**Section 635.APPENDIX C Family Planning Services Application Packet**

Checklist for Completing the FY90

Family Planning Services Application

Check ( ) the following item for completeness before submitting your application for processing. Each must be addressed, filled in or attached as indicated. **CHECKLIST MUST BE SUBMITTED WITH APPLICATION.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cover Sheet Attachment A | | | | |
| Complete Sections | 2 | Applicant Organization |  |
|  | | 3 | Applicant Certification |  |
|  | | 4 | Type of Organization |  |
|  | | 5 | Grant Support Requested |  |
|  | | 6 | Type of Application |  |
|  | | 7 | Legislative District |  |
|  | | 8 | Date of Submission |  |
| Health Care Plan | |  |  |  |
| #10 complete narrative | | |  |
| #11 define target area | | |  |
| #12 list clinic(s) names(s) | | |  |
| and days/hours of operation | | |  |
| #13 complete budget in accordance | | |  |
| with the attached budget and | | |  |
| expenditures category definitions | | |  |
| Checklist – FY 90 | |  |  |  |
| #14 complete cost analysis by IDPH methodology | | |  |
| Between Page 5 & 6 attach schedule of discounts | | |  |
| and sliding fee scale with charges based upon | | |  |
| 1989 Poverty Guidelines. | | |  |
| #15 complete **three (3)** objectives | | |  |
| Complete attached Plans to Achieve | | |  |
| Objective/Program Progress Report | | |  |
| Forms **three (3)** | | |  |

Attachment A

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

535 WEST JEFFERSON STREET

SPRINGFIELD, ILLINOIS 62761

APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| PROGRAM TITLE: | | | | | | | Family Planning Services | | | | | | | | | | | | | | | | | | | | | | | | |
| BRIEF SUMMARY: | | | | | | | To provide comprehensive family planning services pursuant to the application and assurances | | | | | | | | | | | | | | | | | | | | | | | | |
| submitted by the grantee. Such services will be delivered in accordance with the Department's applicable rules | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| entitled Title 77: Public Health, Chapter I: Department of Public Health, Sub Chapter: Maternal and Child Health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part 635 Program Content and Guidelines for Title X Family Planning Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APPLICANT ORGANIZATION: | | | | | | | | | | | | | |  | 4. | TYPE OF ORGANIZATION: | | | | | | | | | | | | | | | |
| NAME: | |  | | | | | | | | | | | |  |  | | | LOCAL HEALTH DEPARTMENT | | | | | | | | | | | | | |
| ADDRESS: | | |  | | | | | | | | | | |  |  | | | PRIVATE NON-PROFIT AGENCY  OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | 5. | GRANT SUPPORT REQUESTED: | | | | | | | | | | | | | | | |
| TELEPHONE: | | | | ( | |  | | | | ) | |  | |  | BEGINNING | | | | | | ENDING | | | | | | AMOUNT | | | | |
| FEIN NUMBER: | | | | |  | | | | | | | | |  |  | | | | | | | | | | | | | | | | |
| PROJECT DIRECTOR: | | | | | | | | | |  | | | |  | 6. | TYPE OF APPLICATION: | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | |  |  | INITIAL | | | CONTINUATION | | | | | | | | | | REVISION | | |
|  | | | | | | | | | | |  | | |  | 7. | LEGISLATIVE DISTRICT | | | | | | | | | | | | | | | |
| FINANCE OFFICER: | | | | | | | |  | | | | | |  |  | CONGRESSIONAL | | | | | | | |  | | | | | | | |
|  | | | | | | | | |  | | | | |  |  | LEGISLATIVE | | | | | | | |  | | | | | | | |
|  | | | | | | | | |  | | | | |  |  | (State Senate) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  |  | REPRESENTATIVE | | | | | | | |  | | | | | | | |
| APPLICANT CERTIFICATION: | | | | | | | | | | | | | |  |  | (State Representative) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  |  |  | | | | | | | | | | | | | | | |
| To the best of my knowledge, the data and  statements in this application are true and  correct. The applicant agrees to comply with  all State/Federal statutes and Rules/Regulations  applicable to the program. | | | | | | | | | | | | | |  | 8. | DATE OF SUBMISSION: | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | |  |  | Month | | | | | | Date | | | | | Year | | | | |
| AUTHORIZED OFFICIAL: | | | | | | | | | | | |  | |  | 9. | | IMPORTANT NOTICE:  This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Illinois Revised Statutes, Ch. 127, Par. 137 et. seq. Failure to provide this information may prevent this form from being processed. This form has been approved by the Forms Management Center. | | | | | | | | | | | | | | | |
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|  | Date | | | | | | | | | | | | Signature |  |  | |  | | | | | | | | | | | | | | | |
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|  | | | | Agency Name | |  | |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT (cont'd.) | | | | | DATE FROM: THROUGH | | |
| 10. | HEALTH CARE PLANS | |  | | | | |
| INSTRUCTIONS: | | Complete a narrative summarizing the major features of the project including: 1. statement of need, 2. characteristics of the target area including other Family Planning Resources, 3. methods used to conduct program and 4. measure its success. | | | | | |
|  | | | | | | |  |
| USE ADDITIONAL SHEETS IF NECESSARY | | | | | | | 3/89 |

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|  | | | | | | | Agency Name | |  | |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT (cont'd.) | | | | | | | | DATE FROM: THROUGH | | |
| 11. | GEOGRAPHIC SERVICE AREA | | | |  | | | | | |
| INSTRUCTIONS: | | | Define your target service area by listing county(ies) or community(ies) served. | | | | | | | |
|  | |  | | | | | | | | |
|  | |  | | | | | | | | |
| 12. | CLINIC(S) SCHEDULE(S) | | |  | | | | | | |
| INSTRUCTIONS: | | List all clinics by name, address and days/hours of operation. | | | | | | | | |
| Clinic(s) Names(s)/Address(es) | | | | | | Days/Hours of Operation | | | | |
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| USE ADDITIONAL SHEETS IF NECESSARY | | | | | | | | | | 3/89 |

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|  | | | | | | | | Agency Name | | |  | | |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT - (continued) | | | | | | | | | DATE FROM: THROUGH | | | | |
| 13. | | BUDGET | | | |  | | | | | | | |
| INSTRUCTIONS: | | | | All funds must be identified and assigned to categories in accordance with the budget and expenditures category definitions. | | | | | | | | | |
| CATEGORY | | | Family Planning Award | | Title XIX | | Patient Fees | | | Other Funds | | TOTAL | |
| Budget | | Budget | | Budget | | | Budget | | Budget | |
| 1. | Personal Services | |  | |  | |  | | |  | |  | |
| 2. | Contractual Services | |  | |  | |  | | |  | |  | |
| 3. | Supplies | |  | |  | |  | | |  | |  | |
| 4. | Travel | |  | |  | |  | | |  | |  | |
| 5. | Patient Care | |  | |  | |  | | |  | |  | |
| 6. | Equipment | | \* | |  | |  | | |  | |  | |
| 7. | Total | |  | |  | |  | | |  | |  | |
| \*Details must be provided below. Use additional sheets if necessary. | | | | | | | | | | | | | |
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Illinois Department of Public Health

Division of Family Health

Budget Category Definitions

Personal Services

"The item 'personal services', means the reward or recompense made for personal services rendered by an employee of the delegate agency in support of this project, or any amount required or authorized to be deducted from the salary of any such person or any retirement or tax law, or both, or deductions from the salary of any such person under the Social Security Enabling Act, or deductions from the salary of such person. Any employee is anyone who receives the fringe benefits offered by the delegate agency.

Contractual Services

"The item 'contractual services', means and includes: (a) Expenditures, incident to the current conduct and operation of an office, department, or agency in direct support of this project for postage and postal charges, telephone expenses, printing, office conveniences and services, exclusive of supplies as herein defined: (b) Expenditures of $5,000 or less for repair or maintenance of property or equipment, utility services, professional or technical services; (c) Expenditures pursuant to multi-year lease, lease-purchase or installment purchase contracts for duplicating equipment authorized by the contract.”

Travel

"The item 'travel', shall include any expenditure directly incident to official travel by employees of the project, involving reimbursement to travelers or direct payment to private agencies providing transportation or related services.”

Supplies

"The item 'supplies' means and includes expenditures in connection with current operation and maintenance for the purchase of articles of a consumable nature which show a material change or appreciable depreciation with first usage, repair parts, and including tools and equipment having a unit value not in any instance exceeding $50, but does not include any expenditure for library books or expenditure included in 'permanent improvements’.”

Equipment

(purchase exceeding $100)

"The item 'equipment', shall mean and include all expenditures for library books, and expenditures, having a unit value exceeding $100, for the acquisition, replacement or increase of visible tangible personal property of a non-consumable nature.”

Patient Care

"The item 'patient care' means services necessary for the care of patients that the delegate can not provide other than by an outside vendor. This includes medical and social service contracts.

IDPH (1987)

Illinois Department of Public Health

Division of Family Health

Expenditures per Category

Listed below are examples of the most common charges shown under their appropriate category. If you have any other type of expense, please do not hesitate to call for assistance in placing it in the correct category.

I. Personal Services

1. Fringe benefits

2. Salaries

II. Contractual Services

1. Advertising costs

2. Building and ground maintenance

3. Conference and registration fees

4. Contractual employees

5. Copy machine rental

6. Insurance (building, fire, theft and malpractice)

7. Legal services and accounting fees

8. Postage (including stamps)

9. Printing

10. Rent or lease of space of property

11. Repair and maintenance of furniture and equipment

12. Statistical and tabulation services (data processing)

13. Subscriptions

14. Telephone

15. Utility cost

III. Supplies

1. Contraceptives

2. Educational and instructional materials

3. Medical supplies

4. Office supplies

5. Pamphlets

IV Travel

1. Lodging

2. Per diem

3. Travel expense (mileage, train, or air fare)

V Patient Care

1. Lab Work

2. Nurse practitioner for patient care (contracted out)

3. Physicians for patient care (contracted out)

VI Equipment

1. All equipment that is purchased

IDPH (1987)

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| Agency Name | | | | | | | | |  | | | |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT (continued) | | | | | | DATE FROM: THROUGH | | | | | | |
| 14. COST ANALYSIS AND FEES | | | | | | | | | | | | |
| INSTRUCTIONS: Complete the cost analysis following the cost analysis manual instructions. Attach a copy of your agency's Schedule of Discounts and sliding fee schedule with charges based upon the 1990 federal poverty guidelines. | | | | | | | | | | | | |
| (a)  Service/Procedure | (b)  Serv. Util. | (c)  RVS | (d)  Total Serv. Units | (e)  Total Cost/Cost Ctr. | | (f)  Avg. Cost/Serv. Unit | | | (g)  Cost/Serv. | | (h)  Fee |
| Medical Cost Center  Minimal |  | 5.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Brief/Intermediate |  | 18.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Extended |  | 30.00 |  | ///////////////////////////////// | |  | | |  | |  |
| IUD Insertion |  | 30.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Diaphragm Fit |  | 15.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Sonography |  | 30.00 |  | ///////////////////////////////// | |  | | |  | |  |
| X-ray/Lost IUD |  | 24.00 |  | ///////////////////////////////// | |  | | |  | |  |
| TOTAL | ///////////////// | ///////// |  |  | | ///////////////////////////////// | | | ////////////////// | | /////// |
| Laboratory Cost Ctr.  HGB/HCT |  | 3.00 |  | ///////////////////////////////// | |  | | |  | |  |
| U/A |  | 4.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Pregnancy Test |  | 10.00 |  | ///////////////////////////////// | |  | | |  | |  |
| VDRL |  | 6.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Pap Smear |  | 8.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Gonococcal |  | 6.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Misc. Culture |  | 6.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Bact.Sm./Wet Mount |  | 5.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Sickle Cell |  | 5.00 |  | ///////////////////////////////// | |  | | |  | |  |
| PP Blood Gluc. |  | 6.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Cholesterol Level |  | 6.00 |  | ///////////////////////////////// | |  | | |  | |  |
| SMA-12 |  | 16.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Colposcopy |  | 30.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Colp./Biopsy |  | 40.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Chlamydia Test |  | 7.00 |  | ///////////////////////////////// | |  | | |  | |  |
| TOTAL | ///////////////// | ///////// |  |  | | ///////////////////////////////// | | | ////////////////// | | /////// |
| Pharmacy Cost Ctr.  Orals |  | 1.20 |  | ///////////////////////////////// | |  | | |  | |  |
| Creams |  | 2.65 |  | ///////////////////////////////// | |  | | |  | |  |
| Jellies |  | 2.65 |  | ///////////////////////////////// | |  | | |  | |  |
| Suppositories (ea.) |  | 0.15 |  | ///////////////////////////////// | |  | | |  | |  |
| Foams |  | 3.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Diaphrams |  | 4.00 |  | ///////////////////////////////// | |  | | |  | |  |
| IUD's |  | 50.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Basal T&C |  | 10.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Sponges (ea.) |  | 1.50 |  | ///////////////////////////////// | |  | | |  | |  |
| Condoms (ea.) |  | 0.22 |  | ///////////////////////////////// | |  | | |  | |  |
| Meds/Vag.Inf. |  | 5.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Meds/STD |  | 5.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Contracep Film |  | 2.00 |  | ///////////////////////////////// | |  | | |  | |  |
| TOTAL | ///////////////// | ///////// |  |  | | ///////////////////////////////// | | | ////////////////// | | /////// |
| Ed./Couns. Cost Ctr.  1 hr. Indepth |  | 30.00 |  | ///////////////////////////////// | |  | | |  | |  |
| Couns./15min.-1hr. |  | 5.50 |  | ///////////////////////////////// | |  | | |  | |  |
| TOTAL | ///////////////// | ///////// |  |  | | ///////////////////////////////// | | | ////////////////// | | /////// |
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|  |  |  | -5- | 3/89 | |  | | |  | |  |
|  |  |  |  | Date Cost Analysis Completed | | |  | | |  | |
|  |  |  |  | BCRR DATA FROM CY 1989 | | | | | | | |

ATTACH SCHEDULE OF DISCOUNTS AND SLIDING FEE SCALE

WITH CHARGES UTILIZED BY YOUR AGENCY

BASED UPON 1990 REVISED POVERTY GUIDELINES

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Agency Name | | | |  | | |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT (cont’d.) DATE FROM: THROUGH | | | | | | |
| 15. OBJECTIVES | | | | | | |
| INSTRUCTIONS: Complete the objectives below by inserting the numbers that are  appropriate for your agency. Agencies must complete objectives #1 and  #2 by inserting the numbers that are appropriate for their agency. #3  **must be an individual agency objective**. Also complete the attached  Plans to Achieve Objectives/Program Progress Report forms using these  numbers and listing the tasks necessary to meet the objectives. | | | | | | |
| 1. Provide family planning services to \_\_\_\_\_\_\_\_\_\_\_\_\_unduplicated users in need of subsidized | | | | | | |
| # | |
| family planning services during State Fiscal Year 1991. At least 85% of users will be | | | | | | |
|  | | | | | | |
| in the group with income equal to or less than 150% of poverty; \_\_\_\_\_\_\_\_% of all users will | | | | | | |
| # | | |
| be teenagers. | | | | | | |
|  | | | | | | |
|  | | | | | | |
| 2. Provide\_\_\_\_\_\_\_\_ information and education programs for an estimated\_\_\_\_\_\_\_\_\_\_ individuals | | | | | | |
| # |  | | | | | # |
| in communities served during State Fiscal Year 19\_\_\_. | | | | | | |
|  | | | | | | |
| 3. **Individual Agency Objective** | | | | | | |
|  | | | | | | |
| USE ADDITIONAL SHEETS IF NECESSARY | | | | | 3/89 | |

FAMILY PLANNING SERVICES

PLANS TO ACHIEVE OBJECTIVES

PROGRAM PROGRESS REPORT

Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Period July 1, 1990 – June 30, 1991

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| Objective | | #1 Provide family planning services users in need of subsidized family planning services | | | | | | | | | | | | | | |
|  | | during State Fiscal Year 1991. At least 85% of users will be in the group with income equal to | | | | | | | | | | | | | | |
|  | | or less than 150% of poverty: % of all users will be teenagers. | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | |
| S C H E D U L E | | | | | | | | | | | | | | | | |
| Tasks to Meet Objective | | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | Status of Task |
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FAMILY PLANNING SERVICES

PLANS TO ACHIEVE OBJECTIVES

PROGRAM PROGRESS REPORT

Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Period July 1, 1990 – June 30, 1991

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Objective | | #2 Provide Information and education programs for an estimated individuals in | | | | | | | | | | | | | | |
|  | | communities served during State Fiscal Year 1991. | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | |
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| S C H E D U L E | | | | | | | | | | | | | | | |
| Tasks to Meet Objective | | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | Status of Task |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |  | |
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FAMILY PLANNING SERVICES

PLANS TO ACHIEVE OBJECTIVES

PROGRAM PROGRESS REPORT

Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Period July 1, 1990 – June 30, 1991

|  |  |
| --- | --- |
| Objective | #3 |
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| S C H E D U L E | | | | | | | | | | | | | | | |
| Tasks to Meet Objective | | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | Status of Task | |
|  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Illinois Department of Public Health | | | | | Attachment A | |
|  | | | | | | | |
| ILLINOIS FAMILY PLANNING RATE SCHEDULE | | | | | | | |
| Effective July 1, 1990 | | | | | | | |
|  | | | | | | | |
| SERVICE | | | RATE | SERVICE | | | RATE |
|  | | |  |  | | |  |
| BILLABLE MEDICAL SERVICES | | | | CONTRACEPTIVE DRUGS & SUPPLIES | | | |
|  | |  | |  |  | | |
| Minimal Service Exam | | 5.50 | | Oral Contraceptives | 1.50/cycle | | |
| Brief/Intermediate Exam | | 12.65 | | Creams | 2.00/tube | | |
| Extended Exam | | 26.65 | | Jellies | 1.30/tube | | |
| (Includes $3.50 for provision | |  | | Suppositories | .25 each | | |
| of basic AIDS education) | |  | | Foams | 2.00/can | | |
| Intrauterine Device Insertion | | 35.30 | | Diaphragms | 4.50 each | | |
| Diaphragm Fit | | 23.15 | | Intrauterine Device | 84.00 each | | |
| Cervical Cap Fit | | 23.15 | | Basal Thermometer & Charts | 15.00 | | |
|  | |  | | Sponges | .50 each | | |
|  | |  | | Condoms | .15 each | | |
|  | |  | | Vag/STD Rx | 5.00/medication | | |
|  | |  | | Contraceptive Film | 2.00/pkg. | | |
|  | |  | | Cervical Cap | 29.95 each | | |
|  | |  | |  |  | | |
| LABORATORY PROCEDURES | | | | STERILIZATION | | | |
|  | |  | |  |  | | |
| Hematocrit | | 3.30 | | Pre-Counseling | 30.00 | | |
| Hemoglobin | | 3.30 | | Female Sterilization |  | | |
| Urinalysis/Dipstick | | 3.30 | | (Reimbursement only with prior |  | | |
| Pregnancy Test | | 8.90 | | approval from IDPH) |  | | |
| Papanicolaou Smear | | 8.63 | | Male Sterilization |  | | |
| Wet Mount/Gram Stain | | 4.40 | | (Reimbursement only with prior |  | | |
| Miscellaneous Culture | | 5.75 | | approval from IDPH) |  | | |
| Sickle Cell Screening | | 5.75 | |  |  | | |
| Post-prandial Blood Glucose | | 5.75 | |  |  | | |
| Cholesterol Level | | 6.80 | |  |  | | |
| SMA-12 Fasting Level | | 16.45 | |  |  | | |
| Colposcopy | | 29.75 | |  |  | | |
| Colposcopy with Biopsy | | 39.90 | |  |  | | |
| Chlamydia Test | | 6.50 | |  |  | | |
|  | |  | |  |  | | |
| COMPLICATIONS | | | | BILLABLE COUNSELING | | | |
|  | |  | |  |  | | |
| X-rays/Lost IUD | | 36.40 | | Indepth/1 Hr. | 30.00 | | |
| Sonography/Lost IUD | | 60.65 | | Education/Counseling | 5.50 | | |
|  | |  | | (15 min – 1 hr.) |  | | |
|  | |  | |  |  | | |

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|  | Poverty Level |  | Reimbursement |
|  |  |  |  |
|  | 0 - 100% |  | Full rate + 25% |
|  | 101 - 150% |  | 85% of full rate + 15% |
|  | 151 - 200% |  | One-third of full rate + 15% |
|  | 201 - 250% |  | 15% only based on one-third rate |
|  | Medicaid |  | 25% of full rate |
|  | 251 - Above |  | No reimbursement |
|  |  |  |  |
| 3947f |  |  |  |
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Illinois Department of Public Health

Family Planning Service Definitions

Billable Medical Services

Reimbursement will be provided for the services and procedures in this section when prescribed, furnished, directed or supervised by a physician. These services are exclusive of laboratory procedures; treatment of complications; billable counseling; and provision of contraceptive drugs, supplies and devices.

1. Family Planning Minimal (Service) Examination – Examination accompanying routine medical revisits to an established client. May include IUD check, diaphragm placement check, visualization of vagina and cervix, possible palpation, weight and blood pressure.

2. Family Planning Brief/Intermediate Examination – Usual examination accompanying problem medical revisits which require a physical examination. Services vary and may include pregnancy diagnosis, vaginal infection, PID, possible IUD complications, follow up on a breast lump or suspicious PAP.

3. Family Planning Extended Examinations – Family planning examinations usually accompanying an initial and annual visit. Examination includes a complete physical including recto-vaginal examination, breast examination, weight and blood pressure.

4. Insertion of IUD – Placement into the uterus (by either the push or withdrawal technique) of an FDA approved contraceptive device following the sounding of the uterus.

5. Diaphragm Fitting – Selection of appropriate size diaphragm based on depth of the vagina and perineal muscle tone.

Laboratory Procedures – The following routine and special laboratory services are reimbursable in connection with the physical examination and evaluation or if needed as a result of positive history or if deemed medically necessary at the time of examination by the attending physician or medical director in charge.

1. Hematocrit/Hemoglobin
2. Urinalysis/Dipstick
3. Pregnancy Test
4. Papanicolaou Smear
5. Wet Mount/Gram Stain – (e.g., Trichomoniasis, Candidiasis, Gardnerella)
6. Miscellaneous Culture – (e.g. Herpes, Urine)
7. Sickle Cell Screening
8. Post-Prandial Blood Glucose
9. Triglycerides Fasting Level Confirmation Test
10. SMA-12
11. Colposcopy – Examination of vagina and cervix by means of the colposcope.
12. Colposcopy with Biopsy – Examination of vagina and cervix by means of the colposcope with removal and examination of tissue.
13. Chlamydia Test – Direct smear FA and enzyme immunoassay (ELISA)

Complications – Occasionally, complications may develop. Such services related to complications will be limited to the following.

1. Sonography/Lost IUD – A record or display obtained by ultrasonic scanning for purpose of locating IUD.

2. X-Ray & Interpretation – Up to two x-rays for the purpose of determining location of IUD.

Billable Counseling

1. Indepth/1 Hr. Counseling – Counseling designed to assist the individual client in understanding and successfully dealing with an identified problem. Such counseling may be related to the emotional aspects of a medical problem or may involve health education. This service should be completed by professional staff such as the public health nurse, health educator or social worker. Such counseling may require only one session or may involve multiple sessions to insure that the client has developed sufficient insight to deal with the related issues. This is not to be understood as a patient education session associated with a medical visit. The time expectation for delivery of this service is approximately 1 hour.

2. Education/counseling (15 minute to 1 hour) – Education or counseling services related to the effective utilization of a family planning method and documented in the patient file. Time expectation for delivery of this service is approximately 15 minutes.

Contraceptive Supplies and Drugs – Reimbursement will be made for the following:

1. Oral Contraceptives
2. Creams
3. Jellies
4. Suppositories
5. Foams
6. Diaphragms
7. IUDs
8. Basal Thermometer & Charts
9. Sponges
10. Condoms
11. Vag/STD Rx
12. Contraceptive Film

Sterilization – The following will be provided under the family planning program if sterilization is medically indicated and IDPH gives prior approval.

1. Pre-Counseling
2. Female Sterilization
3. Male Sterilization
4. Anesthesia
5. Pathology

(Source: Added at 14 Ill. Reg. 20783, effective January 1, 1991)