Program Overview

Completed by shoban@hpclinic.org on 6/9/2022 11:53 AM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

Program Overview

Please provide the following information.

McHenry County American Rescue Plan Project Submission Form

Advance McHenry County is dedicated to the responsible administration of American Rescue Plan funds, investing in resilient public services and supporting community-driven projects to deliver inclusive, innovative, long-term benefits across the County as it recovers and transforms from the pandemic.

Advance McHenry County has announced several categories for community project proposals that will be awarded American Rescue Plan Act (ARPA) funding. Applications are open to agencies throughout the County, including community-based organizations, small businesses, non-profits, local governments, and similar entities.

Selected projects must align to a single Expenditure Category established by ARPA and will require ongoing reporting and compliance efforts. Applications will be evaluated across a range of factors, informed by federal reporting requirements and County priorities. These criteria include:

- Impact vs. effort
- Proposed project budget
- Project fiscal sustainability
- Project risks and uncertainties
- Leveraged funds (e.g., matching grants and collaboration)
- Structure for performance tracking
- Equity considerations
- Evidence-based practices
- Availability of other funding sources (e.g., eligibility for non-ARPA grants)

Successful applications should detail well thought-out project proposals that take full advantage of opportunities for communal collaboration, demonstrate clear need related to ARPA's eligible spending categories, document substantial benefits and evaluation metrics, and are accessible and inclusive for McHenry County residents.

Please note that this application is designed for streamlined review and evaluation of project proposals by McHenry County. Applicants that are selected to move forward for funding will have additional documentation requirements that will be communicated after initial submissions and based on the specific needs of their project(s).

Applications are open indefinitely and will be reviewed on a rolling basis. There is limited funding available. Any questions, requests for technical or language assistance, or other feedback can be made via email with the McHenry County American Rescue Plan project team at ARP@mchenrycountyil.gov.

A. General Information

Completed by shoban@hpclinic.org on 6/9/2022 11:55 AM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

A. General Information

Please provide the following information.

CONTACT INFORMATION

A.1. First Name
Suzanne

A.2. Last Name
Hoban

A.3. E-mail Address
shoban@hpclinic.org

A.4. Phone Number:
(779) 220-9315

A.5. Entity/Organization/County Department
Family Health Partnership Clinic

A.6. Entity/Organization/County Department Address
401 E. Congress Parkway Crystal Lake, IL 60014

PROJECT INFORMATION

A.7. Project Title
Health Connect - Social Determinants of Health

A.8. Funding Request
$256,332.00

A.9. Submission Date
06/10/2022

A.10. Estimated Start Date
08/01/2022

A.11. Estimated End Date
07/31/2025

A.12. Applicant Type
Non-profit

B. Relation to ARPA Funding Uses

Completed by shoban@hpclinic.org on 6/9/2022 12:48 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

B. Relation to ARPA Funding Uses

Please provide the following information.

Below is a list of the eligible project categories that McHenry County can spend ARPA funds on. Every project must align to a *single Expenditure Category*. If multiple categories apply, please select the most relevant.

B.1. Please select the expense category for eligible expenditures for your request.

Public Health

Negative Economic Impacts
Social Determinants of Health: Community Health Workers or Benefits Navigators *^

Public Health-Negative Economic Impact: Public Sector Capacity

Premium Pay

Infrastructure

Revenue Replacement

Administrative

*If you selected an Expenditure Category with a * or ^ beside it, additional information will be required in sections F and G.*

PROJECT DESCRIPTION
B.2. Please provide a description of this proposed project, including the needs that it addresses.
The HealthConnect Project addresses access to health care, and specifically, the other factors that influence health care for the estimated 21,851 McHenry County residents who are without health insurance. It utilizes a validated screening tool to proactively screen low income and uninsured patients for additional needs, and connects them to resources needed. This will directly impact their health.

The target population is the low-income, medically underserved and uninsured patients of the Family Health Partnership Clinic. Virtually all patients are low income, and many have significant social needs that can fall outside the traditional

clinical services. In the latest Northwestern Medicine Community Needs Assessment, 7.3% (22,339) of McHenry County residents lived in poverty. Over twelve percent of adults said their health was fair or poor. More alarmingly, a full 19.1% (58,637) of adults indicated they had delayed medical care because of cost. This compares very unfavorably with Illinois rates (11.6%) and US rates (13%).

Research validates the connection between unmet basic resource needs (housing, food, transportation) and health outcomes for patients. Several groups including the Institute of Medicine and CMS (Centers for Medicaid and Medicare Services) have identified that lack of access to resources has a significant impact not only on an individual's health, but contributes to health inequity throughout the system. The Institute for Healthcare Improvement has done extensive research on health inequity, and has developed ideas and systems that can improve it. Part of this improvement includes screening for social needs directly at the clinical location as well as having the processes in place to connect with resources once a need is identified.

Family Health Partnership Clinic has long recognized this connection, and has implemented strategies to address this problem. Six members of the clinic staff were part of a national learning cohort led by HealthLeads – a nationally recognized health innovator of social needs and healthcare integration – to develop a screening tool and process to be utilized throughout the clinic.

Northwestern Medicine (the primary hospital system in the county) conducted its Community Health Assessment and found that 10.6% of county residents either sometimes or often did not have enough food and not enough money to purchase more. When looking at housing, 10.8% did not have enough money for rent, mortgage or their utility bills at some point in the last year, and 22% found that finding affordable housing was a challenge for them.

In 2019, the clinic implemented a universal screening for patients, but the program had to downsize in 2020 due to limited program funding, and the beginning of the COVID pandemic, and is currently only able to screen patients and provide resources proactively ½ day/week in the waiting room.

When patients present for an appointment, the bilingual Community Health Worker will screen them in the waiting room using the eight question tool. The Community Health Worker will discuss any needs identified on the screening tool, and will provide the patient with immediate resources when possible. For more extensive issues, the Community Health Worker (CHW) may set up an additional phone call or appointment to connect them to services they need.

The CHW will document the needs in the electronic medical record, and will follow up with the patient within two weeks to determine whether the referral was successful or whether the patient had additional needs.

FHPC will screen at least 350 individuals over the course of the year, and connect them with available resources. Information and documentation will be stored in the electronic medical record so that care can be coordinated.

B.3. What are the goals, and outcomes of the proposed project? ***For example, what is the quantified risk reduction or the number of people who will benefit relative to dollars spent?***

The goal of this program is to improve the quality of life for uninsured low income McHenry County residents, reduce emergency room visits for non emergency conditions, and decrease healthcare costs. A study conducted by the University of South Florida College of Public Health found that there was an average of 10% reduction in healthcare costs – an average of $2400/person – when social needs of patients were addressed. (Healthcare Finance, May 2018)

Outcomes will be measured using both process data and outcomes data. Process data includes the number of patients screened and the percentage of referrals considered successful (ie, patients accessed them) These services include

transportation, access to food, connection with financial resources, etc.

Outcomes data includes health measures such as A1c or blood pressure. Patients whose basic needs have been identified and met will have better health outcomes as defined by lowering of A1cs in patients with diabetes, lowering of blood pressure in patients with hypertension, and a longer lifespan. Patients who have chronic illnesses such as diabetes and high blood pressure will have their lab values tracked to monitor progress towards having their conditions under control. Of those patients participating in the program, we expect to see a 10% increase of patients who are considered under control in diabetes and in hypertension.

By the end of the first year, the program will serve 350 patients. Each year, an additional 350 people will be served. Some may be duplicates, but it is expected that by the end of 3 years, over 1000 individuals will be served directly, and 3000 indirectly (families of patients).

B.4. Who are the stakeholders involved in this project? ***For example, who will be affected by this project? What, if any, other organizations are involved?***

The primary beneficiaries of the program will be the uninsured patients of FHPC and their families. By screening and addressing social determinants, FHPC will be able to reduce barriers that can destabilize families and improve health outcomes. Improving health outcomes provides a significant economic impact in the community by reducing unnecessary emergency room visits, reducing unreimbursed care to the health systems, and by keeping people healthy and productive.

There will be many other organizations in this project because of the need to refer people to the necessary resources. These will include, but are not limited to, the Housing Authority, Youth and Family Center, Pioneer Center, Consumer Credit Counseling Service and the various food pantries in the community.

FHPC has a strong history of partnering with other agencies. It has coordinated a homeless outreach clinic that served both the PADS Woodstock Drop in Center and the Old Firehouse Center until the new year round shelter was built at Pioneer Center. The clinic has done vaccine clinics at Pioneer Center, and still does a health outreach clinic at the PADS site one day a month.

Additionally, in 2021, FHPC was the lead agency on a six organization collaborative designed to reduce the impact of COVID on McHenry County residents. This effort – funded by the Illinois Public Health Association - trained and placed community health workers at 5 other organizations – Independence Health and Therapy, Youth and Family Center, McHenry County College, Live 4 Lali and Senior Care Volunteer Network. These community health workers –along with those at FHPC – helped provide rental assistance, food assistance, medical case management, medications and other services needed.

C. Budget and Finance

Completed by shoban@hpclinic.org on 6/9/2022 12:48 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

C. Budget and Finance

Please provide the following information.

C.1. Please fill out the attached ARPA Budget Template spreadsheet and use it to report the breakdown of your anticipated costs for this project in the following table.

Cost	2022	2023	2024	2025	2026
Personnel	$87,563.00	$94,794.00	$69,575.00	$0.00	$0.00
Contracts	$0.00	$0.00	$0.00	$0.00	$0.00
Commodities	$4,400.00	$3,200.00	$3,200.00	$0.00	$0.00
Capital	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$91,963.00	$97,994.00	$72,775.00	$0.00	$0.00

C.2. Please share any major budget uncertainties or unknowns that might impact this project.
There are no major uncertainties with this project. The Clinic has been running a scaled down version of this project for several years, and has a strong track record and understanding of how it can be scaled up.

C.3. Are there any project costs that would not be covered by ARPA? What, if any, other funding sources will be leveraged?
The Clinic will be using funds from its own fundraising programs to help support the additional costs of the program.

The Clinic has a strong history of fundraising and community building. The Clinic does not rely on federal or state dollars and has developed a matrix of funding sources for its operation. This includes community fundraising, events, foundation and corporate support. Additionally, the Clinic does charge for its services, albeit on a sliding fee scale based on income and family size, though no one is turned away due to inability to pay.

Those components ensure that the funding risks are spread out, and solidify community buy-in to the services FHPC provides.

C.4. Describe any available funding alternatives for this project? *For example, are there other grants available to fund this project? Are there opportunities to leverage non-County ARPA funds?*
There are no current alternatives to funding this project, but foundations and funders are increasingly interested in social determinants of health as additional research shows that they do impact overall health as well as economic health.

Many larger hospitals systems are beginning to invest in this work, as well. University of Illinois Hospital system, along with Denver Health, has invested in housing for patients who continually over-utilize the emergency room. They have calculated that it is cheaper to provide housing, than to effectively 'house' people in their emergency rooms.

This is just an example of how larger health systems have understood the relationship between social determinants and health. Foundations and donors are beginning to embrace this shift, and in the future, more funding may become

available to focus specifically on this.

C.5. Are there any known alternatives for this project to accomplish the same project goals? If so, why is the most efficient and most economical way to meet the goals and objectives? *For example, are there more costs effective options to achieve the same goal?*
Addressing the social determinants of health is an exceptionally efficient and cost effective way to improve health as well as improve economic health. People who have stable housing, have food security and accessible transportation are less likely to miss work, and their children are less likely to miss school. Healthy People 2030 (the health goals set by the US Dept of Health and Human Services), has included Social Determinants of Health in their goals to be addressed to improve health.

C.6. Will there be ongoing project costs beyond ARPA? Is there a plan to sustain the project long-term after the ARPA funds are no longer available, if applicable? *Please answer in detail and share any supporting documentation (e.g., alternative revenue plan, service model continuum, potential additional partners, organizational strategy).*
The Clinic has a strong history of fundraising and community building. Though it relies primarily on grants for funding its programs, and despite the fact that the budget has grown from $250,000/year to over $1.7 million today, it has never had to lay off staff due to a grant expiration or budget cuts. This illustrates the fiscal responsibility of the Clinic's management team as well as its strong community support. It also illustrates its ability to find alternate funding when a grant ends.

By its very definition, work in the human service field with low income individuals will never generate enough income to 'sustain' itself, thus the need for supplemental fund development and grant funding. This is the reality of nonprofits who work with this population. The Clinic has a consistent and robust fund development process to replace sun-setting grant funding. This can come in the form of increased revenue from individual giving or event fundraising, as well as exploration for other grant funding that can support the program. Family Health Partnership Clinic has significant experience in replacing grant revenue.

The Development Coordinator uses tools such as Facebook, Twitter, an online newsletter and a print newsletter to foster donor loyalty and funding. It is expected that the additional charitable revenues will be able to be sustain the project.

The Clinic is not a 'free' clinic. More than 80% of the patients do pay a portion of their 'bill' – the average charge for a visit with labs and prescription is between $15-$25. Patients are expected to bring proof of income once a year.

This responsible financial position and transparency has earned FHPC a 4 star rating from Charity Navigator several years in a row. All of these things contribute to the sustainability of its programs and services.

D. Labor Practices

Completed by shoban@hpclinic.org on 6/9/2022 12:02 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

D. Labor Practices

Please provide the following information.

D.1. Is this an infrastructure project related to Expenditure Categories 5.1-5.17 listed in section A?
No

E. Community Engagement

Completed by shoban@hpclinic.org on 6/9/2022 12:49 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

E. Community Engagement

Please provide the following information.

E.1. Is this the result of a community request or a community-identified need?
Yes

Describe how the project will capture diverse feedback from constituents, community-based organizations, and the communities themselves. Include how this engagement will impact people who face significant barriers to service (e.g., English-limited, socioeconomic, and other underserved groups).
To capture patient feedback, patient satisfaction surveys are conducted twice a year, both in English and Spanish. In the last survey in December 2021, in every category from front office to interaction with the provider, 96% of the patients were satisfied or very satisfied. There are 2 questions which are free text allowing patients to provide feedback and suggestions in their own words. It also asks about where patients would go if the clinic were not here. This allows us to assess how many potential emergency room visits were averted.

In 2021, as part of the Improving Healthcare Institute Health Equity Project, the clinic designed and implemented a Patient Advisory Committee which helps guide the clinic in its mission, outreach and programming. This committee is currently made up of Latino patients, as 65% of the clinic's patients are Latino.

By asking patients about and addressing the Social Determinants of Health, the Clinic gets immediate feedback on barriers facing the patients and works to implement solutions, both short and long term.

Addressing other non medical barriers is one of the reasons that clinic patients have better health outcomes. FHPC conducts two quality assurance projects each year, and again this year, clinic patients with diabetes had better outcomes (as measured by their A1c) than patients who are privately insured (National Center on Quality Assurance – HEDIS data, 2019).

Similarly, FHPC patients with hypertension had better blood pressure control than patients with private insurance. These results are not unique this year – the clinic has been tracking this data for over 10 years and consistently outperforms patients with private insurance.

These clinical measures provide quantifiable feedback and evaluation of the program.

F. Equitable Outcomes

Completed by shoban@hpclinic.org on 6/9/2022 12:03 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

F. Equitable Outcomes

Please provide the following information.

McHenry County is required to report whether certain projects primarily serve disadvantaged communities. **Please review the Expenditure Category (EC) you selected in Section B. If the EC has a ^ symbol after it, you must fill out this section.** All applicants are encouraged to fill out this section.

F.1. Please describe any particular historically underserved, marginalized, or adversely affected groups that you intend to serve with this project.
The Family Health Partnership Clinic has a 26 year history of leading in the area of health equity. In 2019, the County had a base population of 310,000. That year, 13.9% of the population identified as Latino – a significant jump from 2000 when 7.5% identified as Latino. The majority of Latinos identify Mexico as their country of ancestry.

This burgeoning Latino population is also the county's most vulnerable. Both the McHenry County Department of Health and the McHenry County Mental Health Board have identified the Latino population as being the most at risk because of factors of poverty, isolation, and lack of available bilingual services.

The Clinic serves as a touchpoint for the Latino community. Since its inception, the Clinic has heavily recruited bilingual staff with the understanding that with increased language access, the more likely it is to reach previously unreachable populations. More than 60% of the clinic's patients are Latino, and the Clinic has a long history of providing culturally and linguistically competent care to its patients.

All forms, information and education are in English and Spanish. Interpreters go into the exam room with patients when needed, and two nurses are fully bilingual.

This long term commitment to the Latino community, along with other vulnerable and underserved populations puts FHPC in a unique position to continue to respond to those needs

F.2. Please explain how you are making residents or businesses aware of this project and its services.
This program is available to only uninsured individuals. The Clinic has done outreach to a variety of businesses and organizations including several small business campaigns designed to reach employees of small businesses who do not have insurance. These include sectors such as auto repair, small manufacturing and restaurants. Additionally, the clinic has deep connections to small businesses who are most likely to have uninsured workers.

The Clinic is also very active in a variety of non profit councils/committees including the Mental Health Board's Network Council, the Continuum of Care, the Advocate Good Shepherd Community Needs Task Force and the Substance Abuse Coalition. Through these connections and relationships, individuals can be referred into the program for services.

F.3. What differences are there in access to benefits and services across groups served by this project? Do any groups require supports to achieve equal opportunity to access services?

All uninsured patients would have access to this program, and would receive assistance for linkage, referrals, and warm hand offs. However, because different programs (like Public Aid or housing assistance) have different requirements and criteria to access them, not everyone would have the same access to all of the outside services. The Clinic understands the variety of criteria for different programs, and would make referrals to the most appropriate ones.

Because some of the individuals may not speak English, the Clinic can provide that interpreting support when needed.

F.4. Describe any project outcomes focused on closing gaps, reaching universal levels of service, or disaggregating progress by race, ethnicity, or other (related) equity dimensions.
The entire program is focused on closing gaps in obtaining services and reducing barriers to health for those who are uninsured and low income. Because Family Health Partnership Clinic has a strong background in culturally and linguistically appropriate services, and has been a leader in health equity across income and racial divides, this program is simply an expansion and outgrowth of that work.

The Clinic has always been able to provide data and information related to measuring progress by a variety of metrics through its electronic medical record. This activity was a major component of the clinic's work with the Institute for Health Improvement's "Pursuing Health Equity" project.

F.5. Service Region: Where will the services or benefits of this project's intervention be located? If at multiple sites, please indicate all locations.
401 E. Congress Parkway Crystal Lake, IL 60014

Address 2:

Address 3

F.6. Please indicate the zip code(s) where your project will take place.

- ☐ **60001**
- ☐ **60012**
- ☐ **60013**
- ☑ **60014**
- ☐ **60021**
- ☐ **60033**
- ☐ **60034**
- ☐ **60039**
- ☐ **60050**
- ☐ **60051**

☐ 60071

☐ 60072

☐ 60080

☐ 60081

☐ 60097

☐ 60098

☐ 60102

☐ 60142

☐ 60152

☐ 60156

☐ 60180

Other

F.7. Does your project primarily (+50%) serve disadvantaged communities?

☐ Yes, the project/service (or majority of sites) is located in a Qualified Census Tract.

☐ Yes, a majority of the project/service's intended beneficiaries lived in a Qualified Census Tract.

☑ Yes, primary intended beneficiaries earn under 60% median income in McHenry County.

☑ Yes, over 25% of the intended beneficiaries fall below the federal poverty line.

☐ No, it does not.

G. Evidence-based Practices

Completed by shoban@hpclinic.org on 6/9/2022 12:25 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

G. Evidence-based Practices

Please provide the following information.

McHenry County is required to report regularly on the status of certain ARPA-funded programs. **Please review the Expenditure Category (EC) you selected in Section B. If the EC has a * symbol after it, you must fill out this section.** All applicants are encouraged to fill out this section.

All subrecipients whose project(s) fall under these Expenditure Categories must report quarterly on the information described in this section.

Unclear or insufficient performance metrics may require follow up revision in the application period before projects can be approved.

G.1. Is this project intervention supported by a base of formal, peer-reviewed evidence, or is it undergoing project evaluation to gauge its effectiveness?
Yes

Please Explain
According to the Annals of Internal Medicine (April 2018), “Social determinants of health, which are defined as “the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life”, are responsible for most health inequalities. Evidence gathered over the past 30 years supports the substantial effect of nonmedical factors on overall physical and mental health. An analysis of studies measuring adult deaths attributable to social factors found that, in 2000, approximately 245,000 deaths were attributable to low education, 176,000 were due to racial segregation, 162,000 were due to low social support, 133,000 were due to individual-level poverty, and 119,000 were due to income inequality. The number of annual deaths attributable to low social support was similar to the number from lung cancer (n = 155 521).”

The American Academy of Family Physicians has committed significant resources towards helping physicians understand social determinants of health and how to incorporate screening for them into clinical practices. They have developed an entire toolkit (The Everyone Project - https://www.aafp.org/family-physician/patient-care/the-everyone-project.html) to help physicians incorporate this screening in to every patient they see to help reduce health disparities and health inequities. Their screening tool is very similar to the one that FHPC developed.

G.2. What measurable benefits or outcomes can reasonably be expected if this request is funded?
By implementing this program, patients could demonstrate better health outcomes compared with a national benchmark supplied by the National Committee for Quality Assurance (NCQA). Additionally, reducing unnecessary emergency room use can be extrapolated from the Patient Satisfaction Surveys which ask questions on this. This saves important healthcare dollars.

G.3. Please fill out the table below to illustrate likely changes expected as a result of award of ARPA funding.

Performance Measure	Current Output/Outcome	Expected Output/Outcome
Hemoglobin A1c Level Among Pts with diabetes	57% under control	60% under control
Blood Pressure Among pts with Hypertension	71% under control	75% under control
Successful Referrals for Additional Services	No data currently	More than 65% of referrals will be successful
Access to fresh food/produce	3000 pounds distributed in 2021	More than 3000 pounds distributed each year
Access to medication	$2,000,000 worth of medication dispensed for free in 2021	More than $2,000,000 worth of medication dispensed each year
Number of Patients Screened for SDOH	45 per year	350 or more each year of the project

G.4. What specifically will be the data that will be reported in the County's ARPA database on a quarterly basis for this project?

Data would be reported in both outcome and process measures. Each of the above performance measures can be tracked and reported quarterly.

Outcome measures would look at a few specific health metrics such as hemoglobin A1c levels or blood pressure in participants compared to national data.

Process measures would be the number of individuals served, as well as number of successful referrals and connections to services made. This are easily tracked in the clinic's electronic medical record program.

H. Project Administration

Completed by shoban@hpclinic.org on 6/9/2022 12:26 PM

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

H. Project Administration

Please provide the following information.

H.1. If you are a non-County applicant, please describe any experience that your agency has managing federal grant funds in the past.
N/A

H.2. Does your organization have written policies and/or procedures with internal controls identified? *Approved applicants may be required to provide such documentation, depending on the nature of their project(s).*
Yes

H.3. Identify the contact information for the person or persons responsible for planning, implementation, follow-up, and reporting.

First Name
Suzanne

Last Name
Hoban

E-Mail
shoban@hpclinic.org

H.4. Identify the contact information for the person who will be responsible for record keeping.

First Name
Suzanne

Last Name
Hoban

E-Mail
shoban@hpclinic.org

H.5. Identify the contact information for the person who will be responsible for financial management.

First Name
Carrie

Last Name

Holtz

E-Mail
choltz@hpclinic.org

There are limits on the use of other Federal fund sources when used in conjunction with ARPA funds to sustain new projects.

H.6. Has or will this expense be submitted for reimbursement through another federal or state relief program?
No

H.7. Is this expense eligible for reimbursement through another federal or state relief program, such as FEMA Public Assistance?
No

H.8. Will ARPA funds supplant or lead to reductions of existing project revenues or budgets?
No

Submit

Completed by shoban@hpclinic.org on 6/9/2022 12:50 PM

Case Id: 10645
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Address: 401 E. Congress Parkway

Once an application is submitted, it can only be "Re-opened" by an Administrator.

☑ **I certify that the information contained herein is true and correct to the best of my knowledge.**

Signature
Suzanne Hoban
Electronically signed by shoban@hpclinic.org on 3/31/2022 3:11 PM

Checklist

No data saved

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

Checklist

Please review and confirm the following items.

Application Review	Date Completed	Notes
Threshold Review Complete		
Threshold Approval Email Sent		
Status Updated		

Approved Applications	Date Completed	Notes
Environmental Review Completed		
Agreement Full Executed		
Purchase Order Received		

Monitoring	Date Completed	Notes
Risk Assessment Completed		
Monitoring Completed		
Monitoring Follow-up (if applicable)		

Threshold Review

No data saved

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Threshold Review

Please provide the following information.

PLEASE VERIFY EACH TIME LISTED BELOW TO ENSURE THE INFORMATION SUBMITTED FOR THE CDBG RFA ACCURATELY MATCHES BY CHECKING THE APPROPRIATE BOX.

☑ **1. Agency SAM Information complete and verified to not be on the debarred list.**

☐ **2. Agency CDBG request does not exceed outlined limit.**

☐ **3. Agency services to be provided to citizens of the City of Neighbors ONLY.**

☐ **4. Agency answered question D.3 and the amount is feasible for funding.**

The Reviewer confirms all of the above-required documentation are eligible and included in the package. The listed ESG applicant:
No

If the CDBG applicant does not meet Threshold or is Ineligible, use the check boxes below to identify the reason(s).

☐ **Agency is debarred from receiving Federal Funds.**

☐ **CDBG request exceeds outlined limit.**

☐ **Agency services provided to all citizens and not limited to City of Neighbors.**

☐ **Agency CDBG lowest funding amount not feasible.**

If denied or ineligible for another reason, please explain below:
The Family Health Partnership Clinic has a 26 year history of leading in the area of health equity. In 2019, the County had a base population of 310,000. That year, 13.9% of the population identified as Latino – a significant jump from 2000 when 7.5% identified as Latino. The majority of Latinos identify Mexico as their country of ancestry.

This burgeoning Latino population is also the county's most vulnerable. Both the McHenry County Department of Health and the McHenry County Mental Health Board have identified the Latino population as being the most at risk because of factors of poverty, isolation, and lack of available bilingual services.

The Clinic serves as a touchpoint for the Latino community. Since its inception, the Clinic has heavily recruited bilingual staff with the understanding that with increased language access, the more likely it is to reach previously unreachable populations. More than 60% of the clinic's patients are Latino, and the Clinic has a long history of providing culturally and linguistically competent care to its patients.

All forms, information and education are in English and Spanish. Interpreters go into the exam room with patients when needed, and two nurses are fully bilingual.

This long term commitment to the Latino community, along with other vulnerable and underserved populations puts FHPC in a unique position to continue to respond to those needs

Reviewer Signature
***Not signed*

Date
08/01/2022

Expenditure Category

No data saved

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

Expenditure Category

Please provide the following information.

Which expenditure category does this agency fall into?

Static Reporting Information

No data saved

Case Id: 10645
Name: Family Health Partnership Clinic - 2021
Address: 401 E. Congress Parkway

Static Reporting Information

Please provide the following information.