



Family and Community Engagement Plan

This Family and Community Engagement Plan is a vision and planning document for engagement goals specific to your community. It's a tool to help reflect on the work you are already doing and expand on those efforts over the course of a year. The plan will be completed once a year with the support of ACT for Youth CYSHCN Program Center of Excellence (COE) at Cornell University. The Family and Community Engagement Plan serves as a guide for your work and will assist in completing your DOH quarterly reports.

County: _____ Date: _____

Name: _____ Title/Role: _____

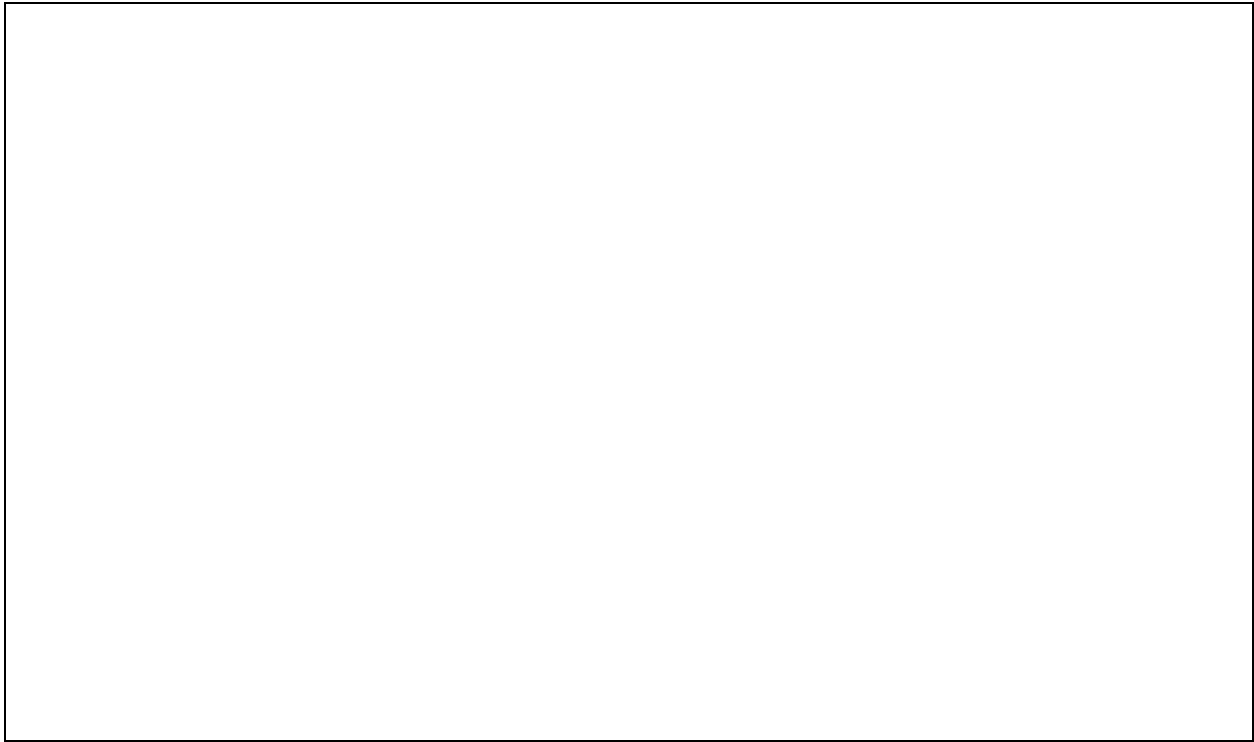
Contact Information: _____

Part I:

Use data to consider who makes up your community and what their unique needs are.

Briefly describe the population of your community; please include demographics, economic and social factors, and geographic considerations and/or barriers (for example: urban, suburban, rural, etc.) **Who makes up your community and what are the barriers they may face?**

How do these diverse aspects of your community contribute to the distinct needs of CYSHCN?



Utilize feedback needs assessments to inform the focus of your engagement plan. Identify the assessment(s) used – ([Community Health Needs Assessment \(CHNA\)](#), CYSHCN Program feedback, advisory council or work group input, child and youth programming input, and/or others). **How are you identifying the needs of your community?**



Identify unmet needs of children and youth with special health care needs and their families in your community to focus on this year (For example: transportation, service providers, respite support, etc.). **What needs will you be focusing on in your engagement plan?**

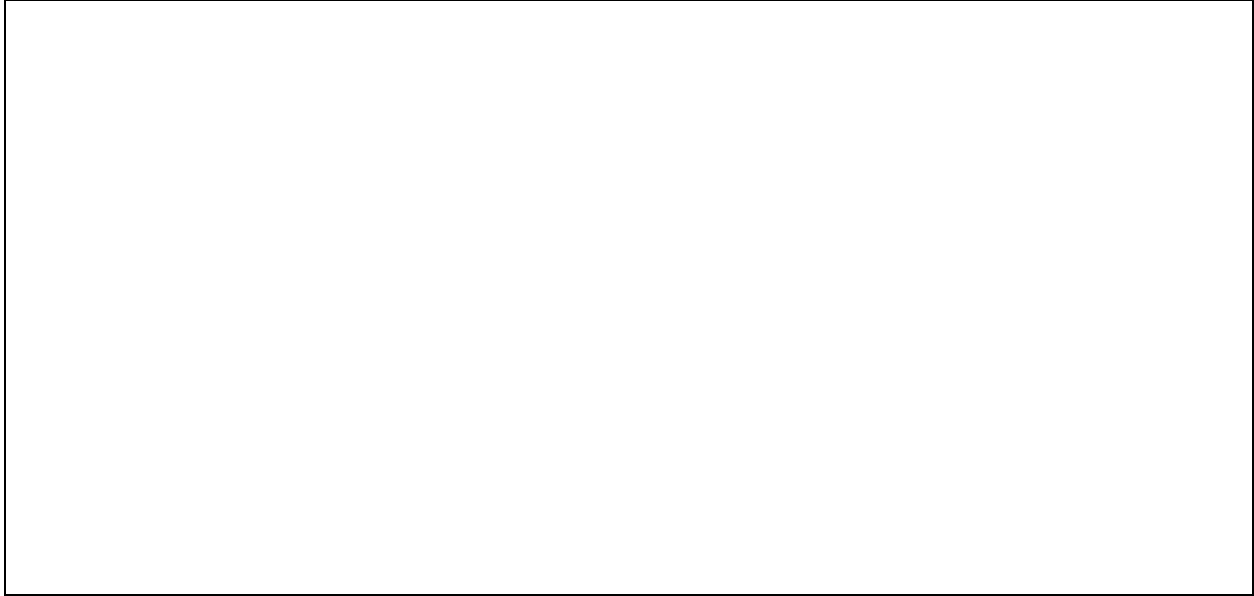
Part II:

List the partners you have strong working relationships with. This section can help you identify beneficial partnerships to establish or strengthen as a Part III goal.

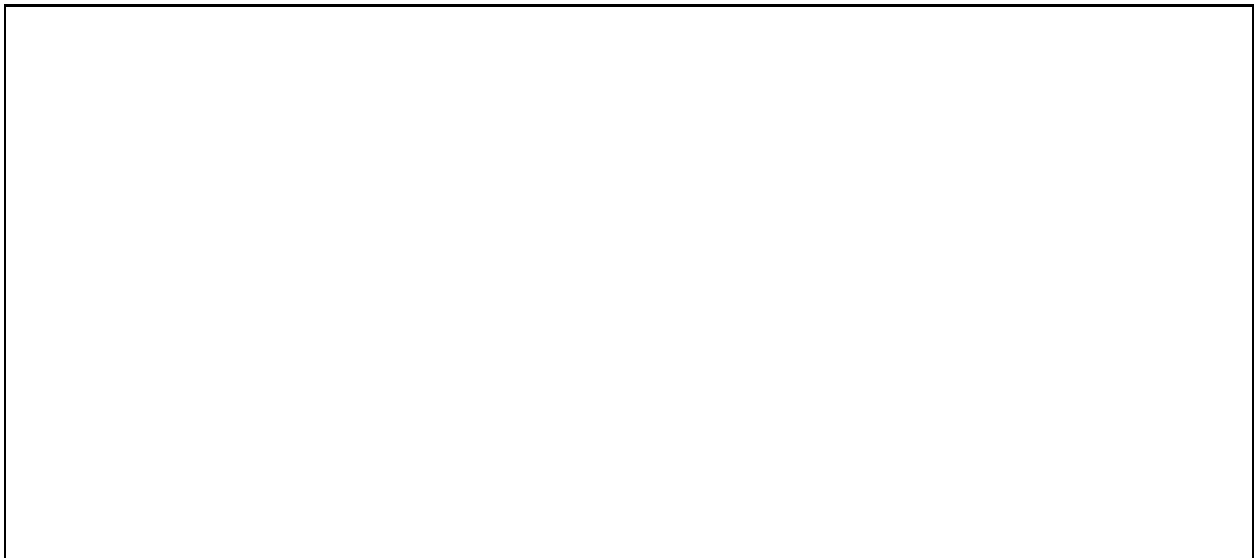
Describe and/or list the partnerships you have with local, state and federal child and youth centered programs under each of the following categories.

Health Equity / Medical Service Partners and Providers (Primary care practices; hospital staff; health homes; county health departments; mental health Single Point of Access (SPOA); Medicaid/Supplemental Security Income (SSI); non-emergency transportation; and others):

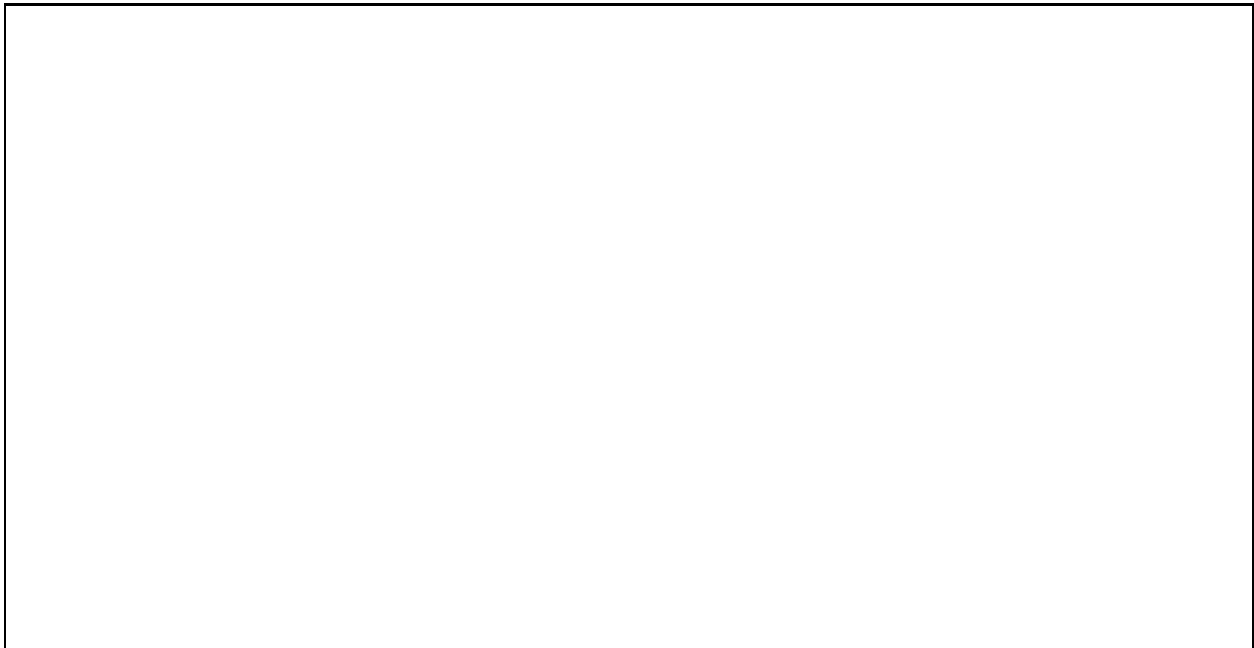
Quality of Life and Well-Being Partners (Department of Social Services (DSS); Department of Children, Youth, and Families (DCYF); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); respite, emergency food relief; supportive housing; workforce development; Office for People with Developmental Disabilities (OPWDD); intensive case management programs; emergency food and clothing relief organizations; childcare services (daycares, summer camps); and others):



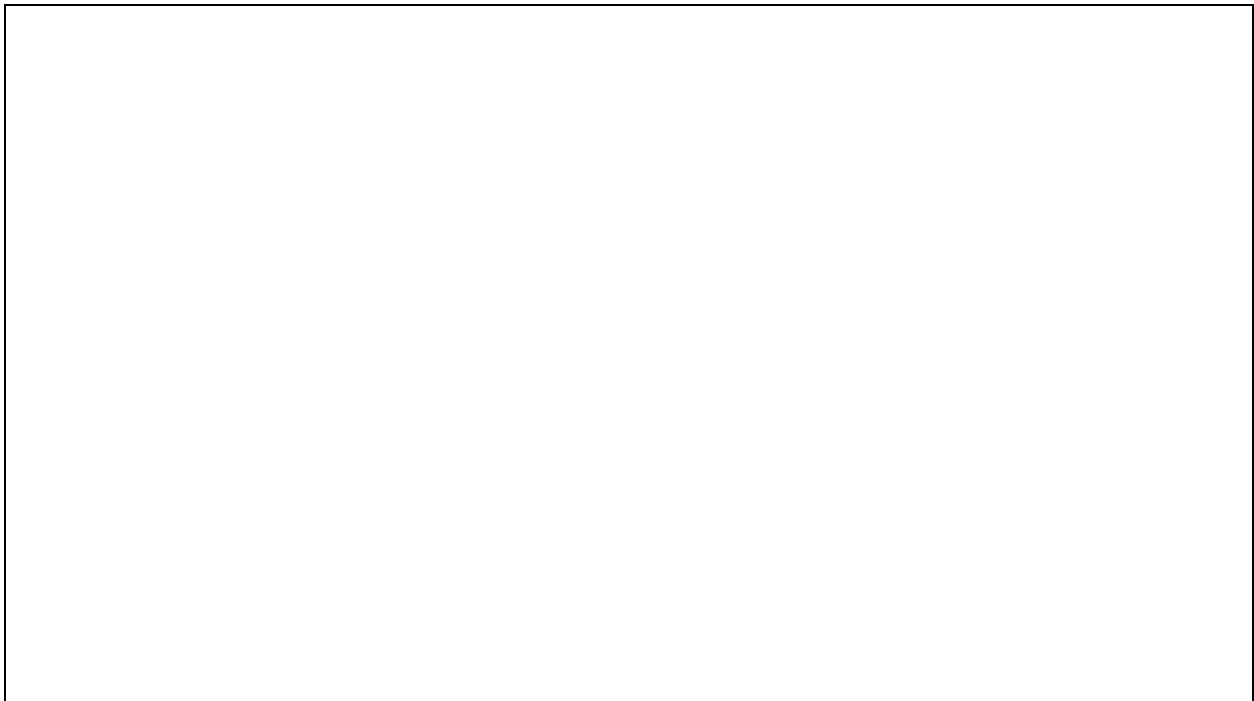
Child Development Partners (Head Start; Early Intervention; Committee on Preschool Special Education (CPSE); preschool programs; school district officials such as: special education departments, nurses, guidance counselors, psychologists, social workers, teachers; Board of Cooperative Educational Services (BOCES); wellness committees; regional evaluation centers; and others):



Emotional and Social Support Partners (County Departments - Recreation, Children, Youth and Families, Community based organizations who provide recreation, leisure, mindfulness, Disability Advocacy Partners - The Arc, Special Olympics, specific disability support groups, sport programs, community activities):



Emergency Preparedness Partners (City and/or county programs; fire departments; law enforcement, and others):



Community Advisory Council Partners (community advisory or work group(s) that you are already involved in):

Part III:

Reflect on parts 1 and 2 of this plan. Identify unmet needs. Think about who to partner with. What partnerships need strengthening? What are some strategies and performance measures that you can use to set engagement goals for this year?

Identified CYSHCN Need #1

Vision	<ul style="list-style-type: none"> ● Increase awareness of the CYSHCN Program with families and community providers. ● Establish yourself as the “go to” person and “bridge” for families and community providers when looking for support for children and youth with special health care needs. ● Serve as a local hub of information and resources for families and community providers. ● Ensure that you understand the needs of your community and what community partners exist.
<p>The work plan requires you to choose three strategies and performance measures to address an identified CYSHCN need. One strategy must address healthy equity and improve access to medical services. The other two strategies can address health equity, quality of life, child development, emotional and social supports, or any other topic that is important to your community.</p>	

<p>Identified CYSHCN Need</p>	
<p>Identify evidence-based, evidence-informed and/or best practice strategies to address the identified need.</p> <p>How will you improve your ability to meet the identified CYSHCN need?</p>	
<p>Action Steps</p>	
<p>Identify performance measures you'll utilize to document your progress.</p> <p>How will you know your strategies/practices are helping to improve the identified need? This is what you will include in your quarterly report at the end of Quarter 2 and 4.</p>	
<p>Quarter 2 Progress Indicators</p>	

<p>Quarter 4 Progress Indicators</p>	
<p>Are there any professional development opportunities or resources that would help with this work (optional)?</p>	
<p>Learning Opportuni- ties</p>	
<p>Are there any obstacles or things that make it hard to do this work (optional)?</p>	
<p>Potential Concerns</p>	

Identified CYSHCN Need #2

<p>Vision</p>	<ul style="list-style-type: none"> ● Increase awareness of CYSHCN Program with families and community providers. ● Establish yourself as the “go to” person and “bridge” for families and community providers when identifying support for children and youth with special health care needs. ● Serve as a local hub of information and resources for families and community providers. ● Ensure that you understand the needs of your community and the community partners that exist there.
<p>The work plan requires you to choose three strategies and performance measures to address an identified CYSHCN need. One strategy must address healthy equity and improve access to medical services. The other two strategies can address health equity, quality of life, child development, emotional and social supports, or any other topic that is important to your community.</p>	
<p>Identified CYSHCN Need</p>	
<p>Identify evidence-based, evidence-informed and/or best practice strategies to address the identified need.</p> <p>What are you going to do to improve your ability to meet the identified CYSHCN need?</p>	
<p>Action Steps</p>	

Identify the performance measures you'll use to measure your progress.

How will you know your strategies/practices are helping to improve the identified need? **This is what you will report on in your quarterly report at the end of Quarter 2 and 4.**

**Quarter 2
Progress
Indicators**

**Quarter 4
Progress
Indicators**

Are there any professional development opportunities or resources that would help with this work (optional)?

**Learning
Opportuni-
ties**

Are there any obstacles or things that make it hard to do this work (optional)?

Potential Concerns

Identified CYSHCN Need #3

Vision

- Increase awareness of CYSHCN Program with families and community providers.
- Establish yourself as the “go to” person and “bridge” for families and community providers when looking for support for children and youth with special health care needs.
- Serve as a local hub of information and resources for families and community providers.
- Ensure that you understand the needs of your community and the community partners that exist there.

The work plan requires you to choose three strategies and performance measures to address an identified CYSHCN need. **One strategy must address healthy equity and improve access to medical services.** The other two strategies can address health equity, quality of life, child development, emotional and social supports, or any other topic that is important to your community.

Identified CYSHCN Need

Identify evidence-based, evidence-informed and/or best practice strategies to address the identified need.

What are you going to do to improve your ability to meet the identified CYSHCN need?

Action Steps

Identify the performance measures you'll use to measure your progress.

How will you know your strategies/practices are helping to improve the identified need? **This is what you will report on in your quarterly report at the end of Quarter 2 and 4.**

**Quarter 2
Progress
Indicators**

**Quarter 4
Progress
Indicators**

Are there any professional development opportunities or resources that would help with this work (optional)?

**Learning
Opportuni-
ties**

Are there any obstacles or things that make it hard to do this work (optional)?

**Potential
Concerns**

This worksheet was adapted from the [Foundations of Family Engagement Action Plan](#), developed by Ohio Statewide Family Engagement Center at The Ohio State University.