John R. Kasich
GOVERNOR

Gregory L. Hall, MD
CHAIRPERSON

COMMISSION ON MINORITY HEALTH

77 South High Street, 18th Floor, Columbus, Ohio 43215
Phone: (614) 466-4000
Fax: (614) 752-9049
Website: http://www.mih.ohio.gov
Email: minhealth@ocmh.state.oh.us

FINAL REPORT
Minority Health Month 2016

Grant # MHM 16 - _____ Federal Tax ID# _____

Agency Name: _____

Address: _____

Contact Person: _____ Telephone Number: ( ) _____

1. Demographics

COMMUNITY PARTICIPATION							
Dates of Events **(List separately)**	Total # served	Number served by Ethnic/Racial Group					
		African & American	Hispanic	Native Am. Indian	Asian American & Pacific Islander	White	Other

a) Date of event/Service Provided: Indicate each separate activity/service and the date on which it occurred.
b) Total # Served: Record the number of people served for each event/service period.
c) Total # by Ethnic/Racial Group: Record the number of African Americans, Asians, Hispanics, and Native American Indians served through each service/event.

THIS REPORT IS REQUIRED WITHIN 15 DAYS OF THE END OF THE GRANT.
FAILURE TO COMPLY WITH THIS REQUIREMENT MAY RESULT IN NON-PAYMENT.
No Personal Health Information such as Name, Social Security Number, Address, Email. No Photos are to be submitted with the report.

Ohio Commission on Minority Health

Demographic Screening Reporting Form

Type of Screenings (List i.e., diabetes, cholesterol, hypertension, mammography, prostate)	Total # screened*	Total # Gender			Total # Abnormal findings* (Ranges if applicable)	Separate Number of Abnormal Findings by Ethnic\Racial Group* Referrals **must** be provided and follow up if possible. Grantees should have community referral resources on hand for abnormal screenings					
		Male	Female	Total		African American	Hispanic	Native American	Asian Amer. Pacific Isldr.	White	Other

*** PLEASE NOTE: ALL ABNORMAL SCREENS MUST RECEIVE FOLLOW UP.**

Each Grantee will be required to collect contact information on a sign in sheet to allow follow up for any abnormal screens as needed.

Sign in sheets and screening registration sheets submitted with the final report must have personal health information and contact information redacted (blocked out or whited out). Only the first name, zip code, race/ethnicity, gender and type of screening may remain visible.

Do not send pictures of participants to the Commission.

2. Program Activity:

Note: Include copies of all handouts, redacted sign-in and redacted screening registration sheets, etc. that were used for **each** activity. Failure to complete this section will deem this report incomplete and will be returned without review.

Summarize all Minority Health Month activities (by date) provided by your agency for the month. Include a written summary of evaluation that was conducted. Add additional sets of questions for each event held, if needed.

Event 1 Name:
Event Date:

- Was the activity conducted on the original confirmed date? If not, why?

- Did you meet the proposed number of participants stated on the activity sheet? If not why?

- Describe accomplishments of the program activity.

- Discuss any problems encountered and/or changes in the original program activity.

- Discuss how the Commission Satisfaction survey was implemented and share feedback from the survey data collected to include an average score for each of 6 rated

items, a list of comments for each of 6 items and the last two comments based items questions and the number of surveys collected.

- Attach press releases, newspapers articles and materials developed with grant funds.

Please DO NOT send pictures to the Commission

Event 2 Name:
Event Date:

- Was the activity conducted on the original confirmed date? If not, why?

- Did you meet the proposed number of participants stated on the activity sheet? If not why?

- Describe accomplishments with the program activities.

- Discuss any problems encountered and/or changes in the original program activity.

- Discuss how the Commission Satisfaction survey was implemented and share feedback from the survey data collected to include an average score for each of 6 rated items, a list of comments for each of 6 items and the last two comments based items questions, and the number of surveys collected.

3. Partnerships/Collaborations/Co-Sponsorship

A. List any agencies that you collaborated with for Minority Health Month.

B. Did your agency receive any donations (monetary or in-kind services/items) for your Minority Health Month activities? If so, please list the donator/agency name, item(s) donated, and the actual/estimate value of donation.

Attach press releases, newspapers articles and materials developed with grant funds.

Minority Health Month - FINAL REPORT

INSTRUCTIONS:

1. Enter the grant number assigned by the Commission MHM 16 -___.

2. Enter the agency's federal tax identification number.

3. Enter the agency's name.

4. Enter the agency's address.

5. Enter the contact name for the person(s) responsible for the program activities and completing the program portion of this MHM Final Report.

6. Enter the telephone number for the person(s) responsible for the program activities and completing the program portion of this MHM Final Report.

7. Enter the demographics for the events (list separately).

    a. Date of event/services provided: Indicate each separate item and date on which the activity occurred.
    b. Total # of persons served for each event/service period.
    c. Total # serviced by Ethnic/Racial Group: Record the number of African Americans, Asians, Hispanics, and Native American Indians served through each service/event.
8. List (separately) types of screening
9. List total number # of persons screened.
10. Identify the number # for each gender (male and female)
11. Identify the number for all abnormal screenings by ethnic/racial groups.
12. Identify abnormal screenings by race ethnic/racial groups.
13. Answer all questions listed under 2. Activity Page.
14. Answer all questions listed under 3. Partnerships/Collaborations/Co-Sponsorship.

Minority Health Month
EXPENDITURE REPORT

Agency Name: _____Grant # MHM 16-_____
Executive Director: _____ Contact Person: _____
Federal Tax ID Number: _____ Phone Number: _____

Item	A	B
BUDGET CATEGORY	**COMMISSION APPROVED BUDGET**	**AMOUNT EXPENDED (Commission Funds Only)**
Speaker(s) Name(s) only	$	$
Rental items only	$	$
Supply, Contract, Other	$	$
Administrative Costs		
Total Commission Cost	$	$

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

_____ _____
Signature of Executive Director Date

_____ _____
Signature of Fiscal Officer Date

THIS PAGE MUST BEAR ORIGINAL SIGNATURES

INSTRUCTIONS

Instructions for Completion of the Minority Health Month Grant Expenditure Report

Agency Name: Insert the legal name of your agency. It must match the name on the 501 (C) 3.

MHM 16- ____-____: The Minority Health Month grant number receive a grant number when it arrives in the Commission office. The agency must use this number on all budget forms and use it whenever you correspond with the Commission.

Executive Director: Insert the name of the Chief Executive Officer of the applicant agency and official title.

Contact Person: Use the name of the person who has day-to-day responsibility for the Minority Health Month Project.

Federal Tax I.D. #: This number is issued by the IRS. It appears on agency's 501 (C)(3) or sometimes as the Entity Identification Number (EIN). The tax ID number must be the number representing the agency that is applying for grant funds. If an applicant is using another agency's tax ID number, the agency whose number is being used will be reimbursed for expenditures made during the grant period.

Phone: Applicant should give the phone number of the contact person(s) who has day-to-day responsibility for the Minority Health Month project.

NOTE:

- **All expenditures must be supported by copies of receipts. For speakers copies of canceled checks are acceptable. Failure to submit supporting documentation will result in non-reimbursement**.
- **Items listed as expenditures that do not appear on the approved budget will be disallowed**.

Speakers

Budget Category: Identify each speaker (by name) whose speaking fee will be paid for by the Commission. List topic(s) as well.
Column A: Identify the amount listed in the Commission's APPROVED BUDGET under Column B.
Column B: Enter the expended amount to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column A of the approved budget.

Rentals

Budget Category: Specify each rented line item with unit cost charged to the Commission (rental of chairs, tables, rooms, etc.), e.g. 50 chairs x .80/chair = $40.
Column A: Specify the cost of the rented line item listed in the Commission's APPROVED BUDGET. The amount listed should be the same amount identified in the APPROVED BUDGET under Column A.
Column B: Enter the amount spent that you want to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column B as it appears in the approved budget.

Supplies Contract & Other

Budget Category: List of all supplies. They must be itemized and specify unit costs (e.g. office supplies, printing, advertising, etc.), and contracts
Column A: Identify the cost of each product or service being charged to the Commission. The amount should not exceed the amount that is listed in the approved budget under Column B.
Column B: Enter the amount that will be charged to the Commission. The amount identified cannot exceed the approved amount for the supplies Contract & Other category.

Total Commission Cost: Add up the dollar amounts in Column A and Column B.
The amount in Column B should not exceed the approved budget of $3,000.00.
The amount in Column B is the amount you wish to be reimbursed by the Commission and may not exceed $3,000.00.
The total amount **cannot** exceed the amount stated in the Acknowledgement of Terms and the Commission's approved budget.

Executive Director and Fiscal Officer:

The Expenditure Report must be signed by the Executive Director and the Fiscal Officer. **Without their signature this report is invalid.**