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COMMISSION ON MINORITY HEALTH

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FINAL REPORT Minority Health Month 2015

Grant # MHM 15 - _____ Federal Tax ID# _____

Agency Name: _____

Address: _____

Contact Person: _____ Telephone Number: () _____

1. Demographics

COMMUNITY PARTICIPATION							
Date(s) of Event(s) (list separately)	Total # served	Number served by Ethnic/Racial Group					
		African American	Hispanic	Native Am. Indian	Asian	White	Other

a) Date of event/Service Provided: Indicate each separate activity/service and the date on which it occurred.
b) Total # Served: Record the number of people served for each event/service period.
c) Total # by Ethnic/Racial Group: Record the number of African Americans, Asians, Hispanics and Native American Indians served through each service/event.

THIS REPORT IS REQUIRED WITHIN 15 DAYS OF THE END OF THE GRANT. FAILURE TO COMPLY WITH THIS REQUIREMENT MAY RESULT IN NON-PAYMENT.

Ohio Commission on Minority Health

Demographic Screening Reporting Form

Type of Screenings (list i.e., diabetes, cholesterol, hypertension, mammography, prostate)	Total # screened*	Total # Gender			# Abnormal findings* (ranges if applicable) Referrals must be provided and follow up if possible. Grantees should have community referral resources on hand for abnormal screenings	Separate Number of Abnormal Findings by Ethnic/Racial Group*					
		Male	Female	Total		African American	Hispanic Latino/Am.	Native American	Asian American	White	Other

*** PLEASE NOTE: ALL ABNORMAL SCREENS MUST RECEIVE FOLLOW UP. Each Grantee will be required to collect contact information on a sign in sheet to allow follow up for any abnormal screens as needed.**

3. Partnerships/Collaborations/Co-Sponsorship

A. List any agencies that you collaborated with for Minority Health Month.

B. Did your agency receive any donations, monetary or other for your Minority Health Month activities? If so, please list their name and actual/estimate value of domination (event in-kind).

Minority Health Month - FINAL REPORT

INSTRUCTIONS:

1. Enter the grant number assigned by the Commission MHM 15 - ____.
2. Enter the agency's federal tax identification number.
3. Enter the agency's name.
4. Enter the agency's address.
5. Enter the contact name for the person(s) responsible for the program activities and completing the program portion of this MHM Final Report.
6. Enter the telephone number for the person(s) responsible for the program activities and completing the program portion of this MHM Final Report.
7. Enter the demographics for the events (list separately).
 - a. Date of event/services provided: Indicate each separate item and date on which the activity occurred.
 - b. Total # of persons served for each event/service period.
 - c. Total # serviced by Ethnic/Racial Group: Record the number of African Americans, Asians, Hispanics, and Native American Indians served through each service/event.
8. List (separately) types of screening
9. List total number # of persons screened.
10. Identify the number # for each gender (male and female)
11. Identify the number for all abnormal screenings by ethnic/racial groups.
12. Identify abnormal screenings by race ethnic/racial groups.
13. Answer all questions listed under 2. Activity Page.
14. Answer all questions listed under 3. Partnerships/Collaborations/Co-Sponsorship.

INSTRUCTIONS

Instructions for Completion of the Minority Health Month Grant Expenditure Report

Agency Name: Insert the legal name of your agency. It must match the name on the 501 (C) 3.

MHM 15- ____ - ____: The Minority Health Month grant number receive a grant number when it arrives in the Commission office. The agency must use this number on all budget forms and use it whenever you correspond with the Commission.

Executive Director: Insert the name of the Chief Executive Officer of the applicant agency and official title.

Contact Person: Use the name of the person who has day-to-day responsibility for the Minority Health Month Project.

Federal Tax I.D. #: This number is issued by the IRS. It appears on agency's 501 (C)(3) or sometimes as the Entity Identification Number (EIN). The tax ID number must be the number representing the agency that is applying for grant funds. If an applicant is using another agency's tax ID number, the agency whose number is being used will be reimbursed for expenditures made during the grant period.

Phone: Applicant should give the phone number of the contact person(s) who has day-to-day responsibility for the Minority Health Month project.

NOTE:

- **All expenditures must be supported by copies of receipts. For speakers copies of canceled checks are acceptable. Failure to submit supporting documentation will result in non-reimbursement.**
- **Items listed as expenditures that do not appear on the approved budget will be disallowed.**

Speakers

Budget Category: Identify each speaker (by name) whose speaking fee will be paid for by the Commission. List topic(s) as well.

Column A: Identify the amount listed in the Commission's APPROVED BUDGET under Column B.

Column B: Enter the expended amount to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column A of the approved budget.

Rentals

Budget Category: Specify each rented line item with unit cost charged to the Commission (rental of chairs, tables, rooms, etc.), e.g. 50 chairs x .80/chair = \$40.

Column A: Specify the cost of the rented line item listed in the Commission's APPROVED BUDGET. The amount listed should be the same amount identified in the APPROVED BUDGET under Column A.

Column B: Enter the amount spent that you want to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column B as it appears in the approved budget.

Supplies Contract & Other

Budget Category: List of all supplies. They must be itemized and specify unit costs (e.g. office supplies, printing, advertising, etc.), and contracts

Column A: Identify the cost of each product or service being charged to the Commission. The amount should not exceed the amount that is listed in the approved budget under Column B.

Column B: Enter the amount that will be charged to the Commission. The amount identified cannot exceed the approved amount for the supplies Contract & Other category.

Total Commission Cost: Add up the dollar amounts in Column A and Column B.

The amount in Column B should not exceed the approved budget of \$2,500.00.

The amount in Column B is the amount you wish to be reimbursed by the Commission and may not exceed \$2,500.00.

The total amount **cannot** exceed the amount stated in the Acknowledgement of Terms and the Commission's approved budget.

Executive Director and Fiscal Officer:

The Expenditure Report must be signed by the Executive Director and the Fiscal Officer. **Without their signature this report is invalid.**