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| The Project Work Plan provides specific details of how services will be implemented under this grant. The Project Work Plan is designed to be flexible and may be revised during the Project Period with FSS approval. To respond to shifting context during the Project Period, Grantee may propose minor revisions to services or operations by requesting Project Work Plan updates. Revisions to the Project Work Plan may not change the overall scope of the Project and HHSC must review and approve any changes prior to implementation. HHSC reserves the right to make the final determination on any proposed changes. | |
| **Applicant Name:** | |
| **Grant Agreement Contract Number:** TBD | **Agency Account ID:** TBD |
| **Program:** TEXAS NURSE-FAMILY PARTNERSHIP (TNFP) | |
| **Project Period:** 09/01/2026 - 08/31/2031 |  |
| **Service Area (County/Counties): \_\_** | |

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| **CONTACT INFORMATION** | | | | |
| **Contact** | **Name** | **Title** | | **Email** |
| **Signatory** |  |  | |  |
| **Program** |  |  | |  |
| **Fiscal** |  |  | |  |
| **PUBLIC CONTACT INFORMATION** | | | | |
| **Agency Web Address:** | | | | |
| **Agency Street Address:** | | | | |
| **Public Phone:** | | | **Public Email Address:** | |

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| **SERVICE SUMMARY**  List services and programming that will be provided under this award and in which Participants will be enrolled. | | | | | | | | |
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| Program/Service | Staff Providing (include number) | Planned Caseload | Duration | Frequency | Output **Families Served Monthly**\* | Output **Families Served Annually**\*\* | PEIRS Reporting Method | |
| **Nurse-Family Partnership** | Nurse Supervisor(s) (\_)  Nurse Home Visitors (\_) |  |  |  |  |  | NFP Workflow | |
| Brief Description: | | | | | | | | |
| \*Indicate the number of families that will be served each month in the program.  \*\*Indicate the total number of families that will be served annually in the program. | | | | | | | | |

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| **SUPPLEMENTAL SERVICE SUMMARY**   1. Supplemental services are FSS-funded services under this Grant Agreement provided to families who are also participating in another service. All families served through supplemental services are duplicated families. 2. Include any FSS-funded supplemental services in the table below. Add or delete rows as needed. For each supplemental service, provide a very brief description of the service and purpose in the row below. | | | | | |
| **Program/Service** | **Staff Providing** (include number) | | **Caseload or Group Size if applicable** | **Anticipated Families Receiving Monthly** | **Anticipated Families Receiving Annually** |
| *Examples: Basic needs support, lactation consultation, doula services, mental health consultation, etc.* |  | |  |  |  |
| Brief Description: Include duration and frequency if applicable. | | | | | |
| Program or service name | | Staff Providing (include number) | Caseload or Group Size | Families Served Monthly | Families Served Annually |
| Brief Description: Include duration and frequency if applicable. | | | | | |
| Program or service name | | Staff Providing (include number) | Caseload or Group Size | Families Served Monthly | Families Served Annually |
| Brief Description: Include duration and frequency if applicable. | | | | | |

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| **EVENTS & INITIATIVES**  *Describe any additional work that will be provided under this Grant Agreement.*  List any planned events or initiatives below. This could include public awareness campaigns, referral system development, community awareness texting services (e.g., Lantern (formerly Bright By Text)), community events and initiatives, community education, etc. Add/delete rows as needed. Brief detail can be provided in the narrative field that follows. | | | | |
| **Event or Initiative** | **Begin Date** | **End Date** | **Audience/ Stakeholders** | **PEIRS Reporting Events Type** |
|  |  |  |  |  |
| Brief description: Include purpose and how impact will be assessed. | | | | |
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| Brief description: Include purpose and how impact will be assessed. | | | | |

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| **Project Organization and Staffing** | | | |
| Describe the staffing structure for the Project. Indicate the staff positions, responsibilities, and activities of each position on the Project. Include administrator(s), supervisors, and direct service staff positions, including Cost Sharing positions. Indicate which positions are responsible for outreach and recruitment, data entry, quality assurance, and oversight. | | | |
| **Position Title (Number)** | **Percent of position on TNFP** | **FSS-Funded or Cost Sharing (Match)** | **Brief description of responsibilities and activities** |
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| **Program and Service Implementation** | | | |
| 1. **Outreach and Recruitment Plans**   Describe outreach and recruitment plans, including staff responsible for planning and execution. Include goals and strategies to engage and enroll families demonstrating eligibility criteria/priority characteristics. Indicate why the strategies will be successful. | | | |
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| 1. **Ongoing Family Engagement** **and Retention Plans** 2. Describe family engagement strategies and activities that will be incorporated into programming, service approaches, and community engagement. | | | |
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| 1. Describe how the organization will incorporate parent and caregiver perspective, priorities, and voice in program development and delivery. | | | |
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| 1. Use of incentives for program engagement and retention: 2. Indicate types of incentives to be used for families and how they are determined. 3. When are incentives provided? At what time points, benchmarks, etc.? | | | |
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| 1. **Focus Populations (*Complete as applicable.*)**   1. Identify any priority populations the program will focus on in addition to generally eligible families - *e.g., adolescent parents, military-connected families, households with substance use, or other.*  2. Describe plans to serve and engage any focus populations. | | | |
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| 1. **Screenings, Assessments, and Surveys**   List all screening and assessment tools that will be used during intake and service provision, *e.g., depression screening, intimate partner violence screening, parent-child interaction observation, etc.* Add rows as needed. | | | |
| **Screening, Assessment** | **Purpose** | **When is it administered?** | **Requirements, if applicable** |
|  |  |  | Required by model  Required by agency  Required by FSS |
|  |  |  | Required by model  Required by agency  Required by FSS |
|  |  |  | Required by model  Required by agency  Required by FSS |
|  |  |  | Required by model  Required by agency  Required by FSS |
| 1. **Use of Basic Needs Support** 2. How will family needs be assessed? 3. What types of basic needs support will be offered? 4. What is your program’s anticipated range of assistance amount per family? 5. How will basic needs assistance be documented and tracked for participants and for the program? | | | |
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| 1. **Referrals** 2. Describe any services to which participants will be routinely linked or referred. 3. Indicate how participating families are referred or linked to other needed services when they would benefit from additional services or supports. Include how families will be referred to other Family Health Services (FHS) when appropriate. 4. Include how referrals to other services or providers are documented, tracked, and supported. | | | |
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| **Anticipated Referrals for TNFP** | **When is referral made?** | **Anticipated Service Provider(s)** | **Requirements, if applicable** |
| Services for depression/anxiety for those with positive screen |  |  |  |
| Developmental support or early intervention services for those indicated through screen |  |  |  |
| IPV resources for those indicated through screen |  |  |  |
| Tobacco cessation services for those reporting use |  |  |  |

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| **PROGRAM MODEL IMPLEMENTATION** |
| 1. *Complete as applicable*. Describe the process the organization will use to ensure implementation with fidelity to Program Model, including frequency and type of contact the organization will have with Program Model developer. Include how fidelity is verified and documented. |
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| 1. *Complete as applicable*. Describe any variations or adaptations that have been approved by the developer that will be used. |
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| **PROGRAM AWARENESS AND PARTNERSHIPS**  Describe outreach and networking plans to support participant success. |
| Include how organization will collaborate with other Family Health Services (FHS) (e.g., WIC, ECI, TTF, THV, etc.) in the service area. |
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| **COMMUNITY COALITION**  Indicate the following for the primary community coalition that the organization will work with under this Grant Agreement. |
| **Coalition Name:** |
| **Coalition Point of Contact:** (Name, Title, Email, Website if available) |
| **Grantee Role** (Please select one)**:**  Coalition lead  Coalition participant |
| **Counties (or Cities) Involved:** |
| **Coalition Description:** (Brief summary, one sentence) |
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| **Coalition Goals**  List the top three to five prioritized issues that the community coalition is addressing or will address. |
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