IOWA CHILD DEVELOPMENT COORDINATING COUNCIL

Shared Visions

PARENT/FAMILY SUPPORT GRANT - YEAR END REPORT

2011 -2012

Grant #:_____

Applicant Agency:_____

Program Name: _____

Name/address at program site:_____

Agency Contact/Program Director:_____

Telephone #: _____ **E-Mail Address:** _____

Due Date: July 31, 2012

Complete report includes:

- **Form A: Quarterly Finance Report**
- **Refund check for any unspent funds**
- **Form B: Identification of In-Kind Support**
- **Form C: Grant Equipment Inventory**
- **Form D: Narrative Report**

NOTE: This completed report must be received and approved by the Department before the second 2012-2013 quarterly payment will be released to the applicant agency.

Send one copy to:

Lisa DuBois, Bureau Chief Secretary
Iowa Department of Education
Bureau of Internal Operations
Grimes State Office Building
400 East 14th St
Des Moines, Iowa 50319-0146

2011-2012 REPORT OF PROJECT EXPENDITURES

Grant #:	**Grant Agency:**

NOTE: Only the Shared Visions Parent/Family Support Grant funds should be reported on Form A. Other agency funds and in-kind contributions are reported on Form B.

QUARTERLY REPORTING PERIODS

ITEMS **Report Period Dates**	**Approved Grant Budget***	**July 1, 2010 to Sept. 30, 2010**	**Oct. 1, 2010 to Dec. 31, 2010**	**Jan. 1, 2011 to March 31, 2011**	**April 1, 2011 to June 30, 2011**	**Total to Date**	**Unexpended Balance***
Salaries and Fringe Benefits							
Professional							
Other							
Administrative Costs							
Subtotal							
Travel and Training							
Staff Travel							
Staff Training							
Subtotal							
Purchased/Contract Services							
Subtotal							
Supplies (Equipment and							
supplies $100 and over)							
Subtotal							
Capital Outlay ($100 and over)							
Subtotal							
Other Expenses							
Other							
Subtotal							
GRAND TOTAL							

*Amounts in the budget column should match your 2011-12 application. **Report the actual grant funds expended and obligated for the time periods indicated.** ***A warrant for any unexpended balance (payable to Department of Education) must accompany the year-end report.*** **Completed form due July 31, 2012 as part of the year end report.**

Signature and Title (Person completing report) **Date** **Phone #**

FUNDING:

Are monies from other sources used to supplement your Shared Visions funding? **Yes_____ No_____**

If yes, please identify the sources of additional funding:

_____Grants from public/private foundations
_____Head Start
_____Local contributions
_____ECI (Empowerment)
_____Other sources:_____

2011-2012 Identification of In-Kind Support

	Specify Cash Contribution by Line Item Identification	Specify In-Kind Support by Line Item Identification	Name of Organization Providing In-Kind	Specify Value/Amount
Salaries				
Staff Fringe Benefits				
Purchased Services				
Supplies				
Capital Outlay				
Other In-Kind Support				
			TOTAL	

Note: There is no requirement for matching funds for the proposed project. However, in-kind support should equal at least 20% of the grant award total.

GRANT PROGRAM EQUIPMENT INVENTORY (2011 – 2012)

List equipment, acquisitions and disposals that occurred during this reporting period.

Date Acquired	Name of Equipment	Kind of Equipment	Description and Serial No.	Manufacturer and Model No.	Quantity	Original Cost	Location of Equipment	Disposal	
								Date	Way

List the community partner(s) who provide assistance with any of the following:

Resource	Partnering Agency	Resource Needed, But Not Met
Housing		
Health Care Coverage		
Health Care		
Dental Care		
Mental Health Care		
Food Security		
Child Care		
Transportation		

STAFFING:

Please complete the staff information for each staff person working in the Shared Vision's Parent/Family Support program for the grant year 2011 – 12. This information will be kept confidential. Information will be used to track state wide data and implications.

Staff Position or Title	Number of months employed in grant year (ex. 12 mos, 9 mos, etc.)	Total Salary	Total Benefits	Years in position	Highest Level of education/training completed: (BA/BS, BSN, RN, BSW, EC endorsement, MA, CDA, AA, etc.)	Major area of study or concentration	Teacher folder number or type of profession licensure	Hours of staff development completed in current grant year	Content of staff development

NARRATIVE REPORT

1. Type of Agency providing Shared Visions program: _____School district
   _____Head Start
   _____AEA
   _____Licensed, non-profit child care
   _____Non-profit agency

2. Counties served by the program: _____

PROGRAM:

3. What curriculum(s) are used for home visitation (in-home, individual family) services? _____
   For parent education (group) services? _____

4. Does your program use any of these assessments with families? (check all that apply). Has staff had training in any of these?

USE	TRAINING	
_____	_____	Life Skills Progression Instrument (Long-term and intensive, in-home, family support services)
_____	_____	Protective Factors Survey (Short term, in-home or group based parent education programs)
_____	_____	Ages and Stages Questionnaire (ASQ)
_____	_____	Developmental Assessment of Young Children (DAYC)

5. Program cost per child (include all sources of funding when estimating cost): **$**_____

6. Has your program earned or currently participating in a state or national credentialing program?
   Credential earned: _____ Date: _____
   Participating in (type) _____

SERVICES PROVIDED:

7. Total number of families in your program that are supported by Shared Visions funding: _____.
   If data is available for the following, please provide **(optional):**
   _____# served in group-based parent education
   _____# served in short term home visitation (6 mos. or less)
   _____average number of home visits per family served
   _____# served in long-term home visitation (12 mos. or more)
   _____average number of home visits per family served

_____# served in long-term, intensive home visitation (weekly visits)
_____average number of home visits per family served

CHILD DEMOGRAPHICS:

For questions 8-14 please use age of child determined by their age on September 15 of the grant year. All data reported should ONLY include children supported by Shared Visions funding.

8. Number of children in your program.
   _____birth to one year
   _____one to two
   _____two to three
   _____three to four
   _____four to five
   _____**Total**

9. Number of children served by gender: _____ Males
   _____ Females
   _____**Total**

10. Please estimate the number of children in each ethnic category. Note: if child is labeled bi-racial and Hispanic/Latino, they must be counted as "Hispanic/Latino" only. If a child is labeled bi-racial and NOT Hispanic/Latino please choose the "Two or more" category below.
    _____American Indian or Alaska Native _____Hispanic or Latino
    _____Native Hawaiian or Other Pacific Islander _____White (not Hispanic)
    _____Black or African American _____Asian
    _____Two or more of American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Black or African American, Asian, or White (not Hispanic).
    _____**Total**

11. Please complete chart to identify demographic characteristics of the children served in your program.

# of homeless children enrolled	# of migrant children enrolled	# of immigrant children enrolled	# of children enrolled with special health care needs	# of children enrolled with IFSPs	# of children put on IFSPs after enrolling

12. Please estimate the **number of children** in your program who do/do not have health insurance.
    _____**DO NOT** have health insurance
    _____Personal health insurance
    _____Title XIX
    _____HAWK-I
    _____**Total**

13. Please estimate the number of children who have been appropriately immunized.
    _____Birth to one
    _____One to two
    _____Two to three
    _____Three to four
    _____Four to five
    _____**Total**

14. How many income eligible children (130%) are on your waiting list? _____

Eligibility Factors for Families/Children Served:

Indicate the eligibility factors of the families that this parent support project is serving. In the following section **families may be reported on more than one documentable variable**:

15._____Number of families receiving services who *"meet the current income eligibility guidelines for free and reduced price meals in a local school or whose total income is, or is projected to be, equal to or less than 130 percent of the federal established poverty guidelines."*

16._____Number of **families** receiving services under the **secondary eligibility factors** where: *(This information may be accessible from intake forms and may be a duplicated count.)*

A. _____Children who were abused.

B. _____Children functioning below chronological age in two or more developmental areas, one of which may be English proficiency, as determined by an appropriate professional.

C. _____Children born with an established biological risk factor, such as very low birth weight (under 1500 grams—approximately three pounds) or with conditions such as spina bifida, Down's syndrome or other genetic disorders.

D. _____Children born to a parent who was under the age of 18.

E. _____Children residing a household where one or more of the adults or guardians: **(Number for E will represent total of 1-8)**

1. _____Has not completed high school;
2. _____Has been identified as a substance abuser;
3. _____Has been identified as chronically mentally ill;
4. _____Is incarcerated;
5. _____Has a history of child or spouse abuse;
6. _____Has limited English proficiency;
7. _____Is a low functioning parent; or
8. _____Has limited literacy.

F. _____Children having other special circumstances, such as: **(Number for F will represent total of 1-4)**

1. _____Foster care;
2. _____Being homeless or without their own household;
3. _____History of family violence; or
4. _____Behavior problems.

Families Served:

Families counted in items 17-20 should be part of the caseload of the project. To be considered part of the caseload, families must have been present for more than 1 parent meeting, or have received more than 2 home visits; or have participated in more than 3 total activities available through resources available from this grant.

17. _____**Total number** of families on whom **intake** was completed.
    - A. _____Total Number of families on caseload
    - B. _____Total number of families who weren't eligible

18. _____Total number of children **prenatally through age three** who were within the families served (use age of children **as of September 15** to calculate this data).
    - A. _____Total number at-risk
    - B. _____Total number not at-risk

19. _____ Median length of months of service.

20. _____Total number of contact hours with families. *(Total should represent combination of A-E)*
    - A. _____Individual
    - B. _____Play group
    - C._____Home visits
    - D._____Parent support group
    - E._____Hours of coordination with a community agency

Evaluation and Outcomes:

1. For each goal and objective outlined in the grant application, provide the **success rate**. (Example: How many completed the program?)

2. Include a compilation of **evaluation activities** implemented during the project period, e.g., summary of written evaluations from individual or group activities: examples of letters, commendations from other agencies or community providers and minutes or videos of forums held by the project.

3. Briefly describe the collaborative relationships within the community that your program has developed that have been of benefit to the children and families you serve. (e.g., community empowerment)

Anecdotal Information:

1. Please describe the progress of the family of which you have had the most success. What were the milestones along the path? What would be recommendations made for transitioning the family for further service?

2. Please describe your program challenges due to funding. What needs can't be addressed by your program?

Name/Title of person completing this report:_____

Address:_____

Telephone:_____ E-Mail:_____

The email distribution list is purged yearly. Please provide contact information for any and all individuals you would like to be included on the Shared Visions Parent/Family Support email distribution list below. Based on their role, they will be placed on the Administrator or Teacher list. (Administrator, Teacher, etc.)

Name	E-mail Address	Role

If you have a staffing change after this report is submitted please notify Diane Moore at Diane.Moore@iowa.gov.