|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Deliverable 1** | | | | | | | | | | | | |
| **1.1:** By March 31, 2024, 100% of clients will have received comprehensive reproductive health and wellness direct health care services per nationally recognized standards of care. | | | | | | | | | | | | |
| **1.2:** By March 31, 2024, 100% of subrecipients will conduct a systematic and coordinated approach in quality improvement to enhance outcomes for patients. | | | | | | | | | | | | |
| **Total Amount Requested this Billing Period for Deliverable 1:** | | | | | | | | | | | | |
|  | | | **Number of client visits this reporting period** | | **Number of special populations/faith based visits** | | | **Number of clients served outside of childbearing status this period** | | | **Amount requested** | | |
| County Name | | |  | |  | | |  | | |  | | |
| County Name | | |  | |  | | |  | | |  | | |
| County Name | | |  | |  | | |  | | |  | | |
| County Name | | |  | |  | | |  | | |  | | |
|  | | | | | | | | | | | | |
|  | | | **Quality Improvement Plan Part 1**  *Attach RHWP QI plan template in GMIS in the expense report section* ***DUE 7/10/23*** | | | | | | **Quality Improvement Plan Part 2**  *Attach RHWP QI plan template in GMIS in the expense report section* ***DUE 10/10/23*** | | | |
| County Name | | | Yes  No | | | | | | Yes  No | | | |
| County Name | | | Yes  No | | | | | | Yes  No | | | |
| County Name | | | Yes  No | | | | | | Yes  No | | | |
| County Name | | | Yes  No | | | | | | Yes  No | | | |
|  | | | | | | | | | | | | |
| **Deliverable 2** | | | | | | | | | | | | |
| **2.1:** By March 31, 2024, 100% of subrecipients will have implemented and maintain appropriate financial and billing procedures. | | | | | | | | | | | | |
| **2.2** By March 31, 2022, 100% of subrecipients will have implemented and utilize an electronic medical record (EMR) system. | | | | | | | | | | | | |
| **2.3** By March 31, 2022, 100% of subrecipients will serve hard to reach and vulnerable populations utilizing various clinical service delivery modalities to increase access and remove barriers to care. | | | | | | | | | | | | |
| **Total Amount Requested this Billing Period for Deliverable 2:** | | | | | | | | | | | | |
|  | | **Agency has billed for 100% of clients with 3rd party coverage who are not seeking confidential services** | | ***Number of Telehealth Visits this reporting period*** | | | ***Number of clients who were assisted with enrollment to Medicaid***  ***/Insurance*** | | | **Amount Requested** | | |
| County Name | | Yes  No | |  | | |  | | |  | | |
| County Name | | Yes  No | |  | | |  | | |  | | |
| County Name | | Yes  No | |  | | |  | | |  | | |
| County Name | | Yes  No | |  | | |  | | |  | | |
|  | **Number of outreach events**  *Attach Outreach Reporting form in GMIS in the Expenditure report section.* | | | | | **Incentives Purchased**(dollar amount)  *If incentives are purchased, must maintain incentive tracking log* | | | | | |
| County Name |  | | | | |  | | | | | |
| County Name |  | | | | |  | | | | | |
| County Name |  | | | | |  | | | | | |
| County Name |  | | | | |  | | | | | |