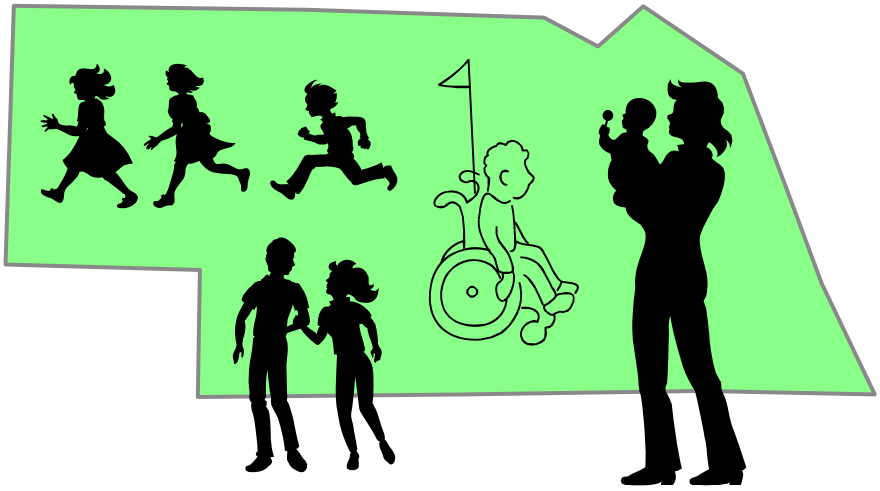
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

PROCEDURE MANUAL

NEBRASKA MATERNAL & CHILD HEALTH (MCH) GRANT

CFDA #93.994

FY 2006—FY 2008



Department of Health and Human Services (HHS)
Regulation and Licensure

Office of Family Health

MCH Planning & Support
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TABLE OF CONTENTS

ATTACHMENTS

Part I. Introduction

A. Purpose of the Procedure Manual

- Provide general information about the Maternal and Child Health (MCH) Services / Title V Block Grant.
- Clarify relationships of the federal Maternal and Child Health Bureau (MCHB), Nebraska Health & Human Services (Department of HHS Regulation and Licensure), and Nebraska MCH Grant Subrecipients.
- Identify the responsibilities of the Office of Family Health/MCH Planning & Support within Department of HHS Regulation and Licensure to administer Nebraska's MCH / Title V Block Grant, and specifically the portion of the Block Grant subgranted to local communities, referred to as **Nebraska MCH Grant**.
- Assist Subrecipients in the management/oversight of their Nebraska MCH Grant-funded program.
- Detail specific requirements for program implementation and reporting outcomes of the approved Work Plan.
- Detail specific requirements for financial reporting.
- Provide resources to assist Subrecipients in their compliance with federal laws and regulations. The manual is intended to augment the federal Office of Management and Budget (OMB) Circulars and Code of federal Regulations (CFR). Please refer to these documents on the Internet for continuous, up-to-date information.

B. Organization of the Procedure Manual

- Most of the information in this manual is arranged in a question and answer format with step-by-step instructions for completing forms and reports.
- Additional information is incorporated in the manual by reference. Information incorporated by reference has at least equal importance as if fully set forth in the manual. Website references helps ensure continuously updated and accurate information that is readily available generally, and provided in a more cost-efficient manner.
- Some key information from the Request for Proposals (RFP) issued May 16, 2005 is set forth in this Procedure Manual for convenience and clarity. However, the RFP in its entirety should be incorporated in Subrecipient document files.

- Subrecipients previously awarded these funds who are familiar with earlier versions of the Procedure Manual should be aware that there have been revisions over the last two project periods. *This manual supercedes all previous manuals.*

Part II. Title V of the Social Security Act / Maternal & Child Health Services Block Grant

A. Background

The Maternal and Child Health (MCH) Services Title V Block Grant, or more commonly known as MCH/Title V Block Grant, is one of the oldest federal funding sources to ensure the health of our Nation's mothers and children. Since passage of the Social Security Act in 1935, the federal Government has pledged its continuous support of Title V of the Act, making Title V the longest lasting public health legislation in United States history. Title V funding was converted to a block grant as part of the Omnibus Budget Reconciliation Act of 1981 (OBRA '81) when seven categorical funds were consolidated into a "block" of funding to broadly address a variety of health needs of mothers and children. OBRA '89 amendments require that State and federal Title V program activities **"improve the health of *all* mothers and children"** consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the Year 2000, i.e. now Healthy People 2010 objectives.

States and territories are allocated funds based on a formula through the United States Department of Health and Human Services, Maternal and Child Health Bureau (MCHB). A state's acceptance of federal MCH/Title V Block Grant funds imparts responsibility to the state to assure the health of all mothers and children in the state; to systematically assess health needs and determine health priorities; to develop systems that build capacity across the state to address these priority needs; and to be accountable for programs and services and their outcomes. States identify their specific health needs of the population through a five-year statewide needs assessment; submit an annual plan for meeting the needs identified by the statewide needs assessment; and report annually on performance measures. Also, States must match three dollars to every four dollars of MCH/Title V Block Grant funds, thereby creating a federal-State Partnership.

B. State Requirements

States prepare and transmit a standardized grant request and report July 15th each year based on the Block Grant Guidance, a comprehensive resource book of required application forms and submission guidelines approved by the Office of Management and Budget (OMB). OMB is organizationally within the Executive Office of the President. There are major requirements in the application, including a Statewide needs assessment, a plan for meeting the needs identified by that assessment, and other specific items on which States must report.

The Title V Block Grant Program requires that every $4 of federal Title V money must be matched by at least $3 of State and local money. This "match" results in the availability of more than 2 billion additional dollars nationwide for MCH programs annually at the State and local level. The program also requires that a minimum of 30% of federal Block Grant funds be used to support services for CSHCN and that a minimum of 30% of federal funds be used to provide preventive and primary care services for children. The States may spend no more than 10% of federal Title V funds on administrative costs. The earmarks are compliance requirements to

states and territories. Subsequently, individual subgrant application budgets do not need to comply with earmarking, however, a state-level budget must demonstrate a plan for compliance of the earmarks.

State MCH programs meet their Title V Block Grant responsibilities through a wide range of programs, with specific goals for:

- Reducing morbidity and mortality by assuring pregnant women, infants, children, and adolescents full access to quality, community-based preventive and primary care
- Developing family-centered, coordinated, community-based systems of care
- Participating in interagency coordination, especially with Medicaid; Women, Infants, and Children (WIC) Supplemental Nutrition program; Individuals with Disabilities in Education Act (IDEA); and other children's health, education, and social services programs
- Providing rehabilitative services to SSI recipients under age 16 who are not covered by Medicaid
- Linking Title V efforts to national year 2010 objectives
- Conducting comprehensive needs assessments every 5 years and preparing annual plans as part of a standardized application process
- Submitting to MCHB State annual reports reviewing program developments, health status and service data, and progress in meeting State and national health objectives. A report for the previous fiscal year and application for the following fiscal year are a combined process due each July 15th.

C. Restrictions

Title V funds, including the amounts paid to Subrecipients awarded Nebraska MCH Grant funds, may NOT be used for:

- inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;
- cash payments to intended recipients of health services;
- the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;
- satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
- providing funds for research or training to any entity other than a public or nonprofit private entity; or
- payment for any item or service (other than an emergency item or service) furnished

    - by an individual or entity during the period when such individual or entity is excluded from providing service under the Maternal and Child Health Act or Title XVIII (Medicare), Title XIX (Medicaid) or Title XX (Services for Families, Children, Aged or

Disabled) of the Social Security Act pursuant to section 42 U.S.C. 1320a-7, 42 U.S.C. 1320a-7a, 42 U.S.C. 1320c-5, or 42 U.S.C. 1395u(j)(2) of the Social Security Act; or

- at the medical direction or on the prescription of a physician during the period when the physician is excluded from providing services in the Maternal and Child Health program or Title XVIII (Medicare), Title XIX (Medicaid) or Title XX (Services for Families, Children, Aged and Disabled) of the Social Security Act pursuant to 42 U.S.C. Section 1320a-7, 42 U.S.C. Section 1320a-7a, 42 U.S.C. Section 1320-5, or 42 U.S.C. 1395u(j)(2) of the Social Security Act and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

D. Federal Organizational Charts and Information

To view the U.S. Department of Health & Human Services (DHHS) organization chart, see *http://www.hhs.gov/about/orgchart.html*. Within DHHS, learn about the Health Resources and Services Administration (HRSA) by either clicking on the HRSA organizational box at the DHHS organization chart, or by going directly to the HRSA website found at *http://www.hrsa.gov/* That site describes various functions of HRSA, including its role as the organizational parent of the Maternal and Child Health Bureau (MCHB).

HRSA's organizational structure is illustrated at *http://www.hrsa.gov/about/orgchart.htm*.

MCHB's organizational structure is shown by clicking on its box within HRSA, or linking at *http://www.hrsa.gov/about/org/mchb.htm*.

For additional information about Title V of the Social Security Act, the MCH Block Grant, and other current issues in the maternal and child health population, see MCHB's website at *http://mchb.hrsa.gov/*. The Title V Information System provides the most current nationwide MCH data reported to MCHB *https://performance.hrsa.gov/mchb/mchreports*.

Part III. Nebraska MCH Grant

A. Nebraska's Ten MCH Priority Needs

The following have been identified as the highest priority needs for Nebraska's mothers and children based on a five-year statewide needs assessment completed March 2005. Needs are addressed through activities directed at the needs of a population, i.e. *services*.

The numbers assigned to the priority needs do not signify a ranking of importance. The numbers provide a means to easily reference the priorities in the Work Plan.

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.

2. Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco *and* reduce the percent of infants, children and youth exposed to second hand smoke

3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.

4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.

6. Reduce the rates of infant mortality, especially racial/ethnic disparities.

7. Reduce alcohol use among youth.

8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.

9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.

10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.

***Infrastructure or projects* focus on overall capacity-building activities to address the needs.**

Essential Public Health Services to Promote Maternal and Child Health in America

1. Assess and monitor maternal and child health status to identify and address problems.

2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.

3. Inform and educate the public and families about maternal and child health issues.

4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

7. Link women, children, and youth to health and other community and family services and assure access to comprehensive, quality systems of care.

8. Assure the capacity and competency of the public health and personal health workforce to effectively address maternal and child health needs.

9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related programs.

"Public MCH Program Functions Framework: Essential Public Health Services To Promote Maternal and Child Health in America," Grason, H.A. and Guyer, B., The Johns Hopkins University Child and Adolescent Health Policy Center, December 1995.

C. Funding Components

The portion of Nebraska's Title V / MCH Block Grant that is subgranted during the current three-year cycle (FY 2006-FY 2008), funds are channeled through two mechanismas:

1) A portion of the MCH Block Grant, totaling **$1.2 million,** is **subgranted through a competitive process to community-based organizations** that propose primarily health services* to address local needs.

2) Annual funds totaling **$200,000** are subgranted to the four federally-recognized Tribes of Nebraska through a **non-competitive tribal setaside** in recognition of their sovereignty and the unique government-to-government relationship with the State of Nebraska. The Nebraska Intertribal Health Coalition (comprised of Tribal Chairs and Tribal Health Directors), through HHS Regulation and Licensure staff , establish the methodology to delineate the setaside funds among the four Tribes. These subgrants to the Tribes are used for MCH services and infrastructure*.

All Subrecipients, i.e. through both subgranted components, are subject to the Procedures set forth in this manual.

* *"Services"* are activities directed at the needs of a population. At least one of Nebraska's Ten MCH Priority Needs will be addressed. *"Infrastructure or projects"* focus on overall capacity-building activities to address those needs. One or more of the Essential Public Health Services to Promote Maternal and Child Health in America will be addressed for capacity-building activities for *infrastructure.*

D. Geographic Relative Risk

Data from primarily the U.S. Census Bureau and Nebraska Vital Statistics is used to develop a relative risk assessment for the population < age 18. Factors selected to determine relative risk are: children in poverty, total racial/ethnic minority proportion, low birth weight rate, adequacy of prenatal care, infant mortality rate, percent adolescent births to total live births (mothers age 19 and under) and population density. Data collected by county is aggregated into larger segments. Funding available is paired with relative risk to create a geographic methodology to equitably distribute funds statewide.

Maternal and Child Health (MCH) Grant -- FY 2006-2008

Competitive subgrants of federal Title V/MCH Block Grant

Subrecipients	Approval Annual Level *FY 2007 - 2008*	FY 2006 Award ***(adjusted: 9 months)****	Assigned Grant # *(FY 2006)*
Central Nebraska Community Services	$ 208,815	$ 156,611	MCH-06-01
Community Action Partnership of Mid-NE	$ 117,667	$ 88,250	MCH-06-02
Goldenrod Hills Community Action	$ 178,302	$ 133,727	MCH-06-03
Great Plains Regional Medical Center	$ 61,000	$ 45,750	MCH-06-04
Hope Medical Outreach	$ 349,696	$ 262,272	MCH-06-05
Lincoln Lancaster Co Health Dept	$ 40,000	$ 30,000	MCH-06-06
Panhandle Partnership for HHS	$ 50,000	$ 37,500	MCH-06-07
Univ of Nebr Center-Maternal Care Program	$ 175,000	$ 131,250	MCH-06-08
	$ 1,180,480	$ 885,360	

* The Fiscal Year 2006 award is adjusted for a nine-month period January 1, 2006 through September 30, 2006 due to a one-quarter extension in the previous fiscal year. The extension was done to allow additional time to: carefully review the applications

NOTE: Grant #s change for the relevant fiscal year, e.g. MCH-06-___ is for FY 2006 awards. FY 2007 and FY 2008 awards will change to grant # MCH-07-___ and MCH-08-___, respectively.

Tribal Setaside subgrants of federal Title V/MCH Block Grant

Subrecipients	Approval Annual Level *FY 2007 - 2008*	FY 2006 Award	Assigned Grant # *(FY 2006)*
Omaha Tribe of Nebraska	$ 55,137.61	$ 55,137.61	MCH-06-09
Ponca Tribe of Nebraska	$ 46,358.94	$ 46,358.94	MCH-06-10
Santee Sioux Nation	$ 39,466.74	$ 39,466.74	MCH-06-11
Winnebago Tribe of Nebraska	$ 59,036.70	$ 59,036.70	MCH-06-12
	$ 200,000	$ 199,999.99	

*** The Fiscal Year 2006 award follows the standard twelve-month period beginning October 1, 2005 and concluding September 30, 2006.** This is in contrast to the awards through the competitive subgrant process which were adjusted to a nine-month period for F

Part IV. Department of HHS Regulation and Licensure Roles & Responsibilities

A. Timelines

The following is intended to clarify the roles and responsibilities of Department of HHS Regulation and Licensure for the administration of 1) Nebraska Title V / MCH Block Grant, and 2) Nebraska MCH Grant. Shaded entries show Department of HHS Regulation and Licensure' role in its responsibilities to the federal Maternal and Child Health Bureau (MCHB).

Year 1 -- (FY 2006)

October 1, 2005.....	Nebraska MCH Grant period begins for Tribal setaside awards
January 1, 2006	Nebraska MCH Grant period begins for competitive awards
January 15, 2006	1st Quarter Reports due (unless previously approved for extension)
April 15, 2006	2nd Quarter Report due (unless previously approved for extension)
April and May, 2006	Public input re: Nebraska's application for Title V/MCH Block Grant FY 2007 funds
July 15, 2006.....	federal MCH/Title V Block Grant Report (FY 2005) & Application (FY 2007) due date
July 15, 2006	3rd Quarter report due (unless previously approved for extension)
August, 2006 *	Requests for continuation (non-competitive) FY 2007 funding (Year 2)
September 30, 2006	Fiscal Year 2006 ends
November 30, 2006.....	4th Quarter/Final Reports due (no extensions to allow for grant close-out)

Year 2 – (FY 2007)

October 1, 2006.....	Nebraska MCH Grant period begins for Tribal setaside awards
January 15, 2007	1st Quarter Reports due (unless previously approved for extension)
April 15, 2007	2nd Quarter Report due (unless previously approved for extension)
April and May, 2007	Public input re: Nebraska's application for Title V/MCH Block Grant FY 2007 funds
July 15, 2007.....	federal MCH/Title V Block Grant Report (FY 2006) & Application (FY 2008) due date
July 15, 2007	3rd Quarter report due (unless previously approved for extension)
August, 2007 *	Requests for continuation (non-competitive) FY 2008 funding (Year 3)
September 30, 2007	Fiscal Year 2007 ends
November 30, 2007.....	4th Quarter/Final Reports due (no extensions to allow for grant close-out)

Year 3 – (FY 2008)

October 1, 2007.....	Nebraska MCH Grant period begins for Tribal setaside awards
January 15, 2008	1st Quarter Reports due (unless previously approved for extension)
March, 2008*	Issue Request for Proposals for next three-year cycle (FY 2009-2011)
April 15, 2008	2nd Quarter Report due (unless previously approved for extension)
April and May, 2008	Public input re: Nebraska's application for Title V/MCH Block Grant FY 2007 funds

July 15, 2008.....	federal MCH/Title V Block Grant Report (FY 2007) & Application (FY 2009) due date
July 15, 2008	3rd Quarter report due (unless previously approved for extension)
September 30, 2008	Fiscal Year 2008 and three-year project period ends
November 30, 2008.....	4th Quarter/Final Reports due (no extensions to allow for grant close-out)

* Approximate dates; all other dates confirmed.

B. State Organizational Charts

The following organizational charts reflect Title V/MCH Block Grant administration at the State level.

Chart 1: overview of the Nebraska Health & Human Services System

Chart 2: detail of the administration of the Title V/MCH Block Grant through **Home and Community Services** within the Department of HHS Finance and Support and **Health Services** within the Department of HHS Regulation and Licensure.

The primary administration of Nebraska's Title V/MCH Block Grant is performed by the Office of Family Health/MCH Planning & Support.

Rayma Delaney
Title V / MCH Grant Administrator
Office of Family Health – MCH Planning & Support
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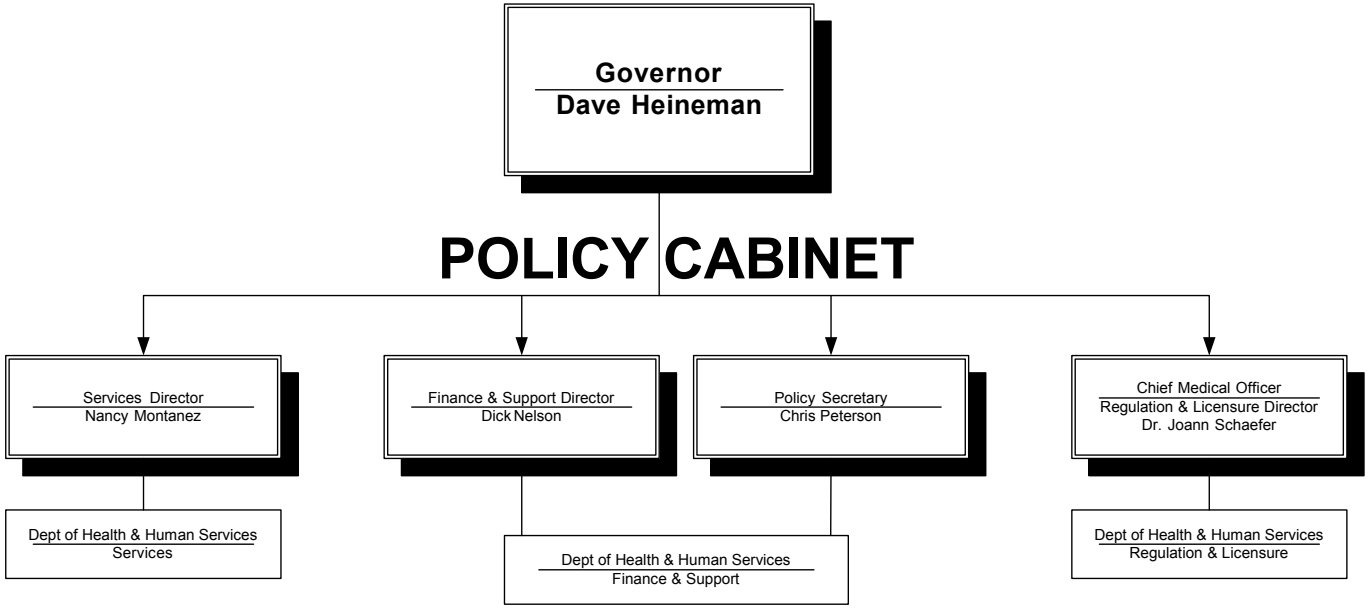
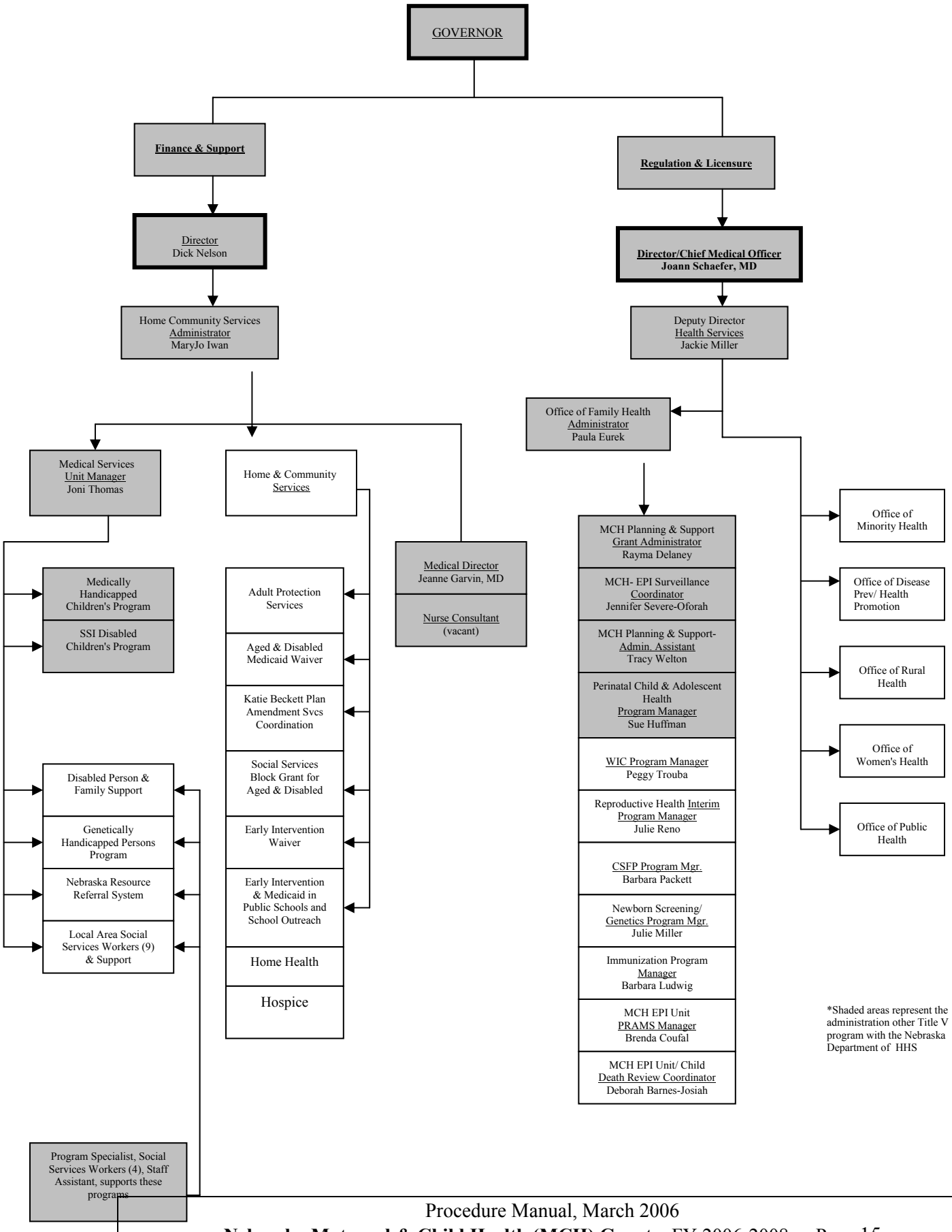
under the direction of:

Nebraska Title V / MCH Block Grant	
MCH Director	CSHCN Director
Paula Eurek Administrator, Office of Family Health	Mary Jo Iwan Deputy Administrator Office of Aging & Disability Services

Health & Human Services System



Part IV. Department of HHS Regulation and Licensure Roles and Responsibilities



C. Contact Information

For general communication, please call or write:

Department of HHS Regulation and Licensure
Office of Family Health
MCH Planning & Support
Attn: Tracy Welton
P.O. Box 95007
Lincoln, Nebraska 68509-5007
Phone: (402) 471-2907
Fax: (402) 471-7049

Subrecipients may also contact a specific state-level staff person for technical assistance, as relevant:

Contact Person	Phone # and E-Mail Address	Content Area
Rayma Delaney Title V/MCH Grant Administrator	MCH Planning & Support (402) 471-0197 rayma.delaney@hhss.ne.gov	MCH grants management, program interventions, budgeting, funding, monitoring
Jennifer Severe-Oforah Epidemiology Surveillance Coordinator	MCH Planning & Support (402) 471-2091 jennifer.severeoforah@hhss.ne.gov	assessment, planning, evaluation
Cinde Swartz Federal Aid Administrator	Grants & Cost Management (402) 471-2792 cinde.swartz@hhss.ne.gov	financial reviews, indirect costs, audit requirements

D. Compliance with Federal Statute, Regulations, and Circulars

Department of HHS Regulation and Licensure Regulation and Licensure must comply with the following federal authorities in the administration of the Title V / Maternal and Child Health Block Grant.

- *Social Security Act, Title V* (45 U.S.C. 701-709)
- *Code of federal Regulations* (42 C.F.R. 96)
- *federal Office of Management and Budget (OMB) Circulars*

E. Monitoring

Q: What type of monitoring will be done on my program?

- Monitoring of the Nebraska MCH Grant-funded programs is accomplished through several methods including review of written program and expenditure reports, telephone calls, electronic mail, or site visits.

- Department of HHS Regulation and Licensure staff will incorporate all or some of these methods in their review of program activities.

- Official records of each program's progress in addressing MCH priority needs and outcomes in the Subrecipient work plan as set forth in the approved application are maintained by MCH Planning & Support.

- Department of HHS Regulation and Licensure staff provides review of federally required audits and performs on-site fiscal monitoring, as needed, to ensure that financial management systems are adequate to meet federal requirements and to provide technical assistance in financial management.

Q: What is the purpose of a site visit?

- Site visits are the first-hand opportunity to review program activities and progress made in addressing the MCH priority needs of the programs funded by Nebraska MCH Grant funds.

- Site visits are one way that MCH Planning & Support staff provides technical assistance to enhance Subrecipient's MCH program and grant management. Examples include needs assessment, program planning, budgeting, implementation, reporting, and program evaluation. In addition, site visits help foster working relationships between staff of MCH Planning & Support and Subrecipients.

Q: What is the process for site visits?

- Subrecipients will be notified in writing of the monitoring site visit.

- The letter will specify information concerning how long the visit will take, who will need to be available for the visit, what activities will occur during the visit, and type of source documentation to be reviewed.

- The site visit will be followed by a letter indicating findings and recommendations for corrective actions, if any.

- The Department of HHS Regulation and Licensure is responsible for fiscal monitoring as required by federal regulations found in OMB Circular A-133. A financial reviewer may accompany MCH Planning & Support staff on site visits to assess the fiscal management of the program and provide technical assistance.

- All records and documentation shall be made available to Department of HHS Regulation and Licensure as the pass-through granting agency, State of Nebraska auditors, or independent auditors retained by Subrecipient, as warranted.

Q: How often should I expect a site visit?

- Site visits will be conducted as needed.

Q: Should I expect unannounced visits?

- Although less likely, MCH Planning & Support staff reserves the right to conduct site visits without prior notice. This may include observation of scheduled activities and events.

- MCH Planning & Support will take advantage of opportunities to consolidate travel to between site visits or other meetings. This could include an unannounced visit to a Subrecipient to meet face-to-face to discuss the program and to answer any questions.

Q: Can we request a site visit?

- Subrecipients are encouraged to invite MCH Planning & Support staff to events or activities of the MCH program. Opportunities to observe programs in action improve understanding.

- Subrecipients may request a site visit to receive technical assistance from MCH Planning & Support. MCH Planning & Support will consider the request based on the most effective and feasible option to provide technical assistance.

Q: Site visits make me nervous. What if I receive a report with many recommendations? Will funding for my program be in jeopardy?

- Site visits should not be viewed as a win or lose situation. Site visits are part of Department of HHS Regulation and Licensure' monitoring responsibility for administration of these federal funds.

- MCH Planning & Support staff will work in partnership with you to make your program successful and cost-effective. Reviews are conducted with this goal in mind.

- Recommendations to improve your program are to help assure that these funds are maximized.

- Only in serious circumstances would MCH Planning & Support staff recommend to the Director of the Department of HHS Regulation and Licensure that funding be suspended or terminated. However, improper administration of the Nebraska MCH Grant funded program or lack of performance to carry out the activities set forth in the program work plan could result in suspension or termination of the subgrant. The terms and conditions for suspension or termination are contained in the Subgrant Terms and Assurances by reference to the federal grants administrative requirements applicable to Subrecipient, i.e. OMB Circulars A-102 or OMB A-110. Subrecipients agreed to comply with the terms and conditions described in the Subgrant Terms and Assurances. The Subgrant Terms and Assurances are part of the approved application on file with the Department of HHS Regulation and Licensure.

F. Reimbursement

Except for an approved Cash Advance, payments to Subrecipient are reimbursements of actual expenses. In any fiscal year if expenses are less than the award, Subrecipients will not be allowed to carry forward grant funds from a prior year into a succeeding year, e.g. any unobligated or unexpended funds in FY 2006 will not be added to the FY 2007 award.

Q: What should I do to ensure timely reimbursement of expenditures?

- Submit reports with original signatures, signed by individuals representing program and finance operations of the Subrecipient. To ensure confidence in the authenticity of the signatures of representatives authorized by the Subrecipient, persons signing the Expenditure Report shall be:

    1) the two persons indicated on the Cover Sheet of the approved grant application,

    or, in the alternative

    2) identified by name, title, and printed name on the Expenditure Report.

    MCH Planning & Support reserves the right to hold a reimbursement payment request pending satisfaction of a concern of segregation of duties and other matters of internal control, or if a portion of a report is missing, incomplete, or unclear. MCH Planning & Support will notify Subrecipient if a payment is being held, the reason for holding, and identify what is needed to resolve the concern.

- Complete the upper portion of the Expenditure Report with accurate, complete information, e.g. Grant #, Subrecipient name and address, federal tax identification number (FTIN), reporting period, etc. Keep MCH Planning & Support informed of any address changes, and always use the current address on the Expenditure Report.

- Submit the Program Report and Expenditure Report together and on or before the due date. Refer to the Timeline in Part I. Introduction, or to Exhibit 1 of the Subgrant Terms and Assurances for the reporting due dates.

Q: When a request for reimbursement is sent to MCH Planning & Support, how long does it take until the Subrecipient receives payment?

- It generally takes at least three to four weeks **from the due date** before the check is sent to your agency. Incomplete and late reports may require additional time to process.

- Electronic payments have a shorter turnaround time. Reimbursements of $75,000 or more must be electronic payment. If Subrecipient is not set up for electronic payment, and needs to be or would like to be, submit the request for electronic payment to MCH Planning & Support. Include the Grant #, the name and phone number of the finance representative for the Subrecipient. MCH Planning & Support will forward the request to the accounting unit.

Q: What is the process for reimbursement?

- The Program Report and Expenditure Report are received in MCH Planning & Support.

- The Expenditure Report is checked for Subrecipient's current billing/payment address, mathematical accuracy, correct federal tax identification number, and two original signatures of authorized representatives of Subrecipient.

- Expenditures are evaluated with respect to the corresponding Program Report to determine if expenses are allowable, allocable, reasonable and within budget. Match expenditures, including program income, are reviewed using the same criteria as grant expenditures.

- The Program Report is reviewed for current status and progress in moving towards expected outcomes from the approved Work Plan.

- If MCH Planning & Support has any questions, or needs clarification, a call is made or e-mail is sent to the relevant contact of Subrecipient, i.e. program or finance. In some cases, other Department of HHS Regulation and Licensure staff may contact the Subrecipient for clarification.

- When the reporting requirements are satisfied, the MCH Grant Administrator approves the reports by signing and forwarding to the Administrator, Office of Family Health for final authorization.

- With authorization, the reimbursement request is sent to the Accounting unit of the Department of HHS Finance and Support where the payment process begins.

- The request is then sent to the Nebraska Department of Administrative Services (DAS) for issuance of the warrant. The warrant is sent U.S. Mail unless electronic payment has been previously established.

G. Technical Assistance

Throughout the funding period there will be opportunities identified by MCH Planning & Support for qualified individuals to provide Subrecipients with assistance of specific health related or administrative services. Topics that may be included are assessment, data analysis, planning, coordination, collaboration leadership, data system development, performance measures, and grants management.

H. Fiscal Year Close-Out

Fiscal year closeout activities are the final review and payment of a funded program. MCH Planning & Support checks to make sure that each of the following five items are satisfied: 1) reports, including the final reporting Tables 1-4, are accurate and completed fully 2) full accounting of a start-up cash advance 3) total reimbursement (shown as cumulative expenditures) does not exceed the grant award, 4) expenditures of match are at least 20% of grant expenditures 5) program income, if any, has been fully reinvested and as shown by cash match. Fiscal year closeout procedures are necessary to determine unliquidated obligations of the federal award to the State. This assists in the accurate projection of funding available in the subsequent fiscal year, and to submit federal reports. Subsequently, final expenditure reports must be received within 60 days from the end of the funding period to perform timely fiscal year close-out. **Department of HHS Regulation and Licensure reserves the right to not process requests for reimbursement received more than 60 days after the end of the funding period.** In addition, a list of equipment purchased with grant funds may be submitted with the final expenditure report. For other fiscal year close-out information refer to the Program Income and Equipment/Supply Sections.

Part V. Subrecipient Responsibilities

A. Timelines

The Department of HHS Regulation and Licensure requested proposals for the three-year period October 1, 2005 – September 30, 2008. The project period is divided by fiscal years as referenced below:

Year 1 / Fiscal Year 2006 ..... October 1, 2005 – September 30, 2006 *
Year 2 / Fiscal Year 2007 ..... October 1, 2006 – September 30, 2007
Year 3 / Fiscal Year 2008 ..... October 1, 2007 – September 30, 2008

Each fiscal year is divided into four quarters *(*with the exception for FY 2006 awards in the competitive component adjusted for a nine-month period January 1, 2006 through September 30, 2006)*. The corresponding reports for the 1st, 2nd, and 3rd Quarters are due on the 15th day following the close of each quarter, *unless otherwise arranged in advance at the beginning of each fiscal year*. For example, consideration will be given to requests from Subrecipients whose internal accounting system function necessitates a change in due date to the 30th/31st day of the month. The Final Report is due November 30th, 60 days after the Fiscal Year ending September 30th.

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
October 1 – December 31	January 1 – March 31	April 1 – June 30	July 1 – September 30
Reports due January 15	Reports due April 15	Reports due July 15	Reports due November 30

Subrecipients receive an award letter based on a one-year budget for Year 1. Subrecipients who applied for and were awarded based on a multi-year project period will be required to submit an updated work plan and budget for continuation years 2 and 3.

The following timeline should be used by Subrecipients as an overview of the three-year project period and the specific dates of the fiscal years. Reporting due dates are specified (see also Exhibit 1, Subgrant Terms & Assurances, RFP), however, requests for extension will be considered prior to the reporting due date. To assist in long-range planning, the following is an approximate timeline for the next funding cycle.

Year 1 – FY 2006

October 1, 2005..... Project period begins
December 31, 2005 ..... 1st Quarter ends
January 15, 2006 ..... 1st Quarter reports due
March 31, 2006 ..... 2nd Quarter ends
April 15, 2006 ..... 2nd Quarter reports due
June 30, 2006 ..... 3rd Quarter ends
July 15, 2006 ..... 3rd Quarter reports due
August, 2006* ..... updated work plans and budgets due for Year 2
September 30, 2006 .... 4th Quarter; Fiscal Year 2006 ends
November 30, 2006..... 4th Quarter/Final Reports due

Year 2 – FY 2007

October 1, 2006..... Fiscal Year 2007 begins
December 31, 2006 ..... 1st Quarter ends
January 15, 2007 ..... 1st Quarter reports due
March 31, 2007 ..... 2nd Quarter ends
April 15, 2007 ..... 2nd Quarter reports due
June 30, 2007 ..... 3rd Quarter ends
July 15, 2007..... 3rd Quarter reports due
August, 2007* ..... updated work plans and budgets due for Year 3
September 30, 2007 .... 4th Quarter; Fiscal Year 2007 ends
November 30, 2007..... 4th Quarter/Final Reports due

Year 3 – FY 2008

October 1, 2007..... Fiscal Year 2008 begins
December 31, 2007 ..... 1st Quarter ends
January 15, 2008 ..... 1st Quarter reports due
March 2008* ..... Request for Proposals FY 2009-2011 issued
March 31, 2008 ..... 2nd Quarter ends
April 15, 2008 ..... 2nd Quarter reports due
June 2008* ..... proposals due for Project Period FY 2009-2011
June 30, 2008 ..... 3rd Quarter ends
July 15, 2008..... 3rd Quarter reports due
August 2008* ..... funding decisions for Fiscal Years 2009-2011 announced
September 30, 2008 .... 4th Quarter; Fiscal Year 2008 ends
November 30, 2008..... 4th Quarter/Final Reports due

* Approximate dates; all other dates confirmed.

B. Compliance with Subgrant Terms and Assurances; Certifications

- The Subgrant Terms and Assurances and its Exhibits 1, 2 and 3, **[ATTACHMENT 4** of the RFP**]** are part of Subrecipient's approved application on file with Department of HHS Regulation and Licensure. Subrecipients must operate the program in accordance with the terms and conditions of the Subgrant Terms and Assurances.

- Signed Certifications **[ATTACHMENT 4** of the RFP**]** are also part of Subrecipient's approved application on file with Department of HHS Regulation and Licensure. In addition, Subrecipients who use MCH Grant funds to contract with another entity must obtain and maintain signed certifications from each subcontractor. [Note: The Certification Regarding Drug-Free Workplace Requirements includes, as an alternate, instructions and a form for grantees who are individuals. This Certification is for subcontracted individuals of a Subrecipient, not for Subrecipients since individuals are not eligible to apply for these MCH Grant funds.]

C. Compliance with Federal OMB Cost Principles, Administrative and Audit Requirements

The Office of Management and Budget (OMB) Circulars are instructions or information to recipients/subrecipients of federal funds. These are expected to have a continuing effect of two years or more. Refer to the OMB Circulars on the Internet for continuous, up-to-date information.

http://www.whitehouse.gov/omb/circulars

To obtain circulars that are not available on-line, call the Office of Management and Budget's information line at (202) 395-3080.

Q: Which Circulars do I Follow?

Subrecipient must adhere to the OMB Circulars. The Circulars pertain to cost principles, administrative requirements, and audit requirements.

- **Cost Principles**
  - A-21 ..... Educational Institutions
  - A-87 ..... State and Local Governments
  - A-122 ..... Non-Profit Organizations

- **Administrative Requirements**
  - A-102 ..... State and Local Governments
  - A-110 ..... Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations

- **Audit Requirements**
  - A-133 ..... States, Local Governments, and Non-Profit Organizations

Although there are six grant circulars, Subrecipient is covered by only three of them. Use the following guide to identify the OMB Circulars relevant to Subrecipient by type of entity:

- **States, local governments, and Indian Tribes** follow
  - A-87 for cost principles
  - A-102 for administrative requirements, and
  - A-133 for audit requirements

- **Educational Institutions** (even if part of a State or local government) follow:
  - A-21 for cost principles
  - A-110 for administrative requirements, and
  - A-133 for audit requirements

- **Non-Profit Organizations** follow:
  - A-122 for cost principles
  - A-110 for administrative requirements, and
  - A-133 for audit requirements

D. **Compliance with Code of Federal Regulations (CFR): 45 CFR**

The *Code of Federal Regulations* (CFR) is a codification of the general and permanent rules published in the F*ederal Register* by the Executive departments and agencies of the federal Government. The CFR online is a joint project authorized by the publisher, the National Archives and Records Administration's Office of the federal Register, and the Government Printing Office (GPO) to provide the public with enhanced access to Government information.

The CFR is divided into 50 titles which represent broad areas subject to federal regulation. Each title is divided into chapters which usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations to the CFR will be provided at the section level. Each volume of the CFR is revised once each calendar year and is issued on a quarterly basis.

Refer to CFR Services online: http://www.gpoaccess.gov/cfr/retrieve.html

Retrieve by citation (see example below; Note: Section # obtained from the Index)

REVISION YEAR	TITLE		PART		SECTION	
Most Recent Available	45	CFR	74	.	1	OR

SUBPART	TYPE OF FILE
	Text

Refer to the Index, Title 45 – Public Welfare for the specific sections, e.g. 45 CFR 74.1 "Purpose and applicability": http://www.access.gpo.gov/nara/cfr/waisidx_01/45cfr74_01.html

See relevant Parts 74, 76, 92, and 93, i.e.
45 CFR 74
45 CFR 76
45 CFR 92
45 CFR 93

Part 74 ..... Uniform Administrative Requirements for Awards and Subawards and to Institutions of Higher Education, Hospitals, Other Non-Profit Organizations, and Commercial Organizations; and Certain Grants and Agreements with States. Local Governments, and Indian Tribal Governments

Part 76 ..... Government Debarment and Suspension (Nonprocurement) and Governmentwide Requirements for Drug-Free Workplace (Grants)

Part 92 ..... Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments – Table of Contents

Part 93 ..... New Restrictions on Lobbying – Table of Contents

E. Internal Policies

1. Personnel Policy

Subrecipients must have a written personnel policy if:

- employees are paid with, in whole or in part, Nebraska MCH Grant funds;
- volunteers donate time to the MCH program which is reported as in-kind (non-cash match).

Written policies and records must be established and maintained, to include:

- current job descriptions of program staff or volunteers; and
- documentation of staff or volunteer time to perform grant-related activities.

All policies, procedures, and time records must be kept on file and be available for inspection.

2. Records Retention

Subrecipient will develop a records retention policy and schedule regarding information associated with the MCH Grant. Use the following guidelines regarding the types of records and length of time to retain those records:

- Refer to OMB Circulars relevant to Subrecipient.

- The Subrecipient's records retention policy will be no less comprehensive than requirements in OMB Circulars relevant to Subrecipient, and may impose additional requirements specific to Subrecipient.

- If Subrecipient provides direct healthcare services, Subrecipient is advised to consult with a legal authority regarding the records retention policy and schedule for medical files of minor children.

3. Sliding Fee Scale

Subrecipients providing a service for which they intend to impose fees directly to the client must develop a sliding fee scale for those persons not low income and not covered by Medicaid. (See also the section entitled "Program Income" in this Part V. Subrecipient Responsibilities, which discusses using the federal Poverty Guidelines. While many programs use the guidelines to classify persons or families as either eligible or ineligible, some other programs use the guidelines for the purpose of giving priority to lower-income persons or families in the provision of assistance or services, the latter of which is the case for Maternal and Child Health programs.)

SAMPLE:

SLIDING FEE SCALE	**Size of Family**			
Poverty Level	1	2	3	4
At or below 100%	No charge	No charge	No charge	No charge
101%--150%	25% of cost	25% of cost	25% of cost	25% of cost
151%--200%	50% of cost	50% of cost	50% of cost	50% of cost
201% -- 300%	100% of cost	100% of cost	100% of cost	100% of cost

F. Program Operations

1. Work Plans

The Work Plan is the result of a community-level planning process. The Work Plan for the MCH Grant includes three parts: Plan Summary, Plan Description, and Timeline. The approved Work Plan must guide the work throughout the grant year.

Q: How do I use the Work Plan from the application?

- Your approved Work Plan is used to guide your program's activities throughout the grant year, and to measure progress. (Note: The approved Work Plan may not be the initial Work Plan submitted, i.e. if a contingency of funding required Work Plan revisions, the final Work Plan submitted to MCH Planning & Support prior to the final notification of the award is considered the approved work plan.)

- Program staff should refer to the Work Plan often to assure that activities are occurring as planned.

- Quarterly Reports include updates to MCH Planning & Support on the status of the Work Plan. Reporting on the Work Plan is a means to gauge achievements, or if limited progress is being achieved, may indicate that the Work Plan requires modifications.

Q: Can I make changes in my Work Plan?

- Revising the Work Plan, specifically adding/deleting outcomes and performance measures, requires a written request to MCH Planning & Support. A change in Work Plan inputs, outputs, and timeline do not require prior approval, but should be communicated in the Quarterly Report.

- A request to revise Work Plan outcomes and performance measures includes:

  - A letter or e-mail requesting the change, referencing requested revisions by the numbering system used for the outcome(s) and/or performance measure(s).

  - Using the approved Work Plan, revise the typewritten document with respect to the revision request.

  - If the request to revise the Work Plan impacts the Budget, the approved Line Item Budget and Budget Justification should be modified accordingly. (See the section entitled "Budget Revisions" in this Part V. Subrecipient Responsibilities.

- Subrecipient will receive a written response regarding the decision to approve or disapprove the requested revision. [**Note**: Proposed changes that appear to significantly alter the direction of the Nebraska MCH Grant funded program may not be approved.]

- If the request is approved, the revisions must be incorporated in all future reporting.

Q: The close of the project period is near and more time is needed to accomplish outcomes listed in my Work Plan. What can I do?

A no-cost extension is applicable in the final year of a Subrecipient's project period.

- A no-cost extension may be requested only if extenuating circumstances have prevented substantial progress in achieving the program's outcomes as identified by performance measures. The maximum length of a no-cost extension is two months, or November 30 of the same year.

- Requests for a no-cost extension cannot include revisions to the outcomes and performance measures of the approved Work Plan. Subrecipient may however request revisions to the inputs and outputs.

- Subrecipient submits a written request no later than September 15th to MCH Planning & Support. The request must outline the reason for the requested no-cost extension and

describe how the extended time will affect the outcomes and performance measures in the approved Work Plan.

- Depending on the level of unexpended funds at the time of the request, Subrecipient may be asked to submit a revised Line Item Budget and Budget Justification for the amount needed during the extended time. No additional funds will be awarded.

- If the no-cost extension is approved by MCH Planning & Support, an amended award letter will be issued to reflect the project period extension to November 30, and may include the specific amount of funds from the award authorized for the no-cost extension.

- The 4th Quarter/Final Report (for no-cost extensions only) is due January 31st in the calendar year following the conclusion of the no-cost extension, i.e. two months after the conclusion of the amended award. For example, the 4th Quarter Report and Final Report are due January 31, 2007 for an approved no-cost extension of the FY2006 amended award ending November 30, 2006.

2. National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

See **[SEE ATTACHMENT 10, RFP]**. Subrecipients are to move towards full compliance with the four mandated CLAS Standards. Department of HHS Regulation and Licensure will provide technical assistance over the grant period to assist subrecipients meet this requirement. Compliance with the other standards is encouraged.

3. Review of Materials and Acknowledgement of Support of Federal Funds.

Materials produced with MCH Grant funds that will be disseminated to the public should be reviewed and approved by MCH Planning & Support prior to dissemination. Materials must acknowledge support from federal funds. A compilation of materials produced by other sources should not credit MCH Grant funds.

As stated in the Subgrant Terms and Assurances, use the following acknowledgement on any materials supported by Nebraska MCH Grant funds:

"This activity is supported by federal Title V / Maternal and Child Health Block Grant Funds awarded to [subrecipient name] by the Nebraska Department of Health and Human Services Regulation and Licensure."

Q: What types of products should be reviewed and credited to Federal Maternal and Child Health funds by Department of HHS Regulation and Licensure?

There are various types of products that may be supported with MCH Grant funds in a variety of forms, i.e. print, electronic, video, or sound productions. Examples include news releases, articles, brochures, flyers, newsletters, websites, video or audio tapes, and models. The products supported with the MCH Grant should contain an acknowledgment of that support (see the

wording in item 3. above.)

Q: What is the reason that products supported with these grant funds should be reviewed and approved prior to dissemination to the public?

MCH Planning & Support respects the uniqueness of communities, their diverse needs and interventions supported with these grant funds. Establishing a centralized process for products supported by these funds statewide is intended to complement the development of community-level products. Review and approval prior to dissemination of products maximizes existing resources, coordinates new development, and expands the Nebraska MCH resource library. The purposes of prior review and approval of products supported by MCH grant funds is to achieve consistent content and quality, and to more readily share information statewide with other Subrecipients.

4. Program Evaluation

The extent of the evaluation design is relative to the value of the award. As a guideline, approximately 5-10% of the budget of MCH Grant funds should be designated for evaluation, e.g. costs associated with evaluation such as personnel, consultants, and supplies to collect and analyze data. Evaluation must be included not only in the planning stages, but throughout the three-year life cycle of the proposal. The process cannot be delayed until the mid-point or at the end of the project period for a valid evaluation plan. Evaluation activities must be incorporated in the Work Plan timeline.

G. Finance Operations

1. Cash Advance

(See also Cash Advance in the Program Specific Requirements [Exhibit 2, Subgrant Terms and Assurances] which is Attachment 4 of the Request for Proposals for Nebraska MCH Grant FY 2006-2008.)

Q: What can I do if I need working capital to get the program started?

A cash advance may be requested if other funds are not available to pay for the startup costs of the activities for the 1st Quarter of a fiscal year. The maximum amount available for a one-time cash advance is 25% of the Subrecipient award. Subrecipient must send a written request, as described below, to be considered by MCH Planning & Support.

Q: What is the process for a cash advance?

- Subrecipient determines if other funds are available to pay for start-up costs of the activities for the 1st Quarter of a fiscal year.
- If other funds are not available, a written request must include a declaration that

Subrecipient will suffer serious cash flow problems without a cash advance. The declaration and rationale for the request must accompany the request, plus any supporting evidence as warranted.

- Complete the Request for Cash Advance form found in the following pages of this section. Instructions for completing the form are included. Note: Representatives for program and finance must both sign the form. Provide contact information for those signing the form for the purpose of notification from MCH Planning & Support regarding approval or non-approval of the request.

- Using the approved budget, describe the budget categories and/or line items where the cash advance will be used as "startup" in the 1st Quarter of the fiscal year.

- Submit the Request for Advance form, written declaration, rationale for the request, and explanation of the budget categories/lines where funds will be used, plus any supporting evidence as warranted. The submission may be faxed to expedite the request. If faxed, items with original signatures should be sent by U.S. Mail.

✓	**Checklist of Items to Submit a Request for Cash Advance**
	Completed Request for Advance form signed by representatives of both program and finance operations. Instructions are provided on the form to fill-in the blanks.
	Written declaration that Subrecipient will suffer serious cash flow problems without the cash advance.
	Explanation or rationale for the percentage of the request (maximum 25% of the one-year award). Include a description of the approved budget categories and/or line items where the cash advance will be used as "startup" in the 1st Quarter of the fiscal year.
	Attach supporting evidence, as warranted.

Send written request to:

Rayma Delaney, Title V/MCH Grant Administrator
Nebraska HHS, Regulation & Licensure
Office of Family Health / MCH Planning & Support
PO Box 95007
Lincoln NE 68509-5007
Fax: (402) 471-7049

- The request is reviewed by MCH Planning & Support. Consideration of the request will also include past performance of Subrecipient in any current and/or prior grants, contracts, cooperative agreements, or subcontracts with Department of HHS Regulation and Licensure, with particular consideration to timely reporting or other evidence of deliverables.

- Written notification regarding approval or non-approval will be sent by fax or e-mail to those who have signed the request, using the contact information provided by Subrecipient on the Request for Cash Advance form.

Q: How is the advance accounted for in my expenditure reports?

- Accounting for a cash advance will occur in each of the four quarters by deducting from the expenses one-fourth of the cash advance in each quarter.

EXAMPLE:

Based on a $50,000 award, with an $8,000 (16%) one-time advance, $2,000 would be deducted from each of the four (4) quarter expense reimbursements. The "Cash Advance" and "Reimbursement" columns (shaded) reflect the "Payment to Date" column. Note: 4th Quarter expense reimbursement will be made up to the $50,000 award, i.e. the total payments cannot exceed the award. For example in the scenario below, $11,500 – 2,000 = $9,500 (4th Quarter expenses minus deduction). However, the reimbursement is $8,000 to not exceed the $50,000 award.

Quarter	Expenses	Deduction	Cash Advance	Reimbursement	Pymt to-date
start-up			$ 8,000		$ 8,000
1st	$ 12,000	$ 2,000		$ 10,000	$ 18,000
2nd	$ 13,000	$ 2,000		$ 11,000	$ 29,000
3rd	$ 15,000	$ 2,000		$ 13,000	$ 42,000
4th	$ 11,500	$ 2,000		$ 8,000	$ 50,000
Total	$ 51,500	$ 8,000	$ 8,000	$ 50,000	$ 50,000

- At the end of the program period, if more cash was advanced to the Subrecipient than the total expenses, Subrecipient will be required to refund the overage to Department of HHS Regulation and Licensure.

- Questions about the process, should be directed to MCH Planning & Support.

DEPARTMENT OF HHS REGULATION AND LICENSURE
Nebraska Maternal and Child Health (MCH) Grant

Request for Cash Advance

Instructions:

- Use the required form. The Request for Advance form is available in print copy or electronically as a Word document.
- Fill-in the blank for Subrecipient name, grant number, and fiscal year. (the grant number for each fiscal year is found in the Final Award Letter, *for example* MCH-**06**-05, FY 20**06**)
- On Line 1, insert the total amount of MCH Grant funds awarded to your program for the fiscal year.
- On Line 2, identify the percent requested, maximum 25%.
- Multiply the amounts of Line 1 and Line 2. Insert the result on Line 3, which is the amount of the requested cash advance.
- Identify by name and contact information, representatives for program and finance operations for the MCH program. **Original** signatures are required.
- Submit to MCH Planning & Support, along with the other items identified on the Checklist found earlier in this section.

Subrecipient: _____ Grant #: MCH-___- _____

1. FY 200___ Award $_____
2. Percent Requested (maximum 25% of the award) X _____%
3. Cash Advance Requested for Start-up Costs $_____

By signing and submitting this request, the undersigned agrees on behalf of the Subrecipient to the following penalty for late reports from Subrecipients with an approved cash advance:

To encourage timely reporting and subsequently the deduction of ¼ of the cash advance from the reimbursement request, a $25.00 per diem penalty will be assessed by MCH Planning & Support and deducted from the reimbursement each day the quarterly report is past the reporting due date.

Program Representative	**Finance Representative**
_____	_____
(signature)	(signature)
Dated: _____	Dated: _____
Print or type:	
Name_____	Name_____
Title _____	Title _____
Address _____	Address _____
_____	_____
Fax _____	Fax _____
E-mail _____	E-mail _____

2. Indirect Cost (IDC) Rate

An indirect cost (IDC) is a cost that cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are in contrast to direct costs. *See the Glossary* **[ATTACHMENT 2]** *for a more complete description of both terms.*

- Direct Costs -- Any cost that can be identified specifically with a particular project or program.

- Indirect Costs -- Indirect costs are those costs incurred for common or joint purposes.

The following **"order of preference"** should be followed to identify the means relevant to recover indirect costs (RFP, p. 19):

1) If there is a federal cognizant agency, use the IDC rate agreement negotiated by it. Attach a copy of the Applicant's most current indirect cost rate agreement which supports the use of the "indirect costs" line item. A negotiated cost rate agreement is typically with an organization's federal cognizant agency, i.e. if the Applicant receives federal funds directly.

2) If there is not a federal cognizant agency, use the IDC rate agreement negotiated by the state cognizant agency. E.g., in the event the Applicant receives federal funds only as passthrough from the primary recipient of a federal award, the cognizant agency is the primary recipient, or typically a state agency.

3) If the Applicant does not have a current negotiated IDC rate, the U.S. Dept of Health and Human Services Grant Policy Directive (referred to as "1/2 or 10%") may be used.

   See http://www.hhs.gov/grantsnet/adminis/gpd/gpd301.htm for the written grants policy by the U.S. Department of Health and Human Services. In particular, p. 3 of 6, second paragraph of 2.b. states: *"If grants management staff determine that a grantee does not have a currently effective indirect cost rate, the award may not include an amount for indirect costs unless the organization has never established an indirect cost rate (usually a new grantee) and intends to establish one.* ***In such cases, the award shall include a provisional amount equaling one-half of the amount of indirect costs requested by the applicant, up to a maximum of 10 percent of direct salaries and wages (exclusive of fringe benefits).*** *" (emphasis added)*

   If Applicant exercises this option, include in the Budget Justification the rationale (calculations) for the rate requested. This is considered a provisional rate. During the award period the Applicant must complete their determination of an indirect cost rate under provisions of either option #1 or #2. If the Applicant does not complete an IDC

rate determination during the award period, the Applicant will be required to return any funds awarded based on the provisional rate.

4) Applicant may choose to direct cost the *allocable* portion of costs associated with multiple programs. The methodology for allocable costs, as determined by the Applicant, should be well documented as it is subject to audit. (See the OMB Circular addressing cost principles as relevant by type of entity of Applicant. The OMB Circulars are on-line at http://www.whitehouse.gov/omb/circulars)

If "indirect costs" are used as a budgeted line item, a copy of the Subrecipient's most current indirect cost rate agreement supporting the use of the "indirect costs" line item was provided to MCH Planning & Support. A Subrecipient's negotiated indirect cost rate agreement identifies the base, provides a percentage, and must be signed to show approval. Approved rates under OMB A-87 may have another base than total costs. Unrecovered indirect costs may be used as match.

3. Budget Revisions

Q: If I want to change my line item budget, how do I know if I need prior approval?

Budgets can be revised *without prior approval* if:

- The cumulative change of all line items is **less than ten percent** of the total grant budget. Your total grant budget includes both MCH Grant funds and matching funds, AND
- A change would neither add nor eliminate a line item, AND
- A change in the budget does not change the goals and objectives of the program AND
- The budget change does not include equipment purchases.

Q: What is the process revising my line item budget when prior approval IS required?

Reimbursement will not be made unless the Subrecipient takes the proper measures.

- The process for approval is:
  - Submit a written request to MCH Planning & Support explaining the need for the change, the line items and dollar amount involved. (This can be done through an e-mail message.)
  - MCH Planning & Support will provide written notification of approval or disapproval of the budget revision request.

- Reimbursement of the associated expenditures related to an unapproved request, or a budget revision which required prior approval and was not sought, may be denied.

Q: What is the process for changing a line item when prior approval IS NOT required?

- Notify MCH Planning & Support of the change by including it in the narrative of the next Quarterly Expenditure Report.

4. Match

There are two types of match: **"Cash match"** is non-federal funds, program income, agency funds, etc. Projected program income should be identified in the line item(s) of cash match to show where program income is expected to be re-invested in the MCH activities. **"In-kind (Non-cash) match"** is a donated service or product contributed to the program to which a value can be assessed. Maintain records showing how a value is assessed to the donated product or service.

Identify both the type (cash or in-kind [non-cash]) and the source (non-federal funds, agency general funds, etc.) of matching resources. Records for tracking match must be kept in the same manner as records for claiming grant expenditures. Subrecipients are not required to provide a full accounting of matching resources as part of the Quarterly Expenditure Report, match expenditures will be monitored in the same manner as grant expenditures. Records for tracking match must be made available for review, if requested, or as part of Department of HHS Regulation and Licensure site visits of Subgrantees. (See **[ATTACHMENT 9]** of the RFP for additional information regarding match requirements.)

Q: What kind of records must be kept to track matching resources for my MCH program?

- Subrecipients are required to maintain written records that fully document cash match and in-kind (non-cash match), just as they are expected to maintain documentation of expenditures of MCH Grant funds.

- Allowable match is determined in the same manner as costs charged to MCH Grant funds, i.e. the budgeted line items must be necessary to accomplish program activities.

- Federal funds, with two exceptions, are not allowable as match. Exceptions: 1) Medicaid dollars received for services provided, and 2) Native American Tribes eligible under P.L. 93-638 may use those federal funds for match. Resources that are used to match other federal, state, or foundation grants cannot be used as match MCH Grant funds**.**

Q: It is near the end of the program year and my entire match has not been contributed, what do I do?

- Subrecipients of Nebraska's MCH Grant funds are required to provide matching resources in the amount of 20% of the award. (See Exhibit 2, Subgrant Terms and Assurances, RFP). MCH Planning & Support places a high value on Subrecipient's ability to enhance and support their MCH program with other local funding.

- When grant applications are reviewed, one consideration for funding is the Subrecipient's ability to gather support within the community that may help sustain the program. The Subrecipient's ability to meet the 20% match requirement was indicated in the approved application.

- As the end of program year approaches, if you believe your program will not be able to meet the 20% match requirement for the year, written notification must be provided to MCH Planning & Support to explain the reason. The reimbursement of expenses will be reduced to allow for a 20% proportion of match provided. Such a factor will also be given strong consideration in future funding decisions.

5. Program Income

Program income is any profit to the Subrecipient, or its subcontractor(s), resulting from the MCH Grant-funded activity. Program income is not MCH Grant funds awarded to the program. Examples of program income include fees for services performed (Medicaid payments, patient fees, insurance payments, cash donations), rental or usage fees for property acquired with grant funds, and income from the sale of commodities or items fabricated under the grant. Further explanation of the types of program income is provided in the Question/Answer format that follows.

- Program income shall be used to finance the non-federal share of the grant-funded activities (shown as cash match). If there is a balance from program income and the match requirement is met, program income shall be added to funds committed to the project or program to further approved outcomes.

> For the MCH Grant, program income shall be cash match (until the match requirement is met). Program income is cash match, although cash match may not be program income.

Q: What are the types of program income?

Revenue generated as a result of MCH Grant funds is program income. Program income includes patient fees, cash donations, Medicaid and private insurance reimbursements. The requirement of Title V/MCH Block Grant to serve all mothers and children emphasizes that there are no eligibility requirements established at the federal level to qualify for services paid by Title V/MCH Block Grant. However, high priority is placed on services to mothers and children who

are under served or low income. To maximize federal funds to serve the low income population, it is expected that MCH Grant-funded programs will determine the health care coverage of persons they serve, determine coverable services, and pursue reimbursement from that source as allowable. If program income results from multiple sources of funding, Subrecipient must establish an allocable method to determine the program income attributable to MCH Grant funds.

Q: How do I know if my program is eligible to receive Medicaid reimbursement?

- According to Title XIX of the Social Security Act, State Medicaid agencies are required to provide—if requested by the Title V recipient or subrecipient in accordance with arrangements specified in the Act—reimbursement for the cost of services furnished Medicaid recipients by or through the MCH Grant. The arrangements discussed in the Act require the state to specify "the kinds of services to be provided by local agencies that are covered by Medicaid."

- Inpatient hospital services, though covered by Medicaid, are restricted with Title V funds, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary (of Health and Human Services) may approve.

- The Nebraska Medical Assistance Program (known as Nebraska Medicaid) covers a wide range of services, when medically necessary and appropriate, under program guidelines and limitations for each service. For a current list of services covered under regulations and the specifics for each types of services, see http://www.hhs.state.ne.us/ /medindex.htm Medicaid-covered services are subject to change, and should be confirmed with the Nebraska Medical Assistance Program periodically.

- If you believe your program provides any service listed on the Nebraska Medicaid website and may be eligible to receive reimbursement from Medicaid for such service, it is very important to pursue reimbursement to maximize your MCH Grant funds.

- Contact MCH Planning & Support for assistance to identify the Medicaid Program Specialist in the Central Office. Depending on the nature of the issue, the Medicaid Program Specialist may direct you to other Medicaid staff responsible for provider enrollment, third-party liability, or billing.

- To provide Medicaid-covered services, you will need to enroll and be a Medicaid-approved provider. You will receive a Medicaid provider number and information on the billing process.

- Medicaid-enrolled providers bill for Medicaid-covered services provided to Medicaid-eligible clients to receive a reimbursement from Nebraska Medicaid. You cannot bill Medicaid clients directly.

- Report Medicaid reimbursements in the program income section of the Quarterly Expenditure Reports. Indicate where program income is re-invested in the program as cash match or additive.

Q: Can my program bill private insurance for a service paid with MCH Grant funds?

- Subrecipients are expected to determine the health care coverage of persons served and, when appropriate, bill private insurance companies for the service provided.
- It is critical to maximize MCH Grant funds in order to assist low income mothers and children who are uninsured and uninsurable.
- Private insurance payments are program income, and should be re-invested and shown on the Quarterly Expenditure Report as cash match or additive.

Q: Is my MCH Grant-funded program allowed to assess fees directly to persons served by the program?

- Fees may be imposed on persons served by Subrecipient. However, certain restrictions apply.
- Fees cannot be directly assessed to an individual who is covered by Medicaid or who is low income.
- As designated by *Title V of the Social Security Act, "***if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services;"**

Low income for this purpose are those whose family's gross annual income falls at or below 100% of the current federal poverty guidelines. The poverty guidelines are updated periodically in the federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). In certain cases, as noted in the relevant authorizing legislation or program regulations, a program uses the poverty guidelines as only one of several eligibility criteria, or uses a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines). Non-federal organizations which use the poverty guidelines under their own authority in non-federally-funded activities also have the option of choosing to use a percentage multiple of the guidelines such as 125 percent or 185 percent. While many programs use the guidelines to classify persons or families as either eligible or ineligible, some other programs use the guidelines for the purpose of giving priority to lower-income persons or families in the provision of assistance or services. In some cases, these poverty guidelines may not become

effective for a particular program until a regulation or notice specifically applying to the program in question has been issued.

http://aspe.hhs.gov/poverty/

2006 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,800	$12,250	$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add	3,400	4,250	3,910

SOURCE: *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849.

- "Pursuant to a public schedule of charges," and "adjusted to reflect the income, resources, and family size of the individual provided the services" is more commonly referred to as a sliding fee scale.

- Subrecipients providing a service for which they intend to impose fees directly to the individual served must develop a sliding fee scale for those persons not low income and not covered by Medicaid. (See sample of a sliding fee scale in Part V. Subrecipient Responsibilities regarding internal policies.)

- Approval from MCH Planning & Support is necessary prior to implementing a new sliding fee scale, and also prior to implementing any revisions to an approved scale.

- When implemented, such fees are considered program income, and should be so reflected on the Quarterly Expenditure Report. These fees must be re-invested in the MCH Grant-funded program either as cash match or additive.

Q: Is my MCH Grant-funded program allowed to accept cash donations from persons served or impacted by the program?

- Cash donations are allowed as optional—but not required—for persons served by Subrecipients.

- No person should be denied service from a MCH Grant-funded program for not offering a cash donation. Also, donations should not be solicited from an individual who is covered by Medicaid or who is low income.

- Cash donations are program income, and should be so reflected on the Quarterly Expenditure Report. Donations must be re-invested in the MCH Grant-funded program as cash match or additive.

Q: How can program income be used?

- There are several ways for organizations to use program income. The MCH Planning & Support permits Subrecipients to re-invest it in the program either as cash match or additive.

- With the matching alternative, program income is used to finance part or all of the cash match of the program budget.

- With the additive alternative, program income is added to the funds already committed to the program and used to support additional program outcomes. In this case, it is not used as match.

- If a program anticipated generating program income, the estimated amount and the plan for re-investment was to be included in your application.

Q: It is near the end of the year and all of my program income has not been spent. What do I do?

- Program income cannot be carried over from year to year.

- The program income beginning balance for each fiscal year must be zero.

- As program income is earned, it must be utilized to enhance the program, either as cash match or additive, resulting in a zero balance on the final Expenditure Report for each fiscal year.

- If the 4th Quarter Expenditure Report reflects a program income balance, the reimbursement for the 4th Quarter will be reduced by that amount.

- In the event that 4th Quarter expenditures are less than the program income balance, Subrecipient must pay the difference to Department of HHS Regulation and Licensure.

6. Equipment and Supplies

Q: Are there any special procedures for purchasing equipment with grant funds?

- Any equipment identified in the line item budget of the grant application for which revision was not required as a condition of the award is already "approved".

- Equipment that was identified post grant application may require prior written approval from MCH Planning & Support. All three OMB Circulars regarding cost principles define equipment as items having a life exceeding one year with a value exceeding the lesser of the agency's capitalization policy or $5,000. The delineation between equipment and supplies cannot be judged on a $5,000 threshold alone, rather it shall be determined to include the Subrecipient's accounting policy and practice.

- Subrecipient shall follow their own capitalization threshold to define equipment (versus supplies).

- The confusion with equipment and supplies comes from a paragraph in Circular A-87 that shortly follows the equipment definition. The paragraph addresses circumstances when equipment can be acquired with and without prior approval. This subsequent section says that equipment (which has already been defined as something that may be less than $5,000) that costs less than $5,000 is considered supplies, therefore does not need prior approval. This means that if the facility has a policy to capitalize anything over $300 they would be able to purchase those equipment items between $300 and $5,000 without prior approval of the grantor agency.

- The same information in A-122 (non-profit organizations) is clearer on the point of prior approvals. It says that capital expenditure for general purpose equipment (e.g. office furniture, computers) is unallowable as a direct cost without prior approval and that capital expenditure for special purpose equipment (e.g. medical equipment) is allowable up to $5,000 without prior approval. Note: The acquisition of major medical equipment is restricted by federal Title V/MCH Block Grant funds.

- Subrecipients shall follow the requirements of applicable federal Regulations and OMB Circulars for maintaining equipment inventories and the disposition of equipment purchased with federal funds.

Q: It is near the end of the program year and I want to buy a lot of office supplies, educational materials, and the like in order to use all the grant funds allocated to the program. Are these expenses allowable?

- The Department of HHS Regulation and Licensure policy is that services must be provided and goods received prior to claiming reimbursement. While the goods would be

received during the grant period, a substantial portion of the goods could not be consumed in the funding period. This is a non-reimbursable cost because the consumption of the goods exceeds the grant period.

- Purchase of consumable supplies far in advance of using them is not good business practice and is subject to disallowance.

7. Financial Reviews and Audits

Financial management and accounting procedures must be sufficient for the preparation of required reports. In addition, the financial operations must be sufficient enough to trace revenue and expenditures to source documentation as part of a financial review or audit. The Office of Management and Budget (OMB) cost principles will be used to determine if costs are allowable and allocable.

- All Subrecipient records and supporting documentation must be available for review by federal funding representatives, State of Nebraska Auditors, and Department of HHS Regulation and Licensure personnel or contractors for auditing and monitoring purposes.

- Accounting records must be supported by source documentation such as canceled checks, paid bills, payroll, time and attendance records, and similar documents that would verify the nature of revenue and costs associated with the MCH Grant-funded program. Subrecipient's accounting system must provide for:

  - accurate, current, and complete disclosure of expenditures;

  - accounting records that adequately identify source of funds (federal, cash match, in-kind) and the purpose of an expenditure;

  - internal control to safeguard all cash, real and personal property, and other assets, and assure that all such property is used for authorized purposes; and

  - budget controls that compare budgeted amounts with actual revenues and expenditures.

- Administrative and Audit Guidance, as stated in the Subgrant Terms and Assurances (Exhibit 3, Attachment 4, RFP), varies according to type of entity and the level of state and federal payments.

- The **Audit Requirement Certification** (Attachment 4, RFP, pp 12-13) was completed and submitted with your application or in response to a contingency to the award. The Certification is on record in the office of Grants and Cost Management, Financial Services Division, Nebraska Health & Human Services, Finance and Support, as well as

incorporated in the Subrecipient file in the MCH Planning & Support, Office of Family Health, Department of HHS Regulation and Licensure.

- Exhibit 3 "Administrative and Audit Guidance" and the Audit Requirement Certification are instructive to organizations regarding the requirements. When an audit is to be performed, it must be completed as specified in the federal law or OMB circulars.

- Subrecipient and auditor must complete and submit all required documents in the reporting package, i.e. as outlined the Audit Requirement Certification, to the federal Audit Clearinghouse. This includes a copy of Subrecipient's financial statements, auditor's report, and the *Data Collection Form for Reporting on Audits of States, Local Governments and Non-Profit Organizations (*SF-SAC). At the same time as the submission to the federal Audit Clearinghouse, the same documents should be furnished to Department of HHS Finance and Support staff in the Grants and Cost Management unit.

H. Reporting

The Reporting packet **[ATTACHMENT 1]** includes forms, instructions, and examples. Follow the instructions to sufficiently complete the reporting requirements. The reporting format is identical for all quarters. The addition of Tables 1, 2, 3, and 4 to the 4th Quarter reporting requirements comprises the Final Report. Questions should be directed to Rayma Delaney, Title V/MCH Grant Administrator, (402) 471-0197, rayma.delaney@hhss.ne.gov.

Q: What is the purpose of reporting?

- Regular reporting assists in establishing a systematic framework for Subrecipients to monitor and evaluate their program.

- Reports are reviewed by MCH Planning & Support to comply, in part, with Subrecipient monitoring requirements which the state agency is charged with as the pass-through entity for federal Block Grant funds.

- Reporting is one source of ongoing communication. Technical assistance needs may be identified in the reporting process.

- Reporting is needed to accomplish reimbursement of Subrecipients' expenses related to the MCH Grant-funded activities.

Q: What types of reports are required?

Subrecipients are required to submit reports in order to receive reimbursement from the MCH Grant award. The **Quarterly** Report for Nebraska MCH Grant has two distinct, ***yet interrelated*** components:

- the Program Report – This component must address all the specific outcomes from the Work Plan by describing the "inputs" and "outputs" during the period of the report. As available during the award period, Subrecipients shall also report on progress toward "outcomes" by reporting on "performance measures".

- the Expenditure Report (with sections for line item, program income, and supporting narrative) -- All expenditures in this component will support the broader outcomes, *and specific outputs in the Program Report.*

The **Final** Report is comprised of:

- The 4th Quarter Program Report and the Expenditure Report components in the Quarterly Report structure.

- Final Data Tables (Tables 1, 2, 3 and 4)

  - Table 1 requests information regarding the number of people receiving services by race and ethnicity.

  - Table 2 requests information regarding the number of people receiving services by class of individuals and percent of health coverage.

  - Table 3 requests information regarding MCH Grant and Match expenditures by types of service.

  - Table 4 requests information regarding MCH Grant and Match expenditures by types of individuals served.

Because services and activities provided through MCH Grant-funded programs vary considerably, the instructions for completing Tables 1-4 may not address each concern for every program. Contact MCH Planning & Support for clarification of any reporting issues encountered.

Q: How is the information provided in the Final Report used by MCH Planning & Support?

- The information required of Subrecipients is part of a comprehensive report which the Department of HHS Regulation and Licensure submits to the federal Maternal and Child Health Bureau.

- This information is used in reports to Congress and in other arenas which influence future appropriations of Title V. Information from each of the state-level applications and

reports is available, by state, to the public via the worldwide web at https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp

- MCH Planning & Support also uses the statistical information as part of its statewide needs assessment for Nebraska which identifies programmatic priority areas.

- The statistical information is one of the data sources for measuring progress toward the Year 2010 Health Objectives.

Q: When are the reports due?

Exhibit 1 of the Subgrant Terms & Assurances, a part of the approved grant application, details reporting requirements. Quarterly Reports are due on the 15th day following the close of the 1st, 2nd, and 3rd Quarter, *unless otherwise arranged in advance at the beginning of the fiscal year, or as early as possible in the quarter covered in the report*. For example, consideration will be given to requests from Subrecipients whose accounting system function necessitates a change in due date to the 30th/31st day of the month. Without exception, the 4th Quarter/Final Report is due November 30, which is 60 days after the close of the fiscal year.

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter/Final
October 1 – December 31	January 1 – March 31	April 1 – June 30	July 1 – September 30
Reports due January 15	**Reports due April 15**	**Reports due July 15**	**Reports due November 30**

Q: What is the importance of timely reports?

Every reasonable effort must be made to assure reports are received on or before the due date.

- MCH Planning & Support staff schedule time to review reports during the week following due dates. Reports submitted after the due date will be reviewed as schedules permit.

- Program and Expenditure Reports are reviewed together. Missing or incomplete reports will delay reimbursement.

Q: What is the purpose of Program Reports?

- Program reporting is a fundamental part of Subrecipients' responsibility for on-going program monitoring and evaluation.

- Program reports are used by the Department of HHS Regulation and Licensure to discuss the status of Maternal Child Health in Nebraska via the annual Title V / MCH Block Grant Application and Report.

- MCH Planning & Support reviews Program Reports to comply, in part, with Subrecipient monitoring requirements that the state agency is charged with as the pass-through entity for federal Block Grant funds.

- The process of reporting may aid in the identification of technical assistance needs.

Q: What should I remember when completing the Program Report?

- The Program Report is not a form, per se. The intent of the non-prescriptive Work Plan created in the RFP was to allow flexibility. Subrecipients should use the Work Plan Description from the approved application as the framework for the Program Report. Provide a report of "inputs" and "outputs" within the structure for the priority need(s) and outcomes. As available during the award period, also report on progress toward outcomes by reporting on "performance measures".

- To help identify progress made, the Program Report may be cumulative for narrative, i.e. Subrecipients may add new information pertaining to the quarter after the text in the previous quarter report. If this method is chosen, clearly delineate the quarters by using a heading or distinguishing text from the previous quarter by selecting a different ink color or typestyle.

- Contact MCH Planning & Support with questions.

Q: What is the purpose of Expenditure Reports?

The purpose of the Expenditure Report component is:

- to receive reimbursement for expenditures incurred during the quarter; and

- for monitoring of:

  - the expenditures of grant funds for allowable, allocable, and reasonable costs, and which are clearly associated with work plan inputs

  - the re-investment of program income

  - the expenditures of matching resources

- The 4th Quarter report is also the final expenditure report for the program year. Additional time (60 days) is given at the end of the grant period to allow for all bills associated with grant activities to pass through Subrecipients' accounting systems.

- **Due date for the Final Report is November 30. MCH Planning & Support reserves the right to deny payment on Final Reports received after the November 30 deadline.**

Q: What should I remember when completing the Expenditure Report?

- Information should be submitted according to the Expenditure Report format. The form and instructions are located in Attachment 1. The forms can also be accessed electronically in a Microsoft Word document provided by MCH Planning & Support. The format would be most ideal set up in Excel or other spreadsheet software, although this is left to Subrecipients to accomplish because it would be impossible for one spreadsheet to suit the various line items in individual budgets. Use of a spreadsheet program is strongly encouraged. If a spreadsheet is not used, double check all addition and subtraction. Mathematical errors significantly slow the reimbursement process.

- The reports must be printed for signatures; the State does not have the technology for electronic signatures.

- The completed report must bear two **original** signatures of individuals authorized by your agency to sign such documents, one from the person responsible for preparing the expenditure report (typically the fiscal director), and the other by a representative involved in the program. (See "**F. Reimbursement"**, pp 19-21 for specific instructions).

- The form must include the billing address of the program.

- All line items as shown on your program's **approved budget** must appear on the expenditure report. This includes line items for both MCH Grant funds and matching funds.

- Complete all sections of the report, including the report of Program Income and explanation of where Program Income was re-invested to the program, plus supporting narrative as needed.

- Include the Subgrant # (e.g. MCH-06-01) on the form. **For State agency programs, include the Subgrant # on the Intrastate Transaction Document as well as on the Expenditure Report.**

- Match expenditures are closely monitored. See the section entitled "Matching Resources".

- Rounding to the nearest dollar is acceptable.

- Expenses must correlate with "outputs" from the approved Work Plan and as described in the Program Report .

- List all personnel by title/position and the person's name.
- Contact MCH Planning & Support with questions.

Q: What if my report will be late?

The following steps apply if a Quarterly Report for 1st, 2nd, or 3rd Quarters must be submitted past the due date:

- Request an extension in **writing** to MCH Planning & Support. The request for extension can be expedited if sent through e-mail or fax.
- Further documentation regarding the reason for an extension may be requested.
- Written notification is by e-mail or fax regarding approval or disapproval of the request. If an extension request is approved, the Subrecipient will receive written notification of the revised due date from MCH Planning & Support by e-mail or fax. Reports approved for extension will not be considered late if received by the revised due date. If request is not approved, the report will be considered late.
- The 4th Quarter/Final Report is due November 30. No requests will be accepted for extension of the 4th Quarter/Final Report. If it is received after November 30, it will be considered late. **MCH Planning & Support, along with the accounting unit of the HHS Finance and Support, reserves the right to deny payment on Final Reports received after the November 30 deadline.**

[**Note**: Subrecipient past performance, including the submission of timely reports, will be a consideration in future grant application review processes. Approved requests for extension will be viewed more favorably than late reports in the consideration of future grant applications.]

Q: Where do I send reports?

Submit the signed, original report by U.S. Mail to:

Rayma Delaney
Nebraska HHS Regulation and Licensure
Office of Family Health – MCH Planning & Support
PO Box 95007
Lincoln NE 68509-5007

DEPARTMENT OF HHS REGULATION AND LICENSURE
Title V / Maternal and Child Health Block Grant

QUARTERLY REPORT

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION AND LICENSURE

Maternal and Child Health (MCH) Grant

QUARTERLY REPORT

Award Period: FY 2006
Report Period: [ ] 1st Qtr [ ] 2nd Qtr [ ] 3rd Qtr [ ] 4th Qtr

Subrecipient: _____ Grant #: MCH-06-___

The Quarterly Report for Nebraska MCH Grant funds has two distinct, ***yet interrelated*** components:

1) the **Program Report**
2) the **Expenditure Report** (includes several subsections: a) reporting costs based on the approved line item budget, b) program income, and c) narrative, as needed, to support the Expenditure Report). Do not estimate costs. Report actual costs which were incurred during the period of the report. All costs must be connected to **"outcomes"** from the approved Work Plan.

The reporting format is identical for all quarters. (Submit Tables 1, 2, 3, 4 in the final report. The final forms are included here for the purpose of identifying the necessary data collection required for the award period.)

Reports are due as noted in the Subgrant Terms and Assurances, Exhibit 1. Submit the signed, original report by U.S. Mail to: Rayma Delaney, Nebraska Health & Human Services, Family Health Division, PO Box 95007, Lincoln NE 68509-5007. Questions should be directed to Rayma Delaney, Title V/MCH Grant Administrator, (402) 471-0197, rayma.delaney@hhss.ne.gov.

Program Report

Submitted by: _____
(signature of authorized representative)

Using the same paragraph numbering and indentation system used in the Work Plan, identify the status of the approved Work Plan at the end of the period reported. At a minimum, the narrative is to describe **"inputs"** and "**outputs"** during the period of the report. As available during the award period, also report on progress toward "**outcomes"** by reporting on "**performance measures"**.

[INSERT TEXT]

INSTRUCTIONS for completing the **Expenditure Report**:

Line Item Section

1. The form is set up in MicroSoft Word using the table feature. It may be accessed electronically from the attached file to e-mail sent to all Subrecipients. The ideal is to set up the format using Excel or other spreadsheet software, however, that is left to Subrecipients to accomplish because it would be impossible for one spreadsheet to suit the various line items in individual budgets. *Use of a spreadsheet program is strongly supported rather than a word document for this portion of the report.* If a spreadsheet is not used, double check all addition and subtraction. Mathematical errors significantly slow the reimbursement process. *If the format is established in a spreadsheet, it must contain all the same information and adhere to the format prescribed in this Quarterly Report*.

2. List in the lefthand section labeled **"Line Items"** all descriptive categories and/or line items as shown on your program's approved budget.
   - For some Subrecipients, this will be the budget submitted with the application.
   - For others, this will be the budget submitted with the response to contingencies before final approval of the application, or other subsequent revisions approved
   - Check the box provided if the budget has been revised since the last report. Describe any budget revisions in the narrative section of the expenditure report.

   If the approved budget includes personnel, list by title/position *and the name(s) for which reimbursement of costs is sought*.

3. In the **"Approved Budget"** section**,** list the budgeted dollars by line item, as shown on your program's final approved budget, or subsequent revisions.

4. Include the Subgrant # (e.g. MCH-06-01) on the form. For State agency programs, include the Subgrant # on the Intrastate Transaction Document as well as on the Expenditure Report. Complete all other demographic information on the form, i.e. Federal Tax Identification Number, Reporting Period, Billing Address, etc. The warrant will be mailed to the address provided. [Note: Electronic payment is strongly encouraged and is a quicker method of reimbursement. A Subrecipient completes a simple process to get set up for electronic payment. State of Nebraska requires any single warrant over $75,000 be an electronic payment.]

5. Expenses must correlate with "outputs" from the approved Work Plan and as described in the Program Report. Rounding to the nearest dollar is acceptable.

6. List all program expenses incurred by the program during the reporting period under the heading **"Expenditures for the Quarter"**. These expenses correspond to line items. If no costs were incurred for a particular line item during a given quarter, record "0" for that item.

Entry in the "Grant Award" column shall indicate a reimbursement with Title V grant funds. Without prior approval, reimbursement with grant funds will not be made for:

- Expenditures exceeding the approved line item amount, unless the cumulative change of all line items is less than 10% of the total budget;
- A new line item without prior approval;
- Costs that appear to be unrelated to Work Plan inputs and outcomes;
- An equipment purchase not included in the approved budget.

Report actual expenditures (rounding is acceptable), i.e. do not estimate by quarterly amounts for the budgeted line item. Unless the item can be reasonably divided, e.g. rent, budgeted line items should not be divided by 4 and reported as a quarterly expenditure. Supplies and telephone expenses each quarter are unpredictable and should not be reported as ¼ of the total budgeted for the line item. However, an entry could be ¼ of the budgeted line as a result of an expenditure which is greater than a reimbursement request in the grant award column. In such cases, use the narrative section to explain how the reported figure was derived.

Entry in the "Cash Match" column indicates a product/service was paid with cash match, i.e. non-federal funds, program income, agency funds, etc. Report exact expenditures, not a quarterly estimate. An entry could be ¼ of the budgeted line as a result of an expenditure which is greater than the amount reported as match. In such cases, use the narrative section, as described below, to explain how the reported figure was derived.

Entry in the "Non-cash Match" column denotes a service or product contributed to the program to which a value has been assessed. If non-cash match is reported, agency source files must contain the documentation to support the value assessed to the intangible product or service, e.g. maintain itemized, signed volunteer time records for valid documentation.

7. **"Cumulative Expenditures"** entries reflect the amount of program expense to-date (cumulative each quarter) by line item for each relevant column (grant funds, cash match, and non-cash match). For the first quarter, the amounts identified under "Expenditures for the Quarter" and "Cumulative Expenditures" will be the same.

8. The reports must be printed for signatures; the State does not presently have the technology for electronic signatures. The completed report must bear two **original** signatures of individuals authorized by your agency to sign such documents, one from the person responsible for preparing the expenditure report (typically the fiscal director), and the other by a representative involved in the program. To ensure reviewer confidence in the authenticity of the signatures of representatives authorized by the Subrecipient, persons signing the Expenditure Report shall be:
   - the two signors of the Cover Sheet of the approved grant application,
     or, in the alternative
   - identified by name, title, and original signature contained in a letter signed by one of the signors of the approved grant.

EXPENDITURE REPORT
Line Item Section

GRANT #: MCH –06-_____ REPORTING PERIOD: _____ TO: _____ [ ] REVISED BUDGET

AGENCY:_____ FEDERAL I.D. NUMBER: _____

PROJECT:_____ PHONE NUMBER:_____

ADDRESS:_____ SIGNATURE: _____ SIGNATURE: _____

CITY & ZIP: _____ Print / type name: _____ Print / type name: _____

Title: _____ Title: _____

TWO (2) ORIGINAL SIGNATURES (representing each financial and program) ARE REQUIRED FOR PROMPT PROCESSING OF REIMBURSEMENTS. UNSIGNED FORMS OR INSUFFICIENTLY SIGNED FORMS WILL RESULT IN A PAYMENT DELAY.

[ ] Check if prepared using computerized spreadsheet function.

Line Items	Approved Budget			Expenditures for the Quarter			Cumulative Expenditures		
	Grant Award	Match		Grant Award	Match		Grant Award	Match	
		Cash	Non-Cash		Cash	Non-Cash		Cash	Non-Cash
	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	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	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	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	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	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	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	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

Line Items	Approved Budget			Expenditures for the **Quarter**			**Cumulative** Expenditures		
	Grant Award	**Match**		**Grant Award**	**Match**		**Grant Award**	**Match**	
		Cash	Non-Cash		Cash	Non-Cash		Cash	Non-Cash
	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	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	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	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	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	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	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	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	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
TOTALS									

Program Income Section

Program income is *any profit to the subrecipient resulting from these grant funds*. Examples of program income include fees, donations, insurance payments, and Medicaid reimbursement resulting from the activities paid with MCH Grant funds. Please note the following main points:

1. This section must be completed by all subrecipients. If no program income is generated, "zero-fill" all table cells.
2. Do not report income resulting from any other grant funds or other grant funds reported as cash match. *Only income generated by MCH Grant funds is to be reported in this section.*
3. The program income "Beginning Balance" for the first quarter is zero ($0).
4. All program income must be re-invested to the program/project by the end of the program year resulting in zero ($0) for the 4th quarter "Ending Balance". Program income should be used first towards the cash match requirement. If program income exceeds the minimum match requirement, Subrecipient may designate the funds as "additive" to the award to further the approved outcomes.* Program income cannot be carried over from year-to-year.
5. Identify where program income is re-invested in the program/project.
6. The Program Income section is a cumulative report, i.e. the "Ending Balance" from the first quarter Expenditure Report is the "Beginning Balance" on the 2nd Quarter Expenditure Report.
7. *Program income is usually cash match, but cash match is not always program income.* If the Title V-funded program does not generate income, or if program income is insufficient to meet the minimum match requirement **(20%)**, the match requirement can be met by other options: a) any non-federal funds may be used as cash match which are not already used as match for another grant award, and/or b) non-cash match.
8. Calculation Formula:

   A. = Always $0 in 1st Quarter. For 2nd, 3rd, and 4th Quarters it is the value of F.
   B. = Identify the revenue by source.
   C. = B.1.+B.2.+B.3.+B.4.
   D. = A.+ C.
   E. = Program income expended during the quarter.
   F. = D. – E. Always $0 in the 4th Quarter.

		1st Quarte	2nd Quarter	3rd Quarter	4th Quarter
A. Beginning balance					
B. Revenue (by source)	**B.1. Medicaid**				
	B.2. Patient Fees				
Specify any other source	**B.3.**				
Specify any other source	**B.4.**				
C. Total revenue					
D. Program income subtotal					
E. Expenditures					
F. Ending balance					

In the space provided, identify the line item(s) in the Expenditure Report (*usually "cash match") where program income is re-invested in the program / project:

Narrative Section

Use this section to clarify and support, as needed, an entry in the line item section. Clarify, in narrative, any check marked boxes.

[ ] Budget revisions. *Prior approval is required* for budget revisions that would create any of the following conditions: deleting or adding a line item, altering the approved Work Plan, purchasing equipment not in the approved budget, or having a cumulative effect exceeding 10% of the approved budget. If none of those conditions pertain, prior approval is not required, but should still be addressed in this section.

[ ] Unanticipated or unique expenditures in the reporting period. If checked, describe how the cost relates to an approved Work Plan **"outcome".**

[ ] Other.

Subrecipient Name: _____

Grant # MCH-06-_____

FINAL REPORT
TABLE 1

Number of Individuals Who Received Services Provided or Paid in Part by Title V/MCH Block Grant Funds FY 2006 by Race and Ethnicity

I. Unduplicated Count By Race

Category of Person Served By the Title V-Funded Program	(A) TOTAL ALL RACES	(B) WHITE	(C) BLACK OR African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More Than One Race Reported	(H) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.								
2.) Infants (children < 1 year not included in any other class of individuals).								

For each row, A=B+C+D+E+F, G & H even if count by race is estimated

II. Unduplicated Count By Ethnicity

Category of Person Served By the Title V-Funded Program	(A) Total Not-Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	Hispanic or Latino (Sub-categories by country or area of origin)				
				(B1) Mexican	(B2) Cuban	(B3) Puerto Rican	(B4) CENTRAL & South American	(B5) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.								
2.) Infants (children < 1 year not included in any other class of individuals).								

For each row, B=(B1)+(B2)+(B3)+(B4)+(B5), even if count by ethnicity is estimated.

If your program has significant Hispanic population, you are encouraged to report subpopulations by country or area of origin. (the shaded areas)

NOTE: I.A = II.A + II.B + II.C for each category of person served

Instructions and Example for Table 1:

**** EXAMPLE ****

Category of Person Served By the Title V-Funded Program	(A) TOTAL ALL RACES	(B) WHITE	(C) BLACK OR African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More Than One Race Reported	(H) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.	77	47	10	9	1	5	3	2
2.) Infants (children < 1 year not included in any other class of individuals).	169	138	9	7	4	4	4	3

Category of Person Served By the Title V-Funded Program	(A) Total Not-Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	Hispanic or Latino (Sub-categories by country or area of origin)				
				(B1) Mexican	(B2) Cuban	(B3) Puerto Rican	(B4) CENTRAL & South American	(B5) Other & Unknown
1.) Women who were provided prenatal, delivery, or postpartum care.	55	15	7	9	1	2	0	3
2.) Infants (children < 1 year not included in any other class of individuals).	140	25	4	12	2	4	2	5

See the Glossary **[ATTACHMENT 2]** for terms applicable to this form. Complete all required data cells and check mathematical calculations. If an actual number is not available, make an estimate. Explain all estimates in a footnote. Give unduplicated number of persons who received a service by phone, in person, or through the process of a test, etc. (not just public information) by category of person served, race, and ethnicity.

For each category of person served, break down the total by race and ethnicity. For federal reporting requirements, Hispanic is an ethnicity. Generally, the Hispanic population considers Hispanic a race. Without a response category for Hispanic as race, it is offensive to Hispanic clients to be reported as "other & unknown" for race. It would be difficult, if not impossible, to change the federal categories for race and ethnicity. The response category for Hispanic could be included in race categories for purposes of data collection. The corresponding data for Hispanic will be reported, however, as ethnicity. This practice is respectful to the population's identification as race, yet simultaneously satisfies the federal reporting requirement by reporting

the corresponding data collected as ethnicity. For the final report to Nebraska Health & Human Services, the total number of clients who identified as Hispanic should be reported under "other & unknown" for race, unless the client responds in one of the other categories for race, e.g. white.

- If your program has significant Hispanic population you are encouraged to report subpopulations by country-of-origin.

If a particular class of individuals is not provided services through your MCH Grant-funded program, write in "0" for the "Total Number Served" and for each race and ethnicity category. Contact MCH Planning and Support with questions.

Subrecipient Name: _____

Grant # MCH -06-____

FINAL REPORT
TABLE 2

Number of Individuals Served (Unduplicated)**
Under Title V / MCH FY 2006
(by Types of Individuals and Health Coverage)

Types of Individuals	Types of Health Coverage			
	(A) Title V MCH	**(B)** Medicaid (Title XIX & Title XXI)	**(C)** Private/Other	**(D)** None
(1) Pregnant women				
(2) Infants <1 year of age				
(3) Children 1 to 22 years of age				
(4) Children with Special Health Care Needs				
(5) Others				
(6) TOTAL				

****For each row: A = B + C + D, even if coverage types are estimates, i.e.**

1A = 1B + 1C + 1D
2A = 2B + 2C + 2D
3A = 3B + 3C + 3D
4A = 4B + 4C + 4D
5A = 5B + 5C + 5D
6A = 6B + 6C + 6D

For Column A: 6A = 1A + 2A + 3A + 4A + 5A.

Instructions for Table 2:

1. See the Glossary **[ATTACHMENT 2]** for terms applicable to this form.

2. Complete all required data cells.

3. **If an actual number is not available make an estimate. Explain all estimates in a footnote.**

4. In Column (A) enter the unduplicated count of individuals by class who received a direct services (in person, by phone) from the Title V/MCH program regardless of the primary source of coverage. Row 6, "Total", should equal the sum of Rows 1 through 5.

5. In the following columns report by the class of individuals served by the Title V/MCH program the number of those who have as their primary source of coverage either:
   Column B: Medicaid*
   Column C: Other (public or private) coverage
   Column D: None
   If individuals are covered by more than one source they should be listed under the column of their primary source. For each row, Column A should equal the sum of Columns B through D.

6. Identify coverage status at the end of the service period.
   - If the individual was pregnant or an infant, and had Medicaid as the primary payor for service, report Medicaid as the insurer, even though Title V/MCH or other third party insurance may have covered part of the care over the period.

7. There is not an "Unknown" Column on this form. **Everyone must be coded by health coverage.**

8. If you have questions, call MCH Planning & Support.

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* Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program*, an expansion of Medicaid* effective September 1, 1998).

Subrecipient Name: _____

Grant #: MCH-06-_____

FINAL REPORT
TABLE 3

Title V / MCH and Match Expenditures FY 2006 by Types of Service

Types of Service	MCH Grant	Match
I. Direct Health Care Services (Basic Health Services And Health Services for CSHCN)	$_____	$_____
II. Enabling Services (Transportation,Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, Consumer Coordination with Medicaid, WIC, and Education)	$_____	$_____
III. Population-based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition and Outreach/Public Education)	$_____	$_____
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems, Program Coordination with Medicaid, WIC, and Education)	$_____	$_____
Total Expenditures	$_____	$_____

Instructions for Table 3:

1. See the Glossary **[ATTACHMENT 2]** for terms applicable to this form.

2. Complete all required data cells by using an estimate of the percentage for each type of service, multiplied by the actual expenditures. Explain all estimates in a footnote.

3. If a particular type of service was not provided through your MCH Grant-funded program, write in "0" for that line.

4. Total expenditures must equal the total reflected on the final Expenditure Report

Subrecipient Name: _____

Grant # MCH-06-_____

FINAL REPORT
TABLE 4

Title V / MCH and Match Expenditures FY 2006
by Types of Individuals Served

Types of Individuals	MCH Grant	Match
Pregnant Women	$_____	$_____
Infants < 1 year old	$_____	$_____
Children 1 – 22 Years Old	$_____	$_____
Children with Special Health Care Needs (CSHCN)	$_____	$_____
All Others	$_____	$_____
Total Expenditures	$_____	$_____

Instructions for Table 4:

1. See the Glossary **[ATTACHMENT 2]** for terms applicable to this form.

2. Complete all required data cells by using an estimate of the percentage for each type of individual served*, multiplied by the actual expenditures. Explain all estimates in a footnote.

3. If a particular type of individual was not provided through your MCH Grant-funded program, write in "0" for that line.

4. Total expenditures must equal the total reflected on the final Expenditure Report

*** Note: For Infrastructure (not services), determine the populations impacted by the activities of this grant.**

Glossary

access

Often defined as the potential and actual entry of a population into the health care system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Utilization rates and subjective evaluations of care describe actual entry into the system. Ability to obtain wanted or the distance one has to travel, waiting time, total income may also influence needed services, and whether one has a regular source of care.

allocable costs

Allocable costs are those allowable costs that actually benefit the grant or contract to which they are being charged. Any cost allocable to a particular federal award may not be charged to other federal awards and only in the proportion attributable to that which it benefits. A cost is allocable to a sponsored agreement if (1) it is incurred solely to advance the work under the sponsored agreement; (2) it benefits both the sponsored agreement and other work of the institution, in proportions that can be approximated through use of reasonable methods, and/or (3) it is necessary to the overall operation of the institution and, is deemed to be assignable in part to sponsored projects. Where the purchase of equipment or other capital items are authorized under a grant or contract, the amounts authorized for such purchases are assignable to the sponsored agreement regardless of the use that may subsequently be made of the equipment or other capital items involved.

allowable costs

Allowable costs are those necessary and reasonable for proper and efficient performance and administration of federal awards.

audits

Fiscal review performed by an independent auditor (CPA) with a formal report being prepared. Refer to **[ATTACHMENT 4, PAGE 11 OF 23].**

base

The "base" means the accumulated direct costs (normally either total direct salaries and wages or total direct costs exclusive of any extraordinary or distorting expenditures) used to distribute indirect costs to individual federal awards. The direct cost base selected should result in each award bearing a fair share of the indirect costs in reasonable relation to the benefits received from the costs.

birth defect

A structural abnormality present at birth.

budget justification

Details about the items of cost and how dollars were calculated in the development of the budget. Describes how planned expenditures will support the Work Plan.

CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) – the collective set of "culturally and linguistically appropriate services." CLAS mandates, guidelines and recommendations were issued by the U.S. Department of Health and Human Services Office of Minority Health intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services. For more information: http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

capacity

Includes delivery systems, workforce, policies, and support systems, and other infrastructure needed to maintain services delivery and policy-making activities.

capacity-building

Creating or enhancing abilities to operate, carry out community assessment and policy development, and manage major administrative areas, such as financial, personnel, and program management to meet the needs of the population (in this case the maternal and child health population, including children with special health care needs).

cash match

Non-federal grant source, agency cash, donations, fees, insurance payments or Medicaid reimbursement. Medicaid is a state-federal partnership. Medicaid payments include federal funds. This is an allowable source of cash match since Medicaid programs are state-operated and financed in part by state funds.

case management

1. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.

2. Management directed toward serious conditions likely to require numerous providers and involve costly care. Case managers handle each case individually, identifying the most cost-effective treatments for extremely resource-intensive conditions, such as accidents, AIDS, cancer, major trauma, prematurity, and strokes.

3. Process of identifying, assessing, organizing, coordinating, and monitoring the necessary and appropriate services to meet and individual's health, vocational and social service needs.

children

A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals. *(Note: Pregnant teens are categorized as Pregnant Women, Not Children. See definition of Pregnant Women in the Glossary.)*

children with special health care needs (CSHCN)

(For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems.

(For planning and systems development) The following is a non-categorical framework which uses three definition components. All three elements must exist for a child to be classified as having a chronic health condition. This approach defines ongoing health conditions in children ages *birth to 21 years of age* as disorders that:

1. Have a biologic, psychologic, or cognitive basis, *and*
2. Have lasted or are virtually certain to last for at least 1 year (or result in death), *and*
3. Produce *2 or more* of the following sequelae:
   a. Limitation of function, activities, or social role in comparison with healthy age peers in the general areas of physical, cognitive, emotional, and social growth and development.
   b. Dependency on one of the following to compensate for or minimize limitation of function, activities, or social role:
      (1) medications
      (2) special diet
      (3) medical technology
      (4) assistive technology
      (5) personal assistance
   c. Need for medical care, mental health care, or other health-related services over and above the usual for the child's age, or for special ongoing treatments, interventions, or accommodations at home or in school.

client fees

Rates charged to persons using services not covered by Medicaid or private insurance.

cognizant agency

The federal agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed under OMB Cost Principles (A-87, and A-122, as relevant to the type of entity) on behalf of all federal agencies. OMB publishes a listing of cognizant agencies.

community-based care

The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

comprehensive health planning (CHP)

Health planning that encompasses all personal factors and community programs that impact on people's health.

consumer

One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

continuity of care

Health care provided on a continuous basis, starting with the patient's initial contact with the primary care practitioner and following the patient through all episodes of his or her health care needs.

cost

Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

cost center

Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

culturally competent

Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

dental health services

All services designed or intended to promote, maintain, or restore dental health including educational, preventive, and therapeutic services.

direct cost

A cost which is identifiable directly with a particular activity, service, or product of the program experiencing the costs. The costs must be specifically identified in and for the

purpose of accomplishing what is described in the grant proposal. These costs do not include the allocation of costs to a cost center, which are not specifically attributable to that cost center.

direct health services

Those services generally delivered one-on-one between the health professional and a patient in an office, clinic, or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support – by directly operating programs or by funding local providers – services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.

enabling services

Services that allow or provide for access to and the derivation of benefits from the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, and consumer coordination with Medicaid, WIC, and Education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential – for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transporta- tion, care coordination and planning, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training work- shops, advocacy, nutrition and social work

evaluation

Collecting, analyzing, and interpreting information on the need for, implementation of and effectiveness and efficiency of intervention efforts to better human-kind.

evidence-based models

A public health approach using sound scientific decisions based on evidence of current research and not anecdotal, rhetoric, or generalities that reflect unsound nonscientific thought or policies.

expenditure report

Summary of financial expenses incurred during a reporting period and used to request reimbursement of those costs.

facilities and administrative (F&A) costs

For the purpose of OMB A-21, the Circular pertaining to educational institutions, means costs that are incurred for common or joint objectives and, therefore, cannot be identified readily and specifically with a particular sponsored project, an instructional activity, or any other institutional activity. F&A costs are synonymous with "indirect" costs, as previously used in OMB A-21 and as currently used in Appendices A and B of that Circular.

family-centered care

8A system or philosophy of care that incorporates the family as an integral component of the health care system.

federal allotment

The monies provided to states under the federal Maternal and Child Health Services Title V/MCH Block Grant in any given year. The Title V/MCH allotment to states has a two-year period of availability.

federal fiscal year

For the Title V/MCH Block Grant, and subsequently the subgrants which are passed through the Nebraska HHS Regulation and Licensure, the federal fiscal year is the period October 1 through September 30.

federal poverty guidelines

The federal poverty guidelines are updated periodically in the federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). In certain cases, as noted in the relevant authorizing legislation or program regulations, a program uses the poverty guidelines as only one of several eligibility criteria, or uses a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines). *While many programs use the guidelines to classify persons or families as either eligible or ineligible, some other programs use the guidelines for the purpose of giving priority to lower-income persons or families in the provision of*

assistance or services, the latter of which is the case for Maternal and Child Health programs.

fiscal year close out

Activities conducted by MCH Planning & Support that are the final review of a MCH Grant-funded program.

fixed costs

The portion of total costs of a program incurred even when output is nil, e.g., costs associated with overhead, facilities, and overhead salaries.

grant award

The dollar amount approved for a Subrecipent based on the approved Work Plan, Financial Plan, and the funds available.

health education

Any planned combination of learning experiences designed to predispose, enable and reinforce voluntary behavior conducive to health in individuals, groups, or communities.

health planning

Planning concerned with improving health, whether undertaken comprehensively for a whole community or for a particular population, type of health service, institution, or health program. The components of health planning include data assembly and analysis, goal determination, action recommendation, and implementation strategy.

health promotion

Any planning combination of education, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.

health service area

Geographic area designated on the basis of such factors as geography, political boundaries, population, and health resources, for the effective planning and development of health services.

indirect cost

A cost which cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the result achieved. Indirect costs are usually allocated among an entity's services in proportion to each service's share of direct costs. A budget line item for indirect costs is allowed in the "order of preference" (See Part V. Subrecipient Responsibilities under "Indirect Cost Rate", MCH Grant Procedure Manual.) Because of the diverse

characteristics and accounting practices of governmental units, the types of costs, which may be classified as indirect costs, cannot be specified in all situations. However, typical examples of indirect costs, may included certain general administration of the grantee department or agency, accounting and personnel services performed within the grantee department or agency, and the costs of operating and maintaining facilities. Indirect cost is in contrast with direct cost. See OMB Circular A-122 or A-87. See also the definition for "Facilities and Administrative (F&A) Costs" pertaining to educational institutions addressed in OMB A-21.

indirect cost rate

A device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) opf the indirect costs to a direct cost base.

infants

Children under 1 year of age not included in any other class of individuals.

infant mortality

The death of a live-born infant before its first birthday.

in-kind

A third-party contribution; a value assessed to a service or product not paid with cash (referred to as *"non-cash match"* in the RFP and this Procedure Manual).

infrastructure building services

The services that are the base of the MCH pyramid of health status and form its foundation are activities at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health care services systems including development and maintenance of health services, standards/guidelines, training, data, and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems, systems of care, and pro- gram coordination with Medicaid, WIC, and Education. In the development of systems of care it should be assured that the systems are family centered, community-based and culturally competent.

input

The resources invested to implement activities for the purpose of achieving an outcome. This includes raw materials needed by services and projects in order to be successful. Resources include but are not limited to financial resources; clients and users; personnel with specific knowledge, training, competencies, or talents; physical facilities, equipment and materials; time energy and commitment from people in leadership roles and cooperation from collateral organizations.

internal control

Internal control is an integral component of an organization's management that provides reasonable assurance that the following objectives are being achieved:

- effectiveness and efficiency of operations
- reliability of financial reporting, and
- compliance with applicable laws and regulations

In a financial management system, for example, the Subrecipient shall ensure that no one person has complete control over all aspects of a financial transaction. For more information, see the U.S. General Accounting Office (GAO) *Standards for Internal Control in the Federal Government* at http://www.gao.gov/special.pubs/ai00021p.pdf

late report

Reports for any of the 1st, 2nd, and 3rd Quarters received after the due date and not pre-approved for an extension.

line items

Separate and defined categories of a budget. Approved budget line items are mirrored in the expenditure report.

local funding

Monies derived from local jurisdiction within the State that are used for MCH program activities; often used as match to the MCH Grant-funded portion of a program.

local health department

Legislative Bill (LB) 692 passed in the 2001 Nebraska Unicameral supports the development of local health departments statewide. Local health departments are those that qualify for the County Public Health Aid Program in Section 11 of LB 692.

low income

A family whose gross annual income falls at or below 100% of the current federal poverty level.

MCH program

The collective activities funded in whole or in part by Nebraska MCH Grant funds. Activities include either or both capacity-building (infrastructure) or services.

MCH Pyramid of Services

See "Types of Services". The federal Annual Report and Application requires budgeting and reporting expenditures by types of services. Department of HHS Regulation and Licensure refers to the types of services for the final reporting tables which contribute to Nebraska's annual submission to the federal Maternal and Child Health Bureau.

management plan

The procedures for successfully managing (maternal child health) activities including the agency's organizational structure, staff responsibilities and qualifications.

matching

The value of third-party in-kind contributions and the portion of the costs of a federally-assisted project or program not borne by the federal Government (Source: the "Uniform Administrative Requirements for Grants and cooperative agreements to State and Local Governments" for the Department of Human Services, 45 C.F.R. Part 92)\

Medicaid

A federally funded, state operated program of medical assistance to people with low incomes, authorized by Title XIX of the Social Security Act. Under broad federal guidelines the individual states determine benefits, eligibility, rates of payment and methods of administration.

medically indigent

People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.

medically underserved population

A population group experiencing a shortage of personal health services. A medically under served population may or may not reside in a particular medically under served area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for federal assistance (e.g., the National Health Service Corps).

mistimed pregnancy

According to questions included in the National Survey of Family Growth, a pregnancy that was intended but occurred sooner than the mother would have liked.

morbidity

The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

mortality

Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

needs assessment
A systemic set of procedures undertaken for the purpose of setting priorities and making decisions about program or organizational improvement and allocation of resources. The priorities are based on identified needs.

neonatal death
Death of a live-born infant from birth to <28 days of life.

no-cost extension
Additional time approved by MCH Planning & Support for Subrecipient to carry out grant activities. Requests for a no-cost extension will be considered only when extenuating circumstances have prevented substantial progress in achieving outcomes in the approved Work Plan. If approved, the extension will not exceed 60 days past September 30 of the final fiscal year in a funding period, i.e. November 30 of the relevant year.

non-cash match
A value assessed to a service or product not paid with cash. See "in-kind."

non-profit
Non-profit status as designated by the Internal Revenue Services (IRS).

operating cost
In the health field, the financial requirements necessary to operate an activity which provides health services. These costs normally include the costs of personnel, materials, overhead, depreciation, and interest.

others
Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other classes of individuals.

outcome
The statement of an intended result.

outputs
The activities implemented towards achieving an outcome.

overhead
The general costs of operating an entity which are allocated to all the revenue producing operations of the entity but which are not directly attributable to a single activity. For a hospital, these costs normally include maintenance of plant, occupancy costs, housekeeping, administration, and others.

periconceptional

Occurring around the time of conception.

planning

The conscious design of a desired future state (described in a plan by its goals and objectives); including: description of, and selection among, alternative means of achieving the goals and objectives; the conduct of the activities necessary to the design (such as data gathering and analysis); and the activities necessary to assure that the plan is achieved.

policy

A course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous, or expedient. The term is sometimes used less actively to describe any stated position and matters at issue, i.e., an organization's policy statement on national health insurance. Policies bear the same relationship to rules (regulations) as rules do to law, except that unlike regulations, they do not have the force of law.

population-based services

Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunizations, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/ public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

prenatal care

1. Care of the pregnant woman before delivery of the infant.

2. Monitoring and management of the woman during pregnancy to prevent complications of pregnancy and promote a health outcome for the mother and infant.

pregnant women

A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

preterm delivery

Conclusion of pregnancy before the 37th completed week of gestation.

preventive care

Comprehensive care emphasizing prevention, early detection, and early treatment of conditions, and generally including routine physical examinations, immunization, and well-person care.

primary health care

1. Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

2. Initial contact for personal health care, including care from physicians and other health care practitioners trained in general pediatrics, general internal medicine, obstetrics and gynecology, and family practice. Also provides for continuity of services and referral for subsequent necessary care.

3. The point when the patient first seeks assistance from the medical care system; also the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and treatment.

process measures

Markers of those steps logically required for the program to be successful in impacting health outcomes or health system capacity.

program income

Revenue generated as a result of the MCH Grant funds.

public health

1. The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.

2. Application of scientific and technical knowledge to address community health needs, thereby preventing disease and promoting health. Core functions include collecting and analyzing data, developing comprehensive policies for entire populations, and assuring that appropriate services are delivered to all.

rehabilitation

The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.

resources

All the things needed to conduct proposed activities. Includes are raw materials needed by services and projects in order to be successful. Resources include but are not limited to financial resources; clients and users; personnel with specific knowledge, training, competencies, or talents; physical facilities, equipment and materials; time energy and commitment from people in leadership roles and cooperation from collateral organizations.

respite care

The provision of temporary care for individuals who require specialized or intensive care or supervision that is normally provided by his or her family at home. Respite care provides the family with relief from the demands of the individual's or family member's care.

revenue

The gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts, or contractual allowances.

scope of work

Work plan activities for the provision of MCH services or development, implementation and maintenance of MCH infrastructure.

services

Services are comprised of "direct health care services", "enabling services" and "population-based services" as identified in the MCH Pyramid developed by the federal Maternal and Child Health Bureau.

sovereignty

Total independence and self-government. A territory existing as an independent state.

Sovereign Nation

Self-governing, independent nation.

subrecipients

Public and non-profit entities, and federally-recognized Native American Tribes headquartered in Nebraska (Omaha, Ponca, Santee, and Winnebago) receiving MCH Grant funds from Department of HHS Regulation and Licensure.

systems development

Activities involving the creation or enhancement of organizational infrastructure at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the quality of service capacity of health care service providers.

terms and assurances

Document agreed upon by Department of HHS Regulation and Licensure and a Subrecipient regarding conditions placed on the grant.

types of services

The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building Services", "Population-based Services", "Enabling Services", and "Direct Health Services." The federal Annual Report and Application requires budgeting and reporting expenditures in these categories. Department of HHS Regulation and Licensure refers to the types of services for the final reporting tables which contribute to Nebraska's annual submission to the federal Maternal and Child Health Bureau.

underinsured

People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.

uninsured

People who lack public or private health insurance.

unintended pregnancy

According to questions included in the National Survey of Family Growth, a pregnancy identified as either unwanted or mistimed.

unintentional injury

Injury arising from unintentional events.

unwanted pregnancy

According to questions included in the National Survey of Family Growth, a pregnancy occurring when the mother reported that she did not want a child at the time of conception or any time in the future.