**PENNSYLVANIA CARE PARTNERSHIP COOPERATIVE AGREEMENT**

**303 WALNUT STREET**

**COMMONWEALTH TOWERS, 11TH FLOOR**

**HARRISBURG, PA 17101**

***Please email to Mark B. Durgin, Project Director @*** ***durginm@upmc.edu***

**COUNTY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROJECT TITLE:** \_\_PA Care Partnership Expansion and Sustainability Grant\_\_

**REPORTING MONTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the report below, please be prepared to detail one or two sentences for each section.**

**Information to be collected and ready on or before the 2nd Friday of the month**

**Number of individuals/families started in the Planning Process in the reporting month:**

**High Fidelity Wraparound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Planning Process: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of individuals/families who declined to be studied:**

**High Fidelity Wraparound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Planning Process: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Successes: (Detail any successes, accomplishments, events, or celebrations that occurred in the reporting month related to the System of Care grant.)**

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| **Challenges and Barriers: (Detail any challenges or barriers you encountered in the reporting month. This should also include challenges you are experiencing with engaging counties, providing Technical Assistance, challenges with technology, or other issues impeding the success and expansion through the PA System of Care Partnership.)** | **Plans to Address Challenges and Barriers and requests for the PA System of Care Partnership for assistance: (Detail any plans, ideas, or solutions you have to address any challenges or barriers related to your program as well as any requests you may have for the PA System of Care Partnership or other agencies for assistance.)** |
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**Opportunities: (This would be any planning, collaboration, or ideas that your County intends to complete during the current reporting month, and the end of the grant on 6/30/17.)**

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**Monthly Optional Update of the TRAC-IPPs/SPARS: (ATTENTION: Counties may submit this information monthly, but must collect the information for the grant and submit on a quarterly basis and submit if not submitted monthly.)**

Has your County Leadership Team made or influenced  any **policy changes**  in your county?  If you have how many were there? Please give a brief description of each change. (PD1)

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| **Result Name:** Enter the name or type of policy change.**Result Description:** Enter a description of 1) the organizations and 2) the completed policy change.**Result Number:** Enter one policy change per result record. |

Have their been any type of  **mental health trainings** for people in your county who work in MH or other related social services? If yes, how many people were trained and what was the topic? (WD2)

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| **Result Name:** Enter the job title of the person or people trained**Number:** Enter the number of people trained in this particular training.**Result Description:** Enter description (2-3 sentences) on 1) who was trained 2) what topic they were trained on. |

Have any **youth or family** members **provided mental health-related services/trainings** as a result of the grant? If yes, who were they and what was the topic or service? (WD5)

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| **Result Name:** Enter the title or position of the persons(s) providing the service. **Result Description:** Enter a one to two sentence description on 1) who provided the service and 2) what type of service was provided.**Result Number:** Enter the total number of people providing the service |

Have any **organizations** entered into formal agreements (**MOUs, MOAs**) to improve MH practices and activities in your county through SOC efforts? If yes, please list the organizations/agencies and a brief description of the agreement.  (PC1)

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| **Result Name:** Enter the name or type of agreement.**Result Description:** Enter a description of 1) the organizations involved, 2) the type of agreement established (e.g., MOU or MOA), 3) the purpose/objective of the agreement, and 4) the expiration date of the agreement.**Result Number:** Enter the total number of organizations that entered into the agreement (as the grantee, do not include yourself). |

SUBMITTED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Representative Completing Form)