

Biennial Final Program Report

Please record the number of clients served by the project in each demographic category

Report Dates: _____ through _____



Agency Name: _____

Grant #: _____

Project Name: _____

Total number of **new** persons served 4th quarter _____

Total number of persons served year 1 and year 2 _____

Total number of persons returning 4th quarter _____

Total number of persons served this quarter _____

SECTION 1: Demographics (Note: For items A- F, please record the number of new participants served this quarter)

A. Record demographic information of the participants below:

A (1). Age in Years														
		<1	1-5	6-10	11-14	15-19	20-24	25-34	35-44	45-54	55-64	65-75	>75	Total
Sex	Female													
	Male													
Total														

FOR SECTIONS B through F, REPORT NEW PERSONS SERVED THIS QUARTER ONLY

B. Race and Ethnic Background (in whole numbers)

_____ African American

_____ Asian:

_____ Cambodian

_____ Hmong

_____ Laotian

_____ Vietnamese

_____ Hispanic:

_____ Mexican American

_____ Puerto Rican

_____ Other _____

_____ White/Non Hispanic

_____ Native American

C. Insurance

_____ Private

_____ Public

_____ Uninsured

D. Household Income

		< \$9,999	\$10,000 - \$14,999	\$15,000 - \$24,999	>\$25,000
Number of Persons in Household	1				
	2				
	3				
	4				
	5+				

E. Last Interaction With Health Care System

Less than 3 months
3 - 6 months
6 months - 1 year
1 year or more

F. Service Most Often Used

Emergency Room
Family Physician
Health Center/ Clinic
Traditional Healer

LUPUS SYMPTOM ASSESSMENT TOOL

(Lupus projects only)

Number of Lupus Risk Assessments _____

Number with 3 or more symptoms _____

Number of Referrals _____

Health Screenings information is to be submitted for all grants that are not lupus related.	HEALTH SCREENINGS			
	Type	#screened	#abnormal	#referrals

Instructions

This report is a compilation of individual client demographic records.

Filling in Section I: Demographics is a mandatory requirement for all Commission-funded projects. Methods of collecting this information on individual clients may vary from agency to agency. The information requested for this section represents the **MINIMUM** reporting requirement. All items reported by an agency must remain **CONSISTENT** with those appearing on this form.

Report:

- A. Age in Years: Report the total number of unduplicated project clients indicating the number served by age and gender during the reporting period.
- B. Race/Ethnicity: Report the total number of clients served by self-reported race or ethnicity. Please note, for example, the total number of Asian or Hispanic clients and then the total number by appropriate sub-group. The total of each sub-group must equal the total for the appropriate racial/ethnic group.
- C. Insurance: Indicate the number of clients having public coverage, private coverage or no coverage. Report the number covered for the entire year and those covered for some part of the year.
- D. Household Income: Report the total number of clients in each income range by number of persons in the household.
- E. Last Interaction with Health Care System: Report each client's last interaction with any health provider **excluding** their first contact with this project.
- F. Service Most Often Used: Report the service most often used by project clients.

By signing below, we certify that the information contained in this report is, to the best of our knowledge, correct and reflective of the project's program records.

Signature of Executive Director

Date

Signature of Project Director

Date

Biennial Final Program Report

Report Dates: _____ through _____

Agency Name: _____

Grant #: _____

Project Name: _____

Total Number of clients served: _____

- I. List the Goals as they appeared in your application, progress toward accomplishing them and the evaluation method used to measure outcome.
(Use separate sheet if necessary)



GOALS	PROGRESS (NARRATIVE)	PROJECT EVALUATION

I. List the Goals as they appeared in your application, progress toward accomplishing them and the evaluation method used to measure outcome.
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GOALS	PROGRESS (NARRATIVE)	PROJECT EVALUATION

II. List the total number of clients served (unduplicated count) by your project, by service area and outcome (i.e., if your project provided screenings, what number of those served were diagnosed with a disease/condition?)

NUMBER OF CLIENTS SERVED (LIST BY SERVICE)	MEASUREABLE OUTCOME	FOLLOW-UP SYSTEM USED

III. Was the methodology proposed in your application implemented? If not, please describe any changes, the rationale for the change and the impact of service delivery.

IV. Describe problems encountered in implementing the project. Describe the steps implemented to remediate the problem, if applicable.

V. What were the strengths, successes or lessons learned which were unanticipated? Please describe in detail.

VI. Did you discover unanticipated and/or unmet training needs for your staff?

VII. Was the Commission staff of assistance administratively, programmatically and/or in fiscal matters as you implemented your program?
If not, explain.

VIII. Did you develop written, audio and/or audio-visual materials with grant funds? Copies are to be forwarded to the Commission with this report.

IX. Did you utilize print or electronic media during the funding cycle? Please list and specify whether utilized information, education or promotion.

X. List agencies that were primary referral sources to you and those to which you made referrals.

AGENCIES REFERRED TO YOU

MAJOR REASON

AGENCIES TO WHICH YOU
REFERRED

MAJOR REASON

XI: Describe your plans for sustainability of the project. Have you secured other funding? If so, from whom did you receive funds? Please specify the amount of funding and for how long the project is funded.

If you do not have a plan for institutionalization of the project, please schedule an appointment to meet with Commission staff to discuss your future plans and ways the Commission may assist you.

XII. Comments, suggestions and/or observations.

Executive Director Date

Project Director Date



OHIO COMMISSION ON MINORITY HEALTH

Ted Strickland
GOVERNOR

STATE SENATOR
RAY MILLER
CHAIRMAN

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BIENNIAL EXPENDITURE REPORT FORM

Agency Name:

Project Title:

Grant Number: Grant Period Beginning: Ending:

	4 th Quarter year 2	Total Year 1 & 2
A) Total Grant Funds Received	\$	\$
B) Grant Expenditures	\$	\$
C) Grant Outstanding Obligations	\$	\$
D) Total Grant Expenditures (B + C)	\$	\$
E) Total Grant Balance [A-D]	\$	\$

F) The BALANCE DUE on Line E is to be submitted to the Commission in a check made payable to the **“Treasurer, State of Ohio”** and mailed to the Commission within sixty (60) days.

Please check one:

- Check enclosed in the amount of \$
- Check to be submitted separately
- No check due

G) Comments and explanations:

H) Are there any outstanding obligations of project funds Yes No If yes, itemize obligations on page 7 of the Biennial Expenditure Report Form . **NOTE:** Obligations must be liquidated within thirty days.

We certify that the information contained in this report is, to the best of our knowledge, correct and reflective of the project accounting records.

Signature of Executive Director

Date

Signature of Fiscal Officer

Date

NOTE: THIS REPORT MUST BE SIGNED TO BE ACKNOWLEDGED AS VALID.

B. Non-Personnel Items

1. Travel

Name of Staff, Mileage, Rate	FY 2006 Itemize according to 2006 approved budget		Biennial Project Funds Add year one and year two personnel amounts and itemize	
	Budgeted for 4 th Quarter	Expended for 4 th Quarter	Budgeted for Biennium	Expended for Biennium
Subtotal – Travel	\$	\$	\$	\$

Non-Personnel Items, Continued

2. Equipment

List Items and Quantities/Lease	FY 2006 Itemize according to 2006 approved budget		Biennial Project Funds Add year one and year two personnel amounts and itemize	
	Budgeted for 4 th Quarter	Expended for 4 th Quarter	Budgeted for Biennium	Expended for Biennium
Subtotal - Equipment	\$	\$	\$	\$

Non-Personnel Items, Continued

3. Supplies, Contracts and Other

List Supply Items and Contractor Names	FY 2006 Itemize according to 2006 approved budget		Biennial Project Funds Add year one and year two personnel amounts and itemize	
	Budgeted for 4 th Quarter	Expended for 4 th Quarter	Budgeted for Biennium	Expended for Biennium
Subtotal – Supplies, Contracts & Other	\$	\$	\$	\$

Non-Personnel Items, Continued

4. Administrative/Indirect Costs

List Items	FY 2006 Itemize according to 2006 approved budget		Biennial Project Funds Add year one and year two personnel amounts and itemize	
	Budgeted for 4 th Quarter	Expended for 4 th Quarter	Budgeted for Biennium	Expended for Biennium
Subtotal – Administrative/Indirect Costs	\$	\$	\$	\$

OUTSTANDING OBLIGATIONS / ENCUMBRANCES

List all outstanding obligations/ encumbrances incurred but not paid at the end of the period.
 (must correspond with your approved budget)

LIST OBLIGATIONS	DATE(S) OBLIGATIONS WERE INCURRED	AMOUNT	DATE OBLIGATION WILL BE LIQUIDATED
Total Outstanding Obligations/Encumbrances		\$	