	Riverhead Health Center	300 Center Drive 2nd Floor County Center , Riverhead 11901	631-852-1810
Suffolk County Department of Health	Dolan Family Health Ctr,	284 Pulaski Rd . Greenlawn 11740	631-470-5367
Suffolk County Department of Health	Kraus Family Health Center Southampton	240 Meetinghouse Lane Schenck Bldg Southampton 11968	631-852-8822
Suffolk County Department of Health	Martin Luther King, Jr Hlth Ctr,	1556 Straight Path Wyandanch 11798	631-854-1768
Suffolk County Department of Health	Brentwood Family Health Ctr,	1869 Brentwood Rd Brentwood 11717	631-853-3434
Sullivan			
Planned Parenthood Mid-Hudson Valley	Monticello	14 Prince St PO Box 1376 Monticello 12701	845-794-3704
Tioga			
Tioga Opportunities	Family Planning Clinic	110 Central Ave PO Box 70 , Owego 13827	607-687-5333
Tompkins			
Planned Parenthood Southern Finger Lakes	Ithaca Center	314 West State St. Ithaca 14850	607-273-1513

Attachment 7

County / Provider	Site	Address	Phone
Ulster			
Planned Parenthood Mid-Hudson Valley	Kingston	169 Washington Ave Kingston 12401	845-338-0840
Warren			
Planned Parenthood Mohawk Hudson	Glens Falls	135 Warren St. Glens Falls 12801	518-792-0994
Washington			
Planned Parenthood Mohawk Hudson	Granville	11 Quaker St , Granville 12832	518-642-1590
Wayne			
East Hill Family Medical	North Rose	5019 North Main St North Rose 14516	315-587-0004
Finger Lakes Community and Migrant Health Care	Newark Community Health	513W Union Street Rt . 31Newark 14513	315-483-1199
Finger Lakes Community and Migrant Health Care	Sodus Community Health	6692 Middle Rd Suite 2100 Sodus 14551	315-483-1199
Westchester			
Hudson River HealthCare	Yonkers	503 South Broadway , Yonkers 10705	914-965-9771
Hudson River HealthCare	Peekskill Adolescent Health	1037 Main St , Peekskill 10566	914-734-8800
Hudson River HealthCare	Peekskill Women's Health	1037 Main St , Peekskill 10566	914-734-8800
Planned Parenthood Hudson Peconic	Mt. Vernon	6 Gramatan Avenue Suite 404 Mt. Vernon 10550	914-668-7927
Planned Parenthood Hudson Peconic	White Plains	175 Tarrytown Rd , White Plains 10607	914-761-6566
Planned Parenthood Hudson Peconic	New Rochelle	247-249 North Ave , New Rochelle 10801	914-632-4442
Planned Parenthood Hudson Peconic	Yonkers	20 South Broadway 11th Fl. Yonkers 10701-3713	914-965-1912
Wyoming			
Wyoming County Health Department	Warsaw Clinic	5362 Mungers Mill Road Building A , Silver Springs 14550	585-786-8881
Wyoming County Health Department	Attica Clinic	3325 E Main St , Attica 14011	585-591-1619
Yates			
Finger Lakes Community and Migrant Health Care	Penn Yan	160 Main St Penn Yan 14527	315-536-2752
Finger Lakes Community and Migrant Health Care	Keuka College	141 Central Avenue , Keuka Park 14478	315-279-5370

NYSDOH Comprehensive Adolescent Pregnancy Prevention Grantees

Attachment 8

County	Organization Name	Street Address	City	ZIP	First Name	Last Name	Title	Phone	E-mail
Albany	Upper Hudson Planned Parenthood	855 Central Ave	Albany	12206	Robert	Curry	Senior Vice President for External Affairs	(518) 434-5678	rob@uhpp.org
Allegany	Allegany County Community Opportunities and Rural Development, Inc.	84 Schuyler Street	Belmont	14813	Tracy	Broshar	Youth Services Division Director	(585) 268-7605	tbroshar@accordcorp.org
Bronx	St. Barnabas Hospital	4422 Third Avenue	Bronx	10457	Patricia	Belair	Senior Vice President	(718) 960-9454	pbelair@sbhny.org
Bronx	The Committee for Hispanic Children and Families, Inc.	110 William Street, 18th FL	New York	10038	Danielle	Guindo	Director of Youth Development	(212) 206-1090	dguindo@chcfinc.org
Bronx	Claremont Neighborhood Centers	489 East 169th Street	Bronx	10456	Abraham	Jones	Executive Director	(718) 588-1000	ajones@claremontcenter.org
Bronx	Urban Health Plan, Inc.	1065 Southern Boulevard	Bronx	10459	Paloma	Hernandez	President/CEO	(718) 991-4833	Paloma.Hernandez@urbanhealthplan.org
Broome	Mothers & Babies Perinatal Network of SCNY	457 State Street	Binghamton	13901	Sharon	Chesna	Executive Director	(607) 772-0517	schesna@mothersandbabies.org
Cattaragus	YWCA of Jamestown	401 North Main Street	Jamestown	14701	Beth	Oakes	Chief Executive Officer	(716) 488-2237	betho@ywcaofjamestown.com
Chautauqua	YWCA of Jamestown	401 North Main Street	Jamestown	14701	Beth	Oakes	Chief Executive Officer	(716) 488-2237	betho@ywcaofjamestown.com
Chemung	Planned Parenthood of the Southern Finger Lakes, Inc.	314 West State Street	Ithaca	14850	Maureen	Kelly	VP for Education	(607) 216-0021	maureen.kelly@ppsfl.org
Columbia	Upper Hudson Planned Parenthood	855 Central Ave	Albany	12206	Robert	Curry	Senior Vice President for External Affairs	(518) 434-5678	rob@uhpp.org
Dutchess	Planned Parenthood of the Mid-Hudson Valley, Inc.	178 Church Street	Poughkeepsie	12601	Frances	Fox-Pizzonia	Director, Community Education and Outreach	(845) 838-1200	fran.foxpizzonia@ppmhv.org

NYSDOH Comprehensive Adolescent Pregnancy Prevention Grantees

County	Organization Name	Street Address	City	ZIP	First Name	Last Name	Title	Phone	E-mail
Erie	Native American Community Services of Erie & Niagara Counties, Inc.	1005 Grant Street	Buffalo	14207	Michael	Martin	Executive Director	(716) 874-2797	mmartin@nacswny.org
Erie	The Buffalo Federation of Neighborhood Centers, Inc.	97 Lemon Street	Buffalo	14204	Jan	Peters	Executive Director	(716) 856-0363	jpeters@bfnc.org
Erie	Planned Parenthood of Western New York, Inc.	2697 Main Street	Buffalo	14214	Najeyah	Sultan	Director of Community Programs	(716) 200-5920	najeyah.sultan@ppwny.org
Jefferson	North Country Prenatal / Perinatal Council, Inc.	200 Washington Street Suite 300	Watertown	13601	Penny	Ingham	Executive Director	(315)788-8533	pingham@ncppc.org
Kings	CAMBA, Inc.	1720 Church Avenue	Brooklyn	11226	Kevin	Coffey	Assistant Deputy Director	(718) 287-2600	KevinC@camba.org
Kings	Diaspora Community Services, Inc.	182 4th Avenue	Brooklyn	11217	Josefina-A	Gonsalves	Director of Operation	(718) 399-0200	jgonsalves@diasporacs.org
Kings	Lutheran Family Health Centers / Lutheran Medical Center	150 55th Street	Brooklyn	11220	Kathy	Hopkins	Vice President for Community Services	(718) 630-7171	khopkins@lmcmc.com
Kings	NYC Health and Hospitals Corporation--Woodhull Hospital	Woodhull Medical Center 160 Water St. Room 1040	New York	10038	Judith	Flores	MD, Medical Director, Ambulatory Care	(718) 724-2419	Judith.Flores@Woodhullhc.nychhc.org
Kings	YWCA of the City of New York	50 Broadway	New York	10007	Sonia	Ramirez	Deputy Director of Program	(212) 735-9799	sramirez@ywcanyc.org
Kings	Research Foundation of SUNY	PO Box 9	Albany	12201	Christine	Rucker	Director, Adolescent Education	(718) 270-3203	christine.rucker@downstate.edu
Kings	Community Counseling and Mediation	1 Hoyt Street 7th Floor	Brooklyn	11201	Emory	Brooks	President and CEO	(718) 802-0666	emoryxbrooks@aol.com

NYSDOH Comprehensive Adolescent Pregnancy Prevention Grantees

County	Organization Name	Street Address	City	ZIP	First Name	Last Name	Title	Phone	E-mail
Monroe	City of Rochester, Bureau of Youth Services	30 Church Street	Rochester	14614	Jackie	Campbell	Assistant Commissioner of Youth	(585) 428-6225	campbelj@cityofrochester.gov
Monroe	Planned Parenthood of the Rochester/Syracuse Region, Inc.	114 University Avenue	Rochester	14605	Rick	Bartell	Director of Education and Outreach	(585) 546-2771	fbartell@pprsr.org
Monroe	Threshold Center for Alternative Youth Services, Inc.	57 Central Park	Rochester	14605	Sue	Davin	Executive Director	(585) 730-6180	sdavin@thresholdcenter.org
Nassau	Planned Parenthood of Nassau County, Inc.	540 Fulton Avenue	Hempstead	11550	JoAnn	Smith	President and CEO	(516) 750-2601	joannd.smith@ppnc.org
Nassau	The Steven and Alexandra Cohen Children's Medical Center of New York	269-01 76th Avenue	New Hyde Park	11040	Linda	Carmine	MD, Director, CAPP and School Based	(516) 465-5203	lcarmine@nshs.edu
New York	Charles B. Wang Community Health Center, Inc.	268 Canal Sreet	New York	10013	Susan	Yee	Program Director	(212) 226-8866	syee@cbwchc.org
New York	Community Healthcare Network	79 Madison Ave; 6th floor	New York	10016	Michele	Perlman	Program Director	(212) 545-2420	mperlman@chnnyc.org
New York	Grand Street Settlement, Inc.	80 Pitt Street	New York	10002	Johanna	De Jesus	Chief Program Officer	(646) 201-4254	jdejesus@grandstreet.org
New York	Harlem RBI, Inc	333 East 100th Street	New York	10029	Angela	Jefferson	Director of Social Services	(212) 722-1608	ajefferson@harlemrbi.org
New York	Inwood House	320 East 82nd Street	New York	10028	Linda	Lausell Bryant	Executive Director	(212) 861-4400	llbryant@inwoodhouse.com
New York	Mount Sinai Hospital	Adolescent Health Center 312-320 East	New York	10128	Angela	Diaz	MD,MPH, Director	(212) 423-2900	Angela.Diaz@mountsinai.org
New York	New York Presbyterian Hospital	60 Haven Avenue Suite B-3	New York	10032	Janet	Garth	CCHE Manager	(212) 304-6076	jag9007@nyp.org
New York	NYC Health and Hospitals Corporation	160 Water St., Room 1040	New York	10038	Orlando	Adamson	MD, Ambulatory Care and Medical	(212) 939-8167	orlando.adamson@nychhc.org

NYSDOH Comprehensive Adolescent Pregnancy Prevention Grantees

County	Organization Name	Street Address	City	ZIP	First Name	Last Name	Title	Phone	E-mail
New York	Planned Parenthood of New York City, Inc.	26 Bleecker Street	New York	10012	Haydee	Morales	Vice President of Education & Training	(212)274-7363	Haydee.Morales@ppnyc.org
New York	The Children's Aid Society	105 East 22nd Street, Rm. 100	New York	10010	Lisa	Handwerker	MD, Medical Director	(212) 949-4957	lHandwerker@childrensaidsociety.org
New York	The Hetrick-Martin Institute, Inc.	2 Astor Place	New York	10003	Lillian	Rivera	Director Capacity Building	(212) 674-2400	lrivera@hmi.org
New York	Union Settlement Association, Inc.	237 East 104th Street	New York	10029	David	Nocenti	Executive Director	(212) 828-6046	dnocenti@unionsett.org
New York	Safe Horizon, Inc.	2 Lafayette Street 3rd Floor	New York	10007	Carolyn	Strudwick	Youth Program Director	(646) 214-3805	cstrudwick@safehorizon.org
New York	Center for Community Alternatives	39 West 19th Street 10th Floor	New York	10011	Josefina	Bastidas	Deputy Director	(212) 691-1911	jbastidas@communityalternatives.org
Niagara	Planned Parenthood of Western New York, Inc.	2697 Main Street	Buffalo	14214	Najeyah	Sultan	Director of Community Programs	(716)200-5920	najeyah.sultan@ppwny.org
Oneida	Planned Parenthood Mohawk Hudson, Inc.	1040 State St	Schenectady	12307	Eileen	Lawson	Education Team Manager	(518) 374-5353	e.lawson@ppmhchoices.org
Onondaga	REACH CNY, Inc.	1010 James Street	Syracuse	13203	Elizabeth	Crockett	Executive Director	(315) 424-0009	execdir@reachcny.org
Orange	Maternal-Infant Services Network of Orange, Sullivan, And Ulster	200 Route 32 PO Box 548	Central Valley	10917	Caren	Fairweather	Executive Director	(845) 561-3575	cfairweather@misn-ny.org
Orleans	Community Action of Orleans and Genesee, Inc	409 East State Street	Albion	14411	Edward	Fancher	Executive Director	(585) 589-5605	efancher@caoginc.org
Oswego	Oswego County Opportunities, Inc.	239 Oneida Street	Fulton	13069	Kathleen	Knopp	Enhancement Services Coordinator	(315) 598-4717	kknopp@oco.org
Otsego	Planned Parenthood of South Central New York, Inc.	37 Dietz Street	Oneonta	13820	Debra	Marcus	Chief Executive Officer	(607) 432-2252	debra.marcus@ppfa.org

NYSDOH Comprehensive Adolescent Pregnancy Prevention Grantees

County	Organization Name	Street Address	City	ZIP	First Name	Last Name	Title	Phone	E-mail
Queens	AIDS Center of Queens County, Inc.	161 - 21 Jamaica Avenue 6th Floor	Jamaica	11432	Mitch	Eisenberg	Associate Executive Director	(718) 896-2500	meisenberg@acqc.org
Queens	The Child Center of NY, Inc.	60-02 Queens Boulevard	Woodside	11377	Amanda	Etienne	Associate Director, Youth Development	(718) 322-4953	amandaetienne@childcenterny.org
Richmond	Staten Island University Hospital	475 Seaview Avenue	Staten Island	10305	Kathleen	Carney-Kielty	Program Coordinator, Adolescent Medicine	(718) 226-6918	Cathi_Carney_Kielty@siuh.edu
Schenectady	Planned Parenthood Mohawk Hudson, Inc.	1040 State St	Schenectady	12307	Eileen	Lawson	Education Team Manager	(518) 374-5353	e.lawson@ppmhchoices.org
St. Lawrence	St. Lawrence County Health Initiative, Inc.	PO Box 5069 6439 SH 56	Potsdam	13676	Ruth	Fishbeck	Executive Director	(315) 261-4760	ruth@gethealthyslc.org
Suffolk	Economic Opportunity Council of Suffolk, Inc. / SNAP Long Island Division	31 West Main Street, Suite 300	Patchogue	11772	Cynthia	Monthie	Director of Services	(631) 447-0698	cmonthie@eoc-suffolk.com
Suffolk	Long Island Gay and Lesbian Youth, Inc.	34 Park Avenue	Bay Shore	11706	Kerrie	O'Neill	Director of Programs	(631) 665-2300	kerrie@ligaly.org
Suffolk	Research Foundation of SUNY	Office of Sponsored Programs Stony Brook University	Stony Brook	11794	Allison	Eliscu	MD, Professor of Pediatrics	(631) 444-7811	allison.eliscu@sbumed.org
Sullivan	Maternal-Infant Services Network of Orange, Sullivan, And Ulster	200 Route 32 PO Box 548	Central Valley	10917	Caren	Fairweather	Executive Director	(845) 561-3575	cfairweather@misn-ny.org
Sullivan	Sullivan County BOCES	6 Wierk Avenue	Liberty	12754	Debra	Fuchs Nadeau	Ed.D, Director Prevention Services	(845) 295-4030	dfuchs@scboces.org
Tioga	Mothers & Babies Perinatal Network of SCNY	457 State Street	Binghamton	13901	Sharon	Chesna	Executive Director	(607) 772-0517	schesna@mothersandbabies.org
Warren	Hudson Headwaters Health Network	9 Carey Road	Queensbury	12804	John	Rugge	M.D., Chief Executive Officer	(518) 761-0300	jrugge@hhhn.org

NYSDOH Comprehensive Adolescent Pregnancy Prevention Grantees

County	Organization Name	Street Address	City	ZIP	First Name	Last Name	Title	Phone	E-mail
Westchester	City of Mount Vernon Youth Bureau	One Roosevelt Square 3rd floor	Mount Vernon	10550	DaMia	Harris	Executive Director	(914) 665-2344	dharris@ci.mount-vernon.ny.us
Westchester	Hudson River HealthCare, Inc.	1037 Main Street	Peekskill	10566	Mary	Brendler	Associate VP Special Populations and Planning	(914)734-8909	mbrendler@hrhcare.org
Westchester	Planned Parenthood Hudson Peconic, Inc.	4 Skyline Drive	Hawthorne	10532	Carol	Lemus	Director of Education and Training	(914) 220-1038	carol.lemus@pphp.org

Rural Health Network Contacts

Contact	Email	Network Name	Address	City	Zip	Counties Served
Danielle Wert	dwert@oco.org	Rural Health Network of Oswego County	239 Oneida Street	Fulton	13069	Oswego County
Betty Falcao	bfalcao@hsctc.org	Tompkins Health Network	100 W. Seneca Street	Ithaca	14850	Tompkins County
Patricia Bishop	patty@nnyrhca.org	Northern New York Rural Health Care Alliance, Inc.	800 Starbuck Avenue Suite A-5	Watertown	13601	Jefferson, Lewis, and northern Oswego Counties
Donna Kahm	dkahm@sthcs.org	Southern Tier Health Care System, Inc.	One Blue Bird Square	Olean	14760	Chautauqua, Cattaraugus and Allegany

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Dave Felton	dfelton@cmhhamilton.com	Hamilton-Bassett-Crouse Health Network, Inc.	150 Broad Street	Hamilton	13346	Madison County, Northern Chenango County
Sharon Mathe	mathes@hcanetwork.org	Healthy Community Alliance, Inc.	26 Jamestown Street	Gowanda	14070-1412	Southern Erie, Northern Cattaraugus, Northern Chautauqua, Western Wyoming Counties
Charlotte Crawford	ccrawford@lakeplains.org	Lake Plains Community Care Network, Inc.	56 Harvester Avenue	Batavia	14020	Orleans, Genesee and Wyoming Counties
Irving Lyons	director@cayugahealthnetwork.org	Cayuga County Community Health Network, Inc.	188 Genesee Street, Suite 207	Auburn	13021	Cayuga County, Seneca County
Andrea Haradon	grantstogo@stny.rr.com	S2AY Rural Health Network	417 Liberty Street, Suite 2120	Penn Yan	14527	Steuben, Schuyler, Seneca, Allegany, Yates, Ontario, and Wayne Counties

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Nanette Cazzola	nc225@cornell.edu	Delaware County Rural Healthcare Alliance	34570 St. Hwy 10	Hamden	13782	Delaware County
Kelli Mannon	mannonk@ihsnet.org	Steuben Rural Health Network	6666 County Road 11	Bath	14810-7722	Steuben County
Kathy Perry-Ernisse	Kathy Perry-Ernisse@Thompsonhealth.org	Jones Noyes Thompson Health Network	350 Parrish Street	Canandaigua	14424	Parts of Ontario, Yates, Livingston, Wayne
Jack Salo	jsalo@ruralhealthnetwork.org	Rural Health Network of South Central New York	PO Box 416	Whitney Point	13862	Tioga County, Delaware County and Rural Areas of Broome County
Tina Utley Edwards	tina@chenangohealth.org	Chenango Health Network	24 Conkey Avenue	Norwich	13815	Chenango County

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Phil Goyeau	pgoyeau@treosolutions.com	North County Healthcare Providers Educational and Research Fund, Inc.	133 Park Street	Malone	12953	St. Lawrence, Franklin
Allison Dubois	adubois@hrhcare.org	Eastern Dutchess County Rural Health Care Network	1037 Main Street	Peekskill	10566	Eastern Dutchess
Linda Keller	.linda.keller@bassett.org	Rural Health Education Network of Delaware, Otsego, Montgomery, Schoharie	Bassett Research Institute	Cooperstown	13326	Delaware, Otsego, Montgomery and Schoharie Counties
Yvonne Lott	yvonne.lott@plattsburgh.edu	Eastern Adirondack Health Care Network	101 Broad Street-Sibley Hall	Plattsburgh	12901	Clinton, Essex, Franklin Counties
Kathryn Reed	kreed@chahec.org.	Mid-Hudson Rural Integrated Delivery System	279 Main Street, Suite 201	New Paltz	12561	Ulster County, eastern Sullivan County, Eastern Delaware County

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Vicky Wheaton-	vwheaton@medserv.net	Adirondack Rural Health Network	9 Carey Road	Queensbury	12804	Warren, Washington, Hamilton, Southern Essex, Northern Saratoga Counties
Margot Gold	mgold@heartnetwork.org	Rural Action Now	126 Kiwassa Road	Saranac Lake	12983	Franklin, Clinton, Essex
Ronald Rouse	rrouse2272@aol.com	Greene County Rural Health Network, Inc.	159 Jefferson Heights	Catskill	12414	Greene County
Barry Brogan	barry@behaviorhealthnet.org	North Country Behavioral Healthcare Network	126 Kiwassa Road	Saranac Lake	12983	Jefferson, St. Lawrence, Franklin, Essex, and Clinton Counties
Stephen Acquario	sacquario@nysac.org	North Country Medical Home Network	540 Broadway	Albany	12207	Clinton, Essec, Franklin, Hamilton, Warren and Towns of Moreau in Saratoga county

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Claire Parde	cparde@columbiahealthnet.org	Columbia County Community Healthcare Consortium, Inc.	325 Columbia Street	Hudson	12534	Columbia County
Carol Ryan	susan.clark@co.sullivan.ny.us	Sullivan County Rural Health Network	PO Box 590	Liberty	12754	Sullivan County
Emilie Sisson	emilie.sisson@viahealth.org	Wayne County Rural Health Network	P.O. Box 111	Newark	14513	Wayne County
Adam Hutchinson	ahutchinson@herkimercounty.org	Herkimer County HealthNet, Inc.	320 North Main Street, Suite	Herkimer	13350	Herkimer
Elizabeth Wattenberg	consultation@ruralhealthresources.com	Rural Health Community Systems, Inc.	7571 State Route 54	Bath	14810	Steuben

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Ann Abdella	abdella@cchn.net.	Chautauqua County Health Network, Inc.	200 Harrison Street, 2nd Fl.	Jamestown	14701	Chautauqua County
Ruth Fishbeck	ruth@gethealthyslc.org	St. Lawrence County Health Initiatives, Inc.	PO Box 5069	Potsdam	13676	St. Lawrence
Jacquelin Carlton	jackie@sevenvalleyshealth.org	Seven Valleys Health Coalition, Inc.	50 Clinton Avenue	Cortland	13045	Cortland County
Carrie Whitwood	whitwoodc@awsrhn.org	Allegany/Western Steuben Rural Health Network, Inc.	85 North Main St., Suite 4	Wellsville	14895	Allegany, Western Steuben
Joyce Hyatt	jhyatt@stny.rr.com	Chemung Valley Rural Health Network	103 Washington Street	Elmira	14901	Chemung, Western Schuyler

Attachment 9

Contact	Email	Network Name	Address	City	Zip	Counties Served
Joan Ellison	jellison@co.livingston.ny.us	Genesee Valley Health Partnership, Inc.	PO Box 545	Dansville	14437	Livingston

Correlation of Maternal and Infant Community Health Collaboratives Activities with Offering and Arranging Activities

Attachment 10

MICHC Performance Standards / Offering and Arranging Activities	High-need women and infants are enrolled in health insurance	High-need women and infants are engaged in health care and other supportive services	The medical, behavioral, and psychological risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral, and follow-up	Within the community there are supports and opportunities in place that help high-need women engage in and maintain healthy behaviors and reduce or eliminate risky behaviors
Disseminating written and oral information about available family planning health services.	Community education sessions on the availability of Family Planning Benefit Program or Family Planning Extension Program Door-to-door outreach in high need areas.	Presentations at community events. Providing speakers on prevention of unintended pregnancies and birth spacing for community. Identifying specific barriers to utilization of family planning services in high-need communities and with hard to engage populations.	Establish relationships with other health and human service providers in the community to identify and refer individuals who may benefit from family planning services.	Peer education programs Presentations to community groups on family planning and birth spacing. Development of PSAs/websites/media campaigns on prevention of unintended pregnancies and birth spacing.
Providing for individual and/or group discussions about all methods of family planning and family planning services.	One-on-one and group education on Family Planning Benefit Program or Family Planning Extension Program.	Tours of family planning clinic for perspective clients. Individual or group education.	Develop collaborations with health and human service providers to implement referral and follow-up system. Utilize CHW to follow-up on utilization of family planning services. Utilize web based data systems to support coordination and referral of high-need women for family planning services.	One-on-one and group sexuality education related to family planning and birth spacing. Individualized social support to encourage and reinforce health promoting behaviors by clients, including consistent use of effective contraception to prevent unintended pregnancy or support birth spacing.
Assisting with arranging visits to family planning provider.	Enrollment of eligible women into Family Planning Benefit Program or Family Planning Extension Program.	Collaboration with community health care providers to facilitate access to reproductive health services to meet needs of target population. Referrals to family planning provider.	Referral to family planning provider. Assistance with scheduling family planning appointments. Follow-up of missed family planning appointments.	Identifying specific barriers to utilization of family planning services through focus groups, community discussions, etc. Assisting with transportation arrangements to family planning appointments.

Attachment 11

Maternal and Infant Health Initiative
Application for Grant Award
Component A: Maternal and Infant Community Health Collaborative (MICHC)

Application Template

To request funding for the Maternal and Infant Health Initiative – Component A: Maternal and Infant Community Health Collaborative, complete this Application Template.

Complete applications should not exceed **48** single-spaced typed pages (not including the cover page, attestation of eligibility, budget tables and forms, and attachments) using a normal 12 pitch font. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

A complete application consists of the following:

- **Application Cover Sheet**
- **Attestation of Eligibility**
- **Executive Summary**
- **Organizational Experience and Capacity**
- **Assessment of Community Needs and Strengths**
- **Improvement Plan**
- **Performance Measurement, Monitoring and Reporting**
- **Budget and Staffing Plan Narrative**
- **Budget Tables and Forms (Complete five one-year budgets)**
    - **Table A: Summary Budget**
    - **Table A-1: Personal Services**
    - **Table A-2: Non Personal Services**
    - **Table A-3: "Offering and Arranging" Activities Summary**
    - **Form B-1: Personal Services Narrative Justification**
    - **Form B-2: Fringe Benefit Rate Narrative Justification**
    - **Form B-3: Nonpersonal Services Narrative Justification**
    - **Form B-4: Detail of Contractor Funds Supporting Initiative**
    - **Subcontractor Budget Forms**
- **Letters of Support**
- **Vendor Responsibility Questionnaire and/or Attestation**
- **Organizational Chart**
- **Subcontractor Organizations**

Application Cover Sheet [0 POINTS]

Provide relevant information on the applicant agency, the proposed target area, and the amount of funding requested.

<table>
<tr><td colspan="2">NAME AND ADDRESS OF APPLICANT ORGANIZATION/AGENCY
ORGANIZATION/AGENCY:
Vender ID Number:
ADDRESS:</td></tr>
<tr><td>Agency Director
Name:
Title:</td><td>Telephone: ( )
E-mail Address:</td></tr>
<tr><td>Project Director
Name:
Title:
Address:

Telephone: ( )
E-mail Address:</td><td>Fiscal Officer
Name:
Title:
Address:

Telephone: ( )
E-mail Address:</td></tr>
<tr><td>Total Costs Requested for first 12-Month Budget Period (July 1, 2013 – June 30, 2014)</td><td>$____________________</td></tr>
<tr><td>Federal Identification Number:</td><td>Charitable Organization Number:</td></tr>
<tr><td>Target County(ies) to be Served:

Zip Code Areas to be Targeted:</td><td>Signature & Date:

____________________________________</td></tr>
<tr><td>CERTIFICATION OF ACCEPTANCE
I certify that the statements herein are true and complete to the best of my knowledge, an accept the obligation to comply with NYS Department of Health terms and conditions if a grant is awarded as the result of this application. A willfully false certification is a criminal offense.</td><td>Official Signing for Application Organization
Name:
Title:
Address:

Telephone: ( )</td></tr>
</table>

Attachment 11

Attestation of Eligibility [0 POINTS]

The attestation certifies to your agency's eligibility for application under this category.

____ certifies the following:
(name of lead agency)

1. It is (check the appropriate selection)

   _____ Article 28 facility

   _____ Local government agency

   _____ Community-based not-for-profit

2. It is located within the target area to be served. List counties and target areas that will be served:

   County(ies) to be served:

   Community/geographic and/or zip code areas to be targeted:

3. The application reflects a close collaboration with other community partners.

4. The lead agency has a substantial coordinating and/or implementation role and is not simply a pass-through for funding to other organizations.

______________________ ______________________

Authorized Representative Print Name

Authorized Representative Signature

____

Date

Executive Summary [0 POINTS]
(One-page limit)

This is a brief overall summary of the entire proposal.

Describe in substantive yet concise terms key aspects of all components of the application including: organizational experience and capacity; assessment of community needs identified and resources, including key communities and populations to be targeted; proposed improvement strategies and results to be accomplished; and how requested funds will support implementation of the proposed improvement plan. Although this section is not scored, it serves as an important summary overview of the proposed project for reviewers.

Attachment 11

Organizational Experience and Capacity [20 POINTS]
(Four page limit)

This section describes the experience, expertise and capacity of the applicant, in collaboration with sub-contractors and other key partners, to assess, develop and implement strategies through the MICHC initiative.

Briefly describe the lead applicant agency/organization, including: mission, experience and capacity, current programs/services, populations targeted and served, and accomplishments in addressing maternal and infant health outcomes within the community. Briefly describe how the proposed program will be integrated within the organizational structure of your agency. A current organizational chart should be included and referenced as an attachment, which will not count against the four page limit.

Describe the lead applicant agency's history, experience and capacity related to serving populations most impacted by racial, ethnic and economic disparities in maternal and infant health outcomes. Highlight any specific ways in which the organization represents the community and populations served including board membership, staffing, or other characteristics.

Describe the lead applicant agency's experience and capacity to effectively engage and collaborate with other community partner agencies, organizations and service providers to assess and address maternal and infant health issues and outcomes within the community.

Identify other specific community organizations, services, programs and initiatives to address maternal and infant health and well-being within the target community. Describe how the lead applicant agency's capacity to positively impact maternal and infant health services and outcomes will be enhanced for the MICHC initiative through partnerships with other community organizations, including a description of any proposed sub-contracts and specific commitments from community partners. Describe partners' experience with serving the high-need target populations targeted in the high-need target neighborhoods. Letters of agreement or other evidence of specific commitments should be included and referenced as attachments, which will not count against the four page limit for this section.

Attachment 11

Assessment of Community Needs and Strengths [20 POINTS]
(Eight-page limit)

The community assessment is a cornerstone of your application, as it will provide the basis for the selection of improvement strategies. The assessment should build upon previous local and state community assessment and planning efforts, including those conducted in association with other NYSDOH-funded initiatives (e.g., Comprehensive Prenatal – Perinatal Services Networks [CPPSN], Community Health Worker Program [CHWP]and Healthy Mom – Healthy Baby Prenatal and Postpartum Home Visiting [HMHB]), as well as the state's Maternal, Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment available at: http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/

Note: As a condition of funding, grantees will be expected to integrate ongoing community assessment activities in their MICHC initiatives to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. Assessment will be an ongoing activity, not a stand-alone "planning" phase of funded projects, with an updated community assessment as an annual grant deliverable. Both initial and ongoing/updated community assessments should reflect collaboration with multiple and diverse partners, including MIH Component B (MIECHV) grantees.

Describe the process, partners and sources of information (both qualitative and quantitative) used to assess and prioritize needs, strengths and gaps within the target community to improve maternal and infant health outcomes across the life course, with a particular emphasis on preconception, prenatal/postpartum and interconception periods. Highlight any ways in which the current assessment builds on prior community assessments and planning activities, including those conducted in association with other DOH-supported initiatives.

*Describe the specific **community/geographic area** to be targeted for the MICHC initiative and the rationale for selecting that area. Identify the zip code areas to be targeted.*

*Describe the specific **high-risk populations** to be targeted for the MICHC initiative and the rationale for selecting that population(s).*

*Describe specific **maternal and infant health outcomes** identified for the target community and population(s), including an assessment of racial, ethnic and economic disparities. Discuss briefly how these outcomes impact the overall health and well-being of low-income individuals and the larger community. Identify the major individual/behavioral, family, organizational and community risk and protective factors that impact the target populations' health across the life course, with particular emphasis on preconception, prenatal/postpartum and interconception periods. Cite the source(s) of information used to identify these factors, and the rationale for prioritizing specific factors to be addressed through MICHC initiative.*

Describe specific risk and protective factors, needs, existing resources/strengths, barriers and gaps in services to address ***enrollment of low-income women and their families in health insurance*** *across the life course, with a particular emphasis on preconception, prenatal/postpartum and interconception periods (Performance Standard 1). Highlight specific relevant risk and protective factors identified within your target community and populations at the individual, family, organizational and community levels. Cite the source(s) of information used to identify these factors, and the rationale for prioritizing specific factors to be addressed through MICHC initiative.*

Describe specific risk and protective factors, needs, existing resources/strengths, barriers and gaps in services to address ***initial and ongoing engagement of low-income women and their families in health care and other supportive community services*** *across the life course, (Performance Standard 2). Highlight specific relevant risk and protective factors identified within your target community and populations at the individual, family, organizational and community levels. Cite the source(s) of information used to identify these factors, and the rationale for prioritizing specific factors to be addressed through MICHC initiative.*

Describe specific risk and protective factors, needs, existing resources/strengths, barriers and gaps in services to address the ***delivery of high quality, comprehensive health care and other supportive services*** *for at-risk populations within the target community, with a particular emphasis on services during the preconception, prenatal/postpartum and interconception periods (Performance Standard 3). Highlight specific relevant risk and protective factors identified within your target community and populations at the individual, family, organizational and community levels. Cite the source(s) of information used to identify these factors, and the rationale for prioritizing specific factors to be addressed through MICHC initiative.*

Describe specific risk and protective factors, needs, existing resources/strengths, barriers and gaps in services to address the ***availability and accessibility of community supports and opportunities for low-income women and their families to practice and maintain health behaviors*** *across the life course, with a particular emphasis on services during the preconception, prenatal/postpartum and interconception periods (Performance Standard 4). Highlight specific relevant risk and protective factors identified within your target community and populations at the individual, family, organizational and community levels. Cite the source(s) of information used to identify these factors, and the rationale for prioritizing specific factors to be addressed through MICHC initiative.*

Attachment 11

Improvement Plan [30 POINTS]
(30 page limit)

The improvement plan describes the specific strategies that MICHC grantees, in collaboration with local partners, will carry out to address the needs and priorities identified through the community assessment, within the MICHC performance management framework. For each defined Performance Standard, applicants will describe specific improvement strategies that:

- Are directly responsive to the needs and strengths identified in their community assessment;
- Address relevant factors across the life course;
- Address relevant factors at multiple social ecologic levels;
- Are targeted to one or more clearly-defined target groups or organizations;
- Build on the strengths, resources and assets of the target community, the lead applicant organization and its collaborative partners; and
- Are based on established or emerging evidence base or other well-defined and relevant empirical and/or theoretical framework(s).

Improvement strategies will include Offering and Arranging activities to increase awareness, accessibility and utilization of family planning services among Medicaid-eligible preconception and interconception women. Offering and Arranging activities may be incorporated in community, organizational and/or individual/family level strategies.

Note: As a condition of funding, grantees will be expected to submit an updated improvement plan as an annual grant deliverable. Both initial and updated improvement plans should reflect collaboration with multiple and diverse community partners, including MIH Component B (MIECHV) grantees.

Briefly describe the overall proposed improvement plan. This summary should illustrate how the individual improvement strategies described below fit together in a coherent, integrated overall strategic approach to improving maternal and infant health outcomes among at-risk populations within the target community. This summary should be no more than one page in length.

Attachment 11

Performance Standard 1: High-need women and infants are enrolled in health insurance

Life Course Period: Preconception

Improvement Strategies - Organizational/Community Level:

<table>
<tr><th colspan="4">Brief summary of improvement strategy:</th></tr>
<tr><td colspan="4">[insert brief summary description of proposed strategy here]</td></tr>
<tr><th>Specific Activities</th><th>Target Audience</th><th>Responsible Parties</th><th>Timeframe</th></tr>
<tr><td>1. [list activity 1]
2. [list activity 2]
3. Etc…</td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Briefly describe the specific factor(s) based on your community assessment this strategy is designed to address:</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Briefly describe the rationale for this strategy - i.e., why you believe this approach will be effective in addressing the selected factors to improve performance in this area, including reference to any relevant evidence base, empirical or theoretical framework:</td></tr>
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<tr><td colspan="4">Briefly describe how you will build on existing organizational and/or community strengths and resources to implement this strategy <u>and</u> any actions that will be taken to build necessary capacity to support effective implementation (e.g., staff training)</td></tr>
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</table>

(Copy and paste table above for each additional strategy.)

Attachment 11

Improvement Strategies - Individual/Family Level

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(Copy and paste table above for each additional strategy.)

Attachment 11

Performance Standard 1: High-need women and infants are enrolled in health insurance

Life Course Period: Prenatal / Postpartum

Improvement Strategies - Organizational/Community Level:

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<tr><td colspan="4">Brief summary of improvement strategy:</td></tr>
<tr><td colspan="4">[insert brief summary description of proposed strategy here]</td></tr>
<tr><td>Specific Activities</td><td>Target Audience</td><td>Responsible Parties</td><td>Timeframe</td></tr>
<tr><td>4. [list activity 1]
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Improvement Strategies - Individual/Family Level

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</table>

(Copy and paste table above for each additional strategy.)

Attachment 11

Performance Standard 1: High-need women and infants are enrolled in health insurance

Life Course Period: Interconception

Improvement Strategies - Organizational/Community Level:

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<tr><td colspan="4">[insert brief summary description of proposed strategy here]</td></tr>
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Attachment 11

Improvement Strategies - Individual/Family Level

<table>
<tr><td colspan="4">Brief summary of improvement strategy:</td></tr>
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</table>

(Copy and paste table above for each additional strategy.)

Performance Standard 2: High-need women and infants are engaged in health care and other supportive services appropriate to their needs

Life Course Period: Preconception

Improvement Strategies - Organizational/Community Level:

Brief summary of improvement strategy:			
[insert brief summary description of proposed strategy here]			
Specific Activities	Target Audience	Responsible Parties	Timeframe
4. [*list activity 1]* 5. *[list activity 2]* 6. *Etc…*			
Briefly describe the specific factor(s) based on your community assessment this strategy is designed to address:			
Briefly describe the rationale for this strategy - i.e., why you believe this approach will be effective in addressing the selected factors to improve performance in this area, including reference to any relevant evidence base, empirical or theoretical framework:			
Briefly describe how you will build on existing organizational and/or community strengths and resources to implement this strategy <u>*and*</u> *any actions that will be taken to build necessary capacity to support effective implementation (e.g., staff training)*			

(Copy and paste table above for each additional strategy.)

Attachment 11

Improvement Strategies - Individual/Family Level

<table>
<tr><td colspan="4">Brief summary of improvement strategy:</td></tr>
<tr><td colspan="4">[insert brief summary description of proposed strategy here]</td></tr>
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</table>

(Copy and paste table above for each additional strategy)

Performance Standard 2: High-need women and infants are engaged in health care and other supportive services appropriate to their needs

Life Course Period: Prenatal / Postpartum

Improvement Strategies - Organizational/Community Level:

<table>
<tr><td colspan="4">Brief summary of improvement strategy:</td></tr>
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Performance Standard 2: High-need women and infants are engaged in health care and other supportive services appropriate to their needs

Life Course Period: Interconception

Improvement Strategies - Organizational/Community Level:

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Attachment 11

Performance Standard 3: The medical, behavioral and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up

Life Course Period: Preconception

Improvement Strategies - Organizational/Community Level:

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Performance Standard 3: The medical, behavioral and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up

Life Course Period: Prenatal / Postpartum

Improvement Strategies - Organizational/Community Level:

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Life Course Period: Interconception

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Attachment 11

Performance Standard 4: Within the community there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors.

Life Course Period: Preconception

Improvement Strategies - Organizational/Community Level:

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Performance Standard 4: Within the community there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors.

Life Course Period: Prenatal / Postpartum

Improvement Strategies - Organizational/Community Level:

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Life Course Period: Interconception

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Attachment 11

Performance Measurement, Monitoring and Reporting [10 POINTS]

(Two-page limit)

All grantees will be expected to incorporate Quality Improvement (QI) activities to critically review the effectiveness of chosen strategies.

Describe current processes for monitoring program performance including use of data to inform continuous quality improvement and to adjust or modify program strategies as needed to optimize their effectiveness.

Describe processes to engage stakeholders including the target populations to develop improvement plans and assess progress.

Attachment 11

Budget and Staffing Plan [20 POINTS]

(Three-page narrative limit, exclusive of budget tables and forms)

Budget Narrative

The Budget Narrative will describe in 3 pages or less: 1) how the proposed budget will support achievement of the proposed Improvement Plan activities; 2) a staffing plan; and 3) inkind support from both the lead agency and collaborative partners. Funding may supplement but cannot supplant funding from other sources such as other grant funds or Medicaid reimbursement which support existing activities. If funding is used to expand existing activities, the budget forms should identify Other Sources of Funds on Budget Tables A, A1 and A-2 which support those activities.

Describe overall how the requested funds will support achievement of the proposed Improvement Plan.

Describe your overall staffing plan for the project and how the requested funds will support this plan. It is expected that the budget will support appropriate and qualified program staff to accomplish the program activities described in the Improvement Plan. Provide a narrative justification, and describe the qualifications required for each position. At a minimum, the budget should support a full-time MICHC program coordinator, a community health worker supervisor that is a public health nurse or licensed social worker, and a sufficient number of community health workers to serve the estimated number of women and families to be reached through CHW services as described in the improvement plan. A full-time CHW supervisor will supervise 4 to 6 CHWs. Resumes of key staff should be included in as attachments. Resumes of key staff should be included in the application. All in-kind contributions should be identified in the budget.

*Identify and describe in-kind contributions in support of the Improvement Plan and budget. Describe how grant funds will leverage additional financial support from partners, including public and private (e.g. businesses, foundations) partners. Describe plans for d*eveloping public-private partnerships and other activities to enhance program sustainability.

Consideration will be given to cost-effectiveness of budgets, meaning the application fulfills all requirements in the least costly manner (e.g., emphasizing direct, personal service and programming, while containing minimal costs for administrative support OTPS budget line items). The budget will be rated on its cost-effectiveness during the review process.

In addition to the budget discussed above, include an agency-wide budget, or in the case of local health units or hospitals, a department-wide budget, which provides information related to all contracts received by the agency, and personnel and other than personal service (OTPS) cost allocation. Wherever possible, include staff names to enable the reviewers to compare costs allocation.

<u>Instructions for completing Budget Tables and Forms</u>

Using the Tables A, A1, A2, and A-3 and Forms B-1, B-2, B-3 and B-4 below, prepare an annualized budget for **each** 12-month period starting July 1, 2013 and ending June 30, 2018 (i.e., a total of five one-year budgets. Label year one budget tables "Appendix **B-1**", year two budget "Appendix **B-2**", and so on. Remember to change the dates on budget pages to reflect actual budget year.

ADMINISTRATIVE/INDIRECT COSTS
Administrative/indirect costs in budget line item detail may not exceed ten percent (10%) of your budget due to federally imposed administrative caps on contract funds. Indirect costs applied as a percentage may not be charged to NYS funds.

Budget Instructions

The budget should reflect all costs and funding for the MICHC program from all sources, including in-kind contributions and other grants.

<u>APPENDIX B: BUDGET</u>

TABLE A: <u>Summary Budget Request</u>

This table should be completed last and will include the subtotal lines only from
Tables A-1 and A-2.

Line 1: Enter appropriate amounts from the detailed personal services budget page.

Line 2: Enter appropriate amounts from the detailed non-personal services budget page.

Grand Total: Reflect the totals of Line 1 and Line 2 above.

Other Sources of Funds (Column 2): All funds and resources the applicant will be providing to support MICHC activities.

Amount Requested from NYS (Column 3): Funds requested from New York State for this grant.

Other Sources of Funds Detail (Bottom of Summary Budget Request)

a. Funds available from the applicant's own sources and monetary value of in-kind services. This can also include fees from education services and fund raising efforts.

b. Funds available from subcontractor's own sources and monetary value of in-kind services. This can also include fees from education services and fund raising efforts.

c. Other Grant funds; includes other state, local or federal grants not requested in this application. Private foundation grants should also be included. Also other miscellaneous income should be disclosed here.

d. The total Other Sources of Funds should equal the amount entered under the column headed "Other Sources of Funds", column 2, Grand Total line of the Summary Budget Request.

Complete the enclosed Compressed Sub Contractor Budget and Compressed Sub Contractor Budget Justification Attachment for **each** MICHC subcontractor (copy as needed). This information is to be

summarized on the lead agency's budget Table A-2 as a single line item. Submit each MICHC subcontractor's compressed forms with your grant application.

TABLE A-1: Detailed Personal Service Budget Request

Personnel with the exception of consultants and per diems contributing any part of their time to the MICHC project should be included. Consultants and per diem expenses should be shown as a non personal services contractual expense on Table A-2.

- In the top row of the heading, fill in the applicant name.
- In column 1, enter **all job titles** and the incumbent's name connected with administration or service provision for MICHC program. Include all titles, regardless of funding source.
- In column 2, enter the annual (12 month) salary rate for each position which will be filled for all or any part of the budget period. Regardless of the amount of time spent on this project, the total annual salary for each position should be given for the number of months applicable to that salary. **For example, if a union negotiated salary increase will impact a portion of the 12 month budget period it should be shown on Table A-1 as follows (the same position will use two lines in the budget):**

Title (Column 1)	Annual Salary (Column 2)	X	# Months (Column 3)	X	%FTE (Column 4)	=	Total Expense (Column 10)
Outreach Worker	**$30,000**	**X**	**9**	**X**	**100%**	**=**	**$22,500**
Outreach Worker	$35,000	X	3	X	100%	=	$8,750

- In column 3, show the number of months out of 12 worked for each title. (If an employee works 9 months out of 12, then 9 months/12 month =.75 This ratio is part of the Total Expense calculation below.)
- In column 4, the proportion of time spent on the MICHC project based on a full time equivalent (FTE) should be indicated. One FTE is based on the number of hours worked in one week by salaried employees (e.g. 40 hour work week). To obtain % FTE, divide the hours per week spent on the project by the number of hours in a work week. For example an individual working 10 hours per week on the MICHC given a 40 hour work week =10/40=.25(show in decimal form).
- In column 10, enter the total amount required for each position using the following formula:

Annual Salary (Column 2)	X	Number of Months/12X (Column 3)	%FTE = (Column 4)	Total Expense (Column 10)

- In columns 5 - 8, indicate **costs** allocated to each "Offering and Arranging" activity. These amounts are determined by multiplying the amount in column 9 by the percent of time dedicated to each activity. The definitions for each of the categories are below.
- In column 9, enter costs allocated to activities **not** related to offering and arranging of family planning services. This is determined by multiplying the amount in column 10 by the percent of time dedicated to activities not related to offering and an arranging for family planning services. The sum of columns 5 through column 9 will equal the amount in column 10.
- In column 11, enter the amount of other sources of funding for each position. This includes both "in kind" contributions and funds from all other sources.

- In column 12, enter the amount of funding requested from the State.

- The sum of columns 11 and 12 should equal the amount in column 10.

- **Fringe Benefits** – Insert the Agency-Wide Fringe Benefit rate (from Form B-2) in space provided. Multiply this rate by the sub-total Personal Service for each column.

- TOTAL PS: In the total Personal Services row, add vertically to obtain totals for each column.

MICHC projects provide a variety of services that are eligible for federal Medicaid matching funds. Eligible activities include "offering and arranging for family planning services."

Offering and Arranging for family planning services is defined in 18 NYCRR 505.13 by three broad categories as follows: disseminating written and oral information about available family planning health services, providing for individual and/or group discussions about all methods of family planning and family planning services, and assisting with arranging visits to a medical family planning provider.

This definition is represented by distinct categories of service as reflected in the MICHC budget Table A-1. The following displays how these categories meet the definition and gives examples of acceptable activities. This list is not all-inclusive:

1. **Disseminating written and oral information about available family planning health services.**
   - Community Education and Outreach (Column 5) includes presentations to local community groups, clinic orientation tours, door to door outreach in high-need areas, media campaign to raise awareness of the prevention of unintended pregnancies, birth spacing and the full range of family planning methods (including abstinence)/services available. Community education and outreach may also include providing speakers at local community and national observances, and at other health and human services programs.

   - Education and Informational Materials Costs (Column 8,Other) includes development and distribution of family planning services information and outreach materials, production of program newsletter addressing barriers to access of services, the prevention of unintended pregnancies, and birth spacing. Costs may also include dissemination through media outlets such as cable, T.V. and internet. For example a MICHC program website aimed at high-need women that include information on locations of clinics. This outreach may be accompanied by palm cards and flyers.

   - Promotion of FPBP and FPEP (Column 6) includes dissemination of information on eligibility for the Family Planning Benefit Program and/or Family Planning Extension Program. Information may be disseminated to individuals, groups of women or to health and human service providers that engage high-need women.

2. **Providing for individual and/or group discussions about all methods of family planning and family planning services.**
   - Community Education and Outreach (Column 5) includes providing one-on-one and group sexuality education to women related to prevention of unintended pregnancy, birth spacing, the importance of family planning services and how to access services in their community. Also included are strategies aimed at engaging other health and human service providers in local efforts to support the prevention of unintended pregnancies, birth spacing, and promote the use of family planning services.

- Promotion of FPBP and FPEP (Column 6) One-on-one and group education on the Family Planning Benefit program and Family Planning Extension Program. Utilizing community health workers to encourage enrollment in FPBP and FPEP.

- Family Planning Information and Referral (Column 7) Arrange for tours of family planning clinics for hard to reach women. Implement web based data systems to support and coordinate referrals of high need women to family planning services. Utilize such systems for follow-up of missed appointments and necessary follow-up information/visits. Participate on community advisory groups with health and human service providers to discuss the importance of prevention of unintended pregnancy, birth spacing and utilization of family planning services.

3. Assisting with arranging visits to family planning provider.

- Community Education and Outreach (Column 5) includes conducting community outreach to identify specific barriers to utilization of family planning services.

- Promotion of FPBP and FPEP (Column 6) Enrollment of women into Family Planning Benefit Program and Family Planning Extension Program.

- Family Planning Information and Referrals (Column 7) includes referrals to a family planning provider, assistance with scheduling appointments, intake and the follow up of missed appointments, assisting with transportation arrangements. This may also include collaborating with community health care providers to address identified barriers to accessing family planning services.

TABLE A-2: Detailed Nonpersonal Services Budget Request

All NPS expenses for the MICHC program should be listed regardless of whether or not funding for these expenses is requested from New York State. In addition to Table A-2, please provide detail for information below in Form B-3 - Budget Narrative/Justification.

- In the top row of the heading, fill in the applicant name.

- In the first column , enter **all non-personal service line items** connected with MICHC.

- Include all items, regardless of funding source. Some examples of non-personal service items include (but are not limited to): Individual Subcontractors, Audit, Payroll Processing, Per Diem Staff, Equipment, Office Supplies, Program Supplies, Food/Refreshments, Staff Development Trainings, Participant Travel, Staff Travel, Advertising, Maintenance and Operations, and Media Development. Each line item should be easily identifiable, “Other” and “Misc” are not allowable line items.

- In columns 1 through 4 for each line item, indicate costs allocated to each activity. Please refer to the definitions under instructions for Table A-1 for each of the categories of activities related to Offering & Arranging for Family Planning Services to ensure accurate reporting.

- In column 5, enter costs allocated to items **not** related to offering and arranging of family planning services. The sum of columns 1 through 5 will equal the amount in column 6.

- In column 7, enter the amount of other sources of funds funding for each NPS item. This includes both “in kind” contributions and funds from all other sources.

- In column 8, enter the amount of funding requested from the State.

TABLE A-3 <u>"Offering and Arranging" Activities Summary</u>

- In the top row of the heading, fill in the applicant name.
- TOTAL PS: In the Total PS row refer to the detailed budget request for personal services Table A-1. Transfer the Corresponding amounts from the Total PS row.
- TOTAL Non personal Services: In the Total NPS row refer to the detailed budget request for non-personal services Table A-2. Transfer the Corresponding amounts from the Total NPS row.
- TOTAL NPS & PS: In the final row, add the Total NPS and Total PS in each column to produce the combined cost for personal and non personal services for the budget period.

BUDGET NARRATIVE/JUSTIFICATION FORMS

Use the Budget Narrative/Justification Forms to provide a justification/explanation for all the NPS expenses included in the Operating Budget and Funding Request. The justification should show all items of expense and the associated cost that comprise the amount requested for each budget category (e.g. if your total travel cost is $1,000, show how that amount was determined-client transportation costs, local staff travel etc.),and if appropriate, an explanation of how these expenses relate to the goals and objectives of the MICHC program. <u>All expenses should be justified, regardless of whether NYS funding is requested or not.</u>

FORM B-1: <u>Personal Services Detail</u>

Include the title, name of incumbent, and a description of duties for each position included on Budget Table A-1. Include all positions even if funding for the positions is not requested from NYS. Indicate if a position is currently vacant. A Project Coordinator who is qualified and accessible full-time for communications, including e-mail, and attending meetings with DOH along with other appropriate staff is required.

FORM B-2: <u>Fringe Benefit Detail</u>

Specify the components (FICA, Health and Life Insurance, Unemployment Insurance, Disability Insurance, Worker's Compensation, and Retirement) and their percentages comprising the fringe benefit rate, then total the percentages to show the fringe benefit rate used in budget calculations. Form B-2 already lists the standard components of a fringe benefit rate that are allowable under this contract. The fringe benefit rate used should be your agency-wide rate.

FORM B-3: <u>Non Personal Services Detail</u>

This page is to be used for detailed cost breakdowns of all NPS items. Please provide narrative/justification for each total expense item. Also, itemize and include a breakdown of cost per item/service for each total expense.

Examples of detail to provide under each category are:

Subcontracts/Consultants/Per Diems/Contractual Services - Provide a justification of why each service listed is needed. Justification should include the name of the consultant/contractor, the specific service to be provided and the time frame for delivery of services. Number of hours and rate of pay should be included for contractual staff. **You should submit a separate Sub Contractor Budget and Justification for each subcontractor.**

Equipment – Delineate each piece of equipment and estimated cost along with a justification of need. Equipment is defined as any item with a cost of $300 or more with a life expectancy of at least two years.

Specify which staff will use the equipment. Any equipment costing less than $300 should be grouped under Office Supplies/Materials.

Supplies/Materials – Provide justification of need and a breakdown for all items. (e.g. if your total expense is for education materials or office supplies, in addition to providing a narrative justification of need, provide a breakdown of each item as total # x cost per item = total expense for that item.)

Travel - Provide a delineation of expenses and justification of need for travel for training/ staff development and outreach and education. Provide estimated number of miles and include agency approved mileage rate.

Maintenance and Operations - Occupancy costs should include square foot value of space and total square footage.

Other - All other NPS expenses should be lined out separately under Other (i.e. telephone, postage, and advertising). Provide justification to support how the expense relates to the goals and objectives of the project. Program incentives are allowed, however, the amount is limited to 1% of the total amount requested from NYS. Agencies are encouraged to seek other sources of funding to support this expense.

FORM B-4: <u>Detail of Contractor Funds Supporting Initiative</u>

Provide detail of all Other Sources of Funds reported on Budget Table A - A-2. An In-kind donation is a contribution of time, service, or goods provided by your organization to support the operations or services of your MICHC program. Other sources may include other grants or cash donations. You should list all other-sources of income, and specify whether funds are state, local, or federal.

Attachment 11

APPENDIX B-__
NYSDOH - Maternal and Infant Health Initiative
Component A: Maternal Infant Community Health Collaborative
TABLE A
SUMMARY BUDGET REQUEST
July 1, 20__ - June 30, 20__

Applicant:________ **Attachment:____**

	Total Expense 1	Other Sources of Funds 2	Amount Requested From NYS 3
1. PERSONAL SERVICE Subtotal Personal Services (Totals only from Table A-1) Personal Services			
2. NONPERSONAL SERVICE Subtotal Nonpersonal Services (Totals only from Table A-2) Non Personal Services			
3. Grand Total			

4. OTHER SOURCES OF FUNDS DETAIL	
a. Applicant (Lead agency)	
I. Unrestricted Funds	
ii. In-Kind Contributions	
b. MIHI Subcontractors	
I. Unrestricted Funds	
ii. In-Kind Contributions	
c. Other Funds	
d. Total Other Sources of Funds (should equal Column 2, Grand Total, above)	0

Attachment 11

Federal funds are being used to support this contract. Code of Federal Domestic Assistance (CFDA) numbers for these funds are: Medicaid Match 93.778

Attachment 11

APPENDIX B-__

NYSDOH - Maternal and Infant Health Initiative

Component A: Maternal Infant Community Health Collaborative

TABLE A-1

DETAILED PERSONAL SERVICE BUDGET REQUEST

July 1, 20__ - June 30, 20__

Applicant: ____________ **Attachment:**____

Personal Service Items[1]	Incumbent Name	Annual Salary Rate	# Mos	% FTE Time on Project	Activities Related to Offering & Arranging For Family Planning Services				Activities Not Related to Offering & Arranging for FP Services	Total Expense	Other Sources of Funds	Amount Requested From NYS
					Comm. Ed & Outreach	Promotion of FPBP & FPEP	FP Information & Referral	Other Offer & Arranging Activities				
1	1	2	3	4	5	6	7	8	9	10	11	12
(example: Outreach Worker)	*Mary Smith*	*35,000*	*12*	*50.00%*	*1,750.00*	*875.00*	*1,750.00*	*0.00*	*13,125.00*	*17,500.00*	*4,000.00*	*13,500.00*
Subtotal Personal Service					0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Fringe Benefits Rate:	**0**											
Total Personal Service					0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Attachment 11

APPENDIX B-__
NYSDOH - Maternal and Infant Health Initiative
Component A: Maternal Infant Community Health Collaborative

TABLE A-2
DETAILED NONPERSONAL SERVICE BUDGET REQUEST
July 1, 20__ - June 30, 20__

Applicant:__________________ **Attachment:____**

Nonpersonal Services (NPS)	Activities Related to Offering & Arranging For Family Planning Services				Activities Not Related to Offering & Arranging for FP Services	Total Expense	Other Sources of Funds	Amount Requested From NYS
	Comm. Ed & Outreach	Promotion of FPBP & FPEP	FP Information & Referral	Other Offer & Arranging Activities				
	1	2	3	4	5	6	7	8
1. Subcontracts/Consultants/Per Diems/Contractual Services								
2. Supplies & Materials								
3. Equipment								

Attachment 11

4. Travel								
5. Operating Expenses								
6. Other								
Total NonPersonal Service	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Attachment 11

APPENDIX B-__
NYSDOH - Maternal and Infant Health Initiative
Component A: Maternal Infant Community Health Collaborative
TABLE A-3
"Offering and Arranging" Activities Summary
July 1, 20__ - June 30, 20__

Applicant: **Attachment:____**

	Activities Related to Offering & Arranging For Family Planning Services				Activities Not Related to Offering & Arranging for FP Services	Total Expense	Other Sources of Funds	Amount Requested From NYS
	Community Education & Outreach	Promotion of FPBP & FPEP	FP Counseling & Referral	Other Offer & Arranging Activities				
	1	2	3	4	5	6	7	8
Total Personal Service (PS)								
Total NPS								
Total NPS & PS								

APPENDIX B-__

NYSDOH - Maternal and Infant Health Initiative
Component A: Maternal Infant Community Health Collaborative

FORM B-1

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
PERSONAL SERVICES
July 1, 20__ - June 30, 20__

Applicant: ______________________________ **Attachment:**____

PERSONAL SERVICES

Title	Incumbent	Description

NYSDOH - Maternal and Infant Health Initiative
APPENDIX B-__
Component A: Maternal Infant Community Health Collaborative
FORM B-2
BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FRINGE BENEFITS
July 1, 20__ - June 30, 20__

Applicant: ____________________ **Attachment:**____

FRINGE BENEFITS

Component	Rate
FICA Health/Life Insurance Unemployment Insurance Disability Insurance Worker's Compensation Retirement	
TOTAL FRINGE BENEFIT RATE*	0.00%

*This amount should equal the percentage used in budget calculations.

Attachment 11

APPENDIX B-__

NYSDOH - Maternal and Infant Health Initiative

Component A: Maternal Infant Community Health Collaborative

FORM B-3

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT

NONPERSONAL SERVICES

July 1, 20__ - June 30, 20__

Applicant: ________________________________ **Attachment:**____

NONPERSONAL SERVICES

Item	Total Expense	Description
1. Subcontracts/Consultants/Per Diems/Contractual Services		
2. Supplies & Materials		
3. Equipment		
4. Travel		
5. Operating Expenses		
6. Other		

Appendix B-1
NYSDOH - Maternal and Infant Health Initiative
Component A: Maternal Infant Community Health Collaborative
FORM B-4
DETAIL OF APPLICANT FUNDS

1/01/2013 - 12/31/2013

Applicant:

Attachment:____

DETAIL OF APPLICANT FUNDS

SOURCE OF FUNDS		AMOUNT
In-kind contributions (list the expense(s) being supported)		
Other Sources, please specify source(s)		
	TOTAL	$0

APPENDIX B-__
NYSDOH - Maternal and Infant Health Initiative
Component A: Maternal Infant Community Health Collaborative

July 1, 20__ - June 30, 20__

Compressed Sub Contractor Budget

Applicant: _______________ - _______ - _______ **Attachment:____**

SubContractor: _______________

Personal Services	Annual Salary Rate	# Mos	% Time	Total Expense	Other Sources of Funds	Amount Requested from NYS
Subtotal(PS)				**0.00**	**0.00**	**0.00**
FRINGE				0.00		
Total Personal Service				***0.00***	***0.00***	***0.00***

Nonpersonal Services (NPS)

Subtotal, NPS	**0.00**	**0.00**	**0.00**
Grand Total	**0.00**	**0.00**	**0.00**

NYSDOH -Component A: Maternal Infant Community Health Collaborative		
Compressed Sub Contractor Budget		
Applicant:		**Attachment:____**
SubContractor:		
PERSONAL SERVICES		
Title	**Incumbent**	**Description**
NONPERSONAL SERVICES		
Item	**Total Expense**	**Description**

FRINGE BENEFITS

Component	Rate	
FICA		
Health/Life Insurance		
Unemployment Insurance		
Disability Insurance		
Worker's Compensation		
Retirement		
TOTAL FRINGE BENEFIT RATE*	0.00%	

*This amount should equal the percentage used in budget calculations.

References/Resources for Quality Improvement (QI) Models in Public Health Practice

Institute for Healthcare Improvement

- http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

National Network of Public Health Institutes (NNPHI) QI Toolkit

- http://nnphi.org/tools/public-health-performance-improvement-toolkit-static/quality-improvement

Public Health Foundation QI Quick Guide & PM/QI Resource

- http://www.phf.org/quickguide/Content1Panel.aspx
- http://www.phf.org/focusareas/pmqi/pages/default.aspx

Michigan's QI Guidebook

- http://www.mphi.org/pubs/Michigans_QI_Guidebook.pdf

NICHQ and The MFI

- http://www.nichq.org/how_we_work/model_for_improvement.html

MFI Video Demonstration

- http://www.youtube.com/watch?v=SCYghxtioIY

Journal of Public Health Management & Practice: February 2012 Issue on QI in Public Health

- http://journals.lww.com/jphmp/pages/default.aspx

States of Change: Stories of Transformation in Public Health

- http://www.turningpointprogram.org/Pages/pdfs/storybook_pdfs/tp_storybook.pdf

NYSDOH Bureau of Maternal and Child Health
Community Health Worker Standards

The Maternal and Infant Community Health Collaborative will support staffing for a team of Community Health Workers (CHS) and a Community Health Worker Coordinator.

Community Health Worker (CHW)

Under the supervision of the CHW Coordinator, the CHW duties and responsibilities include:

- Identify and assist individuals and families to access needed preventive and primary health care services (e.g., preconception care, family planning, prenatal care, immunization, pediatric care and care for acute, chronic, and communicable diseases, Early Intervention, WIC and other nutrition services, interconception care), with an emphasis on pregnant women not enrolled in health care or supportive services;
- Provide assistance and/or referrals to obtain other essential support services such as housing, financial aid, food stamps, emergency food, clothing, transportation, translation, and child care;
- Conduct basic health assessments, assists families to identify needs, provides basic health information, and make appropriate referrals through monthly home visits;
- Provide advocacy, support and follow-up to determine if services are received and assist families with health behavior changes; and
- Provide home visiting services to approximately 25 clients at any given time (40 annually) and an additional 10-15 intermittent clients (clients who do not need intensive case management, but referrals to a community resource or service).

CHW Qualifications:

- Indigenous community resident of the targeted area;
- Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms;
- Bilingual skills, depending on the community and families being served;
- Knowledge of the community, community organizations, and community leaders;
- Ability to work flexible hours, including evening and weekend hours.

Community Health Worker Coordinator

A full-time coordinator will be responsible for the supervision of a team of 4-6 community health workers. Duties and responsibilities include:

- Plan and coordinate outreach, supervise individual and family assessments, assess training needs and provide health education, home visiting, and service coordination performed by Community Health Workers;
- Develop, in conjunction with the coordinating agency, an overall work plan, including outreach strategies for the in the targeted geographic area;
- Conduct community and public education sessions to promote initiative or program, including prenatal, preconception, and interconception health;
- Establish relationships with other community health and human service providers; and
- Prepare required reports and other written material regarding program implementation and activities.

Qualifications:

- A Public Health Nurse (PHN) or Registered Nurse with a Bachelors Degree in Nursing (BSN) or a Licensed Clinical Social Worker (LCSW) with experience in public health, community organization, and clinical case management (focused on individual and family); and experience with supervision and program management.
- Familiarity with the geographic area and the population to be served;
- Ability to work flexible hours, including some evening hours.

CHW Training

Community Health Workers (CHWs) are responsible for performing a variety of tasks, including outreach to find high-need women, helping mothers and infants enroll in health insurance and obtain primary, preventive and prenatal care, and providing basic health education. CHW's attend training provided by the Maternal and Infant Health - Center of Excellence, on these work related topics, confidentiality, performing an effective home visit, and skills building techniques, such as setting boundaries, outreach strategies, communication skills, cultural competency, and using a positive, strength-based approach.

The CHW Coordinator, trains the CHWs on in-house procedures and day-to-day protocol, as well as the following maternal and child health topics: female reproduction, the stages of pregnancy, the post-partum period, caring for a newborn, risks for poor birth outcomes, and maintaining healthy behaviors during the preconception and interconception periods. The coordinator's training also addresses special topic areas to assist CHWs in working with high-need clients, including domestic violence, mental health, substance use, and clients in crisis.

Family Resource Centers funded by New York State Office of Children and Family Services as of 2/2012.

Broome County

Mothers & Babies Perinatal Network of South Central New York
Sharon Chesna, Executive Director
Linda Ruffo, Director of Family Resource Centers
lruffo@mothersandbabies.org

- Parents As Leaders (PAL) Family Resource Center

457 State Street
Binghamton, NY 13901
607-771-6334
Sadie Purdy, Program Coordinator
Mary Kelly, Program Coordinator
palbinghamton@mothersandbabies.org

Clinton, Essex, and Franklin Counties

Child Care Coordinating Council of the North Country
Jamie Basiliere, Executive Director
Juliette Lynch, Coordinator of Parent Education

- Family Connections

PO Box 2640
Plattsburgh, NY 12901
518-561-4999, 1-800-540-2273
Laurie Booth-Trudo, Coordinator
lboothdtrudo@primelink1.net

- Family Matters

Holy Ghost Elementary School
40 Marion Street
Tupper Lake, NY 12986
518-359-8167, 1-800-540-2273
Donna Tanner, Coordinator
donnatnnr2@gmail.com

- Families First, Inc.

Box 565
Elizabethtown, NY 12932
1-800-894-7504, 518-873-9544 x 27
Robin Nelson, Coordinator
rnelson@rnelson@familiesfirstessex.org

- Families R Us Resource Center

24 Fourth Street
Malone, NY 12953
518-481-7281
Diana Grant, Coordinator familiesrus@westelcom.com

Cortland County

Cornell Cooperative Extension of Cortland County
60 Central Avenue
Cortland, NY 13045
607-753-5077
Shawn Smith, CCE Youth & Family Issues Leader
scs239@cornell.edu

- Family Fun & Resource Center

29 Main Street
Cortland, NY 13045
607-753-1351
Nancy Faist Hart, Coordinator nfh2@cornell.edu

Fulton and Montgomery Counties

Catholic Charities of Fulton and Montgomery Counties

- The Family Room/Un Centro Para Familias

1 Kimball Street
Amsterdam, NY 12010
518-842-4202 x 3132
Blanca Tristani, Coordinator blanca.tristani@cc-fmc.org
Heather Dery, Assistant Heather.dery@cc-fmc.org

Jefferson and St. Lawrence Counties

North Country Prenatal/Perinatal Council
200 Washington Street, Suite 300
Watertown, NY 13601
315-788-8533, Ext. 231
Tina Cobb, Youth Services Director tcobb@ncppc.org

- Gouverneur Activity and Learning Center

68 West Main Street
Gouverneur, NY 13642
315-287-1315
Shannon Streeter, Coordinator sstreeter@ncppc.org

Monroe County

Crestwood Children's Center
(Hillside Family of Agencies)

- Southwest Family Resource Center

89 Genesee Street
Bishop Kearney Building – 2nd Floor
Rochester, NY 14611
585-436-0370 x 312
Mary Jo Brach, Service Director mbrach@hillside.com
April Baker, Family Development Coordinator
arbaker@hillside.com
Wyn Frechette, Peer Review Consultant
585-467-7644 wfrechette@rochester.rr.com

(listing continued on next page)

- Peter Castle Family Resource Center

555 Avenue D
Rochester, NY 14621
585-339-3200, 585-339-3214
Linda James Ljames@hillside.com

New York City

Association to Benefit Children (ABC)

- ABC Family Resource Center

1841 Park Avenue
New York, NY 10035
646-459-6149
Marie Nguyen, Director mnguyen@a-b-c.org
LaTonya Givens, Coordinator lgivens@a-b-c.org

Chinese-American Planning Council

- CPC Family Resource Center

165 Eldridge Street
New York, NY 10002
Central Office: 212-941-0920
FRC: 212-941-0030 x250
Jin Feng Jiang, Coordinator jjiang@cpc-nyc.org
Angela Lo, Supervisor alo@cpc-nyc.org

Phipps Community Development Corporation

- FRC – The Family Room

1030 East 178th Street
Bronx, NY 10460
718-542-0109 x5006
Yolanda Briu, Coordinator ybriu@phipps.org
Ana Ventura, Program Assistant aventura@phippsny.org
Amber Cartwright, Director of Early Childhood Programs
ACartwright@phippsny.org

Niagara County

Niagara Falls School District Family Resource Centers
4455 Porter Road
Niagara Falls, NY 14305
716-286-0745
Susan Ross, Director sross@nfschools.net
716-286-4255
Terri Hickey, Field Supervisor thickey@nfschools.net

Ontario and Yates Counties

Child and Family Resources, Inc.
263 Lake Street
Penn Yan, NY 14527
315-536-1134
Julie Champion, Exec. Dir. julie.champion@cfresources.org

Geneva Resource Center
41 Lewis Street
Geneva, NY 14456 , Suite 103
315-781-1491
Dawn Waite, Coordinator dawn.waite@cfresources.org

Steuben and Yates Counties

ProAction of Steuben & Yates, Inc.
Steuben Family Enrichment Collaborative
117 E. Steuben St., Suite 11
Bath, NY 14810
607-776-2125
Dawn Brucie, Deputy Director brucied@proactioninc.com
Wendy Robords, Supervisor robordsw@proactioninc.com

- Woodhull Community Resource Center

PO Box 116
Woodhull Town Hall
Woodhull, NY 14898
607-458-5164
Krystal Watkins, Coordinator wfrc@zoominternet.net

- Jennie Mose Family Resource Center

7 Cleveland Drive
Addison, NY 14801
607-359-3839
Karen Sweeney, Director kasweeney@addisoncsd.org

- Nonnie Hood Parent Resource Center

300 Civic Center Plaza, Suite 200
Corning, NY 14830
607-936-3837
Kimberly Townson, Exec. Dir. ktownson@nonniehoodprc.org

Tioga County

Cornell Cooperative Extension of Tioga County
Family Resource Centers of Tioga
56 Main Street
Owego, NY 13827
607-687-4020
Judith Rae Wolf, Family Development Team Coordinator
jrw19@cornell.edu

- Incredible Years at Home

56 Main Street
Owego, NY 13827
607-687-4020
Jackie Spencer, Parenting Educator jds77@cornell.edu

- Owego Family Resource Center

72 North Avenue
Owego, NY 13827
(mailing address is 56 Main St)
607-687-1571
Donna Gibson, Coordinator dlv22@cornell.edu

- Waverly Family Resource Center

374 Broad Street
Waverly, NY 14892
607-565-2374
Joan Shultz, Coordinator jes49@cornell.edu

Child Care and Referral Agencies

Attachment 15

Albany
Capital District Child Care Coordinating Council, Inc
Ms. Patricia A. Skinner, Executive Director
91 Broadway
Menands, NY 12204
Phone: (518) 426-7181 x 327
Fax: (518) 426- 9649
Email: pskinner@cdcccc.org
Website: www.cdcccc.org

ALLEGANY
Allegany County Community Opportunities and Rural Development, Inc. (Accord)
Charles T. Kalthoff, Executive Director
Ms. Susan Belmont, Child Care Division Director
PO Box 573, 84 Schuyler Street
Belmont, New York 14813
Phone: (585) 268-7605
Fax: (585) 365-2749
Email: sbelmont@accordcorp.org
Website: www.accordcorp.org

Broome
Family Enrichment Network, Inc.
Mr. Darrell Newvine, Executive Director
Jennifer Perney, CCR&R Director
24 Cherry Street
Johnson City, New York 13790
Phone: (607) 723-8313 x 835
Fax: (607) 723-6173
Email: jperney@familyenrichment.cc
Website: www.familyenrichment.cc

Cattaraugus
Allegany County Community Opportunities and Rural Development, Inc. (Accord)
Charles T. Kalthoff, Executive Director
Ms. Susan Belmont, Child Care Division Director
PO Box 573, 84 Schuyler Street
Belmont, New York 14813
Phone: (585) 268-7605
Fax: (585) 365-2749
Email: sbelmont@accordcorp.org
Website: www.accordcorp.org

Cayuga
Child Care Solutions, Inc.
Peggy Liuzzi, Executive Director
Auburn office:
Custom Business Services Suite
360 Grant Avenue
Auburn, NY 13021
Office hours Tues. & Thurs.
Contact main office (Syracuse) for more information.
Phone (315) 446-1220
Fax (315) 446-2010
Find child care: ParentHelp@childcaresolutionscny.org
Website: www.childcaresyracuse.org

Chautauqua
Chautauqua Opportunities, Inc.
Ms. Roberta Keller, Executive Director
Ms. Bonnie Scott-Sleight, CCR&R Director
17 West Courtney Street
Dunkirk, NY 14084
Phone: (716) 366-3333
Fax :(716) 366-7366
or
402 Chandler Street
Jamestown, NY 14701
Phone: (716) 661-9430 x260
Fax:(716) 661-9436
Email: childcare@chautopp.org
Email: bsleight@chautopp.org
Website: **www.chautauquaopportunities.com**

Chemung
Chemung County Child Care Council, Inc.
Ms. Ruth Krusen, Director
571 St. Joseph's Blvd. – Suite 205
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Child Care and Referral Agencies

Attachment 15

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Delaware
Delaware Opportunities, Inc.
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Dutchess
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Child Care and Referral Agencies

New York City
Child Care, Inc.
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Ms. Rhonda Carloss Smith, Associate Executive Directive
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Email: rsmith@centerforchildrensinitiatives.org; or nkolben@centerforchildrensinitiatives.org
Website: http://www.centerforchildrensinitiatives.org
www.nycchildcareconsortium.org

New York City
Child Development Support Corporation
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Ms. Anita Franklin, Director of Child Care Services
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New York City
Chinese American Planning Council, Inc.
Counties Served: New York City
David Chen, Executive Director
Judy Ah-Yune, Director of Community Services
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Fax: (212) 226-5351
Email: dschen@cpc-nyc.org or jah-yune@cpc-nyc.org
Website: www.childcarecpc.org
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New York City
Committee for Hispanic Children & Families, Inc.
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New York City
Day Care Council of New York, Inc.
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Child Care and Referral Agencies

Attachment 15

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Attachment 16

Examples of Measures for Monitoring Quality and Impact of Maternal and Infant Health Strategies

Measure	Level of Measurement	Reference
Enrollment in Health Insurance (PS#1)		
Percent of women enrolled in health insurance: • Prenatal • Postpartum • Interconception	Individual/Family Organizational	NYS MIECHV CHW
Percent of children enrolled in health insurance	Individual/Family Organizational	NYS MIECHV CHW
Percent of children without health insurance	Community	MCHSBG (NPM 13) CHW
Outreach and Engagement in Health and Supportive Services (PS #2)		
Frequency of ongoing prenatal care: percentage of MA deliveries that received ≥ 81 percent of expected visits	Organizational	NCQA/HEDIS NYS QARR
Frequency of ongoing prenatal care: percent of women age 15-44 with a live birth whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuk index	Community	MCHSBG (HSC 04, 05D)
Timeliness of prenatal care: percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization	Organizational	NCQA/HEDIS NYS QARR
Timeliness of prenatal care: percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	Community	MCHSBG (HSC 05C, NPM 18) NYS MIECHV CHW
Timeliness of postpartum care: percentage of deliveries that had a postpartum visit on or between 21-56 days after delivery	Organizational	NCQA/HEDIS NYS QARR CHW
Well Child Care: percent of children with 5+ well child health visits in first 15 months of life	Organizational	NYS QARR NYS MIECHV
Well Child Care: percent of MA	Community	MCHSBG (HSC 02)

enrollees less than age one year who received at least one initial periodic screen		CHW
Well Child Care: percent of MA-enrolled children between the ages of three and six years who had a well-child and preventive health visit in the past year	Organizational Community	NYS QARR MCHSBG (SPM 02) CHW
Preconception Care: percent of women with preventive or family planning visit within 12 months prior to conception	Individual/Family Organizational	NYS MIECHV
Interconception Care: percent of women who received a primary/preventive health care visit > 8 weeks postpartum	Individual/Family Organizational	NYS MIECHV
Risk Identification and Follow-up (PS #3)		
Prenatal care screening and accurate gestational age	Individual/Client Organizational	PCPI Maternity Care Work Group
Behavioral risk assessment - Prenatal screening for: • Alcohol use • Tobacco use • Other substance abuse • Depressive symptoms • Domestic violence	Individual/Client Organizational	PCPI Maternity Care Work Group NYS MIECHV CHW
BMI Assessment and plan of care for patients with BMI > 30	Individual/Client Organizational	PCPI Maternity Care Work Group
Care coordination: prenatal care record present at time of delivery	Individual/Client Organizational	PCPI Maternity Care Work Group
Post-partum follow-up	Individual/Client Organizational	PCPI Maternity Care Work Group CHW
Opportunities and Supports for Healthy Behaviors (PS#4)		
Percent of women who smoke in the last three months of pregnancy	Community	MCHSBG (NPM 15)
Alcohol use: • Prenatal • Postpartum • Interconception	Individual/Family Organizational	NYS MIECHV CHW
Tobacco use: • Prenatal • Postpartum • Interconception	Individual/Family Organizational	NYS MIECHV CHW

Other Substance use: • Prenatal • Postpartum • Interconception	Individual/Family Organizational	NYS MIECHV CHW
Percent of infants who were exclusively fed breast milk in the delivery hospital	Community	MCHSBG (SPM 10) CHW
Percent of mothers who breastfeed their infants at 6 months of age	Community	MCHSBG (NPM 11) CHW
Percent of mothers who breastfeed their infants at: • Birth, • 6 months • 12 months • 18 months • 24 months	Individual/Family Organizational	NYS MIECHV CHW
Percent of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile	Community	MCHSBG (NPM 14)
Interpregnancy Interval	Individual/Family Organizational	NYS MIECHV
Health Outcomes		
Risk-adjusted LBW: The percentage of live infants weighing less than 2,500 grams among all deliveries by women continuously enrolled in a plan for 10 or more months.	Organizational	NYS QARR
Percent of low birth weight (< 2,500 grams) and very low birth weight (<1,500 grams)	Community	MCHSBG (HSC 05A, HSI 01A and 02A) CHW
Ratio of Black infant low birth weight rate to the White infant low birth weight rate	Community	MCHSBG (SPM 03)
Preterm Birth	% live births < 37 weeks gestations	MCHSBG
Infant Mortality Rate: Infant deaths per 1,000 live births	Community	MCHSBG (HSC 05B, HSI 08A)

Key:
CHW- Community Health Worker
HSC- Health System Capacity
MIECHV- Maternal, Infant and Early Childhood Home Visiting
MCHSBG- Maternal and Child Health Services Block Grant
NCQA/HEDIS- National Committee for Quality Assurance/Health Plan Employer Data and Information Set
NPM- National Performance Measure
NYS QARR- New York State Quality Assurance Reporting Requirements
PCPI- Physician Consortium for Performance Improvement
SPM- State Performance Measure

Maternal Infant and Childhood Home Visiting (MIECHV) Grantees

Attachment 17

Projects Funded in Phase 1 of NYS MIECHV Initiative as per State Plan

COUNTY	PROGRAMS
Monroe	**Monroe County Department of Health** **Nurse Family Partnership** 691 Saint Paul Street 4th Floor Rochester, NY 14605
Bronx	**Catholic Guardian Home Bureau** **Healthy Families Parkchester** 1990 Westchester Avenue Bronx, NY 10462 718-828-0300 ext. 225
	Bronx Lebanon Hospital **South Bronx Healthy Families New York** 1650 Selwyn Avenue Suite 5h Bronx, NY 10466 718-960-2084
	Morris Heights Health Center **Healthy Families Morris Heights** 85 West Burnside Avenue Bronx, NY 10453 718-483-1253
	New York City Department of Health and Mental Hygiene **Nurse Family Partnership** 2 Lafayette Street Floor 8 New York, NY 10007 646-672-2892
Erie	**Buffalo Prenatal-Perinatal Services Network** **Buffalo Healthy Families** 625 Delaware Avenue Suite 410 Rochester, NY 14605 716-884-6711

Evidence-based Home Visiting Models – New York State Contacts

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Healthy Families America
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Healthy Families New York
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Healthy Steps
Sheila Darling
Lifetime Care
585-339-4016
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Home Instruction for Parents of Preschool Youngsters (HIPPY)
Ann Marchetti
HIPPY USA
508-468-5156
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Nurse Family Partnership (NFP)
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Parent as Teachers (PAT)
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Nurse Family Partnership Model Elements*

The Nurse-Family Partnership Model Elements are supported by evidence of effectiveness based on research, expert opinion, field lessons, and/or theoretical rationales. When the program is implemented in accordance with these Model Elements, Implementing Agencies can have a high level of confidence that results will be comparable to those measured in research. The 18 NFP Model Elements are:

Clients

- Element 1: Client participates voluntarily in the Nurse-Family Partnership program.
- Element 2: Client is a first-time mother.
- Element 3: Client meets low-income criteria at intake.
- Element 4: Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy.

Intervention context

- Element 5: Client is visited one-to-one, one nurse home visitor to one first-time mother or family.
- Element 6: Client is visited in her home.
- Element 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership guidelines.

Expectations of the nurses and supervisors

- Element 8: Nurse home visitors and nurse supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing.
- Element 9: Nurse home visitors and nurse supervisors complete core educational sessions required by the Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the Nurse-Family Partnership model.

Application of the intervention

- Element 10: Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.
- Element 11: Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods.
- Element 12: A full-time nurse home visitor carries a caseload of no more than 25 active clients.

Reflection and clinical supervision

- Element 13: A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors.
- Element 14: Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision.

Program monitoring and use of data

- Element 15: Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership National Service Office and use Nurse-Family Partnership reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.

Agency

- Element 16: A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.
- Element 17: A Nurse-Family Partnership Implementing Agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.
- Element 18: Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.

*Nurse Family Partnership – Implementation Overview and Planning: A Guide for Prospective Nurse-Family Partnership Implementing Agencies, October 2010; http://www.nursefamilypartnership.org/assets/PDF/Policy/HV-Funding-Guidance/NFP_Overview_Planning last accessed April 13, 2012.

Healthy Families America Model Critical Elements

The Healthy Families America Model Critical Elements ensure that a home visitation program is following best practice standards as established by over 20 years of research into what really works in intensive home visitation. The critical elements represent the field's most current knowledge about how to implement successful home visitation programs.

Service Initiation
Initiate services prenatally or at birth.

Use a standardized (i.e. in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e. social isolation, substance abuse, parental history of abuse in childhood).

Offer services voluntarily and use positive outreach efforts to build family trust.

Service Content
Offer services intensively (i.e. at least once a week) with well-defined criteria for increasing or decreasing frequency of service and over the long-term (i.e. three to five years).

Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.
Services should focus on supporting the parent as well as supporting parent-child interaction and child development.

At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g. timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (i.e., for many communities no more than 15 families per home visitor on the most intense service level. And, for some communities the number may need to be significantly lower, e.g. less than 10).

Staff Characteristics
Service providers should be selected because of their personal characteristics (i.e. non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

Service providers should have a framework, based on education or experience, for handling the variety of situations they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.

Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e. identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.).

Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout.

	Construct	Performance Measure	Improvement Definition	Measurement Metric	Measurement Tool/Instrument and Source	Data Collection Schedule for Reporting	Target Population (Comparison Type)	Notes/Justification
Benchmark 1: Improved Maternal and Newborn Health								
1.1	Prenatal Care	Percent of women who report receiving their first prenatal care visit during their first trimester of pregnancy. (Systems Indicator)	The percent of women receiving their first prenatal care visit during their first trimester of pregnancy will increase from Year 1 cohort to Year 2 cohort.	N: # of enrolled women who report having received their first prenatal visit during their first trimester of pregnancy.	HFNY: Target Child Identification Information and Birth Outcomes Form (see note 1.1.1)	HFNY: At enrollment, or at subsequent home visit if prenatal care not initiated before intake	All enrolled women. (Cohort comparison based on year of enrollment, comparing Year 1 and Year 2 cohorts [For all comparisons Year 1 lasts 6 months from date of first enrolled client, Year 2 lasts 12 months from end of Year 1])	Systems Indicator of community access to/use of early prenatal care.
				D: # of enrolled women who were asked when they began prenatal care.	NFP: Client report on Maternal Health Assessment Form (see note 1.1.2)	NFP: At Intake, or at subsequent home visit if prenatal care not initiated before intake		
1.2	Parental Use of Alcohol, Tobacco, or Illicit Drugs	Percent of women who are screened for alcohol abuse at intake. (Process Measure)	The percent of women who are screened for alcohol abuse at intake will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of enrolled women screened for alcohol abuse at intake	HFNY: AUDIT-C (See note 1.2.1)	HFNY: Collect at assessment. Report at intake	All enrolled women. (Cohort comparison based on year of enrollment, comparing Year 1 and Year 2 cohorts)	Aim to verify women are screened for alcohol abuse upon entry into the program.
				D: # of enrolled women	NFP: Client report on Health Habits Form (See note 1.2.2)	NFP: At Intake, Pregnancy 36 weeks and Infancy 12 months. Report for intake.		
1.3	Preconception Care	Percent of women receiving a health care visit after 8 weeks postpartum and before any subsequent pregnancy. (Outcome measure)	The percent of women who received a health care visit after 8 weeks postpartum and before any subsequent pregnancy will increase from Year 1 cohort to Year 2 cohort.	N: # of enrolled women who report having received a health care visit after 8 weeks postpartum and before any subsequent pregnancy	HFNY: Primary Caretaker 1 Medical Information Form (see note 1.3.1)	HFNY: Every home visit.	All enrolled women who are beyond 8 weeks postpartum and not currently pregnant (Cohort comparison based on year of enrollment, comparing Year 1 and Year 2 cohorts)	Aim to capture general health care visits and omit prenatal or postpartum care visits by considering women who are beyond 8 weeks postpartum and who do not currently have a subsequent pregnancy.
				D: # of enrolled women who are beyond 8 weeks postpartum and who are not pregnant	NFP: Client report on Use of Government and Community Resources Form (see note 1.3.2)	NFP: Collect at Infancy 6, 12, 18 and 24 months (only doctor's visits after birth of first child are counted).		
1.4	Inter-birth Interval	Percent of postpartum women who received instruction about optimal birth spacing or family planning during at least one home visit before 6 months postpartum. (Process measure)	The percent of women who received instruction about optimal birth spacing or family planning after the birth of the target child and before 6 months postpartum will increase from Year 1 cohort to Year 2 cohort.	N: # of postpartum enrolled women who received instruction about optimal birth spacing or family planning before 6 months postpartum	HFNY: Home Visit Log (see note 1.4.1)	HFNY: Activities recorded at every home visit	All postpartum enrolled women. (Cohort comparison based on year of enrollment, looking at women who are 6 months postpartum, comparing Year 1 and Year 2 cohorts)	Aim to capture delivery of family planning and optimal birth-spacing information to postpartum women. [NFP: Will require custom data collection at MIECHV sites to record education activities related to optimal birth spacing and family planning.]
				D: # of enrolled women at 6 months postpartum	NFP: Demographics Update Form (see note 1.4.2)	NFP: Activities recorded at every home visit.		

1.5	Screening for Maternal Depressive Symptoms	Percent of women who are screened for depression at intake. (Process Measure)	The percent of women screened for depression at intake will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of enrolled women screened for depression at intake	HFNY: Patient Health Questionnaire-9 (PHQ-9) (see note 1.5.1)	HFNY: Collect at assessment. Report at intake	All enrolled women. (Cohort comparison based on year of enrollment, comparing Year 1 and Year 2 cohorts)	This construct is complimentary to construct 3.4 (Parent emotional well-being and stress). Here we quantify frequency of screening, #3.4 assesses the frequency of referrals issued for positive screens.
				D: # of enrolled women	NFP: Client report using the PHQ-9 (see note 1.5.1)	NFP: Required at Pregnancy 36 weeks, Infancy 1-8 weeks, Infancy 4-6 months, Infancy 12 months (optional at other times). Reported at intake		
1.6	Breastfeeding	Percent of women enrolled prenatally who report after the birth of the target child that they initiated breastfeeding. (Outcome Measure)	The percent of women enrolled prenatally reporting after the birth of the target child that they initiated breastfeeding will increase from Year 1 cohort to Year 2 cohort.	N: # of women who report initiating breastfeeding after the birth of the target child	HFNY: Target Child Identification Information and Birth Outcomes Form, Follow-up Form, (See note 1.6.1)	HFNY: (1) Birth of TC or enrollment and 2) TC age - 6m, 1y, 2y, 3y, 4y, 5y and Discharge), report at target child's birth	All women enrolled prenatally. (Cohort comparison based on year of enrollment, looking at women who have given birth to the target child, comparing Year 1 and Year 2 cohorts)	Women enrolled prenatally considered only to attribute change to program impact. Plan to collect but not report breastfeeding to 6 months and exclusive breastfeeding to 3 months.
				D: # of women enrolled prenatally asked about breastfeeding at target child's birth	NFP: Client report on Infant Birth Form (See note 1.6.2)	NFP: At Infant's Birth and at Infancy 6, 12, 18 and 24 months, report at target child's birth		
1.7	Well-child Visits	Percent of target children enrolled by birth who had four or more well-child and preventive health visits in their first 12 months of life. (Outcome Measure)	The percent of target children who have had four or more well-child and preventive health visits by age 12 months will increase from Year 1 cohort to Year 2 cohort.	N: # of target children who had four or more well-child and preventive health visits by age 12 months.	HFNY: Target Child Medical Information Form (See note 1.7.1)	HFNY: On-going collection, at each home visit. Report total at 12 months	All target children already enrolled at birth and who are 12 months old. (Cohort comparison based on year of enrollment, looking at target children who have reached 12 months of age, comparing Year 1 and Year 2 cohorts)	Based on QARR metric (Medicaid Managed Care performance measure), but adjusted to fit MIECHV reporting timeline
				D: # of target children enrolled by birth who are age 12 months	NFP: Client report on Infant Health Care Form (See note 1.7.2)	NFP: At Infancy 6, 12, 18 and 24 months. Report total at 12 months		
1.8	Maternal and Child Health Insurance Status	Percent of enrolled postpartum women and target children who report having some form of health insurance (Medicaid, PCAP, Child Health Plus, private, other) when the target child reaches 6 months of age. (Outcome Measure)	The percent of enrolled postpartum women and children who report having some form of health insurance when the target child reaches 6 months of age will increase from Year 1 cohort to Year 2 cohort.	N: total # of enrolled postpartum women and target children who report having health insurance	HFNY: Intake Form, Target Child Identification Information and Birth Outcomes Form, Follow-up Form (See note 1.8.1)	HFNY: Maternal: Enrollment; TC age - 6m, 1y, 2y, 3y, 4y, 5y; and Discharge Target Child: At Birth or Enrollment; and TC age - 6m, 1y, 2y, 3y, 4y, 5y and Discharge, report at TC age 6 months	All enrolled postpartum mothers with a 6-month-old enrolled child and target children at 6 months of age (Cohort comparison based on year of enrollment, looking at postpartum woman and 6-month-old target child pairs, comparing Year 1 and Year 2 cohorts)	Looking only at enrolled women when their child reaches 6 months of age and target children at 6 months of age. Intended to capture dyads that are still insured after the 60-day postpartum MA coverage. Complimentary to construct #5.3 that assess continuity of insurance coverage to 12 months postpartum.
				D: total # of enrolled postpartum women with enrolled child at 6 months of age and target children at 6 months of age	NFP: Client report on Use of Government and Community Resources Form (See note 1.8.2)	NFP: At Intake, Infant's Birth, Infancy 6, 12, 18 and 24 months, report at TC age 6 months		

	Construct	Performance Measure	Improvement Definition	Measurement Metric	Measurement Tool/Instrument and Source	Data Collection Schedule for Reporting	Target Population (Comparison Type)	Notes/Justification
Benchmark 2: Child Injuries, Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits								
2.1	Visits for children to ED from all causes	Rate of visits to the ED or urgent care for any reason by enrolled target children. (Outcome Measure)	The rate of visits to the ED for any reason by enrolled target children will decrease from Year 1 to Year 2.	N: # of ED visits for any reason by enrolled target children	HFNY: Target Child Medical Information Form (See note 2.1.1)	HFNY: Collects at 6, 12, 24, 36, 48, & 60 months of age	All enrolled target children (Cross-sectional comparison of all enrolled children, comparing Year 1 and Year 2)	Must report aggregate and by age category (0-12, 13-36, & 37-60 months). Must compare aggregate figures only. ED and urgent care visits are combined because variations in hospital systems and their relationships with urgent care facilities can make differentiating visit types misleading.
				D: # of enrolled target children	NFP: Client report on Infant Health Care Form (See note 2.1.2)	NFP: Collects at 6, 12, 18, & 24 months of age		
2.2	Visits of mothers to ED from all causes	Rate of visits to the ED or urgent care for any reason by pregnant or postpartum women. (Outcome Measure)	The rate of visits to the ED for any reason by enrolled pregnant or postpartum women will decrease from Year 1 to Year 2.	N: # of ED visits for any reason by enrolled pregnant or postpartum women	HFNY: Primary Caretaker 1 Medical Form (See note 2.2.1)	HFNY: Collect at TC age - 6m, 1y, 2y, 3y, 4y, 5y and Discharge, report annually, beginning at enrollment	All enrolled pregnant and postpartum women (Cross-sectional comparison of all enrolled pregnant or postpartum women, comparing Year 1 and Year 2)	Aims to assess the appropriate usage of ED by all enrolled women. ED and urgent care visits are combined because variations in hospital systems and their relationships with urgent care facilities can make differentiating visit types misleading.
				D: # of enrolled pregnant or postpartum women	NFP: Client report on Demographic Update Form (See note 2.2.2)	NFP: Collect at Intake, Infancy 6 and 12 months, Toddler 18 and 24 months, report annually beginning at enrollment		
2.3	Participant training on prevention of child injuries	Percent of pregnant or postpartum women who receive education or information about child injuries and prevention by 6 months postpartum. (Process Measure)	The percent of pregnant or postpartum women who receive education or information about child injuries and prevention by 6 months postpartum will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of women who receive education or information about child injuries and prevention by 6 months postpartum	HFNY: Home Visit Log (See note 2.3.1)	HFNY: Collect at each home visit	All enrolled pregnant and postpartum women (Cohort comparison based on year of enrollment, looking at families when target child reaches 6 months of age, comparing Year 1 and Year 2 cohorts)	
				D: # of enrolled pregnant or postpartum women	NFP: Nurse report on Home Visit Encounter Form (See note 2.3.2)	NFY: Collect at every home visit (frequency varies)		
2.4	Incidence of child injuries requiring medical treatment	Rate of visits to the ED or urgent care due to injury by enrolled target children (Outcome Measure)	The rate of visits to the ED or urgent care due to injury by enrolled target children will decrease from Year 1 to Year 2.	N: # of ED or urgent care visits due to injury by enrolled target children	HFNY: Target Child Identification Information and Birth Outcomes Form (See note 2.4.1)	HFNY: TC age - 6m, 1y, 2y, 3y, 4y, 5y and Discharge.	All enrolled target children (Cross-sectional comparison of all enrolled children, comparing Year 1 and Year 2)	Must report aggregate and by age category (0-12, 13-36, & 37-60 months). Must compare aggregate figures only. ED and urgent care visits are combined because variations in hospital systems and their relationships with urgent care facilities can make differentiating visit types misleading.
				D: # of enrolled target children	NFP: Client report on Infant Health Care Form (See note 2.4.2)	NFP: At Intake, Infancy 6 and 12 months, Toddler 18 and 24 months		

2.5	Reported suspected maltreatment for children in the program	The incidence of reported suspected maltreatment of enrolled target children, verified through CPS.	The incidence of reported suspected maltreatment of enrolled target children will decrease from Year 1 to Year 2.	N: # of suspected maltreatment reports of enrolled target children. D: # of enrolled target children	Administrative data accessed from CPS Central Registry	Calculated annually	All enrolled target children (Cross-sectional comparison of all enrolled children, comparing Year 1 and Year 2)	Must report aggregate and by age category (0-12, 13-36, & 37-60 months). Must compare aggregate figures only. Must report by maltreatment type (neglect, physical abuse, sexual abuse, emotional, other)
2.6	Reported substantiated maltreatment for children in the program	The incidence of reported substantiated maltreatment of enrolled target children, verified through CPS.	The incidence of reported substantiated maltreatment of enrolled target children will decrease from Year 1 to Year 2.	N: # of substantiated maltreatment reports of enrolled target children. D: # of enrolled target children	Administrative data accessed from CPS Central Registry	Calculated annually	All enrolled target children (Cross-sectional comparison of all enrolled children, comparing Year 1 and Year 2)	Must report aggregate and by age category (0-12, 13-36, & 37-60 months). Must compare aggregate figures only. Must report by maltreatment type (neglect, physical abuse, sexual abuse, emotional, other)
2.7	First-time victims of maltreatment for children in the program	The incidence of target children reported to CPS as victims of maltreatment for the first time in their life.	The incidence of target children reported to CPS for maltreatment for the first time will decrease from Year 1 to Year 2.	N: # of target children reported to CPS as victims of maltreatment for the first time in their life. D: # of enrolled target children	Administrative data accessed from CPS Central Registry	Calculated annually	All enrolled target children (Cross-sectional comparison of all enrolled children, comparing Year 1 and Year 2)	Must report aggregate and by age category (0-12, 13-36, & 37-60 months). Must compare aggregate figures only. Must report by maltreatment type (neglect, physical abuse, sexual abuse, emotional, other)

	Benchmark 3: Improvements in School Readiness and Achievement							
	Construct	**Performance Measure**	**Improvement Definition**	**Measurement Metric**	**Measurement Tool/Instrument and Source**	**Data Collection Schedule for Reporting**	**Target Population (Comparison Type)**	**Notes/Justification**
3.1	Parent support for children's learning and development	Percent of families assessed by the HOME Inventory tool at 6 months postpartum. (Process Measure)	The percent of families assessed by the HOME Inventory tool at 6 months postpartum will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of families assess by the HOME Inventory tool at 6 months postpartum	HFNY: HOME Inventory tool (See note 3.1.1)	HFNY: Collect at 6 months	All enrolled families (Cohort comparison based on year of enrollment, looking at families when target child reaches 6 months of age, comparing Year 1 and Year 2 cohorts)	Aims to quantify the timely assessment of target children's home environments.
				D: # of enrolled families with a 6-month-old target child	NFP: Nurse observation and client report, HOME Inventory tool (See note 3.1.1)	NFP: At Infancy 6 months, Toddler 18 months, report at 6 months		
3.2	Parent knowledge of child development and of their child's developmental progress	Percent of families that reviewed the target child's ASQ and ASQ-SE scores with the home visitor. (Process Measure)	The percent of families that reviewed the target child's ASQ and ASQ-SE scores with the home visitor will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of times that a target child's ASQ and ASQ-SE scores were reviewed with a home visitor	HFNY: Home Visit Log (See note 3.2.1)	HFNY: Collect at Target Child age: 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48 months	All enrolled target children assessed by ASQ and ASQ-SE (Cohort comparison based on year of enrollment, comparing Year 1 and Year 2 cohorts)	Aims to assess proportion of families reviewing the results of the assessment of their child's cognitive and emotional development. [NFP: Will require custom data collection at MIECHV sites to record reviewing ASQ scores with families.]
				D: # of ASQ and ASQ-SE assessments conducted	NFP: Infant Health Care Form (See note 3.2.2)	NFP: Collect at Infancy 4 and 10 months, Toddler 14 and 20 months		
3.3	Parenting behaviors and parent-child relationship	Percent of families assessed by the HOME Inventory tool at 6 months postpartum. (Process Measure)	The percent of families assessed by the HOME Inventory tool at 6 months postpartum will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of families assess by the HOME Inventory tool at 6 months postpartum	HFNY: HOME Inventory tool (See note 3.1.1)	HFNY: Collect at 6 months	All enrolled families (Cohort comparison based on year of enrollment, looking at families when target child reaches 6 months of age, comparing Year 1 and Year 2 cohorts)	Aims to quantify the timely assessment of target children's home environments.
				D: # of enrolled families with a 6-month-old target child	NFP: Nurse observation and client report, HOME Inventory tool (See note 3.1.1)	NFP: At Infancy 6 months, Toddler 18 months, report at 6 months		
3.4	Parent emotional well-being or parenting stress	Percent of women who screened positive for depression receiving a referral to relevant services by 6 months postpartum . (Outcome Measure)	The percent of women who screened positive for depression receiving a referral to relevant services by 6 months postpartum will increase from Year 1 cohort to Year 2 cohort.	N: # of women who received a referral to relevant services by 6 months postpartum	HFNY: PHQ-9 (See note 1.5.1) and Service Referral (See note 6.2.1)	HFNY: Assessed at intake, TC age 6m, 1y, 2y, 3y, 4y, 5y, & discharge. Report at 6 months postpartum	All enrolled women screened for depression (Cohort comparison based on year of enrollment, looking at enrolled women at 6 months postpartum, comparing Year 1 and Year 2 cohorts)	This construct is complimentary to construct 1.5 (Screening for Maternal Depressive Symptoms). Here we assess the frequency of referrals issued for positive screens, #1.5 quantifies frequency of screening.
				D: # of women who screened positive for depression	NFP: Client report using the PHQ-9 (See note 1.5.1) and Home Visit Encounter form (See note 3.4.1)	NFP: Collect at Pregnancy 36 weeks, Infancy 1-8 weeks, Infancy 4-6 months, Infancy 12 months (optional at other times). Report and 6 months postpartum		

#	Construct	Measure	Objective	Numerator/Denominator	Source	Timing	Target Population	Notes
3.5	Child's communication, language and emergent literacy	Percent of target children assessed by the "Communication" subscale of the Ages & Stages Questionnaire (ASQ) at 4 months. (Process Measure)	The percent of target children assessed by the "Communication" subscale of the ASQ at 4 months will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of 4-month-old target children assessed by the "Communication" subscale of the ASQ	HFNY: ASQ 1 or 2 (See note 3.5.1)	HFNY: Collect at Target Child age: 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48 months, report 4-month assessments	All target children enrolled by 4 months of age (Cohort comparison based on year of enrollment, looking at families when target child reaches 4 months of age, comparing Year 1 and Year 2 cohorts)	Aim to assess early and timely assessment of target children's development. (NFP: Once an infant/toddler is screened for needing a referral, the ASQ is not repeated.)
				D: # of 4-month-old target children	NFP: Nurse observation and client report, ASQ (See note 3.5.1)	NFP: Collect at Infancy 4 and 10 months, Toddler 14 and 20 months, report 4-month assessments		
3.6	Child's general cognitive skills	Percent of target children assessed by the "Problem Solving" subscale of the Ages & Stages Questionnaire (ASQ) at 4 months. (Process Measure)	The percent of target children assessed by the "Problem Solving" subscale of the ASQ at 4 months will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of 4-month-old target children assessed by the "Problem Solving" subscale of the ASQ	HFNY: ASQ 1 or 2 (See note 3.5.1)	HFNY: Collect at Target Child age: 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48 months, report 4-month assessments	All target children enrolled by 4 months of age (Cohort comparison based on year of enrollment, looking at families when target child reaches 4 months of age, comparing Year 1 and Year 2 cohorts)	Aim to assess early and timely assessment of target children's development. (NFP: Once an infant/toddler is screened for needing a referral, the ASQ is not repeated.)
				D: # of 4-month-old target children	NFP: Nurse observation and client report, ASQ (See note 3.5.1)	NFP: Collect at Infancy 4 and 10 months, Toddler 14 and 20 months, report 4-month assessments		
3.7	Child's positive approaches to learning including attention	Percent of target children assessed by the "Personal-Social" subscale of the Ages & Stages Questionnaire (ASQ) at 4 months. (Process Measure)	The percent of target children assessed by the "Personal-Social" subscale of the ASQ at 4 months will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of 4-month-old target children assessed by the "Personal-Social" subscale of the ASQ	HFNY: ASQ 1 or 2 (See note 3.5.1)	HFNY: Collect at Target Child age: 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48 months, report 4-month assessments	All target children enrolled by 4 months of age (Cohort comparison based on year of enrollment, looking at families when target child reaches 4 months of age, comparing Year 1 and Year 2 cohorts)	Aim to assess early and timely assessment of target children's development. (NFP: Once an infant/toddler is screened for needing a referral, the ASQ is not repeated.)
				D: # of 4-month-old target children	NFP: Nurse observation and client report, ASQ (See note 3.5.1)	NFP: Collect at Infancy 4 and 10 months, Toddler 14 and 20 months, report 4-month assessments		
3.8	Child's social behavior, emotion regulation, and emotional well-being	Percent of target children assessed by the Ages & Stages Questionnaire-Social Emotional (ASQ-SE) at 6 months. (Process Measure)	The percent of target children assessed by the ASQ-SE at 6 months will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of 6-month-old target children assessed by the ASQ-SE	HFNY: ASQ 3 SE (See note 3.8.1)	HFNY: Collect at Target Child age: 6, 12, 18, 24, 30, 36, 48 months, report 6-month assessments	All target children enrolled by 6 months of age (Cohort comparison based on year of enrollment, looking at families when target child reaches 6 months of age, comparing Year 1 and Year 2 cohorts)	Aim to assess early and timely assessment of target children's development. (NFP: Once an infant/toddler is screened for needing a referral, the ASQ-SE is not repeated.)
				D: # of 6-month-old target children	NFP: Nurse observation and client report, ASQ-SE (See note 3.8.1)	NFP: At Infancy 6 and 12 months, Toddler 18 and 24 months, report 6-month assessments		
3.9	Child's physical health and development	Percent of target children assessed by the "Gross Motor Skills" and "Fine Motor Skills" subscales of the Ages & Stages Questionnaire (ASQ) at 4 months. (Process Measure)	The percent of target children assessed by the "Gross Motor Skills" and "Fine Motor Skills" subscales of the ASQ at 4 months will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of 4-month-old target children assessed by the "Gross Motor Skills" and "Fine Motor Skills" subscales of the ASQ	HFNY: ASQ 1 or 2 (See note 3.5.1)	HFNY: Collect at Target Child age: 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48 months, report 4-month assessments	All target children enrolled by 4 months of age (Cohort comparison based on year of enrollment, looking at families when target child reaches 4 months of age, comparing Year 1 and Year 2 cohorts)	Aim to assess early and timely assessment of target children's development. (NFP: Once an infant/toddler is screened for needing a referral, the ASQ is not repeated.)
				D: # of 4-month-old target children	NFP: Nurse observation and client report, ASQ (See note 3.5.1)	NFP: Collect at Infancy 4 and 10 months, Toddler 14 and 20 months, report 4-month assessments		

	Construct	Performance Measure	Improvement Definition	Measurement Metric	Measurement Tool/Instrument and Source	Data Collection Schedule for Reporting	Target Population (Comparison Type)	Notes/Justification
Benchmark 4: Crime or Domestic Violence								
	Crime: Arrests	N/A						
	Crime: Convictions	N/A						
4.1	Domestic Violence: Screening for domestic violence	Percent of pregnant and postpartum women screened for domestic violence at intake. (Process Measure)	The percent of pregnant or postpartum women screened for domestic violence at intake will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of enrolled women screened for domestic violence at intake	HFNY: HITS assessment tool (See note 4.1.1)	HFNY: Collect at assessment. Report at intake	All enrolled women (Compare cohorts based on year of enrollment, comparing Year 1 and Year 2 cohorts)	Aim to verify women are screened for domestic violence upon entry into the program.
				D: # of enrolled women	NFP: Client report on Relationship Assessment Form (See note 4.1.2)	NFP: Collect at Intake, Pregnancy 36 weeks, Infancy 12 months; nurses can make inquiries if suspected IPV emerges at other points in time. Report at intake		
4.2	Domestic Violence: Of families identified for the presence of domestic violence, referrals made for relevant services	Percent of women who were identified with a domestic violence issue for whom referrals were initiated for relevant services during reporting year. (Process Measure)	The percent of referrals initiated for relevant services for women who were identified with domestic violence issue will increase and be maintained from Year 1 cohort to Year 2 cohort.	N: # of referrals initiated for relevant services to women who were identified with domestic violence issue during reporting year	HFNY: Service Referral Form (See note 4.2.1)	HFNY: On-going, as needed. Report annually	All enrolled women who screened positive for domestic violence (Compare cohorts based on year of enrollment, comparing Year 1 and Year 2 cohorts)	
				D: # of enrolled women who are identified as having a domestic violence issue (screened positive for domestic violence or identified by home visitor)	NFP: Client report on Home Visit Encounter Form (See note 4.2.2)	NFP: At every home visit as needed (frequency varies). Report annually		
4.3	Domestic Violence: Of families identified for the presence of domestic violence, families completing a safety plan	Percent of women who were identified as having a domestic violence issue with whom safety or a domestic violence safety plan was discussed, completed or reviewed by 12 months postpartum.	The percent of women who were identified as having a domestic violence issue with whom safety or a safety plan was discussed, completed or reviewed by 12 months postpartum will increase or be maintained from Year 1 cohort to Year 2 cohort.	N: # of women with whom safety or a safety plan was discussed, completed, or reviewed	HFNY: Follow-up Form (See note 4.3.1)	HFNY: At every home visit	All enrolled women (Cohort comparison based on year of enrollment, looking at women who are 12 months postpartum, comparing Year 1 and Year 2 cohorts)	
				D: # of enrolled women who are identified as having a domestic violence issue (screened positive for domestic violence, identified by home visitor, or domestic violence referral initiated by home visitor)	NFP: Client report on Home Visit Encounter Form and Relationship Assessment Form (See note 4.3.2)	NFP: At every home visit (frequency varies)		

	Construct	Performance Measure	Improvement Definition	Measurement Metric	Measurement Tool/Instrument and Source	Data Collection Schedule for Reporting	Target Population (Comparison Type)	Notes/Justification
Benchmark 5: Family Economy and Self-sufficiency								
5.1	Household income and benefits	The number of families that demonstrate an increase in the total amount of monthly income and benefits received (i.e., TANF, Food Stamps, Emergency Assistance, WIC, SSI/SSD) reported at 12 months postpartum compared to at enrollment. (Outcome Measure)	The number of families that demonstrate an increase in the total amount of monthly income and benefits received reported at 12 months postpartum from enrollment will increase from Year 1 cohort to Year 2 cohort.	N: # of families whose monthly income and benefits at 12 months postpartum is greater than at enrollment	HFNY: Intake, Follow-up Form (See note 5.1.1)	HFNY: At Enrollment, TC age - 6m, 1y, 2y, 3y, 4y, 5y; and Discharge. Report for month of enrollment and 12 months postpartum	All enrolled women (Cohort comparison based on enrollment, looking at clients who completed assessments at enrollment and 12-month postpartum, comparing Year 1 and Year 2 cohorts)	Household defined as enrolled pregnant or postpartum woman and target child. Note: NFP collects annual income; NYS NFP sites will use additional question asking income from past month.
				D: # of families who reported their monthly income and benefits at 12 months postpartum and at enrollment	NFP: Client report on Demographics: Pregnancy - Intake Form and Demographics: Update Form (See note 5.1.2)	NFP: At Intake, Infancy 6 and 12 months, Toddler 18 and 24 months. Report for month of enrollment and 12 months postpartum		
5.2	Employment or education of adult members of the household	Employment: The number of families that demonstrate an increase in the number of hours worked in the past month reported at 12 months postpartum compared to at enrollment. (Outcome Measure)	The number of families that demonstrate an increase in the number of hours worked in the past month reported at 12 months postpartum compared to at enrollment will increase from Year 1 cohort to Year 2 cohort. (See note 5.2.1)	N: # of families whose total number of hours worked in the past month at 12 months postpartum is greater than at enrollment	HFNY: Intake, Follow-up (See note 5.2.2)	HFNY: At enrollment and TC age: 6m, 1y, 2y, 3y, 4y, 5y and Discharge. Report for month of enrollment and for 12 months postpartum	All enrolled women (Cohort comparison based on enrollment, looking at clients who completed assessments at enrollment and 12-month postpartum, comparing Year 1 and Year 2 cohorts)	Must report both, but require improvement in one only. Household defined as enrolled pregnant or postpartum woman and target child.
				D: # of families who reported the total number of hours worked in the past month at 12 months postpartum and at enrollment	NFP: Client report on Demographics: Pregnancy Intake Form and Demographics Update Form (See note 5.2.3)	NFP: At Intake, Infancy 6 and 12 months, Toddler 18 and 24 months. Report for month of enrollment and for 12 months postpartum		
		Education: The number of families that report being enrolled in an educational or vocational program at 12 months postpartum that reported not being enrolled in an educational or vocational program at enrollment. (Outcome Measure)	The number of families that reported being enrolled in an educational or vocational program at 12 months postpartum who reported not being enrolled in an educational or vocational program at enrollment will increase from Year 1 cohort to Year 2 cohort.	N: # of enrolled women who reported being enrolled in an educational or vocational program at 12 months postpartum and not being enrolled in such a program at enrollment	HFNY: Intake, Follow-up (See note 5.2.2)	HFNY: At enrollment and TC age: 6m, 1y, 2y, 3y, 4y, 5y and Discharge. Report for month of enrollment and for 12 months postpartum	All enrolled women (Cohort comparison based on enrollment, looking at clients who completed assessments at enrollment and 12-month postpartum, comparing Year 1 and Year 2 cohorts)	
				D: # of enrolled women who reported about their enrollment status in an educational or vocational program at 12 months postpartum and at enrollment	NFP: Client report on Demographics: Pregnancy Intake Form and Demographics Update Form (See note 5.2.3)	NFP: At Intake, Infancy 6 and 12 months, Toddler 18 and 24 months. Report for month of enrollment and 12 months postpartum		
5.3	Health insurance status	Percent of enrolled postpartum women and target children who report having some form of health insurance (Medicaid, PCAP, Child Health Plus, private, other) when the target child reaches 12 months of age. (Outcome Measure)	The percent of enrolled postpartum women and children who report having some form of health insurance when the target child reaches 12 months of age will increase from Year 1 cohort to Year 2 cohort.	N: total # of enrolled postpartum women and target children who report having health insurance	HFNY: Intake Form, Target Child (TC) ID Form, Follow-up Form, (See note 1.8.1)	HFNY: Maternal: Enrollment; TC age - 6m, 1y, 2y, 3y, 4y, 5y; and Discharge Target Child: At Birth or Enrollment; and TC age - 6m, 1y, 2y, 3y, 4y, 5y and Discharge. Report at TC age 12 months	All enrolled postpartum mothers with a 12-month-old enrolled child and target children at 12 months of age (Cohort comparison based on year of enrollment of postpartum women and 12-month-old target child pairs, comparing Year 1 and Year 2 cohorts)	Household defined as enrolled pregnant or postpartum woman and target child. Looking only at enrolled women when their child reaches 12 months of age and target children at 12 months of age. Intended to assess continuity of insurance coverage to 12 months postpartum. Complimentary to construct #1.8 that captures dyads that are still insured after the 60-day postpartum MA coverage.
				D: total # of enrolled postpartum women with enrolled child at 12 months of age and target children at 12 months of age	NFP: Client report on Use of Government and Community Resources Form, (See note 1.8.2)	NFP: At Intake, Infant's Birth, Infancy 6, 12, 18 and 24 months. Report at TC age 12 months		

	Benchmark 6: Improved Coordination and Referrals for Other Community Resources and Support							
	Construct	**Performance Measure**	**Improvement Definition**	**Measurement Metric**	**Measurement Tool/Instrument and Source**	**Data Collection Schedule for Reporting**	**Target Population (Comparison Type)**	**Notes/Justification**
6.1	Number of families identified for necessary services	Percent of enrolled families screened for necessary services. (Process Measure)	The percent of enrolled families screened for necessary services will increase or be maintained from Year 1 to Year 2.	N: # of families screened for necessary services annually	HFNY: Kempe FSC, Follow-up Form, (See note 6.1.1)	HFNY: Collect at assessment and TC age - 6m, 1y, 2y, 3y, 4y, 5y. Report annually	All enrolled families (Cross-sectional comparison of all enrolled clients, comparing Year 1 and Year 2)	
				D: # of enrolled families	NRP: Client report on Home Visit Encounter Form, (See note 6.1.2)	NFP: Collect at every home visit (frequency varies). Report annually		
6.2	Number of families requiring services who received a referral to available community resources	Percent of enrolled families identified as requiring services who received a referral to relevant services. (Process Measure)	The percent of families, who were identified as requiring services, receiving referrals to relevant services will increase or be maintained from Year 1 to Year 2.	N: # of families that were identified as requiring services who received a referral	HFNY: Service Referral, (See note 4.2.1)	HFNY: Collects on-going, as needed. Report annually	All enrolled families who were identified as requiring services (Cross-sectional comparison of all enrolled clients, comparing Year 1 and Year 2)	
				D: # of enrolled families identified as requiring services	NFP: Client report on Use of Government and Community Resources, (See note 6.2.1)	NFP: Collect at Intake, Infant's Birth, Infancy 6 and 12 months, Toddler 18 and 24 months. Report annually		
6.3	Number of MOUs or other formal agreements with other social service agencies in community	MOUs and other formal agreements will be written agreements outlining the specific terms of the agreement . A categorized list of MOUs and other formal agreements will be provided annually by each program.	The number of MOUs and other formal agreements with other social service agencies will increase or be maintained from Year 1 to Year 2.	Categorized list of organizations with whom the program has a MOU as defined by NYSDOH.	HFNY: Agency administrative data to be collected at the agency level	HFNY: Report annually.	All program administrative centers (Compare Year 1 and Year 2)	
					NFP: Agency administrative data to be collected at the agency level	NFP: Report annually.		
6.4	Number of agencies with which home visiting provider has a clear point of contact in collaboration (including information sharing)	A list of collaborative agreements with designated individual(s) to contact with other agencies in the program's community will be provided annually by each program.	The number of collaborative agreements with designated individual(s) to contact will increase or be maintained from Year 1 to Year 2.	Categorized list of collaborative agreements with other agencies in the program's community and with a clear point of contact.	HFNY: Agency administrative data to be collected at the agency level	HFNY: Report annually.	All program administrative centers (Compare Year 1 and Year 2)	
					NFP: Agency administrative data to be collected at the agency level	NFP: Report annually.		
6.5	Number of completed referrals	Percent of issued referrals that were reported as completed by the client to the Nurse/Home Visitor. (Outcome Measure)	The percent of issued referrals that were reported as completed will increase or be maintained from Year 1 to Year 2.	N: # of completed referrals reported to Nurse/Home Visitors	HFNY: Service Referral (See note 4.2.1)	HFNY: on-going, as needed	All enrolled families. (Cross-sectional comparison of all enrolled clients, comparing Year 1 and Year 2)	(N.B. both programs do not get independent confirmation that client obtained/has received service, all based on client self-report)
				D: # of referrals issued to enrolled families	Client report on Use of Government and Community Resources (See note 6.5.1)	NFP: At Intake, Infant's Birth, Infancy 6 and 12 months, Toddler 18 and 24 months		

Maternal and Infant Health Initiative
Component B: Maternal Infant and Early Childhood Home Visiting Program

Application Template

To request funding for the Maternal and Infant Health Initiative – Component B: Maternal, Infant and Early Childhood Home Visiting, complete the template below.

Complete applications should not exceed **40** single-spaced typed pages (not including the application cover sheet, attestation of eligibility, budget tables and forms, letters of support, vendor responsibility questionnaire, organizational chart, and subcontracts) using a normal 12-point font. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

A complete application consists of the following:

- ☐ **Application Cover Sheet**
- ☐ **Attestation of Eligibility**
- ☐ **Executive Summary**
- ☐ **Organizational Experience and Capacity**
- ☐ **Assessment of Community Needs and Strengths**
- ☐ **Improvement Plan**
- ☐ **Performance Measurement, Monitoring and Reporting**
- ☐ **Budget and Staffing Plan Narrative**
- ☐ **Budget Tables and Forms**
  - **Table A: Summary Budget**
  - **Table A-1: Personal Services**
  - **Table A-2: Non Personal Services**
  - **Form B-1: Personal Services Narrative Justification**
  - **Form B-2: Fringe Benefit Rate Narrative Justification**
  - **Form B-3: Nonpersonal Services Narrative Justification**
  - **Form B-4: Detail of Applicant Funds Supporting Initiative**
  - **Subcontractor Budget Forms**
- ☐ **Letters of Support**
- ☐ **Vendor Responsibility Questionnaire and/or Attestation**
- ☐ **Organizational Chart**
- ☐ **Subcontractor Organizations**

Application Cover Sheet [0 POINTS]
Not counted in page limit.
Provide relevant information on the applicant agency, the proposed target area, and the amount of funding requested.

<table>
<tr><td colspan="2">NAME AND ADDRESS OF APPLICANT ORGANIZATION/AGENCY
ORGANIZATION/AGENCY:
Vendor ID Number:
ADDRESS:</td></tr>
<tr><td>Agency Director
Name:
Title:</td><td>Telephone: ( )
E-mail Address:</td></tr>
<tr><td>Project Director
Name:
Title:
Address:

Telephone: ( )
E-mail Address:</td><td>Fiscal Officer
Name:
Title:
Address:

Telephone: ( )
E-mail Address:</td></tr>
<tr><td>Total Costs Requested for first 12-Month
Budget Period (July 1, 2013 – June 30, 2014)</td><td>$____________________</td></tr>
<tr><td>Federal Identification Number:</td><td>Charitable Organization Number:</td></tr>
<tr><td>Target County(ies) to be Served:</td><td>Signature & Date:

____________________________________</td></tr>
<tr><td>CERTIFICATION OF ACCEPTANCE
I certify that the statements herein are true and complete to the best of my knowledge, an accept the obligation to comply with NYS Department of Health terms and conditions if a grant is awarded as the result of this application. A willfully false certification is a criminal offense.</td><td>Official Signing for Application Organization
Name:
Title:
Address:

Telephone: ( )</td></tr>
</table>

Attestation of Eligibility [0 POINTS]
Not counted in page limit.

The attestation form certifies to your agency's eligibility for application under this category.

__________(name of lead agency)__________ certifies the following:

1. It is a (check the appropriate selection):

   _____ Article 28 facility

   _____ Article 36 facility

   _____ Local government agency

   _____ Community-based not-for-profit

2. It is located within the target area to be served. List counties and target areas that will be served:

   County(ies) to be served:

   Community/geographic and/or zip code areas to be targeted:

3. The application reflects a close collaboration with other community partners.

4. Applicant has approval from model developer(s). A letter from the national program developer(s) for the respective model(s) documenting agreement to work with the applicant to establish and/or expand and implement the evidence-based home visiting program as proposed is included in the application.

________________________	___________________________
Authorized Representative Print Name	Authorized Representative Signature
	___________________________
	Date

Executive Summary [0 POINTS]

(One-page limit)

This is a brief overall summary of the entire proposal.

Describe in comprehensive yet concise terms key aspects of the components of the application including: organizational experience and capacity, community needs identified and issues/needs being addressed, characteristics of the target population, characteristic of the target community which impact the need being addressed, evidence-based home visiting model to be implemented, activities proposed, results to be accomplished, anticipated effect on identified needs, and staffing of program.

Organizational Experience and Capacity [20 POINTS]
(Seven page limit)
This section describes the experience, expertise and capacity of the applicant to develop and implement the selected evidence-based home visiting program model, and to integrate home visiting services into a comprehensive, coordinated system of maternal, infant and early childhood services.

Briefly describe your agency, its mission, programs and capacity, and how those are aligned with the goals of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative. Describe any organizational history of serving populations most impacted by racial, ethnic and economic disparities in maternal and child health outcomes, and how your agency is representative of affected populations. Include evidence of ongoing collaboration with other community health and human services providers, social service agencies, home visiting programs and community-based organizations.

Describe your agency's experience implementing home visiting program services including any experience with the specific model(s) you propose to support with MIECHV funding. Identify populations targeted, numbers reached and accomplishments for high-need women, infants and children. Include the number of years of experience your agency has in providing these home visiting services.

Describe how the proposed program will be integrated within the organizational structure in your agency. A current organizational chart should be included and referenced as an attachment, which will <u>not</u> count against the seven page limit for this section.

Describe your agency's capacity to carry out the proposed project (i.e., to expand / enhance existing evidence-based home visiting services or to establish a new evidence-based home visiting program). Highlight any in-kind support your agency will provide to support the proposed project.

Identify other home visiting programs serving the target population operating in your target area, both within your organization and implemented by other organizations, and describe how you will collaborate with those initiatives, including protocols to ensure families are referred to the most appropriate home visiting program to meet their needs.

Provide evidence of collaborative linkages and letters of cooperative agreement with other organizations and state-funded programs within the targeted communities. Letters of collaboration should describe the specific contribution to be provided to your proposed program by the collaborating agency. Letters of collaboration and cooperative agreements or other evidence of specific commitments should be included as attachments and will not count against the seven page limit for this section.

Assessment of Community Needs and Strengths [20 POINTS]
(Seven-page limit)
The assessment of community needs and strengths provides a rationale for the proposed improvement plan by describing the problems/needs being addressed and the related resources currently available in seven pages or less. The assessment describes specific high-need populations including racial and ethnic minority populations, and relevant community-level data, needs, strengths, and barriers to access related to each of the six MIECHV benchmark areas: 1) maternal and newborn health; 2) child injuries, child abuse, neglect or maltreatment; 3) school readiness and achievement; 4) crime, including domestic violence; 5) family economic self-sufficiency; and 6) associated community resources and supports. The assessment of community needs should build upon previous community assessment and planning efforts including the state's MIECHV Needs Assessment available at:
http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/

Note: As a condition of funding, grantees will be expected to integrate ongoing community needs assessment activities in their MIECHV initiatives to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal, infant and child health within target communities. Assessment will be an ongoing activity, not a stand-alone "planning" phase of funded projects, and will be done in collaboration with other community partners, including Component A grantees.

Describe specific maternal, infant and child outcomes and issues affecting the target community in each of the six MIECHV benchmark areas, including: 1) maternal and newborn health, including the impact of premature birth, low-birth weight, and infant mortality; 2) child injuries, child abuse, neglect or maltreatment; 3) school readiness and achievement; 4) crime, including domestic violence; 5) family economic self-sufficiency; and 6) associated community resources and supports.

Describe the specific target populations impacted by the needs described, including relevant data regarding health and developmental status and/or service utilization as well as unique barriers which prevent access to needed maternal, infant and child health services. Provide relevant demographics of the target populations including race, ethnicity, age groups, income, and education.

Describe the specific geographic communities (villages, townships, counties, boroughs, zip codes, census tracts, NYC Health Areas) to be served by the proposed home visiting program and why these areas are to be targeted. Identify the high need zip codes to be targeted. Describe specific community factors, conditions, gaps and barriers that impact the needs identified.

Describe the quality and capacity of existing programs for maternal, infant and early childhood home visiting in the target community, including the number and types of programs and the numbers of individuals and families receiving services under such programs; the gaps in maternal, infant and early childhood home visiting, and the extent to which such programs are meeting the needs of eligible families. Describe the reason that your agency is needed to implement the evidence-based home visiting model, and how your activities will enhance existing home visiting services without duplicating these programs.

Describe plans to develop an annual assessment of community needs and resources, including sources of data, involvement of community partners including MIH Component A grantees, and how community residents will be involved in identifying barriers, resources and opportunities.

Improvement Plan [30 POINTS]
(20 page limit)
The improvement plan succinctly but substantively describes and explains the proposed strategies and activities to be implemented to accomplish each of the established Component B performance standards. Using the template below, applicants should describe their proposed approach including strategies and activities, who will perform the activities, a timeframe for implementation and completion, and anticipated challenges and barriers to achieving the performance standard.

Performance Standard 1: Home-visitors are recruited, trained and deployed consistent with model-specific requirements

1-1: Describe strategies and activities to recruit and hire staff that meet minimum qualifications for program management, supervision and home visiting positions as required by the model developer of the home visiting model selected. Identify the number of home visitors that will staff the program. Qualifications of staff should be consistent with model developer requirements, and the number of staff should be adequate to carry out the intent of the initiative.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		
1-2: Describe strategies and activities to facilitate provision of core training of home visiting staff as required by the model developer, as well as additional training to be provided through the MIH-COE.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		
1-3: Describe strategies and activities to provide professional supervision of home visiting staff in accordance with model developer requirements.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

1-4: Describe strategies and activities to promote staff retention through staff development, achievement recognition, diversification of caseload assignments, and supportive supervision.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

Performance Standard 2: High-need families are identified, screened for eligibility and enrolled in evidence-based home visiting services.

2-1: Describe strategies and activities to identify high-need women eligible for program participation, including those not already receiving prenatal care, and those eligible pregnant women and families who may be likely to avoid health services for such reasons as substance abuse, domestic violence, adolescence, disabling impairment, and unintended or unwanted pregnancies.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		
2-2: Describe strategies and activities to partner with local hospitals, prenatal care providers, schools, WIC clinics, community- and faith-based organizations and other agencies serving high-need pregnant and newly parenting families to promote referrals of potential home visiting clients.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

2-3: Describe strategies and activities to effectively engage high-need women to improve the acceptance rate for home visiting program enrollment among those who are eligible for services, with particular emphasis on any sub-groups that typically have lower acceptance rates.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

2-4: Describe strategies and activities to improve retention and minimize attrition of home visiting clients. Examples of strategies include but may not be limited to: scheduling home visits at times convenient to the clients including nights and weekends; maintaining consistent schedules of visits; motivational interviewing; hiring staff that are representative of the culture and language spoken by the target community; partnering with other community providers to reinforce continued engagement in home visiting services.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

Performance Standard 3: Home visiting services are provided to enrolled clients with fidelity to the evidence-based program model selected

*3-1: Describe strategies and activities to conduct ongoing home visiting services to eligible clients and to assure that services are delivered with fidelity to the evidence-based program model selected. (See RFA **Attachment 27** for specific model requirements for the NFP and **Attachment 28** for specific model requirements for HFA).*		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

Performance Standard 4: Measureable improvements across key benchmark areas will be achieved for families participating in home visiting services.

*4-1: Describe specific strategies and activities to be implemented within the selected home visiting program model(s) to improve client outcomes in each of the six MIECHV benchmark areas: 1) maternal and newborn health; 2) child injuries, child abuse, neglect or maltreatment; 3) school readiness and achievement; 4) crime, including domestic violence; 5) family economic self-sufficiency; and 6) associated community resources and supports. (see RFA **Attachment 21**).*		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

Performance Standard 5: Home visiting programs are coordinated and integrated within larger community maternal, infant and early childhood service systems.

5-1: Describe strategies and activities to coordinate outreach, referral, assessment and intake processes with other home visiting programs and other service providers, including Component A grantees, in the community.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		
5-2: Describe strategies and activities to establish referral agreements with prenatal care providers and local supportive service agencies including substance abuse, mental health, domestic violence, nutrition services, child protective services and other health and social services agencies.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

5-3: Describe strategies and activities to develop and implement coordinated systems for outreach, screening, referral, follow-up and ongoing service delivery to high-need women and families with Component A grantees, other home visiting programs, and other relevant community partners.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		
5-4: Describe strategies and activities to promote and facilitate partnerships and integration with broader family support resources within the community (e.g., Family Resource Centers, libraries, parks and recreational activities, breastfeeding support groups, formal and informal parenting groups, job training, etc.).		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		
5-5: Describe strategies and activities to collaborate with other grantees and community providers to achieve population-level improvements, including reduction of racial, ethnic and economic disparities in measurable outcomes within the target community.		
Specific Strategies and Activities	Responsible Parties	Timeframe
Anticipated Challenges and Barriers		

Performance Measurement, Monitoring and Reporting [10 POINTS]
(Two-page limit)
This section describes the plans for collecting, reviewing and reporting on a set of defined performance measures to monitor and assess progress and performance in implementing the evidence-based home visiting program and improving outcomes among clients served.

Note: A set of draft performance (benchmark) measures is provided in **Attachment 21**.

Describe the current and/or proposed processes for collecting and reporting data on performance measures.

Describe the current and/or proposed processes for reviewing data and applying findings to support continuous improvement in program quality.

Budget and Staffing Plan [20 POINTS]
(Three-page narrative limit, exclusive of budget tables and forms)

Budget Narrative
The Budget Narrative will describe: how the proposed budget will support achievement of the proposed project and associated Improvement Plan activities; a staffing plan that adheres to model-specific staffing requirements (*see below); and how in-kind support from the applicant agency and partners and funding from other sources will be leveraged and effectively allocated to maximize support for the proposed project. Funding may supplement but cannot supplant funding from other sources such as other grant funds or Medicaid reimbursement which support existing activities. If funding is used to expand existing activities, the budget forms should identify Other Sources of Funds on Budget Tables A, A1 and A-2 which support those activities.

Note: *See **Attachment 27** NFP Staff Requirements and **Attachment 28** HFNY Staffing Requirements.

Describe overall how the requested funds will support achievement of the proposed project and associated Improvement Plan.

Describe your overall staffing plan for the project and how the requested funds will support this plan, including staff training and professional development. It is expected that the budget will support appropriate and qualified program staff to accomplish the program activities described in the Improvement Plan, including home visiting staff and appropriate supervision in accordance with model developer requirements. The appropriate qualifications required for the each position should be stated. Staffing should reflect sufficient number of home visiting staff to serve the estimated number of clients. Resumes of key staff should be included in the application.

Identify and describe in-kind contributions in support of the Improvement Plan and budget. Describe how grant funds will leverage additional financial support from partners, including public and private (e.g. businesses, foundations) partners. If you are proposing to expand an existing home visiting program, describe how new grant funds requested will support that expansion and will be allocated with respect to other sources of funding/revenue. Examples of sources of financial support for home visiting may include Medicaid reimbursement, Temporary Assistance for Needy Families (TANF) funds, flexible local funding streams for prevention services (such as COPS and Article VI) and other dedicated grants. Describe plans for developing public-private partnerships and other activities to enhance program sustainability.

Consideration will be given to cost-effectiveness of budgets, meaning the application fulfills all requirements in the least costly manner (e.g., emphasizing direct, personal service and programming, while containing minimal costs for administrative support OTPS budget line items). The budget will be rated on its cost-effectiveness during the review process.

<u>Instructions for completing Budget Tables and Forms</u>

Using the Tables A, A1, and A2, and Forms B-1, B-2, B-3 and B-4 below, prepare an annualized budget for **each** 12-month period starting July 1, 2013 and ending June 30, 2018 (i.e., a total of five one-year budgets). Label year one budget tables "Appendix **B-1"**; year two – "Appendix **B-2"** and so on. The budget should encompass the entire home visiting program, i.e. if you are proposing to expand an established home visiting program, the budget submitted with your RFA application should include the costs and sources/allocation of funding for the entire program and should clearly demonstrate how requested MIH grant funds will support the expansion described in your application.

Remember to change dates on budget pages to reflect actual budget year for each of the five annualized budgets. If there are anticipated delays in hiring, in the first grant year, you will need to include the annualized salary and pro-rate it based on the number of months actually employed. Your budgets will need to be constructed so the annualized salary for the first grant year is accommodated in each of the four subsequent years. Rollover of funds from one year to the next is not anticipated. No increase in funding amounts for subsequent years of the 5-year term contract is anticipated.

ADMINISTRATIVE/INDIRECT COSTS

Administrative/indirect costs in budget line item detail may not exceed ten percent (10%) of your budget due to federally imposed administrative caps on contract funds. Indirect costs applied as a percentage may not be charged to NYS funds.

<u>BUDGET TABLES</u>

TABLE A: SUMMARY BUDGET

This table should be completed last and will include the total lines <u>only</u> from Table A-1 (Personal Services) and Table A-2 (Nonpersonal Services) and the Grand Total. As a check, grand total NYS should match the amount you are requesting from NYS. Total expense = NYS + Other Source. Other Source may be in-kind, other grants etc.

TABLE A-1: PERSONAL SERVICES

Personnel, with the exception of consultants and per diems, contributing any part of their time to the project should be listed with the following items completely filled in (consultants/per diems should be shown as a Nonpersonal Services expense on Table A-2):

<u>Title/Incumbent Name</u>: The title given should reflect either a position within your organization or on this project. Include incumbent's name.

<u>Annual Salary</u>: Regardless of the amount of time spent on this project, the <u>total</u> annual, actual salary for each position should be given for the <u>number of months applicable to that salary</u>. **For example, if a union negotiated contract salary increase will impact a portion of the 12 month budget period it should be shown on the Table A-1 as follows (the same position will use two lines in the budget):**

Title	Annual Salary	% FTE	# months	Total Expense
Supervisor	$50,000	100%	4	$16,667
Supervisor	$54,000	100%	8	$36,000

% FTE: The proportion of time spent on the project based on a full time equivalent (FTE) should be indicated. One FTE is based on the number of hours worked in one week by salaried employees (e.g. 40 hour work week). To obtain % FTE, divide the hours per week spent on the project by the number of hours in a work week. For example, an individual working 10 hours per week on the project given a 40 hour work week = 10/40 = .25 (show in decimal form).

# of Months: Show the number of months out of 12 worked for each title. If an employee works 10 months out of 12, then 10 months/12 months = .833. This ratio is part of the total expense calculation below. Indicate the number of months a position is subject to a specific salary if a portion of annual salary will be subject to a salary increase (see □Annual Salary□ above).

Total Expense: Total expense can be calculated using the following method:

Total Actual Annual Salary * % FTE * (months worked/12) = Total Expense.

Fringe Benefits: The total fringe amount should be shown (total expense annual salaries * fringe rate from Form B-2) where indicated on the Table A-1.
See "Administrative/Indirect Costs" above regarding indirect and administrative costs.

TABLE A-2: NONPERSONAL SERVICES
All Nonpersonal Services expenses should be listed regardless of whether or not funding for these expenses is requested from New York State. As with Table A-1, distribute total expense between NYS and Other Source (specify Other Source). **See "Administrative/Indirect Costs" above regarding indirect and administrative costs.**

- In the top row of the heading, fill in the applicant name.
- In the first column , enter **all non-personal service line items** connected with MIECHV.
- Include all items, regardless of funding source. Some examples of non-personal service items include (but are not limited to): Individual Subcontractors, Audit, Payroll Processing, Per Diem Staff, Equipment, Office Supplies, Program Supplies, Staff Development Trainings, Staff Travel, Advertising, Maintenance and Operations, and Media Development. Each line item should be easily identifiable, "Other" and "Misc" are not allowable line items.
- The budget should allow for reasonable costs for the required annual independent audit, if an audit is required by state and federal requirements. Audit and other shared costs should be allocated based on a defined agency allocation methodology.

BUDGET NARRATIVE/JUSTIFICATION FORMS

Form B-1: Personal Services
Form B-2: Fringe Benefit Rate
Form B-3: Nonpersonal Services
Form B-4: Detail of Contractor Funds Supporting the Initiative

Use Forms B-1 and B-3 to provide a justification/explanation for the expenses included in the Operating Budget and Funding Request (Tables A, A-1, and A-2). The justification should show all items of expense and the associated cost that comprise the amount requested for each budget category (e.g. if your total travel cost is $1,000, show how that amount was determined - conference, local travel etc.), and if appropriate, an explanation of how these expenses relate to the goals and objectives of the project.

FORM B-1: PERSONAL SERVICES
Include a description for each position, including the percentage of time spent on various duties where appropriate, on this form. A Project Coordinator who is qualified and accessible full-time for communications, including e-mail, and attending meetings with DOH along with other appropriate staff is required. Contracted or per diem staff are not to be included in personal services; these expenses should be shown as consultant or contractual services under Nonpersonal Services. Resumes of key staff should be included. **See "Administrative/Indirect Costs" above regarding indirect and administrative costs.**

FORM B-2: FRINGE BENEFIT RATE
Specify the following components and their percentages comprising the fringe benefit rate: FICA & Medicare Tax, Health Insurance, Unemployment Insurance, Disability Insurance, Life Insurance, Worker's Compensation, and Pension/Retirement (other components may be listed but require narrative justification/approval). Total the percentages to show the fringe benefit rate used in budget calculations. If positions have different fringe benefit rates, use an average for all positions.

FORM B-3: NONPERSONAL SERVICES
Any item of expense not applicable to the below categories should also be listed along with a justification of need.
See "Administrative/Indirect Costs" above regarding indirect and administrative costs.

<u>Supplies and Materials</u>
Provide a delineation of the items of expense and estimated cost of each along with justification of their need. Some routine supplies may be consolidated under office supplies.

<u>Travel</u>
Provide a delineation of the items of expense and estimated cost (i.e., travel costs associated with conferences, including transportation, meals, lodging, registration fees; administrative travel vs. programmatic travel; staff travel) and estimated cost along with a justification of need. Costs should not exceed state travel rates.

<u>Subcontracts/Consultants/Per Diems/Contractual Services</u>
Provide a justification of why each service listed is needed. Justification should include the name of the consultant/contractor, the specific service to be provided and the time frame for the delivery of services.
Subcontracts are subject to review and approval by the NYS Health Department.

<u>Equipment</u>
Delineate each piece of equipment and estimated cost along with a justification of need. Equipment costing less than $300 should be included in the Supplies and Materials category. Anticipated equipment purchases $300 and greater should be included in the equipment line.

FORM B-4: DETAIL OF CONTRACTOR FUNDS SUPPORTING INITIATIVE
Provide detail of all ~~3rd Party and~~ Other Source Funds reported on Budget Table A - A-2. An In-kind donation is a contribution of time, service, or goods provided by your organization to support the operations or services of your MIHIC program. Other sources may include other grants or cash donations. You should list all other-sources of income, and specify whether funds are state, local, or federal.

Attachment 22

Applicant: ___________________________________

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

Table A
SUMMARY BUDGET AND FUNDING REQUEST
July 1, 20__ - June 30, 20__

	Total Expense	Amount Requested	Other Source	Specify Other Source
Total Personal Services				
Total Other Than Personal Services				
GRAND TOTAL				

Applicant: ______________________________________

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

Table A-1
PERSONAL SERVICES
July 1, 20__ - June 30, 20__

Title	Annual Salary	% FTE	# of Mos.	Total Expense	Amount Requested	Other Source	Specify other source
(List Personnel Budgeted)							
Sub-Total Personnel Services							
Fringe Benefits* _____ %							
Total Personal Services							

- **If more than one fringe benefit is used, use an <u>average</u> fringe rate for the calculation on this form.**

Applicant: ______________________________________

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

Table A-2
NONPERSONAL SERVICES
July 1, 20__ - June 30, 20__

	Total Expense	Amount Requested	Other Source	Specify Other Source
(List Budgeted Expenses) **A. Contractual**				
Subtotal, Contractual				

Applicant: ________________________________

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

Table A-2
NONPERSONAL SERVICES
July 1, 20__ - June 30, 20__

	Total Expense	Amount Requested	Other Source	Specify Other Source
(List Budgeted Expenses) **B. Equipment**				
Subtotal, Equipment				
(List Budgeted Expenses) **C. Staff Development**				
Subtotal, Staff Development				

Applicant_________________________________

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

Table A-2
NONPERSONAL SERVICES
July 1, 20__ - June 30, 20__

	Total Expense	Amount Requested	Other Source	Specify Other Source
(List Budgeted Expenses) **D. Supplies**				
Subtotal, Supplies				
(List Budgeted Expenses) **E. Other**				
Subtotal, Other				

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-1: PERSONAL SERVICES
July 1, 20__ - June 30, 20__

Applicant: ________________________

PERSONAL SERVICE

Title	Incumbent	Description

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-2: FRINGE BENEFIT RATE
July 1, 20__ - June 30, 20__

Applicant: ________________________

FRINGE BENEFITS

Component	Rate
Total Fringe Benefit Rate*	

*This amount should equal the percentage used in budget calculations unless positions have different fringe rates. If this is the case, include one form for each rate and indicate which positions are subject to that rate.

Attachment 22

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-3: NON-PERSONAL SERVICE
July 1, 20__ - June 30, 20__

Applicant: ________________________

NON-PERSONAL SERVICES

Item	Cost	Description

Appendix B-__

NYSDOH - Maternal and Infant Health Initiative
Component B: Maternal Infant and Early childhood home visting

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-4: DETAIL OF APPLICANT FUNDS
July 1, 20__ - June 30, 20__

Applicant: ______________________________

DETAIL OF APPLICANT FUNDS	
SOURCE OF FUNDS	**AMOUNT**
In-kind contributions (list the expense(s) being supported)	
Other Sources, please specify source(s)	
TOTAL	**$0**

REGISTRATION FOR APPLICANT CONFERENCE WEBINAR

New York State Department of Health
Bureau of Maternal and Child Health
Application for Funding for Maternal and Infant Health Initiative

_____I/we intend to participate in the applicants' conference call for the Request for Applications (RFA) for the Maternal and Infant Health Initiative on **October 29, 2012**:

Organization Name: ____

Contact Name: ____

Address: ____

Title(s): ____

Telephone Number: ____

Fax Number ____

E-mail address: ____

The **Registration for Applicant Conference Webinar** form must be received via E-mail* or mail by ***October 25, 2012*** to:

Fran Mazzariello
Bureau of Maternal and Child Health
NYS Department of Health
ESP Corning Tower Room 831
Albany, NY 12237-0621
bmchph@health.state.ny.us

***Note: E-mail responses must contain all of the above information.**

Those applicants submitting a "Registration for Applicant Conference Webinar" will be provided the internet address, call-in telephone number and participant code number to enable the applicant to view and listen to the Applicant Conference Webinar.

Attachment 24

Letter of Intent to Apply

Fran Mazzariello
Bureau of Maternal and Child Health
NYS Department of Health
ESP Corning Tower Room 831
Albany, NY 12237-0621

Re: RFA #1207271237
Maternal and Infant Health Initiative

Dear Fran Mazzariello:

This letter is to indicate our interest in the above Request for Applications (RFA) to apply for (please check all that apply):

_____ Component A: Maternal and Infant Community Health Collaborative

_____ Component B: Maternal Infant and Early Childhood Home Visiting Program

We understand that the Department of Health will post a list of organizations that have submitted letters of intent to apply to assist potential applicants in developing collaborative applications. Contact information for our organization should be posted as follows:

Name of Organization: ______________________

Name of Contact: ______________________

Phone: _______________________

Email: _______________________

Address: _______________________

____

Sincerely,

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section IV, Administrative Requirements, H. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

☐ An on-line Vender Responsibility Questionnaire has been updated or created at OSC's website: https://portal.osc.state.ny.us within the last six months.

☐ A hard copy Vendor Responsibility Questionnaire is included with this application and is dated within the last six months.

☐ A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: ______________________________

Print/type Name: ______________________________

Title: ______________________________

Organization: ______________________________

Date Signed: ____________________

GRANT CONTRACT (MULTI YEAR)

STATE AGENCY (Name and Address): . NYS COMPTROLLER'S NUMBER: ______
.

. ORIGINATING AGENCY CODE: 12000 3450000

___________________________________ .________________________________

CONTRACTOR (Name and Address): . TYPE OF PROGRAM(S)
. Maternal and Infant Health Initiative
.

___________________________________ .________________________________

FEDERAL TAX IDENTIFICATION NUMBER: . INITIAL CONTRACT PERIOD

. FROM: July 1, 2013

MUNICIPALITY NO. (if applicable): .

. TO: June 30, 2018

.

CHARITIES REGISTRATION NUMBER: . FUNDING AMOUNT FOR INITIAL PERIOD:

__ __ - __ __ - __ __ or ( ) EXEMPT: .

(If EXEMPT, indicate basis for exemption): .________________________________

. MULTI-YEAR TERM (if applicable):
. FROM: July 1, 2013
. TO: June 30, 2018

____

CONTRACTOR HAS( ) HAS NOT( ) TIMELY FILED WITH THE ATTORNEY GENERAL'S CHARITIES BUREAU ALL REQUIRED PERIODIC OR ANNUAL WRITTEN REPORTS.

____

CONTRACTOR IS( ) IS NOT( ) A SECTARIAN ENTITY

CONTRACTOR IS( ) IS NOT( ) A NOT-FOR-PROFIT ORGANIZATION

APPENDICES ATTACHED AND PART OF THIS AGREEMENT

__X___	APPENDIX A	Standard clauses as required by the Attorney General for all State contracts.
__X___	APPENDIX A-1	Agency-Specific Clauses (Rev 10/08)
__X___	APPENDI X B	Budget
__X___	APPENDIX C	Payment and Reporting Schedule
__X___	APPE NDIX D	Program Workplan
__X___	APPE NDIX G	Notices
__X___	APPENDI X X	Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)

OTHER APPENDICES

__X___	APPE NDIX A-2	Program-Specific Clauses
__X___	APPENDIX E-1	Proof of Workers' Compensation Coverage
__X___	APPENDIX E-2	Proof of Disability Insurance Coverage
_____	APPENDIX H	Federal Health Insurance Portability and Accountability Act Business Associate Agreement

IN WITNESS THEREOF, the parties hereto have executed or approved this AGREEMENT on the dates below their signatures.

_______________________________________	_______________________________________
	Contract No. ______________________
_______________________________________	_______________________________________
CONTRACTOR .	STATE AGENCY
_______________________________________	_______________________________________
By: ___________________________________ (Print Name)	By: ______________________________ (Print Name)
_______________________________________	_______________________________________
Title: _________________________________	Title: ______________________________
Date: _________________________________	Date: ______________________________
	State Agency Certification: "In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."
_______________________________________	_________ ______________________________

STATE OF NEW YORK)
) SS:
County of ____________)

On the ___ day of __________ in the year ______ before me, the undersigned, personally appeared ___________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

____
(Signature and office of the individual taking acknowledgement)

ATTORNEY GENERAL'S SIGNATURE	STATE COMPTROLLER'S SIGNATURE
____	_________ ____________________________
Title: _________________________________	Title: ______________________________
Date: _________________________________	Date: ______________________________

STATE OF NEW YORK

AGREEMENT

This AGREEMENT is hereby made by and between the State of New York agency (STATE) and the public or private agency (CONTRACTOR) identified on the face page hereof.

WITNESSETH:

WHEREAS, the STATE has the authority to regulate and provide funding for the establishment and operation of program services and desires to contract with skilled parties possessing the necessary resources to provide such services; and

WHEREAS, the CONTRACTOR is ready, willing and able to provide such program services and possesses or can make available all necessary qualified personnel, licenses, facilities and expertise to perform or have performed the services required pursuant to the terms of this AGREEMENT;

NOW THEREFORE, in consideration of the promises, responsibilities and covenants herein, the STATE and the CONTRACTOR agree as follows:

I. Conditions of Agreement

A. The period of this AGREEMENT shall be as specified on the face page hereof. Should funding become unavailable, this AGREEMENT may be suspended until funding becomes available. In such event the STATE shall notify the CONTRACTOR immediately of learning of such unavailability of funds, however, any such suspension shall not be deemed to extend the term of this AGREEMENT beyond the end date specified on the face page hereof.

B. Funding for the entire contract period shall not exceed the amount specified as "Funding Amount for Initial Period" on the face page hereof.

C. This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.

D. To modify the AGREEMENT, the parties shall revise or complete the appropriate appendix form(s). Any change in the amount of consideration to be paid, change in scope, or change in the term, is subject to the approval of the Office of the State Comptroller. Any other modifications shall be processed in accordance with agency guidelines as stated in Appendix A-1.

E. The CONTRACTOR shall perform all services to the satisfaction of the STATE. The CONTRACTOR shall provide services and meet the program objectives summarized in the Program Workplan (Appendix D) in accordance with: provisions of the AGREEMENT; relevant laws, rules and regulations, administrative and fiscal guidelines; and where applicable, operating certificates for facilities or licenses for an activity or program.

F. If the CONTRACTOR enters into subcontracts for the performance of work pursuant to this AGREEMENT, the CONTRACTOR shall take full responsibility

for the acts and omissions of its subcontractors. Nothing in the subcontract shall impair the rights of the STATE under this AGREEMENT. No contractual relationship shall be deemed to exist between the subcontractor and the STATE.

G. Appendix A (Standard Clauses as required by the Attorney General for all State contracts) takes precedence over all other parts of the AGREEMENT.

II. Payment and Reporting

A. The CONTRACTOR, to be eligible for payment, shall submit to the STATE's designated payment office (identified in Appendix C) any appropriate documentation as required by the Payment and Reporting Schedule (Appendix C) and by agency fiscal guidelines, in a manner acceptable to the STATE.

B. The STATE shall make payments and any reconciliations in accordance with the Payment and Reporting Schedule (Appendix C). The STATE shall pay the CONTRACTOR, in consideration of contract services for a given PERIOD, a sum not to exceed the amount noted on the face page hereof or in the respective Appendix designating the payment amount for that given PERIOD. This sum shall not duplicate reimbursement from other sources for CONTRACTOR costs and services provided pursuant to this AGREEMENT.

C. The CONTRACTOR shall meet the audit requirements specified by the STATE.

D. The CONTRACTOR shall provide complete and accurate billing vouchers to the Agency's designated payment office in order to receive payment. Billing vouchers submitted to the Agency must contain all information and supporting documentation required by the Contract, the Agency and the State Comptroller. Payment for vouchers submitted by the CONTRACTOR shall be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/epay.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

III. Terminations

A. This AGREEMENT may be terminated at any time upon mutual written consent of the STATE and the CONTRACTOR.

B. The STATE may terminate the AGREEMENT immediately, upon written notice of termination to the CONTRACTOR, if the CONTRACTOR fails to comply with the terms and conditions of this AGREEMENT and/or with any laws, rules and regulations, policies or procedures affecting this AGREEMENT.

C. The STATE may also terminate this AGREEMENT for any reason in accordance with provisions set forth in Appendix A-1.

D. Written notice of termination, where required, shall be sent by personal messenger service or by certified mail, return receipt requested. The termination shall be effective in accordance with the terms of the notice.

E. Upon receipt of notice of termination, the CONTRACTOR agrees to cancel, prior to the effective date of any prospective termination, as many outstanding obligations as possible, and agrees not to incur any new obligations after receipt of the notice without approval by the STATE.

F. The STATE shall be responsible for payment on claims pursuant to services provided and costs incurred pursuant to terms of the AGREEMENT. In no event shall the STATE be liable for expenses and obligations arising from the program(s) in this AGREEMENT after the termination date.

IV. Indemnification

A. The CONTRACTOR shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the CONTRACTOR or its subcontractors pursuant to this AGREEMENT. The CONTRACTOR shall indemnify and hold harmless the STATE and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT.

B. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the STATE nor make any claims, demand or application to or for any right based upon any different status.

V. Property

Any equipment, furniture, supplies or other property purchased pursuant to this AGREEMENT is deemed to be the property of the STATE except as may otherwise be governed by Federal or State laws, rules and regulations, or as stated in Appendix A-2.

VI. Safeguards for Services and Confidentiality

A. Services performed pursuant to this AGREEMENT are secular in nature and shall be performed in a manner that does not discriminate on the basis of religious belief, or promote or discourage adherence to religion in general or particular religious beliefs.

B. Funds provided pursuant to this AGREEMENT shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

C. Information relating to individuals who may receive services pursuant to this AGREEMENT shall be maintained and used only for the purposes intended under the contract and in conformity with applicable provisions of laws and regulations, or specified in Appendix A-1.

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to

be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the

subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
http://www.empire.state.ny.us

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
http://www.empire.state.ny.us

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.

To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

APPENDIX A-1
(REV 10/08)

AGENCY SPECIFIC CLAUSES FOR ALL
DEPARTMENT OF HEALTH CONTRACTS

1. If the CONTRACTOR is a charitable organization required to be registered with the New York State Attorney General pursuant to Article 7-A of the New York State Executive Law, the CONTRACTOR shall furnish to the STATE such proof of registration (a copy of Receipt form) at the time of the execution of this AGREEMENT. The annual report form 497 is not required. If the CONTRACTOR is a business corporation or not-for-profit corporation, the CONTRACTOR shall also furnish a copy of its Certificate of Incorporation, as filed with the New York Department of State, to the Department of Health at the time of the execution of this AGREEMENT.

2. The CONTRACTOR certifies that all revenue earned during the budget period as a result of services and related activities performed pursuant to this contract shall be used either to expand those program services funded by this AGREEMENT or to offset expenditures submitted to the STATE for reimbursement.

3. Administrative Rules and Audits:

   a. If this contract is funded in whole or in part from federal funds, the CONTRACTOR shall comply with the following federal grant requirements regarding administration and allowable costs.

      i. For a local or Indian tribal government, use the principles in the common rule, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments," and Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments".

      ii. For a nonprofit organization other than
         - an institution of higher education,
         - a hospital, or
         - an organization named in OMB Circular A-122, “Cost Principles for Non-profit Organizations”, as not subject to that circular,

         use the principles in OMB Circular A-110, "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-profit Organizations," and OMB Circular A-122.

      iii. For an Educational Institution, use the principles in OMB Circular A-110 and OMB Circular A-21, "Cost Principles for Educational Institutions".

      iv. For a hospital, use the principles in OMB Circular A-110, Department of Health and Human Services, 45 CFR 74, Appendix E, "Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals" and, if not covered for audit purposes by OMB Circular A-133, “Audits of States Local Governments and Non-profit Organizations”, then subject to program specific audit requirements following Government Auditing Standards for financial audits.

b. If this contract is funded entirely from STATE funds, and if there are no specific administration and allowable costs requirements applicable, CONTRACTOR shall adhere to the applicable principles in “a” above.

c. The CONTRACTOR shall comply with the following grant requirements regarding audits.

i. If the contract is funded from federal funds, and the CONTRACTOR spends more than $500,000 in federal funds in their fiscal year, an audit report must be submitted in accordance with OMB Circular A-133.

ii. If this contract is funded from other than federal funds or if the contract is funded from a combination of STATE and federal funds but federal funds are less than $500,000, and if the CONTRACTOR receives $300,000 or more in total annual payments from the STATE, the CONTRACTOR shall submit to the STATE after the end of the CONTRACTOR's fiscal year an audit report. The audit report shall be submitted to the STATE within thirty days after its completion but no later than nine months after the end of the audit period. The audit report shall summarize the business and financial transactions of the CONTRACTOR. The report shall be prepared and certified by an independent accounting firm or other accounting entity, which is demonstrably independent of the administration of the program being audited. Audits performed of the CONTRACTOR's records shall be conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States covering financial audits. This audit requirement may be met through entity-wide audits, coincident with the CONTRACTOR's fiscal year, as described in OMB Circular A-133. Reports, disclosures, comments and opinions required under these publications should be so noted in the audit report.

d. For audit reports due on or after April 1, 2003, that are not received by the dates due, the following steps shall be taken:

i. If the audit report is one or more days late, voucher payments shall be held until a compliant audit report is received.

ii. If the audit report is 91 or more days late, the STATE shall recover payments for all STATE funded contracts for periods for which compliant audit reports are not received.

iii. If the audit report is 180 days or more late, the STATE shall terminate all active contracts, prohibit renewal of those contracts and prohibit the execution of future contracts until all outstanding compliant audit reports have been submitted.

4. The CONTRACTOR shall accept responsibility for compensating the STATE for any exceptions which are revealed on an audit and sustained after completion of the normal audit procedure.

5. FEDERAL CERTIFICATIONS: This section shall be applicable to this AGREEMENT only if any of the funds made available to the CONTRACTOR under this AGREEMENT are federal funds.

a. LOBBYING CERTIFICATION

1) If the CONTRACTOR is a tax-exempt organization under Section 501 (c)(4) of the Internal Revenue Code, the CONTRACTOR certifies that it will not engage in lobbying activities of any kind regardless of how funded.

2) The CONTRACTOR acknowledges that as a recipient of federal appropriated funds, it is subject to the limitations on the use of such funds to influence certain Federal contracting and financial transactions, as specified in Public Law 101-121, section 319, and codified in section 1352 of Title 31 of the United States Code. In accordance with P.L. 101-121, section 319, 31 U.S.C. 1352 and implementing regulations, the CONTRACTOR affirmatively acknowledges and represents that it is prohibited and shall refrain from using Federal funds received under this AGREEMENT for the purposes of lobbying; provided, however, that such prohibition does not apply in the case of a payment of reasonable compensation made to an officer or employee of the CONTRACTOR to the extent that the payment is for agency and legislative liaison activities not directly related to the awarding of any Federal contract, the making of any Federal grant or loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement. Nor does such prohibition prohibit any reasonable payment to a person in connection with, or any payment of reasonable compensation to an officer or employee of the CONTRACTOR if the payment is for professional or technical services rendered directly in the preparation, submission or negotiation of any bid, proposal, or application for a Federal contract, grant, loan, or cooperative agreement, or an extension, continuation, renewal, amendment, or modification thereof, or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal contract, grant, loan or cooperative agreement.

3) This section shall be applicable to this AGREEMENT only if federal funds allotted exceed $100,000.

a) The CONTRACTOR certifies, to the best of his or her knowledge and belief, that:

- No federal appropriated funds have been paid or will be paid, by or on behalf of the CONTRACTOR, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal amendment or modification of any federal contract, grant, loan, or cooperative agreement.

- If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract,

grant, loan, or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

b) The CONTRACTOR shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

c) The CONTRACTOR shall disclose specified information on any agreement with lobbyists whom the CONTRACTOR will pay with other Federal appropriated
funds by completion and submission to the STATE of the Federal Standard Form-LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions. This form may be obtained by contacting either the Office of Management and Budget Fax Information Line at (202) 395-9068 or the Bureau of Accounts Management at (518) 474-1208. Completed forms should be submitted to the New York State Department of Health, Bureau of Accounts Management, Empire State Plaza, Corning Tower Building, Room 1315, Albany, 12237-0016.

d) The CONTRACTOR shall file quarterly updates on the use of lobbyists if material changes occur, using the same standard disclosure form identified in
(c) above to report such updated information.

4) The reporting requirements enumerated in subsection (3) of this paragraph shall not apply to the CONTRACTOR with respect to:

a) Payments of reasonable compensation made to its regularly employed officers or employees;

b) A request for or receipt of a contract (other than a contract referred to in clause (c) below), grant, cooperative agreement, subcontract (other than a subcontract referred to in clause (c) below), or subgrant that does not exceed $100,000; and

c) A request for or receipt of a loan, or a commitment providing for the United States to insure or guarantee a loan, that does not exceed $150,000, including a contract or subcontract to carry out any purpose for which such a loan is made.

b. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE:

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this AGREEMENT, the CONTRACTOR certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The CONTRACTOR agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

c. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1) APPENDIX B TO 45 CFR PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

a) By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

b) The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

c) The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

d) The terms *covered transaction, debarred, suspended, ineligible*, *lower tier covered transaction, participant, person, primary covered transaction, principal, proposal,* and *voluntarily excluded*, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

e) The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

f) The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.

g) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded From Federal Procurement and Non-procurement Programs.

h) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a

participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

i) Except for transactions authorized under paragraph "e" of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2) Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

a) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department agency.

b) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

6. The STATE, its employees, representatives and designees, shall have the right at any time during normal business hours to inspect the sites where services are performed and observe the services being performed by the CONTRACTOR. The CONTRACTOR shall render all assistance and cooperation to the STATE in making such inspections. The surveyors shall have the responsibility for determining contract compliance as well as the quality of service being rendered.

7. The CONTRACTOR will not discriminate in the terms, conditions and privileges of employment, against any employee, or against any applicant for employment because of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status. The CONTRACTOR has an affirmative duty to take prompt, effective, investigative and remedial action where it has actual or constructive notice of discrimination in the terms, conditions or privileges of
employment against (including harassment of) any of its employees by any of its other employees, including managerial personnel, based on any of the factors listed above.

8. The CONTRACTOR shall not discriminate on the basis of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status against any person seeking services for which the CONTRACTOR may receive reimbursement or payment under this AGREEMENT.

9. The CONTRACTOR shall comply with all applicable federal, State and local civil rights and human rights laws with reference to equal employment opportunities and the provision of serv ices.

10. The STATE may cancel this AGREEMENT at any time by giving the CONTRACTOR not less than thirty (30) days written notice that on or after a date therein specified, this AGREEMENT shall be deemed terminated and cancelled.

11. Where the STATE does not provide notice to the NOT-FOR-PROFIT CONTRACTOR of its intent to not renew this contract by the date by which such notice is required by Section 179-t(1) of the State Finance Law, then this contract shall be deemed continued until the date that the agency provides the notice required by Section 179-t, and the expenses incurred during such extension shall be reimbursable under the terms of this contract.

12. Other Modifications

    a. Modifications of this AGREEMENT as specified below may be made within an existing PERIOD by mutual written agreement of both parties:

        - Appendix B - Budget line interchanges; Any proposed modification to the contract which results in a change of greater than 10 percent to any budget category, must be submitted to OSC for approval;
        - Appendix C - Section II, Progress and Final Reports;
        - Appendix D - Program Workplan will require OSC approval.

    b. To make any other modification of this AGREEMENT within an existing PERIOD, the parties shall revise or complete the appropriate appendix form(s), and a Modification Agreement (Appendix X is the blank form to be used), which shall be effective only upon approval by the Office of the State Comptroller.

13. Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for

    Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:

    - **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR

    - **C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR

    - **SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

    Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:

    - **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR

    - **DB-120.1** -- Certificate of Disability Benefits Insurance OR

- **DB-155** -- Certificate of Disability Benefits Self-Insurance

14. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). Contractor shall be liable for the costs associated with such breach if caused by Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Contractor's agents, officers, employees or subcontractors.

15. All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

16. Additional clauses as may be required under this AGREEMENT are annexed hereto as appendices and are made a part hereof if so indicated on the face page of this AGREEMENT.

APPENDIX A-2

PROGRAM SPECIFIC CLAUSES

1. Unless otherwise authorized or directed by the Department, all proposed subcontracts for the performance of the obligations contained herein require the review and approval of the Department prior to the execution of an agreement between the Contractor and subcontractors. All such agreements between the Contractor and subcontractors shall be by bona fide written contract, which may only be changed by expressed written consent of both parties and upon prior approval of the Department.

2. The Department shall have the right to contact any subcontractor directly concerning the performance of the obligations contained herein and to require the attendance of the subcontractor at any or all meetings between the Contractor and the Department, at which the performance of the Contractor pursuant to this AGREEMENT will be discussed.

3. Any interest accrued on funds provided to the contractor by the Department pursuant to the contractor's request for an advance payment, shall either be used to reduce reimbursement owed to the Contractor by the Department pursuant to this AGREEMENT, or at the direction of the Department, used to provide additional services provided for under this AGREEMENT.

4. The Contractor agrees to identify the position(s) and the incumbent(s) responsible for directing the work to be done under this AGREEMENT. The Department may, at its discretion, require the Contractor to request prior approval from the Department to change or substitute such responsible person(s), to the degree that such change is within the reasonable control of the Contractor.

5. PUBLICATIONS AND COPYRIGHTS

   a. The Contractor agrees that any and all materials, publications, videos, curricula conceived, produced and/or reduced to practice in the course of, or under this AGREEMENT, or with monies supplied pursuant to this AGREEMENT, shall become property of the Department and shall acknowledge the support of the Department of Health with the following language: "Produced with funding from the New York State Department of Health, Division of Family Health".

   b. The Department and the State of New York expressly reserve the right to reproduce, publish, distribute, copyright, or otherwise use, in perpetuity, any and all materials, publication, videos, curricula conceived and produced, resulting from the AGREEMENT or activity supported by this AGREEMENT.

   c. The Contractor agrees that unless otherwise provided by the terms of this agreement, the Contractor is expressly prohibited from copyrighting the materials developed in the course of this AGREEMENT, or permitting others to do so without the prior written consent of the Department.

   d. If any materials paid for under this contract are used in a revenue generating activity, the Contractor shall report such intentions to the Department for prior written approval and shall be subject to the direction of the Department as to the disposition of such revenue.

e. The results of any activity supported under this AGREEMENT may not be published without prior written approval of the Department, which results (1) shall acknowledge the support of the Department and the State of New York and (2) shall state that the opinions, results, findings and/or interpretations of data contained therein are the responsibility of the Contractor and do not necessarily represent the opinions, interpretation or policy of the Department or the State of New York.

6. PURCHASING

a. All procurement transactions, including but not limited to equipment purchases and leases, supplies, conference, training, or seminar related expenditures, and other services whose cost is borne in whole or in part by this contract shall be conducted in a manner to provide, to the maximum extent practicable, open and free competition.

b. Procurement records and files for purchases in excess of $5,000 shall include the following:

i. basis for selection;

ii listing of bidders solicited or vendors contacted, including but not limited to the response from each bidder or vendor to the solicitation;

iii. justification for lack of competition when competitive bids or offers are not obtained;

iv. basis for award cost or price.

7. Reimbursement for any travel related expenses, including but not limited to transportation, lodging, and meal expenses shall be based upon the actual, necessary, and reasonable expenses essential to the ordinary comforts of the traveler in the performance of the duties under this AGREEMENT. Out-of-state travel must have prior written approval from the Department if such travel will use funds provided under this contract. Written requests must include a conference brochure, explanation of how this training will promote attainment of the contract deliverables. Such expenses shall be limited to the established travel reimbursement guidelines for State employees, issued by the Office of the State Comptroller.

8. Contractors shall participate in Department-sponsored meetings and training, as required by the Department.

9. In the event of termination of this AGREEMENT, client case records SHALL be transferred or disposed of as directed by the Department or its agent.

APPENDIX B

Insert Budget Tables A, A-1 and A-2 for years 2013-2018 here

APPENDIX C
PAYMENT AND REPORTING SCHEDULE

I. Payment and Reporting Terms and Conditions

A. The STATE may, at its discretion, make an advance payment to the CONTRACTOR, during the initial or any subsequent PERIOD, in an amount to be determined by the STATE but not to exceed twenty-five (25) percent of the maximum amount indicated in the budget as set forth in the most recently approved Appendix B. If this payment is to be made, it will be due thirty calendar days, excluding legal holidays, after the later of either:

- the first day of the contract term specified in the Initial Contract Period identified on the face page of the AGREEMENT or if renewed, in the PERIOD identified in the Appendix X, OR

- if this contract is wholly or partially supported by Federal funds, availability of the federal funds;

provided, however, that the STATE has not determined otherwise in a written notification to the CONTRACTOR suspending a Written Directive associated with this AGREEMENT, and that a proper voucher for such advance has been received in the STATE's designated payment office. If no advance payment is to be made, the initial payment under this AGREEMENT shall be due thirty (30) calendar days, excluding legal holidays, after the later of either:

- the end of the first quarterly period of this AGREEMENT; or

- if this contract is wholly or partially supported by federal funds, availability of the federal funds;

provided, however, that a proper voucher for this payment has been received in the STATE's designated payment office.

B. No payment under this AGREEMENT, other than advances as authorized herein, will be made by the STATE to the CONTRACTOR unless proof of performance of required services or accomplishments is provided. If the CONTRACTOR fails to perform the services required under this AGREEMENT the STATE shall, in addition to any remedies available by law or equity, recoup payments made but not earned, by set-off against any other public funds owed to CONTRACTOR.

C. Any optional advance payment(s) shall be applied by the STATE to future payments due to the CONTRACTOR for services provided during initial or subsequent PERIODS. Should funds for subsequent PERIODS not be appropriated or budgeted by the STATE for the purpose herein specified, the STATE shall, in accordance with Section 41 of the State Finance Law, have no liability under this AGREEMENT to the CONTRACTOR, and this AGREEMENT shall be considered terminated and cancelled.

D. The CONTRACTOR will be entitled to receive payments for work, projects, and services rendered as detailed and described in the program workplan, Appendix D. All payments shall be in conformance with the rules and regulations of the Office of the State Comptroller.

E. The CONTRACTOR will provide the STATE with the reports of progress or other specific work products pursuant to this AGREEMENT as described in this Appendix, below. In addition, a final/annual report must be submitted by the CONTRACTOR no later than 30 days after the end date of this AGREEMENT. All required reports or other work products developed under this AGREEMENT must be completed as provided by the agreed upon work schedule in a manner satisfactory and acceptable to the STATE in order for the CONTRACTOR to be eligible for payment.

F. The CONTRACTOR shall submit to the STATE quarterly voucher claims and reports of expenditures on such forms and in such detail as the STATE shall require. The CONTRACTOR shall submit vouchers to the State's designated payment office located in the **NYS Department of Health, Bureau of Maternal & Child Health Administration Unit, Room 878, Corning Tower Building, Empire State Plaza, Albany, NY 12237-0618.**

All vouchers submitted by the CONTRACTOR pursuant to this AGREEMENT shall be submitted to the STATE no later than **forty-five (45)** days after the end date of the period for which reimbursement is being claimed. In no event shall the amount received by the CONTRACTOR exceed the budget amount approved by the STATE, and, if actual expenditures by the CONTRACTOR are less than such sum, the amount payable by the STATE to the CONTRACTOR shall not exceed the amount of actual expenditures. All contract advances in excess of actual expenditures will be recouped by the STATE prior to the end of the applicable budget period.

The Contractor SHALL submit the final voucher for the budget period no later than **forty-five (45)** days after the end of the budget period. The final voucher (must be marked 'Final') and expenditure report is due in Bureau of Maternal & Child Health Administration Unit by **February 15**th each year.

G. If the CONTRACTOR is eligible for an annual cost of living adjustment (COLA), enacted in New York State Law, that is associated with this grant AGREEMENT, payment of such COLA shall be made separate from payments under this AGREEMENT and shall not be applied toward or amend amounts payable under Appendix B of this AGREEMENT.

Before payment of a COLA can be made, the STATE shall notify the CONTRACTOR, in writing, of eligibility for any COLA. The CONTRACTOR shall be required to submit a written certification attesting that all COLA funding will be used to promote the recruitment and retention of staff or respond to other critical non-personal service costs during the State fiscal year for which the cost of living adjustment was allocated, or provide any other such certification as may be required in the enacted legislation authorizing the COLA.

II. Nurse Family Partnership Reports:

Receipt of reports is a prerequisite for voucher payment and reimbursement.

A. Narrative/Qualitative and Quantitative Reports

Quarterly and Annual Narrative Reports: The Contractor SHALL submit, on a quarterly basis, not later than thirty (30) days from the end of the quarter, a narrative report which will detail how the Contractor has progressed toward attaining the goals enumerated in the Workplan (Appendix D) in a format to be provided by the Department. The report SHALL address all goals and objectives of the project and include discussion of problems encountered and steps taken to resolve them. Q**uarterly reports are due 30 days after the end of each quarter as follows: May 31, August 30, November 30, and January 31.**

The Contractor SHALL submit an annual narrative report, consisting of a brief summary of program information for the entire contract year. **The due date for the annual report is March 31 each year (90 days after the end of the year).**

The annual report will include the following sections and information:

Goals and Objectives

- Progress made under each goal and objective during the reporting period including discussions of barriers to progress and steps taken to overcome thos barriers;
- Any updates or revisions to goals and objectives.

Implementation

- Summary of planning and implementation activities for the home visiting programs for each targeted community, including:
    - Progress for engaging the at-risk communities;
    - Staff recruitments, hiring and retention for all positions including subcontracts;
    - Participant recruitment and retention efforts;
    - Status of home visiting program caseload with each at-risk community;
    - Coordination between home visiting programs and other existing programs and supportive services in those communities;
    - Anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.
- Discussion of any barriers or challenges encountered with program implementation and steps taken to overcome those barriers.

Progress

- Summary of data collection efforts for each of the six benchmark areas, including an update on data collected on all constructs within the benchmark areas along with definitions of what constitutes improvement, sources of data for each measure utilized, barriers/challenges encountered during data collection efforts, and steps taken to overcome them.

Final Report (End of Contract Report)
The Contractor SHALL submit a final report within 60 days of the end of the multiple-year contract, in a format designated by the Department, reporting on all aspects of the program, detailing how the use of grant funds were utilized in achieving the goals set forth in the

program Workplan (Appendix D). The report will summarize major accomplishments and identify problems and strategies relative to program goals and objectives.

Equipment: Both annual and final reports SHALL include an updated, comprehensive inventory of all furniture, equipment and other items (with a purchase value of $300.00 or more and a useful life of at least 3 years) that were purchased with State grant funds over the course of the five-year contract period. Items must be identified by tag numbers, manufacturer's serial numbers and any relevant remarks. If no equipment was purchased the Contractor shall include a statement in the annual and final summaries that no equipment was purchased during the contract year.

B. Financial Records

The CONTRACTOR will maintain financial records, as required by the STATE, in such manner as to allow the identification of expenditure and revenue data associated with the services provided as part of the AGREEMENT.

C. Budget Statement and Report of Expenditures (BSROE)

The Contractor SHALL submit on at least a quarterly basis, not later than **forty-five (45) days** after the end date for which reimbursement is being claimed, a detailed expenditure report by object of expense. This report will accompany the voucher submitted for such period. Documentation of all expenses SHALL be available upon request. The Department MAY require documentation of expenses before payment is made of any particular voucher. Vacant positions should be reported as an attachment to the quarterly voucher and progress report. The explanation must include what has been done to recruit and fill the positions and describe any problems with filling the vacancy(s).

The Contractor SHALL submit all budget modification requests to the Department of Health for approval. All budget modification requests must be approved by the Department prior to the commitment and use of funds. Refer to Appendix A-1, Section 12 (a) regarding proposed budget modifications resulting in a change greater than 10 percent to any budget category. The requests must be dated and signed by an individual authorized by the Contractor before submission to the Department, and must follow the approved format. Final budget modifications are due 60 days prior to the end of the contract period. After that deadline has passed, only "clean-up" budget modifications (for example, minor reconciliation of travel expenses) will be allowed up until 30 days after the end of the contract period. Major budget modifications will not be accepted after the 60 day deadline.

D. Expenditure and Revenue Report

The Contractor will sub mit, on a qu arterly basis, not later than forty-five (45) days a fter the end date for which reimbursement is being cl aimed a program expe nditure and revenue report. Program revenue and expenses are to be reported on an accrued basis. This report will accompany the voucher submitted for such period.

APPENDIX D

Maternal and Infant Community Health Collaborative
Component A
Standard Work Plan
July 1, 2013 - June 30, 2018

Contractor:	Contract Number:
Target Area (Include ZIP codes):	

Standard	Activities
1. High-need women and infants are enrolled in health insurance	1.1 Identify specific factors and barriers to enrollment in health insurance among high-need populations within targeted communities – including factors at the community systems, organizational and individual/family levels. 1.2 Conduct appropriate outreach and education to identify high-risk women currently without health insurance and ensure enrollment across the life span, including enrollment of eligible women in Medicaid Family Planning Benefit Program.
2. High-need women and infants are engaged in health care and other supportive services appropriate to their needs	2.1 Identify specific factors and barriers to accessing and utilizing health and other needed supportive services among high-need populations within targeted communities – including factors at the community systems, organizational and individual/family levels. 2.2. Effectively engage and retain high-need, hard to reach populations in timely and ongoing health and other needed supportive services across the life course stages (preconception, prenatal/postpartum, interconception), including increasing awareness and utilization of family planning services.
3. The medical, behavioral, and psychosocial risk factors of high-need women and infants are identified and addressed through timely and coordinated counseling, management, referral and follow-up	3.1 Identify specific factors and barriers to identifying and addressing medical, behavioral and psychosocial risk factors of women and infants among high-need populations within their selected targeted communities – including factors at the community systems, organizational and individual/family levels. 3.2 Improve timely risk identification, follow-up and coordination of interventions and supportive services across the reproductive life course, including identifying, counseling and referring individuals who may benefit from family planning services as part of required Offering and Arranging activities.
4. Within the community there are supports and opportunities in place that help high-need women to be engaged in and maintain healthy behaviors and reduce or eliminate risky behaviors.	4.1 Identify specific needs and strengths within target communities and populations that influence the availability of structural, environmental and social supports and opportunities for health-promoting behaviors across the life course. 4.2 Develop meaningful partnerships with a diverse set of community organizations and actors – including those not traditionally involved in the public health and health care sectors – to plan, develop and implement collaborative community and system level solutions, including promoting family planning, birth spacing, prevention of unintended pregnancy, and

	utilization of family planning services.
5. Demonstrate improvements in measurable outcomes for participating families.	5.1 Collect and report data on individual participants from the point of the initial eligibility screen to case closing to report on performance measures to be provided by NYSDOH
6. Submit narrative quarterly and annual reports in a format to be provided by NYSDOH.	6.1 Submit narrative quarterly and annual reports in a format to be provided by NYSDOH.
7. Develop an updated annual needs assessment.	7.1. Develop a local community needs assessment in a format to be provided by NYSDOH that includes critical analysis of community-level data, existing community services, resources, gaps in services and characteristics of high-risk populations. 7.2. Submit an updated needs assessment on an annual basis. 7.3. Update and revise workplan goals, objectives and program activities based on results of annual needs assessments.

<u>**APPENDIX D**</u>

Maternal, Infant and Early Childhood Home Visiting
Component B
Standard Work Plan
July 1, 2013 - September 29, 2016

Contractor:	**Contract Number:**
Target Area (Include ZIP codes):	
Objective	**Activities Related to Objective**
1. Home visitors are recruited, trained and deployed consistent with model-specific requirements	1.1 Recruit and hire staff that meet minimum qualifications for program management, supervision and home visiting positions as required by the model home visiting program; 1.2 Facilitate provision of core training of home visiting staff as required by the program's national organization, as well as additional training to be provided by NYSDOH; and 1.3 Provide professional supervision of home visitor staff in accordance with the model requirements
2. High-need families are identified, screened for eligibility and enrolled in evidenced-based home visiting program services	2.1 Identify high-risk women eligible for program participation, including those not already receiving prenatal care, and those eligible pregnant women and families who may be likely to avoid health services for such reasons as substance abuse, domestic violence, adolescences and other factors; 2.2 Partner with local hospitals, prenatal care providers, schools, WIC clinics, community and faith based organizations and other agencies serving high-risk pregnant and newly parenting families to promote referrals of potential home visiting clients; 2.3 Effectively engage high-risk women to improve the acceptance rate for home visiting program enrollment among those who are eligible for services, with particular emphasis on any sub-groups that typically have lower acceptance rates; and 2.4 Improve retention/minimize attrition of home visiting clients. Examples of strategies include but may not be limited to: scheduling home visits at times convenient to the clients including nights and weekends; maintaining consistent schedules of visits; motivational interviewing; hiring staff that are representative of the culture and language spoken by the target community; partnering with other community providers to reinforce continued engagement in home visiting services.

3. ***Home visiting services are provided to enrolled clinets with fidelity to the evidence-based program model***	3.1. Conduct ongoing hom e visiting se rvices, with fidelity to the evidence-based hom e visiting model.
4. ***Measurable improvements across key benchmark areas will be achieved for families participating in home visiting services***	4.1. Collect and report data on individual participants from the point of the initial eligibility screen to case closing to report on performance measures to be provided by NYSDOH for all required constructs to measure improvement within each of the required six benchmark areas: 1. Maternal & Child Health; 2. Childhood Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits; 3. School Readiness and Achievement; 4. Domestic Violence; 5. Family Economic Self-Sufficiency; 6. Coordination and Referrals.
5. ***Home visiting programs will be coordinated and integrated with larger community maternal, infant and early childhood service systems***	5.1. Coordinate outreach, referral, assessment and intake processes with other home visiting programs and other service providers in the community; 5.2. Establish referral agreements with prenatal care providers and local supportive service agencies including substance abuse, mental health, domestic violence, nutrition services, child protective services and other health and social services agencies; 5.3. Coordinate with other home visiting programs, and other relevant community partners including Maternal and Infant Community Health Collaboratives, to develop and implement coordinated systems for outreach, screening, referral, follow-up and ongoing service delivery to high-risk women and families. 5.4. Promote and facilitate partnerships and integration with broader family support resources within the community (e.g., Family Resource Centers, libraries, parks and recreational activities, breastfeeding support groups, formal and informal parenting groups, job training, etc.)
6. Submit narrative quarterly and annual reports in a format to be provided by NYSDOH.	6.1. Submit narrative quarterly and annual reports in a format to be provided by NYSDOH.

7. *Develop an updated annual community needs assessment.*	7.1. Develop a community needs assessment in a format to be provided by NYSDOH, that includes critical analysis of community-level data, existing home visiting programs and their quality and capacity, existing community resources, gaps in services and characteristics of high-risk populations. 7.2. Submit an updated community needs assessment on an annual basis. Include a description of how implementation of the improvement plan will be impacted by results of the community needs assessment including any updates or revisions to goals, objectives and program activities.

Appendix G

NOTICES

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

(a) via certified or registered United States mail, return receipt requested;
(b) by facsimile transmission;
(c) by personal delivery;
(d) by expedited delivery service; or
(e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health
Name: Amy B. Hauptli
Title: Health Program Administrator
Address: Bureau of Maternal & Child Health Administration Unit
Telephone Number: (518) 474-4569
Facsimile Number: (518) 473-3391
E-Mail Address: ABB03@health.state.ny.us

[*Insert Contractor Name*]
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

Agency Code 12000
APPENDIX X

Contract Number:__________ Contractor:________________________

Amendment Number X-______

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the STATE), and ___________________________________ (hereinafter referred to as the CONTRACTOR), for amendment of this contract.

This amendment makes the following changes to the contract (check all that apply):

______ Modifies the contract period at no additional cost

______ Modifies the contract period at additional cost

______ Modifies the budget or payment terms

______ Modifies the work plan or deliverables

______ Replaces appendix(es) _________ with the attached appendix(es)_________

______ Adds the attached appendix(es) ________

______ Other: (describe) ________________________________

This amendment *is*__ *is not*__ a contract renewal as allowed for in the existing contract.

All other provisions of said AGREEMENT shall remain in full force and effect.

Prior to this amendment, the contract value and period were:

$____________________ From ___/_____/____ to ____/____/____.__________
(Value before amendment) (Initial start date)

This amendment provides the following modification (complete only items being modified):

$____________________ From ___/_____/____ to ____/____/____.

This will result in new contract terms of:

$ ____________________ From ___/_____/____ to ____/____/____.
(All years thus far combined) (Initial start date) (Amendment end date)

Signature Page for:

Contract Number:__________ Contractor:_______________ __________

Amendment Number: X-_____

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By:________________________________ Date: _________________________
(signature)

Printed Name:______________________________________

Title:____

STATE OF NEW YORK)
) SS:
County of _____________)

On the ___ day of ___________ in the year ______ before me, the undersigned, personally appeared ___________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

____
(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this contract, I also certify that original c opies of this signature page will be attached to all other exact copies of this contract."

By:________________________________ Date :______________________________
(signature)

Printed Name:______________________________________

Title:____

ATTORNEY GENERAL'S SIGNATURE

By:________________________________ Date:______________________________

STATE COMPTROLLER'S SIGNATURE

By:________________________________ Date:______________________________

Revised 4/2003

APPENDIX X

MODIFICATION AGREEMENT

Agency Code: 25000 Contract No. Period: 06/01/2013 – 06/30/2018

Funding Amount for Period $

☐ **This contract is funded with non-Federal funds only**

☐ **This contract is funded in whole or part with Federal funds (see Appendix A3, paragraph 14 for Federal audit information)**

☐ **OCFS has determined that the Contractor is NOT a subrecipient**

☐ **OCFS has determined that the Contractor is a subrecipient**

The Federal Funds for this contract are from the Catalogue of Federal Domestic Assistance (CFDA) Number(s):

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through the Office of Children and Family Services, having its principal office at 52 Washington Street, Rensselaer, New York 12144 (hereinafter referred to as the STATE), and ______________________ (hereinafter referred to as the CONTRACTOR), for modification of Contract Number ______________ , as amended in attached Appendix(ices).

Single Year & Simplified Renewals – ______________

APPENDIX A-1

APPENDIX B

APPENDIX C

APPENDIX D APPLICATION COVER PAGE AGREEMENT - ______________

APPENDIX M/WBE

All other provisions of said AGREEMENT shall remain in full force and effect.

+

The parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR	**STATE AGENCY** Office of Children and Family Services
Electronically Signed by:	Electronically Signed by:
	State Agency Certification "In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

I certify that I have personally verified the electronic signature of the Contractor to this Agreement.

BCM SIGNATURE: ______________________________

Title: ______________________ Date: ______________________

ATTORNEY GENERAL'S SIGNATURE

Approved:
Thomas P. DiNapoli
State Comptroller

Title: ______________________ Title: ______________________

Date: ______________________ Date: ______________________

STATE OF NEW YORK
AGREEMENT
(SINGLE YEAR AND SIMPLIFIED RENEWAL CONTRACTS)

(Revised June 2012)

This AGREEMENT is hereby made by and between the State of New York agency (STATE) and the public or private agency (CONTRACTOR) identified on the face page hereof.

WITNESSETH:

WHEREAS, the STATE has the authority to regulate and provide funding for the establishment and operation of program services and desires to contract with skilled parties possessing the necessary resources to provide such services; and

WHEREAS, the CONTRACTOR is ready, willing and able to provide such program services and possesses or can make available all necessary qualified personnel, licenses, facilities and expertise to perform or have performed the services required pursuant to the terms of this AGREEMENT;

NOW THEREFORE, in consideration of the promises, responsibilities and covenants herein, the STATE and the CONTRACTOR agree as follows:

I. Conditions of Agreement

A. This AGREEMENT may consist of successive periods (PERIOD), as specified within the AGREEMENT or within a subsequent Modification Agreement(s) (Appendix X). Each additional or superseding PERIOD shall be on the forms specified by the particular State agency, and shall be incorporated into this AGREEMENT.

B. Funding for the first PERIOD shall not exceed the funding amount specified on the face page hereof. Funding for each subsequent PERIOD, if any, shall not exceed the amount specified in the appropriate appendix for that PERIOD.

C This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.

D. For each succeeding PERIOD of this AGREEMENT, the parties shall prepare new appendices, to the extent that any require modification, and a Modification Agreement (The attached Appendix X is the blank form to be used). Any terms of this AGREEMENT not modified shall remain in effect for each PERIOD of the AGREEMENT.

   To modify the AGREEMENT within an existing PERIOD, the parties shall revise or complete the appropriate appendix form(s). Any change in the amount of consideration to be paid, or change in the term, is subject to the approval of the Office of the State Comptroller. Any other modification shall be processed in accordance with agency guidelines as stated in Appendix A1.

E. The CONTRACTOR shall perform all services to the satisfaction of the STATE. The CONTRACTOR shall provide services and meet the program objectives summarized in the Program Workplan (Appendix D) in accordance with: provisions of the AGREEMENT; relevant laws, rules and regulations, administrative and fiscal guidelines; and where applicable, operating certificates for facilities or licenses for an activity or program.

F. If the CONTRACTOR enters into subcontracts for the performance of work pursuant to the AGREEMENT, the CONTRACTOR shall take full responsibility for the acts and omissions of its subcontractors. Nothing in the subcontract shall impair the rights of the STATE under this AGREEMENT. No contractual relationship shall be deemed to exist between the subcontractor and the STATE.

G. Any proposed modification to the AGREEMENT that will result in a transfer of funds among program activities or budget cost categories, but does not affect the amount, consideration, scope or other terms of such AGREEMENT must be submitted to the Office of the State Comptroller for approval when: **1)** The amount of the modification is equal to or greater than ten percent of the total value of the contract for contracts less than five million dollars; **OR, 2)** The amount of the modification is equal to or greater than five percent of the total value of the contract for contracts equal to or greater than five million dollars.

H. Appendix A (Standard Clauses as required by the Attorney General for all State contracts) takes precedence over all other parts of the AGREEMENT.

II. Payment and Reporting

A. The CONTRACTOR, to be eligible for payment, shall submit to the STATE's designated payment office (identified in Appendix C) any appropriate documentation as required by the Payment and Reporting Schedule (Appendix C) and by agency fiscal guidelines, in a manner acceptable to the STATE.

B. The STATE shall make payments and any reconciliations in accordance with the Payment and Reporting Schedule (Appendix C). The STATE shall pay the CONTRACTOR, in consideration of contract services for a given PERIOD, a sum not to exceed the amount noted on the face page hereof or in the respective Appendix designating the payment amount for that given PERIOD. This sum shall not duplicate reimbursement from other sources for CONTRACTOR costs and services provided pursuant to this AGREEMENT.

C. The CONTRACTOR shall meet the audit requirements specified by the STATE.

III. Terminations

A. This AGREEMENT may be terminated at any time upon mutual written consent of the STATE and the CONTRACTOR.

B. The STATE may terminate the AGREEMENT immediately, upon written notice of termination to the CONTRACTOR, if the CONTRACTOR fails to comply with the terms and conditions of this AGREEMENT and/or with any laws, rules, regulations, policies or procedures affecting this AGREEMENT.

C. The STATE may also terminate this AGREEMENT for any reason in accordance with provisions set forth in Appendix A1.

D. Written notice of termination, where required, shall be sent by personal messenger service or by certified mail, return receipt requested. The termination shall be effective in accordance with the terms of the notice.

E. Upon receipt of notice of termination, the CONTRACTOR agrees to cancel, prior to the effective date of any prospective termination, as many outstanding obligations as possible, and

agrees not to incur any new obligations after receipt of the notice without approval by the STATE.

F. The STATE shall only be responsible for payment on claims pursuant to services provided and costs incurred prior to the termination date and pursuant to terms of the AGREEMENT. In no event shall the STATE be liable for expenses incurred after the termination date.

IV. **Indemnification**

A. The CONTRACTOR shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the CONTRACTOR or its subcontractors pursuant to this AGREEMENT. The CONTRACTOR shall indemnify and hold harmless the STATE and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT.

B. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the STATE nor make any claim, demand or application to or for any right based upon any different status.

V. **Property**

Any equipment, furniture, supplies or other property purchased pursuant to this AGREEMENT is deemed to be property of the STATE except as may otherwise be governed by Federal or State laws, ruled or regulations, or as stated in Appendix A1.

VI. **Safeguards for Services and Confidentiality**

A. Services performed pursuant to this AGREEMENT are secular in nature and shall be performed in a manner that does not discriminate on the basis of religious belief, or promote or discourage adherence to religion in general or particular religious beliefs.

B. Funds provided pursuant to this AGREEMENT shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

Information relating to individuals who may receive services pursuant to this AGREEMENT shall be maintained and used only for the purposes intended under the contract and in conformity with applicable provisions of laws and regulations, or specified in Appendix A1.

APPENDIX A-1

STANDARD CLAUSES FOR ALL

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES CONTRACTS

(Revised 05-2012)

1. PERSONNEL

a. The Contractor agrees to be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries and management of its project personnel, which shall be as shown in the APPENDICES. These functions shall be carried out in accordance with the provisions of this AGREEMENT, and all applicable Federal and State laws and regulations.

b. It is the policy of the Office to encourage the employment of qualified applicants for, or recipients of public assistance by both public organizations and private enterprises who are under contractual AGREEMENT to the Office for the provision of goods and services. Contractors will be expected to make best efforts in this area.

c. The Contractor agrees to identify, in writing, the person(s) who will be responsible for directing the work to be done under this AGREEMENT. No change or substitution of such responsible person(s) will be made without prior approval in writing from the Office, to the degree that such change is within the reasonable control of the Contractor.

2. NOTICES

a. All notices permitted or required hereunder shall be in writing and shall be transmitted either:

- By certified or registered United States mail, return receipt requested;
- By facsimile transmission;
- By personal delivery;
- By expedited delivery service; or
- By e-mail.

Notices to the Office shall be addressed to the Program Manager assigned to this contract at the Address, Telephone Number, Facsimile Number or E-Mail Address provided to the Contractor during contract development, or to such different Program Manager as the Office may from time-to-time designate.

Notices to the Contractor shall be addressed to the Contractor's designee as shown on the Cover Page in Appendix D, or to such different designee as the Contractor may from time-to-time designate.

b. Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

c. The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

3. OFFICE SERVICES

a. The Contractor shall be responsible for the provision of necessary equipment and services for Contractor's staff, pursuant to and described in the narratives and budgets contained in the APPENDICES.

b. For Federally funded contracts, title to real property and non-expendable personal property whose requisition cost is borne in whole or in part by monies provided under this AGREEMENT shall be determined

between the Contractor and the Office, pursuant to Federal regulations 45 CFR 92 unless such authority is otherwise inappropriate. Title to all equipment, supplies and material purchased with funds under this AGREEMENT under contracts which are not Federally funded shall be in the State of New York and the property shall not be transferred, conveyed, or disposed of without written approval of the Office. Upon expiration or termination of this AGREEMENT, all property purchased with funds under this AGREEMENT shall be returned to the Office, unless the Office has given direction for, or approval of, an alternative means of disposition in writing.

c. Upon written direction by the Office, the Contractor shall maintain an inventory of those properties that are subject to the provisions of sub-paragraph b of this section.

4. <u>GENERAL TERMS AND CONDITIONS</u>

a. The Contractor agrees to comply in all respects with the provisions of this AGREEMENT and the attachments hereto. The Contractor specifically agrees to perform services according to the objectives, tasks, work plan and staffing plan contained in the APPENDICES. Any modifications to the tasks or workplan contained in Appendix D must be mutually agreed to by both parties in writing before the additional or modified tasks or workplan shall commence.

b.i. If any specific event or conjunction of circumstances threatens the successful completion of this project, in whole or in part, including where relevant, timely completion of milestones, the Contractor agrees to submit to the Office within three days of occurrence or perception of such problem, a written description thereof together with a recommended solution thereto.

b.ii. The Contractor immediately shall notify in writing the OCFS Program Manager assigned to this contract of any unusual incident, occurrence or event that involves the staff, volunteers or officers of the Contractor, any subcontractor or Program participant funded through this contract, including but not limited to the following: death or serious injury; an arrest or possible criminal activity; any destruction of property; significant damage to the physical plant of the Contractor; or other matters of a similarly serious nature.

c. In providing these services, the Contractor hereby agrees to be responsible for designing and operating these services, and otherwise performing, so as to maximize Federal financial participation to the Office under the Federal Social Security Act.

d. If funds from this contract will be used to pay any costs associated with the provision of legal services of any sort, the following shall apply:

- No litigation shall be brought against the State of New York, the New York State Office of Children and Family Services, or against any county or other local government or local social services district with funds provided under this contract. The term “litigation” shall include commencing or threatening to commence a lawsuit, joining or threatening to join as a party to ongoing litigation, or requesting any relief from either the State of New York, the New York State Office of Children and Family Services or any county or other local government or local social services district, based upon any agreement between such agency in litigation with another party and such party, during the pendency of the litigation.

- Opinions prepared by consultant law firms construing the statutes or Constitution of the State of New York do not constitute the view of the State unless the prior written approval of the Attorney General is obtained. Requests for said approval shall be submitted to the Solicitor General, Division of the Appeals and Opinions Bureau, Department of Law, The Capitol, Albany, New York 12224.

- The contractor shall provide to the New York State Office of Children and Family Services in a format provided by the Office such additional information concerning the provision of legal services as the Office shall require.

e. The Office will designate a Contract Manager who shall have authority relating to the technical services and operational functions of this AGREEMENT and activities completed or contemplated there under. The Contract Manager and those individuals designated by him/her in writing shall have the prerogative to make announced or unannounced on-site visits to the project. Project reports and issues of interpretation or direction relating to this AGREEMENT shall be directed to the Contract Manager.

f. Except where the Office otherwise authorizes or directs in writing, the Contractor agrees not to enter into

any subcontracts, or revisions to subcontracts, for the performance of the obligations contained herein until it has received the prior written approval of the Office, which shall have the right to review and approve each and every subcontract prior to giving written approval to the Contractor to enter into the subcontract. All AGREEMENTS between the Contractor and subcontractors shall be by written contract, signed by individuals authorized to bind the parties. All such subcontracts shall contain provisions for specifying (1) that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, (2) that nothing contained in the subcontract shall impair the rights of the Office under this AGREEMENT, (3) that nothing contained in the subcontract, nor under this AGREEMENT, shall be deemed to create any contractual relationship between the subcontractor and the Office, and (4) incorporating all provisions regarding the rights of the Office as set forth in Section 9 of this Appendix A-1 and in Appendix A-3, where applicable. The Contractor specifically agrees that the Contractor shall be fully responsible to the Office for the acts and omissions of subcontractors and of persons either directly or indirectly employed by them, as it is for the acts and omissions of persons directly employed by the Contractor

g. The contractor warrants that it, its staff and any and all Subcontractors which must be approved by the Office, have all the necessary licenses, approvals and certifications currently required by the laws of any applicable local, state or federal government to perform the services pursuant to this AGREEMENT and/or subcontract entered into under this AGREEMENT. The Contractor further agrees such required licenses, approvals and certificates will be kept in full force and effect during the term of this Agreement, or any extension thereof, and to secure any new licenses, approvals or certificates within the required time frames and/or to require its staff and Subcontractors to obtain the requisite licenses, approvals or certificates. In the event the Contractor, its staff, and/or Subcontractors are notified of a denial or revocation of any license, approval or certification to perform the services under the AGREEMENT, Contractor will immediately notify Office.

h. Prior to executing a subcontract agreement the Contractor agrees to provide to the Office the information the Office needs to determine whether a proposed Subcontractor is a responsible vendor. The determination of vendor responsibility will be made in accordance with Section 3 m. of this Appendix A-1.

i. If the Contractor intends to use materials, equipment or personnel paid for under this contract in a revenue generating activity, the Contractor shall report such intentions to the Office forthwith and shall be subject to the direction of the Office as to the disposition of such revenue.

j. Any interest accrued on funds paid to the Contractor by the Office shall be deemed to be the property of the Office and shall either be credited to the Office at the closeout of this AGREEMENT or expended on additional services provided for under this AGREEMENT.

k. The Contractor ensures that the grounds, structures, buildings and furnishings at the program site(s) used under this AGREEMENT are maintained in good repair and free from any danger to health or safety and that any building or structure used for program services complies with all applicable zoning, building, health, sanitary, and fire codes.

l. The Contractor agrees to produce, and retain for the balance of the calendar year in which produced, and for a period of six years thereafter, any and all records necessary to substantiate upon audit, the proper deposit and expenditure of funds received under this contract. Such records shall include, but not be limited to, original books of entry (e.g., cash disbursements and cash receipts journal), and the following specific records (as applicable) to substantiate the types of expenditures noted:

- Payroll Expenditures: cancelled checks and the related bank statements, time and attendance records, payroll journals, employee personal history folders, and cost allocation plans, if applicable.

- Payroll Taxes and Fringe Benefits: cancelled checks, copies of related bank statements, reporting forms, and invoices for Fringe Benefit expenses.

- Non-Personal Services Expenditures: original invoices/receipts, cancelled checks and related bank statements, consultant agreements, leases, and cost allocation plans, if applicable.

- Receipt and Deposit of Advance and Reimbursements: Itemized bank stamped deposit slips, and a copy of the related bank statements.

Although not required, the Office recommends that the Contractor retain records directly pertinent to this contract for a period of ten (10) years after the end of the calendar year in which they were made, as the

statute of limitations for the New York False Claims Act is ten years.

m. By signing this contract, the contractor certifies that within the past three years the contractor has engaged in no actions that would establish a basis for a finding by OCFS that the contractor is a non-responsible vendor or, if the contractor has engaged in any such action or actions, that all such actions have been disclosed to OCFS prior to entering into this contract. The actions that would potentially establish a basis for a finding by OCFS that the contractor is a non-responsible vendor include:

   - The contractor has had a license or contract suspended, revoked or terminated by a governmental agency.
   - The contractor has had a claim, lien, fine, or penalty imposed or secured against the contractor by a governmental agency.
   - The contractor has initiated a bankruptcy proceeding or such a proceeding has been initiated against the contractor.
   - The contractor has been issued a citation, notice, or violation order by a governmental agency finding the contractor to be in violation of any local, state or federal laws.
   - The contractor has been advised by a governmental agency that a determination to issue a citation, notice or violation order finding the contractor to be in violation of any local, state or federal laws is pending before a governmental agency.
   - The contractor has not paid all due and owed local, state and federal taxes to the proper authorities.
   - The contractor has engaged in any other actions of a similarly serious nature.

   Where the contractor has disclosed any of the above to OCFS, OCFS may require as a condition precedent to entering into the contract that the contractor agree to such additional conditions as will be necessary to satisfy OCFS that the vendor is and will remain a responsible vendor. By signing this contract, the contractor agrees to comply with any such additional conditions that have been made a part of this contract.

   By signing this contract, the contractor also agrees that during the term of the contract, the contractor will promptly notify OCFS if the contractor engages in any actions that would establish a basis for a finding by OCFS that the contractor is a non-responsible vendor, as described above.

n. By signing this contract, the contractor agrees to comply with State Tax Law section 5-a.

o. If additional funds become available for the same purpose as described in the original procurement, OCFS reserves the right to modify the AGREEMENT to provide additional funding to the Contractor for provision of additional mutually agreed upon services and/or to extend the provision of services under the AGREEMENT. This additional funding can be provided within an existing period, or in conjunction with a change in the original term. Any changes in the amount or changes in period and amount are subject to the approval of the Office of the State Comptroller.

p. Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the contract or procurement will comply with New York State Enterprise IT Policy NYS-P08-005, Accessibility Web-Based Information and Applications, and New York State Enterprise IT Standard NYS-S08-005, Accessibility of Web-Based Information Applications, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and Internet information and applications are accessible to person with disabilities. Web content must conform to New York State Enterprise IT Standards NYS-S08-005, as determined by quality assurance testing. Such quality assurance testing will be conducted by OCFS and the results of such testing must be satisfactory to OCFS before web content will be considered a qualified deliverable under the contract or procurement.

q. Contractors must maintain Workers Compensation Insurance in accordance with the Workers Compensation Law. If a contractor believes they are exempt from the Workers Compensation insurance requirement then they must apply for an exemption. Contractors can apply for the exemption online through the New York State Workers Compensation Board website at :
   http://www.wcb.state.ny.us/content/ebiz/wc_db_exemptions/wc_db_exemptions.jsp

r. All organizations that receive Federal financial assistance under social service programs are prohibited from discriminating against beneficiaries or prospective beneficiaries of the social service programs on the basis of religion or religious belief. Accordingly, organizations, in providing services supported in whole or in part with Federal financial assistance, and in their outreach activities related to such services, are not allowed to discriminate against current or prospective program beneficiaries on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to attend or participate in a religious practice.

Organizations that engage in explicitly religious activities (including activities that involve overt religious content such as worship, religious instruction, or proselytization) must perform such activities and offer such services outside of programs that are supported with direct Federal financial assistance (including through prime awards or sub-awards), separately in time or location from any such programs or services supported with direct Federal financial assistance, and participation in any such explicitly religious activities must be voluntary for the beneficiaries of the social service program supported with such Federal financial assistance.

5. REPORTS AND DELIVERABLES

The Contractor shall prepare and submit all reports, documents, and projects required by this AGREEMENT to the Office's Contract Manager for review and approval. These reports shall be in such substance, form, and frequency as required by the Office and as necessary to meet State and Federal requirements.

6. CONFIDENTIALITY AND PROTECTION OF HUMAN SUBJECTS

a. The Contractor agrees to safeguard the confidentiality of financial and/or client information relating to individuals and their families who may receive services in the course of this project. The Contractor shall maintain the confidentiality of all such financial and/or client information with regard to services provided under this AGREEMENT in conformity with the provisions of applicable State and Federal laws and regulations. Any breach of confidentiality by the Contractor, its agents or representatives shall be cause for immediate termination of this AGREEMENT.

b. Any contactor who will provide goods and/or services to a residential facility or program operated by OCFS agrees to require all of its employees and volunteers who will have the potential for regular and substantial contact with youth in the care or custody of OCFS to sign the Employee Confidentiality Certification and Employee Background Certification before any such employees and volunteers are permitted access to youth in the care or custody of OCFS and/or any financial and/or client identifiable information concerning such youth. Additionally, OCFS will require a database check of the Statewide Central Register of Child Abuse and Maltreatment (SCR) of each employee and volunteer of the contractor who has the potential for regular and substantial contact with children in the care or custody of OCFS. Any other contractor whose employees and volunteers will have access to financial and/or client identifiable information concerning youth in the care or custody of OCFS agrees to require all such employees and volunteers to sign the Employee Confidentiality Certification before any such employees and volunteers are permitted access to any financial and/or client identifiable information concerning such youth.

7. PUBLICATIONS AND COPYRIGHTS

a. The results of any activity supported under this AGREEMENT may not be published without prior written approval of the Office, which results (1) shall acknowledge the support of the Office and the State of New York and, if funded with federal funds, the applicable federal funding agency, and (2) shall state that the opinions, results, findings and/or interpretations of data contained therein are the responsibility of the Contractor and do not necessarily represent the opinions, interpretation or policy of the Office or the State of New York.

b. The Office and the State of New York expressly reserve the right to a royalty-free, non-exclusive and irrevocable license to reproduce, publish, distribute or otherwise use, in perpetuity, any and all copyrighted or copyrightable material resulting from this AGREEMENT or activity supported by this AGREEMENT. All publications by the Contractor covered by this AGREEMENT shall expressly acknowledge the Office's right to such license.

c. All of the license rights so reserved to the Office and the State of New York under this paragraph are equally reserved to the United States Department of Health and Human Services and subject to the provisions on copyrights contained in 45 CFR 92 if the AGREEMENT is federally funded.

d. The Contractor agrees that at the completion of any scientific or statistical study, report or analysis prepared pursuant to this AGREEMENT, it will provide to the Office at no additional cost a copy of any and all data supporting the scientific or statistical study, report or analysis, together with the name(s) and business address(es) of the principal(s) producing the scientific or statistical study, report or analysis. The Contractor agrees and acknowledges the right of the Office, subject to applicable confidentiality restrictions, to release the name(s) and business address(es) of the principal(s) producing the scientific or statistical study, report

or analysis, together with a copy of the scientific or statistical study, report or analysis and all data supporting the scientific or statistical study, report or analysis.

8. PATENTS AND INVENTIONS

The Contractor agrees that any and all inventions, conceived or first actually reduced to practice in the course of, or under this AGREEMENT, or with monies supplied pursuant to this AGREEMENT, shall be promptly and fully reported to the Office. Determination as to ownership and/or disposition of rights to such inventions, including whether a patent application shall be filed, and if so, the manner of obtaining, administering and disposing of rights under any patent application or patent which may be issued, shall be made pursuant to all applicable law and regulations.

9. TERMINATION

a. This AGREEMENT may be terminated by the Office upon thirty (30) days prior written notice to the Contractor. Such notice is to be made by way of registered or certified mail return receipt requested or hand delivered with receipt granted by the Contractor. The date of such notice shall be deemed to be the date the notice is received by the Contractor established by the receipt returned, if delivered by registered or certified mail, or by the receipt granted by the Contractor, if the notice is delivered by hand. The Office agrees to pay the Contractor for reasonable and appropriate expenses incurred in good faith before the date of termination of this AGREEMENT.

b. If the Contractor fails to use any real property or equipment purchased pursuant to this AGREEMENT for the purposes set forth in this AGREEMENT, or if at any time during the term of this AGREEMENT the Contractor ceases to provide the services specified in the AGREEMENT for which the equipment was purchased, the Office may terminate this AGREEMENT upon thirty (30) days written notice to the Contractor, where the Contractor has failed to cure as set forth hereafter. Said notice of breach shall be sent by way of registered or certified mail return receipt requested, or shall be delivered by hand, receiving Contractor's receipt therefore. Said notice shall specify the Contractor's breach and shall demand that such breach be cured. Upon failure of the Contractor to comply with such demand within thirty (30) days, or such longer period as may be specified therein, the Office may, upon written notice similarly served, immediately terminate this AGREEMENT, termination to be effective upon the date of receipt of such notice established by the receipt returned to the Office. Upon such termination, the Office may require a) the repayment to the Office of any monies previously paid to the Contractor, or b) return of any real property or equipment purchased under the terms of this AGREEMENT or an appropriate combination of a) and b), at the Office's option.

c. To the extent permitted by law, this AGREEMENT shall be deemed in the sole discretion of the Office terminated immediately upon the filing of a petition in bankruptcy or insolvency, by or against the Contractor. Such termination shall be immediate and complete, without termination costs or further obligation by the Office to the Contractor.

d. Should the Office determine that Federal or State funds are limited or become unavailable for any reason, the Office may reduce the total amount of funds payable to the Contractor, reduce the contract period or deem this contract terminated immediately. The Office agrees to give notice to the Contractor as soon as it becomes aware that funds are unavailable, in the event of termination under this paragraph. If the initial notice is oral notification, the Office shall follow this up immediately with written notice. The Office will be obligated to pay the Contractor only for the expenditures made and obligations incurred by the Contractor until such time as notice of termination is received either orally or in writing by the Contractor from the Office. For Legislative and other special purpose grants funded from a State Community Projects Fund (State Finance Law § 99-d) account, the state shall not be liable for payments under this agreement made pursuant to an appropriation to the account if insufficient monies are available for transfer to the account, after any required transfers are made pursuant to State Finance Law § 99-d (3).

e. The Contractor shall provide to the Office such information as is required by the Office in order that the Office may determine whether the Contractor is a responsible vendor for purposes of compliance with Section 163 of the State Finance Law and requirements of the Office of the State Comptroller established thereunder. If there is any change in any of the vendor responsibility information provided to the Office by the Contractor at any time during the term of this AGREEMENT, the Contractor shall be required to immediately notify the Office so that the Office may assess whether the Contractor continues to be a responsible vendor. Should the Contractor fail to notify the Office of any change in the vendor responsibility information or should the Office otherwise determine that the Contractor has ceased to be a responsible

vendor for the purposes of this AGREEMENT, the Office may terminate this AGREEMENT upon thirty (30) days written notice to the Contractor. Said notice of termination shall be sent by way of registered or certified mail return receipt requested, or shall be delivered by hand, receiving Contractor's receipt therefore. Said notice shall specify the reason(s) that the Contractor has been found to no longer be a responsible vendor.

Upon determination that the Contractor is no longer a responsible vendor the Office may, in its discretion and as an alternative to termination pursuant to this paragraph, notify the Contractor of the determination that the Contractor has ceased to be a responsible vendor and set forth the corrective action that will be required of the Contractor to maintain the contact. Should the Contractor fail to comply with the required corrective action within thirty (30) days of the date of notification, or such longer period as may be specified therein, the Office may, upon written notice similarly served, immediately terminate this AGREEMENT, termination to be effective upon the date of receipt of such notice established by the receipt returned to the Office. Upon such termination, the Office may require (a) the repayment to the Office of any monies previously paid to the Contractor, (b) return of any real property or equipment purchased under the terms of this AGREEMENT, or an appropriate combination of (a) and (b), at the Office's option.

10. CONTRACTOR COMPLIANCE

The Office shall have the right to audit or review the Contractor’s performance and operations as related to this AGREEMENT and/or to retain the services of qualified independent auditors or investigators to perform such audit and review on the Office’s behalf. If the review indicates that the Contractor has violated or is in non-compliance with any of the terms of the AGREEMENT, or has abused or misused the funds paid to the Contractor, the Contractor agrees to pay to the Office any costs associated with the review.

If the review indicates that the Contractor has violated or is in non-compliance with any of the terms of the AGREEMENT, or has abused or misused funds paid to the Contractor, or if the Contractor has violated or is in non-compliance with any term of any other AGREEMENT, or has abused or misused funds paid to the Contractor under any other AGREEMENT with the Office, the rights of the Office shall include, but not be limited to:

- Recovery of any funds expended in violation of the AGREEMENT;
- Suspension of Payments
- Termination of the AGREEMENT; and/or
- Employment of another entity to fulfill the requirements of the AGREEMENT.

The Contractor shall be liable for all reasonable costs incurred on account thereof, including payment of any cost differential for employing such entity. The Contractor will assist the Office in transferring the operation of the contracted services to any other entity selected by the Office in a manner that will enable the Office or clients to continue to receive services in an on-going basis, including, but not limited to, notifying clients of the new entity to which the services will be transferred and the effective date of the transfer, providing the new entity promptly and at no charge with a complete copy of the clients’ and all other records necessary to continue the provision of the transferred services, and transferring any equipment purchased with funds provided under this AGREEMENT.

Nothing herein shall preclude the Office from taking actions otherwise available to it under law including but not limited to the State’s “Set-Off Rights” and “Records” provisions contained in Appendix A (Standard Clauses for all New York State Contracts).

The Contractor agrees to cooperate fully with any audit or investigation the Office or any agent of the Office may conduct and to provide access during normal business hours to any and all information necessary to perform its audit or investigation. The Contractor shall also allow the NYS Attorney General, State Comptroller, the Office, and any representatives specifically directed by the State Comptroller or the Office to take possession of all books, records and documents relating to this AGREEMENT without prior notice to the Contractor. The Office will return all such books, records and documents to the Contractor upon completing the official purposes for which they were taken.

The Contractor agrees that all AGREEMENTS between the Contractor and a subcontractor or consultants for the performance of any obligations under the AGREEMENT will be by written contract (subcontract) which will contain provisions including, but not limited to, the above specified rights of the Office.

11. FISCAL SANCTION

In accordance with the OCFS Fiscal Sanction policy, contractors may be placed on fiscal sanction when the Office identifies any of the following issues:

- The contractor has received an Advance, overpayment or other funds under this or another agreement that has not been refunded to OCFS within the established timeframe;
- An OCFS, Office of the State Comptroller, or other audit identifies significant fiscal irregularities and/or that funds are due to OCFS;
- The Contractor has not provided satisfactory services as required under the terms of this or another OCFS agreement;
- The contractor has not provided fiscal or program reports as required under the terms of this or another OCFS agreement;
- A local, State or federal prosecutorial or investigative agency identifies possible criminal activity, or significant fiscal or programmatic irregularities on the part of the contractor;
- The contractor is not in compliance with State or federal statutes or regulations, or applicable OCFS guidelines, policies and/or procedures; or
- Unsafe physical conditions exist at a program site operated by the contractor and funded under an agreement with OCFS.

Once the contractor has been placed on Fiscal Sanction, payments on all open contracts and any new awards, amendments or contract renewals will not be processed until the issues have been satisfactorily resolved. The contractor will be notified in advance of any proposed Fiscal Sanction and will be provided a timeframe within which the issues must be resolved in order to avoid a Fiscal Sanction. Issues that are not resolved within the timeframe established by OCFS may be referred to the Attorney General (AG) for collection or legal action. If a contract is referred to the AG a collection fee will be added to the amount owed. In addition, interest will be due on any amount not paid in accordance with the timeframes established by the AG. The contractor will remain on Fiscal Sanction until the amount owed, including any collection fee and interest is paid.

12. PROCUREMENT LOBBYING LAW

The Contractor will comply with all New York State and Office procedures relative to the permissible contacts and disclosure of contacts as required by State Finance Law Sections 139-j and 139-k and Office procedures and will affirmatively certify that all information provided pursuant to those provisions is complete, true and accurate. This certification is included in the Offerer's Certification and Affirmation of Understanding and Agreement pursuant to State Finance Law Sections 139-j and 139-k.

The Office reserves the right to terminate this contract if the Offerer's Certification filed by the Contractor in accordance with the New York State Finance Law Section 139-k was intentionally false or intentionally incomplete. Upon such a determination by the Office, the Office may exercise its termination right by providing written notification to the Contractor in accordance with the written notification terms of this contract. Nothing herein shall preclude or otherwise limit the Office's right to terminate this contact as set forth at Paragraph 8 of this Appendix A-1.

13. REQUIRED REPORTS – CONTRACTS FOR CONSULTING SERVICES

If consulting services (including services for analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal, or similar services) are provided, the contractor must submit on or before May 15th of each year for the annual period ending March 31st, Form OCFS-4843, State Consultant Services – Contractor's Annual Employment Record. This form must report information for all employees who provided services under the contract whether employed by the contractor or a subcontractor. This form will be available for public inspection and copying under the Freedom of Information Law with any individual employee names and social security numbers redacted.

Contractors can obtain this form from their Contract Manager or through the Internet at the following site:
http://ocfs.state.nyenet/admin/Forms/Contracts/word2000/OCFS-4843%20State%20Consultant%20Services-Contractors%20Annual%20Employment%20Record.doc

The contractor must submit a completed Form OCFS-4843, State Consultant Services – Contractor's Annual Employment Record, to each of the following addresses:

New York State Office of Children and Family Services

Bureau of Contract Management
52 Washington Street, South Building, Room 202
Rensselaer, New York 12144

New York State Office of the State Comptroller
Bureau of Contracts
110 State Street, 11th Floor
Albany, New York 12236
Attn: Consultant Reporting

New York State Department of Civil Service
Alfred E. Smith Office Building
8th Floor Counsel's Office
Albany, New York 12239

14. IRAN DIVESTMENT ACT

As a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York, a new provision has been added to the State Finance Law (SFL), § 165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) will be developing a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list is expected to be issued no later than 120 days after the Act's effective date, at which time it will be posted on the OGS website.

By entering into this Contract, Contractor (or any assignee) certifies that once the prohibited entities list is posted on the OGS website, it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list.

Additionally, Contractor agrees that after the list is posted on the OGS website, should it seek to renew or extend the Contract, it will be required to certify at the time the Contract is renewed or extended that it is not included on the prohibited entities list. Contractor also agrees that any proposed Assignee of the Contract will be required to certify that it is not on the prohibited entities list before OCFS may approve a request for Assignment of Contract

During the term of the Contract, should OCFS receive information that a person is in violation of the above-referenced certification, OCFS will offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment which is in violation of the Act within 90 days after the determination of such violation, then OCFS shall take such action as may be appropriate including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

OCFS reserves the right to reject any request for assignment for an entity that appears on the prohibited entities list prior to the award of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the prohibited entities list after contract award.

15. ADDITIONAL ASSURANCES

a. The Office and Contractor agree that Contractor is an independent contractor, and not an employee of the Office. The Contractor agrees to indemnify the State of New York for any loss the State of New York may suffer when such losses result from claims of any person or organization (excepting only the Office) injured by the negligent acts or omission of Contractor, its officers and/or employees or subcontractors. Furthermore, The Contractor agrees to indemnify, defend, and save harmless the State of New York, and its officers, agents, and employees from any and all claims and losses occurring or resulting to any and all contractors, subcontractors, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of the contract, and from all claims and losses occurring or resulting to any person, firm, or corporation who may be injured or damaged by the Contractor in the performance of the contract, and against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, or use, or disposition of any data furnished under the contract or based on any libelous or other unlawful matter contained in such data or written materials in any form produced pursuant to this contract.

b. The Contractor agrees that Modifications and/or Budget Revisions that do not affect any change in the amount of consideration to be paid, or change the term, will be in accordance with Appendix C.

c. Expectation of Insured: The Contractor, if a municipal corporation, represents that it is a self-insured entity. If a not-for-profit corporation or entity other than a self-insured municipal corporation, the Contractor agrees to obtain and maintain in effect a general policy of liability insurance in an appropriate amount. The Contractor agrees that it will require any and all Subcontractors with whom it subcontracts pursuant to this contract to obtain and maintain a general policy of liability insurance in an appropriate amount.

d. Notwithstanding the provisions of Article 14 of this contract, to the extent the contractor provides health care and treatment or professional consultation to residents of facilities operated by OCFS, in conformance with Executive Law §522 the provisions of paragraphs A, B and C of Article 14 (Article 14 A., B. and C.) shall not apply. In such cases, the provisions of Public Officers Law §17, to the extent provided by Executive Law §522, shall apply instead.

16. RENEWAL NOTICE TO NOT-FOR-PROFIT CONTRACTORS

With respect to contracts that include a renewal option, if the Office does not provide notice to Contractor of its intent to not renew this contract by the date by which such notice is required by §179-t (1) of the State Finance Law, this contract shall be deemed continued until the date that the Office provides the notice required by §179-t (1), and the expenses incurred during such extension shall be reimbursable under the terms of this contract.

A-1 Summary of Personnel Costs

Position/Title	Annual Salary	% of Time	Salary times % of Time**	Local Share	OCFS Grant Funds	Total Cost
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
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			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
			$0			$0
1. Personnel Total				$0	$0	$0
2. Fringe Benefits Total	***Enter Rate:***					$0
3. Total Personal Services Costs			0	$0	$0	$0

** The figures in the column are for comparison purposes only. It may not exactly equal the Total Cost figure.

A-1 Personal Narrative

Budget Narrative: Attach a description of the role/responsibility of each person included above.
Resumes of key project staff should be included as an addendum to the Project Narrative Section.

1. Title:

Enter Role/Responsibility Below

2. Title:

Enter Role/Responsibility Below

3. Title:

Enter Role/Responsibility Below

4. Title:

Enter Role/Responsibility Below

5. Title:

Enter Role/Responsibility Below

6. Title:

Enter Role/Responsibility Below

7. Title:

Enter Role/Responsibility Below

8. Title:

Enter Role/Responsibility Below

9. Title:

Enter Role/Responsibility Below

10. Title:

Enter Role/Responsibility Below

11. Title:

Enter Role/Responsibility Below

12. Title:

Enter Role/Responsibility Below

13. Title:

Enter Role/Responsibility Below

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14. Title:

Enter Role/Responsibility Below

15. Title:

Enter Role/Responsibility Below

16. Title:

Enter Role/Responsibility Below

17. Title:

Enter Role/Responsibility Below

18. Title:

Enter Role/Responsibility Below

19. Title:

Enter Role/Responsibility Below

20. Title:

Enter Role/Responsibility Below

B4. Contractual/Consultant

Item	Local Share	OCFS Funds	Total Costs
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
Total Contractual/Consultant Costs	$0	$0	$0

Enter Budget Narrative Below:

B5. Travel

Item	Local Share	OCFS Funds	Total Costs
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
Total Travel Costs	$0	$0	$0

Enter Budget Narrative Below:

B6. Equipment

Item	Local Share	OCFS Funds	Total Costs
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
Total Equipment Costs	$0	$0	$0

Enter Budget Narrative Below:

B7. Supply Costs

Item	Local Share	OCFS Funds	Total Costs
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
Total Supply Costs	$0	$0	$0

Enter Budget Narrative Below:

B8. Other Expenses

Item	Local Share	OCFS Funds	Total Costs
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
			$0
Total Other Expenses	$0	$0	$0

Enter Budget Narrative Below:

Contractor Name:	
Period of Budget:	
Contract Number:	

APPENDIX B
BUDGET SUMMARY

(Rev. 1/8/02)

The purpose of this form is to document the budget for the proposed project. Indicate the amount of funds being requested to support the proposed project under "OCFS Funds."

Expense Category	**Local Share/ Local Match** (if applicable)	**OCFS Funds**	**Total Project Cost**
1	2	3	4
A. Personal Services			
1. Project Staff Salaries	$0	$0	$0
2. Fringe Benefits			$0
3. Total (Lines 1 + 2)	$0	$0	$0
B. Non-Personal Services			
4. Contractual/Consultant	$0	$0	$0
5. Travel/Per Diem	$0	$0	$0
6. Equipment	$0	$0	$0
7. Supplies	$0	$0	$0
8. Other Expenses	$0	$0	$0
9. Total (Total Lines 4 to 8)	$0	$0	$0
C. Project Total (Lines 3 + 9)	$0	$0	$0

	Local Match (if required) Use *calculation below

***Local Match Calculation** = % of matching funds (if required in the RFP or contract agreement) X OCFS grant award.

Total costs entered for each budget category above must reflect totals from attached Budget Sections.

Local Share refers to all funds other than this grant award, including in-kind contributions to support the project as described in the narrative section of the application. The type and amount of in-kind contributions should be specifically identified under the appropriate Budget Section. The total amount of the in-kind portion of Local Share should be entered in parenthesis next to Local Share Project Total space.

OCFS Funds are the funds you are requesting through this application.

Total Cost refers to the combined Local Share and Grant Funds for this project.

Budget Narrative: Complete the narrative section for each part of the budget. Instructions are included on the following application budget pages.

Note: All items in the Budget must be consistent with the goals and objectives of the Project Narrative. Additional budget narrative pages may be attached as necessary.

* Total Project Cost must agree with Total Anticipated Revenue form as submitted with this application.

Local Share/Match Breakdown

	Source	Amount
A. Cash Donations		
B. In-Kind Donations		
C. Volunteers/Intern		
D. Fees for Service		
E. Unrestricted Cash or Fund Balance		
F. Grants:		
- Other grants supporting this project		
Amount of OCFS Funds		
Non-OCFS Funds supporting this project		
Total		$0

Itemize amounts of assured revenue, potentially available funds, and estimated income from in-kind contributions to support this project.

Cash Donations should be calculated on the basis of what the applicant organization can realistically be expected to raise during the program year; attach a description of fund raising efforts.

In-Kind Donations refers to equipment, furnishings and other non-personal expenses that are donated to support the function of this project.

Volunteers (another type of in-kind contribution) refers to project personnel who donate their time to the functioning of this project. Volunteer job descriptions and timecards should be kept to substantiate this line item.

Unrestricted Cash or Fund Balance Unrestricted funds include all revenues that are not specifically restricted as to their use. Unrestricted funds include income from dues, publication sales, advertising sales, conference fees, mailing label sales, interest income from unrestricted funds, fees obtained in the execution of externally funded projects, and contributions.

Fees for Services refers primarily to income received from clients directly. In addition, any income received by the applicant organization for reimbursable activities funded by this contract such as counseling, training, speaking engagements, etc., must be listed here.

Grants refers not only to the amount being requested under this grant but also to monies received (or applied for) from another funding source for activities related to this contract, e.g., state, federal, local. Each grant must be listed separately under Section F.

APPENDIX C
PAYMENT AND REPORTING TERMS AND CONDITIONS

Line Item Budget

Revised June 2012

- ☐ This Contract is funded with non-Federal funds only
- ☑ This contract is funded in whole or in part with Federal funds (see Appendix A3, Paragraph 14, for federal audit information)
- ☐ OCFS has determined that the Contractor IS NOT a Subrecipient
- ☑ OCFS has determined that the Contractor IS a Subrecipient
- ☑ The Federal funds for this contract are from Catalog of Federal Domestic Assistance (CFDA Number(s): **93.505**

I. PAYMENT TERMS AND CONDITIONS

In consideration of the services to be performed by the Contractor pursuant to this AGREEMENT, the Office of Children and Family Services (OCFS) agrees to pay and the Contractor agrees to accept a sum not to exceed the amount specified on the face page of this AGREEMENT for the initial AGREEMENT period and, for subsequent periods, the amount specified in Appendix X for that period. All payments shall be in accordance with the budget contained in Appendix B for the applicable period. Payment under this AGREEMENT is conditional upon the continued availability of funds. Should funds become unavailable, the Contractor shall be relieved of any obligation to continue this project beyond the period for which funds were available. Payments and future funding are contingent on the availability of funding for the activities to be conducted in accordance with this AGREEMENT.

Funds cannot be expended until the contract is approved by the Office of the State Comptroller (OSC). Expenditures cannot precede the contract start date. If the Contractor makes expenditures subsequent to the contract start date, but prior to OSC approval of the contract, they do so at their own risk.

See Appendix A-2 for any additional program-specific Payment Terms and Conditions applicable to this AGREEMENT. To the extent that there is a conflict between any Payment Terms and Conditions set forth in this Appendix and in Appendix A-2, the Payment Terms and Conditions in Appendix A-2 will supersede the Payment Terms and Conditions in Appendix C.

Contractor shall provide complete and accurate billing invoices to the Office in order to receive payment. Billing invoices submitted to the Office must contain all information and supporting documentation required by this AGREEMENT, the Office and the Office of the State Comptroller. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner of the Office, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the Office of the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the Office of the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us, or by telephone at 518-474-4032. Contractor acknowledges that it will not receive payment on any invoices submitted under this AGREEMENT if it does not comply with the Office of the State Comptroller's electronic payment procedures, except where the Commissioner of the Office has expressly authorized payment by paper check as set forth above.

II. ADVANCE PAYMENT AND RECOUPMENT

a. To the extent permitted by applicable laws and regulations, OCFS may, at its own discretion, make advance payment(s) to the Contractor, up to **25%** of the annual period amount, upon the submission by the Contractor of sufficient justification therefor. Any advance may be eligible for payment only upon approval of this AGREEMENT by the Attorney General and by OSC and upon the submission to OCFS by the Contractor of a properly executed State of New York Claim for Payment (Ac3253-S), or on-line claim submitted through the OCFS Contract Management System (CMS), in a form acceptable to OCFS and to OSC.

b. Recoupment of any advance payment(s) shall be recovered by crediting

   10% of the advance amount each month for the first 10 months

   or as otherwise specified in Appendix A-2. If for any reason the amount of any claim is not sufficient to cover the proportionate advance amount to be recovered, then subsequent claims will be reduced until the advance is fully recovered. Any unexpended advance balance at the end of the AGREEMENT period will be refunded by the Contractor to OCFS. In the event either party terminates the AGREEMENT prior to its expiration, the Contractor agrees to refund to OCFS immediately any advance balance then outstanding.

c. An initial advance, if determined to be payable to the contractor, shall be payable thirty days from the start date of services within the contract period or thirty days from the submission of a properly executed State of New York Claim for Payment, or on-line claim submitted through CMS, in a form acceptable to the Office and to the Comptroller of the State of New York, whichever is later.

d. For purposes of interest determinations pursuant to Article XI-B of the State Finance Law, claims for payment of advances are payable 30 days from the start date of services within the contract period if deemed acceptable by OCFS and the Office of the State Comptroller. If the Contractor's claim or on-line claim submitted through CMS is not received within 30 calendar days of the contract becoming fully executed no additional interest shall accrue after such thirtieth day.

III. CLAIMS FOR REIMBURSEMENT

a. The Contractor shall submit claims for the reimbursement of expenses incurred on behalf of OCFS under this AGREEMENT within fifteen (15) days after the end of each **monthly** claiming period or as otherwise specified in Appendix A-2.

b. The Contractor shall submit a New York State Claim for Payment or on-line claim submitted through CMS and a New York State Financial Claim Report within fifteen (15) days after the end of each claiming period as identified in Appendix A-2. The Contractor shall also submit the appropriate supporting fiscal documentation for the expenses claimed. The final claim shall be submitted within thirty (30) days after the expiration of each annual contract period or the early termination of this AGREEMENT or as otherwise specified in Appendix A-2.

c. OCFS agrees to pay the Contractor for expenses incurred in behalf of fulfilling this AGREEMENT, according to the budget contained in Appendix B and upon the submission of a properly executed State of New York Claim for Payment, or on-line claim submitted through CMS, in a form acceptable to OCFS and to OSC and the submission of required Program reports. OCFS agrees to submit each approved claim to OSC for payment, unless it shall have notified the Contractor of its disapproval of payment, in writing, together with a justification therefor.

d. Claims other than those for payment of advances are payable on the 45th day after the end of the claiming period (monthly or quarterly as defined in this agreement) if deemed acceptable by OCFS and the Office of the State Comptroller, and if the Contractor's claim or on-line claim submitted through CMS is received within 15 days after the end of said period. If the Contractor's claim or on-line claim submitted through CMS is received later than 15 days after the end of said period, then the

claim will be payable 30 days after receipt if deemed acceptable by OCFS and the Office of the State Comptroller."

e. For purposes of interest determinations pursuant to Article XI-B of the State Finance Law, claims or on-line claims submitted through CMS other than those for the payment of advances are payable 30 days after the end of the claiming period (monthly or quarterly as defined in this agreement) if deemed acceptable by OCFS and the Office of the State Comptroller. If the Contractor's claim or on-line claim submitted through CMS is not received within 30 calendar days of the contract becoming fully executed no additional interest shall accrue after such thirtieth day.

f. OCFS reserves the right to withhold up to ten percent (10%) of the total amount of the contract as security for the faithful completion of services under this AGREEMENT. OCFS ☑ will or ☐ will not withhold up to 10% of the total amount of this contract. This amount may be withheld in whole or in part from any single payment or combination of payments otherwise due under this AGREEMENT. The amount withheld will be paid to the Contractor upon the receipt of all required reports, including the final programmatic and fiscal reports, all products of the project as provided in the AGREEMENT as detailed in Appendix D, a final claim or on-line claim submitted through CMS, the accounting for any advance payment(s) made pursuant to this AGREEMENT, and upon certification by the Contractor that it has completed its obligations and duties under this AGREEMENT.

g. OCFS will not be liable for payments on any contract, grant or agreement made pursuant to an appropriation if insufficient monies are available, pursuant to Section 99-d(3) of the State Finance Law.

h. The Contractor shall require any and all subcontractors to submit all financial claims for services rendered and required supporting documentation and reports necessary to complete the financial claim and expense report as referenced in Section III.a. above in sufficient time for said information to be received by the Contractor no later than ten (10) days following the final day of the claiming period. Subcontractors shall be informed by the Contractor of the possibility of non-payment or rejection by the Contractor of claims that do not contain the required information and/or are not received by the Contractor by said due date. Subcontractors shall be paid on a timely basis after submitting the required reports and vouchers for reimbursement of services.

i. Subcontracts should not be signed by Contractor prior to OCFS approving the subcontract and OSC approving the contract. Subcontracts cannot have start dates prior to the contract start date. If Contractor obtains signature on a subcontract subsequent to the start date, but prior to OSC approval of the contract, they do so at their own risk.

j. Payment for travel costs and related expenses incurred by the Contractor's staff, employees and consultants shall be made at no greater than the prevailing New York State rates established for travel costs and related expenses for State employees as set by OSC and listed at the following internet website http://www.osc.state.ny.us/agencies/travel/travel.htm

k. OCFS may specifically request the return of any equipment purchased pursuant to this AGREEMENT. At the discretion of OCFS, the Contractor may retain custody of such equipment, provided it continues to be used for the children, family, and youth services outlined in the AGREEMENT. No equipment purchased with OCFS funds may be transferred or disposed of without written permission from OCFS. Equipment items purchased and claimed must be listed in the approved contract budget. Any changes in the equipment listed in the budget must have prior approval by OCFS in writing before implementing the change.

l. If the Contractor receives funds under this AGREEMENT to construct, renovate or improve the property it occupies, then the improved property will be used for the children, family and youth services outlined in this AGREEMENT for the period set forth in Appendix A-2 of this AGREEMENT

m. All obligations must be incurred prior to the end date of the contract. The Contractor has up to 90 days after the contract end date to make expenditures as long as the obligation was made prior to the contract end date.

n. Any goods or services ordered by the Contractor prior to the contract start date must be received and paid for during the contract period in order for the cost of such goods and/or services to be reimbursed to the contractor using funds from this AGREEMENT. Should the contractor order goods and/or services prior to Office of the State Comptroller's approval of the contract, the contractor does so at their own risk and OCFS will not reimburse the contractor for the cost of such goods and/or services if such goods and/or services were received or paid for prior to the commencement of the contract period.

IV. BUDGET REVISIONS

a. The Contractor may make revisions to the budget contained in Appendix B up to ten percent (10%) of the total contract value without prior approval of OCFS except that any budget revisions that affect changes in the workplan contained in Appendix D shall require prior written approval of OCFS unless otherwise specified in Appendix A-2. The Contractor agrees to submit any and all revisions made pursuant to this subparagraph to the Designated Payment Office identified in Appendix A-2 within ten (10) days of implementing such revisions or as an attachment to any claims for reimbursement that may be associated with such revisions, whichever is the earlier date.

b. Budget revisions in excess of ten percent (10%) of the total contract value or which affect changes in the workplan as contained in Appendix D shall be submitted in writing to the Designated Payment Office identified in Appendix A-2 for approval, accompanied by justification therefor. The OCFS Project Officer shall notify the Contractor, in writing, of OCFS' approval of such budget revisions, or shall, in writing, notify the Contractor of OCFS' disapproval and identify the reasons for such disapproval.

c. Any proposed modification to the contract that will result in a transfer of funds among program activities or budget cost categories, but does not affect the amount, consideration, scope or other terms of the contact must be submitted to the Office of the State Comptroller for approval when: **1)** The amount of the modification is equal to or greater than ten percent of the total value of the contract for contracts of less than five million dollars; **OR, 2)** The amount of the modification is equal to or greater than five percent of the total value of the contract for contracts equal to or greater than five million dollars.

V. AUDIT AND RECORDS RETENTION

The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this AGREEMENT (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. OSC, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this AGREEMENT, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation. If the Records are in any way relevant to audit findings, litigation or claims and the audit findings, litigation, or claims are not resolved within a period of

six (6) years after the end or termination of this AGREEMENT, the Contractor will retain such records until notified in writing by OCFS to dispose of them.

VI. REFUNDS

In the event that the contractor must make a refund to OCFS for contract related activities (repayment of an advance, an audit disallowance, or for any other reason), payment must be made in the form of a check or money order payable to "New York State Office of Children and Family Services". The contractor must include with the payment a brief explanation of why the refund is being made and reference the contract number. Refund payments must be submitted to:

NYS Office of Children and Family Services
Attention: Contract Cash Receipts
Bureau of Contract Management
Capital View Office Park
52 Washington Street
South Building, Room 202
Rensselaer, NY 12144

VII. PROGRAM REPORTING REQUIREMENTS

a. The Contractor shall submit a Program Report on the schedule stated in Appendix A-2 and in the format specified by OCFS.

b. In addition to the periodic reports stated above, the Contractor shall, prior to receipt of final payment under this AGREEMENT, submit a final program report satisfactory to OCFS no later than thirty (30) days following the termination of this contract or the completion of expenditures, whichever is sooner or as otherwise specified in Appendix A-2.

VIII. REPORTING SCHEDULE

All periodic reports as identified in Appendix A-2 shall be submitted in accordance with the schedule provided unless otherwise designated in writing by the Program Officer. All periodic reports must be submitted no later than fifteen (15) days after the end of the reporting period or as otherwise specified in Appendix A-2.

IX. DESIGNATED PAYMENT OFFICE

Designated Payment Office information is contained in Appendix A-2.

Appendix D
Application Cover Page – Agreement

<table>
<tr><td colspan="2">I. Incorporated Agency Name:</td><td colspan="4"></td></tr>
<tr><td colspan="2">II. Project Title:</td><td colspan="4"></td></tr>
<tr><td colspan="2">III. New York State Vendor ID:</td><td colspan="4"></td></tr>
<tr><td colspan="2">IV. Amount of OCFS Funds Requested:</td><td colspan="4"></td></tr>
<tr><td colspan="2">V. Proposed Dates of Project:</td><td colspan="4"></td></tr>
<tr><td colspan="2">VI. Address:
(Include Street, City, State, Zip Code)</td><td>Mailing</td><td>Payment</td><td>Site</td><td>Agency Record</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td><td></td></tr>
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<tr><td colspan="2"></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">VII. Federal Tax Identification Number or Municipality Code:</td><td colspan="4"></td></tr>
<tr><td colspan="2">VIII. Does the Business Entity have a Data Universal Numbering System (DUNS) Number?
If yes, what is the DUNS Number?</td><td colspan="2">☐ Yes ☐ No</td><td colspan="2">DUNS Number:</td></tr>
<tr><td colspan="2">IX. Is the Business Entity a:
(a) For Profit entity; <u>and</u>
(b) A New York Certified Minority Owned Business Enterprise (MBE), Women Owned Business Enterprise (WBE), New York State Small Business or a Federally Certified Disadvantaged Business Enterprise (DBE)?</td><td colspan="2">☐ Yes</td><td colspan="2">☐ No</td></tr>
<tr><td colspan="2">If yes, please specify the type of entity:</td><td colspan="4">☐ Minority Owned Business Enterprise (MBE)
☐ Women Owned Business Enterprise (WBE)
☐ Disadvantaged Business Enterprise (DBE)
☐ New York State Small Business</td></tr>
<tr><td colspan="2">X. Is the Business Entity a:
(a) Not-For-Profit entity; <u>and</u>
(b) A Minority Community-Based Organization (MCBO)</td><td colspan="2">☐ Yes</td><td colspan="2">☐ No</td></tr>
<tr><td colspan="2">XI. Charities Registration Number:
(If exempt, enter reason for exemption)</td><td colspan="4"></td></tr>
<tr><td colspan="2">XII. Has the Business Entity filed all required periodic or annual written reports with the Office of the Attorney General's Charities Bureau?</td><td colspan="2">☐ Yes</td><td colspan="2">☐ No</td></tr>
</table>

XIII. Congressional/Legislative District Information: (If Known)	
Federal Congressional District(s):	
State Assembly District(s):	
State Senate District(s):	
XIV. County:	

XV. Contact Person(s):

Key Contacts	Name	Address	Telephone & E-Mail Address **	Authorized to Sign Contracts	Authorized to Sign Vouchers
Board Chairperson					
Chief Administrative Officer[1]					
Contract Contact					
Chief Fiscal Officer					

****An E-mail address is required. If you do not have a personal e-mail address, please supply your Organization's shared e-mail address.**

[1] The Chief Administrative Officer is defined as the person who is responsible for the contractor's overall administration, eg. Executive Director, County Executive, or Agency Commissioner

Appendix M/WBE

Participation by Minority Group Members and Women with Respect to State Contracts: Requirements and Procedures

July 2012

I. General Provisions

a. The Office of Children and Family Services ("OCFS") is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 ("MWBE Regulations") for all State contracts as defined therein, with a value: **1)** in excess of $25,000 for labor, services, equipment, materials, or any combination of the foregoing **or; 2)** in excess of $100,000 for real property renovations and construction.

b. The Contractor to the subject Contract (the "Contractor" and the "Contract," respectively) agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State OCFS , to fully comply and cooperate with OCFS in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women ("EEO") and contracting opportunities for certified Minority and Women-Owned Business Enterprises ("MWBE"). Contractor's demonstration of "good faith efforts" pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the "Human Rights Law") or other applicable federal, state or local laws.

c. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

d. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to Section VIII of this Appendix, or enforcement proceedings as allowed by the Contract.

II. Contract Goals

a. For purposes of this Contract, OCFS hereby establishes an overall goal of 22.5% for MWBE participation, 9.5% for Minority-Owned Business Enterprises ("MBE") participation and 13% for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs).

b. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in Section II.a. hereof, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address:
http://www.esd.ny.gov/mwbe.html

   Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development (DMWBD) to discuss additional methods of maximizing participation by MWBEs on the Contract. DMWBD contact numbers: (518) 292-5250; (212) 803-2414; or (716) 846-8200).

c. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with Section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to OCFS for liquidated or other appropriate damages, as set forth herein.

III. Equal Employment Opportunity (EEO)

OCFS-3460 – MWBE – Equal Employment Opportunity Policy Statement

a. Contractor agrees to be bound by and comply with the provisions of Article 15-A and the MWBE Regulations promulgated by the DMWBD. If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.

Contractor shall comply with the following provisions of Article 15-A:

b. Contractor and Subcontractors shall undertake or continue existing Equal Employment Opportunity (EEO) programs to ensure that minority group members and women are afforded employment opportunities without discrimination because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.

c. The Contractor shall submit an EEO Policy Statement to OCFS within 3 (three) business days after the notice of award by OCFS to the Contractor.

d. If Contractor or Subcontractor does not have an existing EEO Policy Statement, OCFS may provide a model Policy Statement OCFS-3460 – MWBE – Equal Employment Opportunity Policy Statement

e. The Contractor's EEO Policy Statement shall include the following language:

   i. The Contractor and/or Subcontractor will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest; will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.

   ii. The Contractor and/or Subcontractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

iii. The Contractor and/or Subcontractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest; and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.

iv. The Contractor shall comply with the provisions of the Human Rights Law, and all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and Subcontractor shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

v. The Contractor and/or Subcontractor will include the above-noted language provisions outlined in numbers **i.** through **iv.**, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements in the language will be binding upon each subcontractor as to work in connection with the Contract.

IV. Project Staffing Plan Form

OCFS-4629 - Project Staffing Plan Form

a. To ensure compliance with the Equal Employment Opportunity (EEO) Section above, the Contractor shall submit a Project Staffing Plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. Contractors shall complete the Staffing plan form and submit it as part of their bid or proposal.

b. Once a contract has been awarded, and during the term of Contract, Contractor will, on a quarterly basis, submit to OCFS any modifications or changes to the Project Staffing Plan Form. The Contractor's Project Staffing Plan Form will only include workforce data for staff utilized on the prime contract, and should not include data on staff performing work under any subcontracts. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Project Staffing Form and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Project Staffing Form and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the contract.

V. Subcontracting/Suppliers Utilization Form

OCFS-4631 – Subcontracting/Suppliers Utilization Form

a. The Contractor represents and warrants that Contractor has submitted a Subcontracting/Supplier Utilization Form prior to the execution of the contract.

b. Contractor agrees to use such Subcontracting/Supplier Utilization Form for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in Section II.a. of this Appendix.

c. Contractor further agrees that failure to submit and/or use such Subcontracting/Suppliers Utilization Form may constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, OCFS shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

VI. M/WBE Subcontractors & Suppliers Letter of Intent to Participate Forms

OCFS-4630 - Subcontractors and Suppliers Letter of Intent to Participate Form

The OCFS-4630 Subcontractor and Suppliers Letter of Intent to Participate Form is to be completed by the proposed M/WBE Subcontractor/Supplier. It is to be submitted prior to the execution of the contract, attached to the OCFS-4631 Subcontracting/Suppliers Utilization Form, for each certified Minority or Women-Owned Business Enterprise the Bidder proposes to utilize as subcontractors, service providers or suppliers. If the MBE or WBE proposed for a portion of this Contract is a part of a joint venture or other temporarily-formed business arrangement, the name and address of the joint venture or the temporarily formed business entity should be indicated.

VII. Waivers

OCFS-4442 - M/WBE Request for Waiver Form

For Waiver Requests, Contractor should use the OCFS-4442 MWBE Request for Waiver Form.

a. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit an OCFS-4442 MWBE Request for Waiver Form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the waiver request is complete, OCFS shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.

b. If OCFS, upon review of the OCFS-4631 Subcontracting/Suppliers Utilization Form and updated OCFS-4441 MWBE Quarterly Reports, determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, OCFS may issue a Notice of Deficiency to the Contractor. The Contractor must respond to the Notice of Deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VIII. MWBE Quarterly Report

OCFS-4441 - M/WBE Quarterly Report Form

Contractor is required to submit an MWBE Quarterly Report to OCFS with 10 days following the end of each applicable reporting quarter over the term of the Contract, documenting the progress made towards achievement of the MWBE goals.

IX. Liquidated Damages - MWBE Participation

a. Where OCFS determines that the Contractor is not in compliance with the requirements of the Contract concerning participation by minority and women-owned business enterprises, and that

such failure to comply was willful and intentional, or that Contractor refused to comply with such requirements after being notified by OCFS of non-compliance with such requirements, Contractor shall be obligated to pay liquidated damages to OCFS.

b. Such liquidated damages shall be calculated up to amount equaling the difference between:

   i. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
   ii. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.

In the event a determination has been made which requires the Contractor pay liquidated damages and the identified sums of liquidated damages has not been withheld by the OCFS from any payments due to the Contractor, the Contractor shall pay such liquidated damages as have not been withheld to the OCFS within sixty (60) days after the Contractor is notified by the OCFS that the Contractor is required to pay such damages unless, prior to the end of the sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development (Director) pursuant to Subdivision 8 of Section 313 of the Executive Law in which event the liquidated damages shall be payable within 30 days after issuance of Director's decision if the Director renders a decision in favor of the OCFS.

Nurse Family Partnership Staffing Requirements:

- **Administrator**
  Provides a leadership role for the program:
  - Creates a supportive organizational environment
  - Assures home visitors are solely dedicated to NFP
  - Aids in program quality and program improvement strategies
  - Supports supervisor
  - Advocates for funding and other resources
  - Participates in establishing an advisory board
  - Aids as liaison to county, state government

- **Nurse Supervisor** (generally master's level nursing)
  Provides program management and clinical supervision of nurse home visitors:
  Management
  - Fosters community awareness of an ongoing support for NFP through creation of Community Advisroy Board and outreach education
  - Generates and Sustains referrals into the NFP
  - Learns about community services and forms relations with service providers to ensure clients access needed services

  Clinical Supervision (supervises 4 to 6 Nurse Home Visitors)
  - Supervises nurse home visitors with one-to-one weekly, one hour sessions
  - Case conferences twice/month for at least one hour using a reflective process for solution-finding, problem-solving and professional growth
  - Holds team meetings twice a month for at least an hour to discuss program implementation and team building
  - Conducts field supervision with nurse home visitors at a minimum of 2-3 hours per nurse every four months

- **Nurse Home Visitor** (Full-time nurse home visitor carriers a caseload of no more than 25 active clients)
  - Preferably holds a Bachelor's degree with some experience in obstetrics, maternal and child health, community health nursing, or public health
  - Conducts home-based preventive intervention with young families
  - Develops therapeutic relationships with each parent
  - Assess, teaches, makes appropriate referrals and nurtures the development of young parents across several domains of functioning.

- **Administrative and Data Entry Support** (0.5 FTE per 100 clients)
  Provides support to nurse home visitors and nursing supervisors:
  - Enters program and home visit data into the national web-based Efforts to Outcomes (ETO) software
  - Helps with program communications, client correspondence and tracking, filing, organizing community and family events, etc.

Healthy Families New York Staffing Requirements

- **Program Manager** (master's degree in social work or health recommended)
  Directs, develops and guides the project in achieving its objectives with experience in:
  - Administering human service programs.
  - Managing, supporting and motivating staff.
  - Knowledge in maternal infant health concepts and child abuse and neglect.
  - Providing services to culturally diverse communities and families.

- **Program Supervisor**
  Provides direct supervision of Family Support Workers and/or Family Assessment Workers (FAWs)
  - Schedules and directs work.
  - Assists in interviewing, hiring, evaluating, and training.
  - Provides supervision, quality services and monitors performance.
  - Acquires necessary materials for staff.
  - Conducts or arranges for family and child assessments conducted during home visits.
  - Conducts participant record reviews.
  - Oversees quality of data management system.
  - Provides documentation on services needed and provided to families.

- **Family Assessment Worker (FAW)**
  Under the supervision of the program manager or program supervisor:
  - Reviews hospital or clinic records.
  - Completes participant record screens.
  - Conducts *Kempe Family Stress Checklist* assessment.
  - Provides information and referral services.
  - Outreaches to hard to reach communities and families.
  - Interfaces with other agencies.

- **Data Manager**
  - Enters data into the Management Information System.

- **Child Development Specialist** (staff or consultant)
  - Reviews child's development assessment tool, *The Ages and Stages Questionnaire.*
  - Offers training and consultation for program staff.

AC 3237-S (Rev. 1/12)

NEW YORK STATE OFFICE OF THE STATE COMPTROLLER
SUBSTITUTE FORM W-9:
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER & CERTIFICATION

TYPE OR PRINT INFORMATION NEATLY. PLEASE REFER TO INSTRUCTIONS FOR MORE INFORMATION.

Part I: Vendor Information

1. Legal Business Name:

2. If you use a DBA, please list below:

3. Entity Type (Check one only):
☐ Sole Proprietor ☐ Partnership ☐ Limited Liability Co. ☐ Business Corporation ☐ Unincorporated Association/Business ☐ Federal Government

☐ State Government ☐ Public Authority ☐ Local Government ☐ School District ☐ Fire District ☐ Other ______________________________

Part II: Taxpayer Identification Number (TIN) & Taxpayer Identification Type

1. Enter your TIN here: *(DO NOT USE DASHES)* ☐☐☐☐☐☐☐☐☐

2. Taxpayer Identification Type (check appropriate box):
☐ Employer ID No. (EIN) ☐ Social Security No. (SSN) ☐ Individual Taxpayer ID No. (ITIN) ☐ N/A (Non-United States Business Entity)

Part III: Address

1. Physical Address:	2. Remittance Address:
Number, Street, and Apartment or Suite Number	Number, Street, and Apartment or Suite Number
City, State, and Nine Digit Zip Code or Country	City, State, and Nine Digit Zip Code or Country

Part IV: Exemption from Backup Withholding and Certification

For payees exempt from Backup Withholding, check the box below. Valid explanation required for exemption. See instructions.

☐ **Exempt from Backup Withholding**

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (TIN).

Sign Here:

____ Signature

____________________ Date

____ Print Preparer's Name

____________________ Phone Number

____________________ Email Address

Part V: Contact Information – Individual Authorized to Represent the Vendor

Vendor Contact Person: ____ Title:____

Contact's Email Address: ____ Phone Number: ______________________________

DO NOT SUBMIT FORM TO IRS – SUBMIT FORM TO NYS ONLY AS DIRECTED

FOR OSC USE ONLY

NYS Office of the State Comptroller

Instructions for Completing Substitute Form W-9

New York State (NYS) must obtain your correct Taxpayer Identification Number (TIN) to report income paid to you or your organization. NYS Office of the State Comptroller uses the Substitute Form W-9 to obtain certification of your TIN in order to ensure accuracy of information contained in its payee/vendor database and to avoid backup withholding.[1] We ask for the information on the Substitute Form W-9 to carry out the Internal Revenue laws of the United States. You are required to give us the information.

Any payee/vendor who wishes to do business with New York State must complete the Substitute Form W-9. Substitute Form W-9 is the only acceptable documentation. We will not accept IRS Form W-9.

Part I: Vendor Information

1. **Legal Business Name**: For individuals, enter the name of the person who will do business with NYS as it appears on the Social Security card or other required Federal tax documents. An organization should enter the name shown on its charter or other legal documents that created the organization. Do not abbreviate names.
2. **DBA (Doing Business As)**: Enter your DBA name.
3. **Entity Type**: Mark the Entity Type doing business with New York State.

Part II: Taxpayer Identification Number (TIN) and Taxpayer Identification Type

1. **Taxpayer Identification Number:** Enter your nine-digit Social Security Number, Individual Taxpayer Identification Number (ITIN)[2] or Employer Identification Number.
2. **Taxpayer Identification Type:** Mark the type of identification number provided.

Part III: Address

1. Physical Address: List the location of where your business is physically located.
2. Remittance Address: List the location where payments should be delivered.

Part IV: Exemption from Backup Withholding and Certification

Generally, reportable payments made by New York State are subject to Backup Withholding. Exemption from Backup Withholding applies to government and non-United States Business Entities[3]. Please sign, date, provide the preparer's name, telephone and email address. The preparer should be employed by your organization.

Part V: Contact Information

Please provide the contact information for an executive at your organization. This individual should be the person who makes legal and financial decisions for your organization.

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[1] According to IRS Regulations, OSC must withhold 28% of all payments if a payee/vendor fails to provide OSC its certified TIN. The Substitute Form W-9 certifies a payee/vendor's TIN.

[2] An ITIN is a nine-digit number used by the United States Internal Revenue Service for individuals not eligible to obtain a Social Security Number, but are required to file income taxes. To obtain an ITIN, submit a completed W-7 to the IRS. The IRS will notify you in writing within 4 to 6 weeks about your ITIN status. In order to do business with New York State, **you must submit IRS Form W-8** along with our Substitute Form W-9 showing your ITIN. IRS Form W-8 certifies your foreign status. To obtain IRS FormsW-7 and W-8, call 1-800-829-3676 or visit the IRS website at www.irs.gov.

[3] In order to do business with New York State, **you must submit IRS Form W-8** along with our Substitute Form W-9. IRS Form W-8 certifies your foreign status and exempts you from United States information return reporting and backup withholding rules. To obtain IRS Form W-8, call 1-800-829-3676 or visit the IRS website at www.irs.gov.