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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Deliverable 1** | | | | | | | | | |
| 1.1: By March 31, 2026, 100% of clients will have received comprehensive reproductive health and wellness direct healthcare services per nationally recognized standards of care. | | | | | | | | | |
| 1.2: By March 31, 2026, 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 client visits served outside of childbearing status this period** | | | | **Amount requested** | |
| *County Name* | |  | |  | | | |  | |
| *County Name* | |  | |  | | | |  | |
| *County Name* | |  | |  | | | |  | |
| *County Name* | |  | |  | | | |  | |
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| **Deliverable 2** | | | | | | | | | |
| 2.1: By March 31, 2026, 100% of subrecipients will have implemented and maintain appropriate financial and billing procedures. | | | | | | | | | |
| 2.2 By March 31, 2026, 100% of subrecipients will continue to utilize an electronic medical record (EMR) system. ***Implemented EMR system***: *Choose an item.* Click to enter date implemented. | | | | | | | | | |
| 2.3 By March 31, 2026, 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 visits where clients were assisted with enrollment to Medicaid***  ***/Insurance this period*** | | **Amount Requested** | | |
| *County Name* | Yes  No | |  | |  | |  | | |
| *County Name* | Yes  No | |  | |  | |  | | |
| *County Name* | Yes  No | |  | |  | |  | | |
| *County Name* | Yes  No | |  | |  | |  | | |
|  | **Number of outreach events this period**  *Attach Outreach Reporting form in GMIS in the Expenditure report section.* | | | | | **Incentives Purchased this period** (dollar amount)  *If incentives are purchased, must maintain incentive tracking log* | | |
| *County Name* |  | | | | |  | | |
| *County Name* |  | | | | |  | | |
| *County Name* |  | | | | |  | | |
| *County Name* |  | | | | |  | | |

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| Deliverable 3 | | | | | | |
| **3.1:** By Monday, March 31, 2026, 100% of subrecipients will provide preconception health clinical services and promote awareness of preconception health in the community. | | | | | | |
| **Total Amount Requested this Billing Period for Deliverable 3:** | | | | | | |
|  | | **Number of visits with POSITIVE pregnancy tests this period.** | **Number of visits with POSITIVE pregnancy tests that were offered STI testing.** | **Number of visits with POSITIVE pregnancy test that REFUSED STI testing.** | **Number of visits with preconception health screening tool used this period.** | **Number of preconception health referrals to primary care or specialist for chronic disease management this period.** |
| County Name | |  |  |  |  |  |
| County Name | |  |  |  |  |  |
| County Name | |  |  |  |  |  |
| County Name | |  |  |  |  |  |
|  | **Number of community preconception health education sessions this period**  **using provided teaching curriculum and pre/posttest.**  **(Must complete at least one of these between 4/1/25-3/31/26.)** | | | **Number of preconception health community screening events this period. (Must complete at least one of these between 4/1/25-3/31/26.)** | | |
| *County Name* |  | | |  | | |
| *County Name* |  | | |  | | |
| *County Name* |  | | |  | | |
| *County Name* |  | | |  | | |
|  | | | | | | |
|  | | | | | | |
| **Other reimbursable preconception health purchases/activities this period** | | | | | | | | |
| |  |  | | --- | --- | | Choose an item. |  | | Choose an item. |  |  |  |  | | --- | --- | | Choose an item. |  | | Choose an item. |  | | | | | | | | | |
| *Additional purchases for reimbursement (please list)* | | | | | | | | |
|  | | | | | | | | |