Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grant/Contract Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Budget Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select if this is a Mid-year or Year-end report

* Mid-year
* Year-end

Budget Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount Spent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Report Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please describe the following:**

1. **Target population**
2. **Types of services provided and how those services addressed the need of your (geographic) community.**
3. **Number of staff and total FTEs for the program**
4. **Indicate if this was a new service, expansion of a current service or a continuation of existing service.**

**Please describe the following:**

1. **Goals & Progress and Outcomes including objectives, services, and numbers**

**Goal #1:**

**Progress and Outcomes:**

**Goal #2:**

**Progress and Outcomes**

**Goal #3:**

**Progress and Outcomes:**

**Goal #4:**

**Progress and Outcomes:**

**Goal #5:**

**Progress and Outcomes:**

**Goal #6:**

**Progress and outcomes:**

1. **Products Developed (please include at the end of this report any pictures /brochures/ flyers or marketing material created.)**
2. **Our equity goal is to serve the needs of diverse and/or hard to reach persons and populations. Please describe how your organization is adapting programming, or the organization itself is changing to engage all populations.**
3. **What is your process for women who enter the program while pregnant and how does your organization document prenatal substance and alcohol exposure to refer for potential services and/or possible evaluation when FASD is suspected?**
4. **What referrals to community-based agencies and/or FASD diagnostic clinics took place, both for infants and for the woman’s other children if PAE is suspected?**
5. **How does your organization train staff to be FASD informed, and how are you changing current practices to provide FASD prevention and intervention?**
6. **Activities Not Completed**

**Please describe success stories:**

**Successes:**

**Program Assessment**

1. Challenges/Problems Encountered in Collecting Data
2. Challenges/Barriers in Providing Services and Dealing with Each

**Future Outlook: Please describe your:**

1. Continuation of Project
2. Changes in Staffing, Target Population, Funding for Coming Year
3. Plans to reduce incidence of prenatal alcohol exposure
4. Programming
5. Data collection

# Service Summary Form:

# Programs that provide Services for Pregnant Women & Women with Dependent Children must complete this form as part of their Final Report. These numbers are to be unduplicated individuals served.

AGENCY & PROGRAM NAME: **\_\_\_\_\_\_\_\_\_\_\_** BUDGET YEAR AMOUNT: $ **\_\_\_\_\_\_\_\_\_\_\_\_\_**

GRANT/CONTRACT NUMBER: **\_\_\_\_\_\_** BUDGET YEAR AMOUNT SPENT: $ **\_\_\_\_\_\_\_\_**

1. What geographic area does this program serve?

 Single County [ ]  multi-county [ ]  Statewide [ ]  Reservation [ ]

* Counties served**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

3a. Number of ***Pregnant Women*** who received services this year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Number of ***Women with Dependent Children*** who received services this year (this only includes women who were not already counted as Pregnant) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Total number** of women served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Each woman served is only counted once, as either Pregnant or as With Dependent Children.)**

* ***Pregnant:*** She is counted as Pregnant if she was pregnant at any time during the year while she received services. She may also have dependent children, but she is still only counted as Pregnant.
* ***With Dependent Children***: She is counted as with dependent children if she was not pregnant at any time during the year while she received services but does have dependent children.

3b. Total number of women who entered the program this year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following demographic information about women who entered the program this year.

* Age: Under 18:  18-48: **\_\_\_\_\_** Over48:
* Ethnicity: Hispanic/Latino: Not Hispanic/Latino:  Unknown:

**(The number of Hispanic/Latino + not Hispanic/Latino + unknown should equal the number of women who entered the program this year.)**

* Race: **Total will self-calculate and should equal the number of women who entered the program.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| White |  |  | American Indian/Alaska Native |  |
| Black or African American |  | More than One Race |  |
| Asian |  | Race Not Known or Other |  |
|  |  | Total |  |

4a. Number of ***Dependent Children served*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(This number includes all dependent children of the women who received services. “Dependent children” are those children for whom the women still have parental rights).**

4b. Total number of dependent children who entered the program this year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following demographic information about children who entered the program this year.

* Gender: Males: Females:
* Age: 0-4 yrs: 5-11 yrs:  12 up to 18: Unknown:

Total number of toxic free babies born:

* at birth
* from 6 months gestation to birth \_\_\_\_\_
* from 3 months gestation to birth\_\_\_\_\_
* conception to birth\_\_\_\_
* Total number of babies born to mothers in the program

**(Total number of babies born to mothers in the program should equal the total number of babies born in the above section.)**

1. Number of **Women who were neither Pregnant nor had Dependent Children at the time of enrollment**
2. How many pregnant women had a positive UA **at intake** or **during programming**?
3. Number of staff trained (training/technical assistance/etc.) this grant year:

Please identify the staff role/position(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Director Program Coordinator Public Health Nurse LADC
* Case Manager Recovery Coach Other

1. Please briefly describe the types of trainings the staff received

8. Please describe any marketing and outreach effort your program engaged in to increase community awareness of the service:

9. Offer any additional information about your program:

10. Name and title of person who completed this form**:**

11. Phone Number:

12. E-mail address: