

The Ohio Commission on Minority Health
Healthy U Quarterly Program/Fiscal Report

Q1	Q2	Q3	Q4
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FINAL

Agency name:	Grant #MGS12/_____MGS13/_____
I. Total number new consumers/participants served this period: _____	II. Total number of consumer workshops conducted this quarter: _____
III. Total number of persons returning this quarter: _____	IV. Total number of consumer/participants workshop conducted year-to-date: _____

SECTION I: Demographics (Note: Only record the number of NEW persons served this quarter)

A. Report number of new unduplicated participants/consumers who received DSMP/CDSMP workshops through this project below:

Age in Years	<30	30-39	40-49	50-59	60-69	70>	Total
SEX	F						
	M						

B. Number of active Healthy U Lay Leaders and Master Trainers provided the consumer workshops this Quarter

Age in Years	<30	30-39	40-49	50-59	60-69	70>	Total
SEX	F						
	M						

Report new number Persons served this Quarter only:

II. Race and Ethnic Background			
Ethnicity Data Standard (One or more categories may be selected)	Participants	Lay Leaders	Master Trainers
African American/Black			
American Indian or Alaska Native			
Asian American Pacific Islander (AAPI)			
Asian Indian			
Chinese			
Cambodian			
Filipino			
Guamanian or Chamorro			
Japanese			
Korean			
Lao people/Hmong			
Native Hawaiian			
Samoan			
Vietnamese			
Other Asian American Pacific Islander			
Hispanic/Latino			
Mexican American			
Puerto Rican			
Cuban			
Another Hispanic, Latino, or Spanish Origin			
White/Caucasian			

III. Last Interaction with health care system:

Summary of last interaction with health care system	Service most often used
Less than 3 months	Emergency Room
3-6 months	Family physician
6 months – 1 year	Health Centers/Urgent Care/Clinic
1 year or more	Traditional Healer

Section IV: Program Summary:

Instructions: State the original project goals/objectives provide specific details on a total number of participants projected to be served on your goal statement. Please report your activities conducted during the period and include the outcomes in whole number below:	
Goal 1:	Outcome:
Objective 1:	
Objective 2:	

Section IV: Program Summary (continued):	
Goal 2:	Outcome:
Objective 1:	
Objective 2:	
Objective 3:	
Goal 3:	
Objective 1:	
Objective 2:	
Objective 3:	
Goal 4:	
Objective 1:	
Objective 2:	
Barrier	Resolution

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

Signature of Executive Director

Date _____

Signature of Project Director

Date _____

Instructions for Completion of Grant Expenditure Report

NOTE: All expenditures must be supported by copies of receipts and/or legible, legal invoices. 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.

Grant Number: The number assigned on your Notice of Award.

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

Contact Person: Use the name of the person who has day-to-day responsibility for the Healthy U Training.

Phone: Applicant should give the phone number of the contact person(s) who has day-to-day responsibility for the Healthy U Training.

Federal Tax ID#: This number is issued by the IRS. It appears on agency's 501 (C)(3) or sometimes as the Entity Identification Number (EIN).

Personnel:

Column A: Identify Project Director/Coordinator whose **salary** will be paid for by the Commission.

Column B: Identify the amount listed in the APPROVED BUDGET under Column B.

Column C: Enter the **expended amount** to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column B of the approved

Supplies, Contract & Other:

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 A.

Column B: 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 C: Enter the amount that will be charged to the Commission. The amount identified cannot exceed the approved amount for the supplies Contract & Other category.

Food/Refreshments: Consistent with the Governor's Executive Order 2007-09S, "refreshments" are not reimbursable under this grant. (See Commission website at www.mih.ohio.gov.)

Total Commission Add up the dollar amounts in Column B and Column C. The amount in Column B should not exceed the approved budget. The amount in Column C is the amount you wish to be reimbursed by the Commission. The total amount cannot exceed the amount stated in the Notice of Award and 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.