HEALTH FIRST INDIANA

Lake County Health Department
2900 West 93rd Ave., Crown Point, IN 46307 | Phone: 219-755-3655

LAKE COUNTY HEALTH DEPARTMENT CONTRACT AGREEMENT

This Agreement ("Agreement") is made effective this _____day of _____ _____, ____, by and between Lake County Health Department, with a principal place of business at 2900 West 93rd Ave., Crown Point, IN 46307 ("LCHD"), and Prenatal Well with a principal place of business at 8691 Connecticut, Unit B, Merrillville, IN 46410 ("Grantee"), collectively referred to herein as the "Parties."

WITNESSETH

WHEREAS the LCHD is engaged in grant-making activities designed to address public health concerns including chronic disease prevention.

WHEREAS under Indiana law, LCHD is empowered to grant money from their allocated Health First Indiana ("HFI") funds to external organizations which agree to complete Core Public Health Services ("CPHS") and work toward completion of the required Key Performance Indicators ("KPIs").

WHEREAS the LCHD is in need of assistance from external organizations to complete some of the state required CPHS and KPIs and is requesting Grantee to become a community partner in the delivery of certain services as delineated herein.

WHEREAS the Grantee represents that it is duly qualified and agrees to perform all services and reporting described in this grant contract to the satisfaction of the LCHD.

WHEREAS the Grantee has submitted a program proposal asking for funding to provide the core public health services in accordance with the Health First Indiana Initiative; details can be found at https://www.in.gov/healthfirstindiana.

WHEREAS the LCHD has determined that such a program is in public interest and wishes to support it with the grant funds subject to the terms and conditions herein.

NOW, THEREFORE, in consideration of the mutual covenants as contained herein, the parties agree as follows:

1. ORGANIZATION
   1.1. Name: Prenatal Well
   1.2. Contact Name and Title: Maya Dominique MD, MPH, FACOG, Executive Director
   1.3. Address: 235 W. 75th Ave Merrillville, IN 46410
   1.4. Phone: 316-371-2019
   1.5. Fax: none
   1.6. Email: mdominique@prenatalwell.org
   1.7. Name of Proposed Program: Early connect: Community-Based Prenatal Safety Net Program
   1.8. Target Population: Lake County pregnant individuals who are at risk of initiating prenatal care late (after 10 weeks gestation) or not at all.

2. PROGRAM, PURPOSE, AND SCOPE
   2.1. Grantee has submitted a proposal entitled Early connect: Community-Based Prenatal Safety Net Program (“Program”).

   2.2. Program Purpose. : The purpose of this grant is to support the Grantee’s Program, which aims to: reduce maternal and infant morbidity and mortality in Lake County by increasing early engagement in prenatal care among underserved and at-risk populations. Facilitated by Prenatal Well, the program addresses one of the county’s most urgent public health challenges—delayed initiation of prenatal care—by identifying pregnant individuals early through strategic healthcare partnerships and connecting them to comprehensive care within 48 to 72 hours of referral. Through a combination of timely clinical access, education, transportation assistance, nutritional support, and integrated social services, Early Connect empowers patients, improves birth outcomes, and supports Lake County’s maternal health equity goals.

   2.3. Scope of Program Services. Early Connect provides rapid prenatal care coordination, transportation assistance, trimester-specific education, nutritional support, and access to over 100 community-based resources for pregnant individuals at risk of delayed care. These services are delivered through a hybrid model of in-person and virtual support, ensuring timely, patient-centered care beginning within 48–72 hours of referral and continuing through postpartum.

3. FINANCIAL TERMS
   3.1. Consideration. The Grantee shall be compensated at a rate of N/A for performing the duties described herein. Total compensation under this Contract shall not exceed N/A. *This contract has been reapproved by the Board of Health for funds already disbursed; however, the scope of work has since been revised.*

   3.2. Breakdown of Total Program Amount Requested.

Item Description	Price	Quantity	Total
Program Administrator (1)	$8,500.00	1	$8500.00
Junior Program Administrator/Adm	$5000.00	1	$5,000.00
Asst.	$5000.00	1	$5000.00
Case Worker	$5000.00	1	$5000.00

Total	**$18,500.00**		**$18,500.00**
Communications and Marketing Services	**Price**	**Quantity**	**Total**
Materials & Promotions, flyers, brochures, partner resources	$750.00	Variable-100 participants	$750.00
Social Media	$500.00	Variable	$500.00
Email	$75.00	One-time	$0
Media Relations	$150.00	Variable	$150.00
Partner Training & Outreach, Onboarding for clinics, EDs, Urgent Care Sites	$750.00	One time	$0
Community Outreach	$250.00	Variable	$250.00
Total			**$1650.00**
Professional Services	**Price**	**Quantity**	**Total**
Nutrition Program (food boxes and Nutrition Educator)	#7800.00	#30	$7800.00
Nutrition Educator	$2,250.00	One-time cost	$2,250.00
Accounting Audit	$0	One-time cost	$0
Tax Prep	$0	One-time cost	$0
Data Analyst Consultant	$0	$5000	$5000.00
Total			**$15,050.00**
Indirect Costs			
Insurance	$275.00	Annual	$275.00
Transportation (Uber Cards, ect.)	$3,375.00	Variable #35 participants per month	$3375.00
IT and Equipment	$0	Variable	$0
Telehealth Platform	$1500.00	1 Platform	$1500.00
Tablets/Phones for Outreach Staff, Technology for remote check-ins	$0	Variable	$0
Data Collection Tools	$1275.00	1 platform	$1275.00
Financial Software & Payroll	$647.00	2 platforms	$647.00
Rent/Utilities	$6325.00	Variable	$6325.00
Office Supplies	$575.00	Variable	$575.00
Total			**$13,972.00**
Contract Total			**$0.00**

3.3. Proposed Schedule of Payments.

Payment #	Due Date	Description	Amount
1	07/01/2026	*Funds already disbursed.*	$0.00

3.4. Payments. (*entered here and below*)

3.4.1. Payment Information.

3.4.1.1. Any payment-related questions or concerns should be directed to Otis Dominique, Operations Director odominique@prenatalwell.org 773-443-3074.

3.4.1.2. The check or wire memorandum section must specify: Attn: Otis Dominique - Operations Director.

3.4.1.3. Payments by Check. Payments will be made to [organization] and mailed to:

Prenatal Well
Early Connect
235 W. 75th Ave.
Merrillville, IN 46410

4. TERMS AND TERMINATION

4.1. Term. This Agreement shall commence on **[Start Date]** and shall remain in effect through December 31, 2026, unless earlier terminated in accordance with the terms of this Agreement.

4.2. Termination. Both parties will make good-faith efforts to resolve issues and mitigate damages prior to terminating this Agreement. However, this Agreement and any outstanding payments may be terminated if the agreed-upon activities are not being carried out satisfactorily or if the necessary reports and/or data are not submitted as outlined below.

4.3. Renewal. Further funding is not assured. If provided, it will depend on ongoing funding from HFI, compliance with required or requested KPIs as outlined in the continuation agreement with the LCHD, an evaluation of grant deliverable performance relative to this agreement, and the completion of activities/reports specified below.

4.4. Termination without Cause. Either party may terminate this agreement after the initial term for any or no reason by providing at least ninety (90) days written notice.

5. PROGRAM WORK PLAN.

5.1. Program Work Plan.

5.1.1. Project Objective. The Early Connect program aims to reduce maternal and infant morbidity and mortality in Lake County by rapidly connecting pregnant individuals to comprehensive prenatal care within 48–72 hours of referral. Through clinical coordination, education, nutritional support, transportation assistance, and integrated social services, the program improves birth outcomes and promotes maternal health quality.

5.1.2. Project Goal(s).

	Goal	Strategy	Activity
1	Increase early engagement in prenatal care (within the first 10 weeks of pregnancy).	Establish a rapid referral pipeline from community detection sites.	- Partner with ERs, urgent cares, and ultrasound clinics to identify early pregnancies. - Intake referrals and schedule prenatal visits within 48–72 hours.
2	Improve maternal and fetal health outcomes through continuous, holistic prenatal support.	Provide comprehensive, ongoing education and care coordination.	- Deliver trimester-specific education modules. - Track and support prenatal appointments, labs, and ultrasounds. - Educate on risk factors and warning signs during pregnancy.
3	Reduce disparities in access to prenatal services for underserved and at-risk populations.	Offer transportation, virtual support, and culturally relevant outreach.	- Provide Uber gift cards for appointments. - Offer telehealth-based check-ins and virtual education. - Meet patients at preferred community locations.
4	Empower patients through education and social support.	Integrate personalized education, postpartum preparation, and social service navigation.	- Assign a maternal health advocate to each participant. - Provide monthly pregnancy and postpartum classes. - Coordinate referrals to over 100 partners.
5	Improve maternal nutrition and reduce complications associated with poor prenatal diet.	Incorporate nutrition education and food access into care plans.	- Enroll participants in bi-weekly pregnancy food box program. - Require monthly nutrition education class attendance.
6	Use data to improve program delivery and track outcomes.	Implement a secure data collection system and continuous evaluation process.	- Maintain EMR and outcome tracking system. - Monitor metrics (referrals, visit attendance, birth outcomes, satisfaction). - Conduct patient surveys.

5.2. Scalability. Scalability. Grantee will expand or restrict the Program Work Plan to further efforts that will result in fulfilling the Purpose and Scope of the Program before modifying Performance.

6. PERFORMANCE: KPIs, METRICS, AND REPORTING.

6.1. Key Performance Indicators ("KPIs") and Scope. The Program will provide services that specifically address the KPIs from the Core Public Health Services outlined in the Health First Indiana initiative: (*entered here and below*)

6.1.1. Trauma and Injury Prevention. Preventing harm due to injury and substance use and facilitating access to trauma care.

6.1.2. Chronic Disease Prevention. Preventing and reducing cardiovascular disease chronic diseases.

6.1.3. Maternal and Child Health. Services focused on the health and well-being of mothers, children, and families, including prenatal care.

6.1.4. Access and Linkage to Clinical Care. Facilitating access to essential healthcare services for all members of the community.

6.2. Metrics.

6.2.1. Definitions.

6.2.1.1. Deliverable: the quantifiable services to be provided at various steps in the Program to keep it on course. The deliverable provides a metric whose value can be tracked for state-level reporting.

6.2.1.2. Metric: a standard for measuring the value of the deliverable.

6.2.1.3. Value: the number or percentage of the metric that is being measured.

6.2.2. List of Metrics.

6.2.2.1. Number of people educated and/or trained on substance use prevention.

6.2.2.2. Number of people educated and/or trained on mental health and suicide prevention.

6.2.2.3. Number of women and children referred for assistance with physical and mental health recovery from domestic violence

6.2.2.4. Number of women and children referred for active domestic violence assistance

6.2.2.5. Number of people screened for high blood pressure through local health department or partners.

6.2.2.6. Number of people screened for diabetes risk factors through local health department or partners

6.2.2.7. Number of people referred to or enrolled in a diabetes prevention program

6.2.2.8. Number of people referred to or enrolled in a diabetes self-management education support program
6.2.2.9. Number of people screened for BMI
6.2.2.10. Number of adults participating in nutrition and physical activity education programming
6.2.2.11. Number of women referred to prenatal care
6.2.2.12. Number of women provided prenatal services
6.2.2.13. Number of women provided nutrition support
6.2.2.14. Number of women provided other prenatal services
6.2.2.15. Number of women referred to My Healthy Baby
6.2.2.16. Number of women referred to postpartum care
6.2.2.17. Number of women provided postpartum services
6.2.2.18. Number of women provided clinical care (state what services)
6.2.2.19. Number of women provided mental health/substance use disorder services
6.2.2.20. Number of women provided breastfeeding education or support
6.2.2.21. Number of women referred to breastfeeding education or support
6.2.2.22. Number of families referred to pediatric care
6.2.2.23. Number of people provided with parenting classes/education
6.2.2.24. Number of people provided safe sleep education
6.2.2.25. Number of referrals to housing supports or resources
6.2.2.26. Number of families referred to home visiting services, such as a home visiting program
6.2.2.27. Number of people provided contraceptive education
6.2.2.28. Number of women referred to WIC
6.2.2.29. Number of families referred or connected to local food pantries
6.2.2.30. Number of people screened for high blood pressure through local health department or partners
6.2.2.31. Number of people screened for diabetes risk factors through local health department or partners
6.2.2.32. Number of people referred to or enrolled in a diabetes prevention program
6.2.2.33. Number of people screening positive for food insecurity
6.2.2.34. Number of people referred to a food assistance program

Number of adults participating in nutrition and physical activity education programming

6.2.3. Reporting Frequency: Reports will be sent monthly to the LCHD.

6.2.4. Reporting Format:

7. Item	KPI	Metric	Deliverable	Value (monthly)
1.	Trauma and Injury Prevention:	Number of people educated and/or trained on substance use	Enrolled participants will receive evidence-based education on substance use prevention,	8 (Avg)

	Training	prevention.	including risks associated with substance use during pregnancy, impacts on maternal and infant health, and available community support resources. Education will be conducted through individual counseling sessions and facilitated group workshops utilizing validated substance use prevention curricula (ex. SAMHSA's "Substance Use in Pregnancy Toolkit"). Education will be provided within the trimester educational session by certified addiction specialists or maternal health educators. Educate at least 90 individuals on substance use prevention. Participant attendance and engagement will be documented through sign-in sheets and session feedback surveys. All educational sessions will be tracked through electronic medical records (EMR) and aggregated in quarterly performance reports.	
2.	Trauma and Injury Prevention: Training	Number of people educated on mental health and suicide prevention.	Participants will receive education on mental health awareness, recognizing signs of depression, anxiety, and suicidal ideation, and strategies for accessing immediate support. Educational sessions will include suicide prevention techniques, such as QPR (Question, Persuade, Refer), tailored specifically to pregnant individuals and their support networks.	4 (Avg)

			Educational sessions will be facilitated monthly by mental health professionals or certified maternal health educators. Educate at least 50 individuals on mental health and suicide prevention strategies.	
3.	Trauma and Injury Prevention	Referral- Number of women and children referred for active domestic violence assistance	During the initial intake and at regular check-ins, all participants will be screened using a validated domestic violence screening tool (ex: HITS or the WAST tool). If domestic violence is disclosed or suspected, maternal health advocates will make immediate referrals to local domestic violence crisis organizations that provide emergency shelter, legal assistance, and safety planning. The referral process will be confidential and trauma-informed, with the participant's safety prioritized throughout. Refer at least 20 women and/or children experiencing or at risk of domestic violence to active crisis intervention or shelter services. Referrals will be tracked in the EMR and confirmed through case notes and monthly reporting logs.	2 (Avg)
4.	Trauma and Injust Prevention	Referral- Number of women and children referred for assistance with physical and mental health recovery from domestic violence	Following the initial crisis referral, participants will be assessed for ongoing needs in physical and mental health recovery, including trauma therapy, support groups, primary care, and psychiatric services.	(2 Avg)

			Maternal health advocates will partner with **t**rauma-informed mental health providers, federally qualified health centers (FQHCs), and women's health clinics to provide appropriate referrals. Follow-up will be built into case management to ensure engagement with recovery services and identify any ongoing barriers. Refer at least 15 women and/or children to trauma-informed physical or mental health recovery services following domestic violence exposure. All referrals will be documented in the participant record with follow-up confirmation logged by case managers.	
Item	KPI	Metric	Deliverable	Value (Monthly)
1.	Chronic Disease Prevention-Screening and referrals	Screening and Referrals - Number of people screened for high blood pressure through local health department or partners	Participants will be offered blood pressure screenings during intake and in-person prenatal visits in partnership with local health department nurses or clinical partners. Screenings will also be available during visits at Prenatal Well and partners. Provide blood pressure screenings to at least 90 individuals through in-clinic visits and in person visits at Prenatal Well. Results will be recorded in participant files and monthly screening logs**.**	8 (Avg)

2.	Chronic Disease Prevention-Screening and referrals	Number of people screened for diabetes risk factors through local health department or partners	All participants will complete a diabetes risk assessment during enrollment and receive education about gestational diabetes. Those with identified risk factors will be referred for testing through clinical partners or the local health department. Screen at least 90 individuals for diabetes risk factors using a standardized tool, with follow-up referrals tracked through care coordination notes and EMR entries.	8 (Avg)
3.	Chronic Disease Prevention-Screening and referrals	Number of people referred to or enrolled in a diabetes prevention program	Individuals identified as high-risk for Type 2 diabetes (based on BMI, history, or screenings) will be referred to local or virtual Diabetes Prevention and Education Programs. Prenatal Well will establish referral partnerships with existing DPPs in Lake County. Refer at least 25 eligible participants to a Diabetes Prevention Program, with referral outcomes tracked through case manager follow-up and documented in referral logs	2 (Avg)
4.	Chronic Disease Prevention-Screening and referrals	Number of people referred to or enrolled in a diabetes self-management education support program	Participants with a gestational or pre-existing diabetes diagnosis will be referred to local DSMES providers for support with blood sugar control, medication management, and lifestyle change. Referrals will be part of routine	2(Avg)

			pregnancy care coordination. Refer at least 20 participants with diabetes diagnoses to DSMES programs, with confirmation of enrollment and participation documented by program staff.	
5.	Chronic Disease Prevention-Screening and referrals	Number of people screened for BMI	Height and weight data will be collected at intake or from initial prenatal provider records to calculate BMI for each participant. Participants with high or low BMI will receive tailored nutrition and physical activity education and referrals as needed. Collect BMI data for at least 90 program participants during intake or first trimester and document results in the EMR for program tracking and follow-up.	8 (Avg)
6.	Chronic Disease Prevention-Programming	Number of adults participating in nutrition and physical activity education programming	All participants will be enrolled in trimester-specific nutrition education, including monthly classes and bi-weekly food box pickup/delivery with healthy eating guides. Physical activity recommendations appropriate for pregnancy will be included, with referrals to prenatal fitness classes or walking groups as appropriate. Engage at least 20 adults in structured nutrition and physical activity education	2 (Avg)

			through virtual or in-person sessions, tracked through sign-in sheets, digital participation logs, and food box distribution records.	

Item	KPI	Metric	Deliverable	Value (Monthly)
1.	Maternal Child Health-Prenatal Services	Number of women referred to prenatal care	Every pregnant participant is referred to a prenatal care provider within 48–72 hours of a positive pregnancy test. Refer at least 90 women to prenatal care providers and document referrals through EMR and care coordination logs.	8 (Avg)
2.	Maternal Child Health-Prenatal Services	Number of women provided prenatal services	Participants receive ongoing prenatal care navigation, screenings, trimester education, and wraparound services Provide comprehensive prenatal services to at least 75 women, with participation tracked through service logs and case notes.	7 (Avg)
3.	Maternal Child Health-Prenatal Services	Number of women provided nutrition support	Participants receive bi-weekly pregnancy nutrition food boxes and monthly nutrition education. Deliver nutrition support (food boxes + classes) to at least 20 women, with sign-in logs and delivery receipts maintained	2 (Avg)
4.	Maternal Child Health-Prenatal Services	Number of women provided other prenatal services	Includes prenatal labs coordination, transportation, social service referrals, and trimester education. Provide at least 75 women with additional prenatal services beyond clinical care, tracked in case management files.	7 (Avg)

5.	Maternal Child Health-Prenatal Services	Number of women referred to My Healthy Baby	All eligible participants are screened and referred to Indiana's My Healthy Baby program. Refer at least 50 women to My Healthy Baby, confirmed via referral system documentation.	4 (Avg)
6.	Maternal Child Health-Postpartum Services	Number of women referred to postpartum care	Maternal health advocates coordinate postpartum care appointments before discharge or within two weeks postpartum. Refer at least 60 postpartum participants to follow-up care, documented in discharge planning records.	5 (Avg)
7.	Maternal Child Health-Postpartum Services	Number of women provided postpartum services	Includes care coordination, emotional support, and postpartum health screening via telehealth or in-person visits. Provide postpartum services to at least 50 women, tracked through EMR entries and postpartum contact logs.	4 (Avg)
8.	Maternal Child Health-Postpartum Services	Number of women provided clinical services (postpartum exams, postpartum depression screening and lactation support)	Referrals and support for postpartum physical exams, depression screening (EPDS), blood pressure checks, and lactation consults. Ensure at least 50 women receive postpartum clinical services, with participation tracked via follow-up confirmations and clinical partner reports.	4 (Avg)
9.	Maternal Child Health-Postpartum Services	Number of women referred to mental health/substance use disorder services	Screen for behavioral health needs and substance use during and after pregnancy, with referrals to treatment providers as needed. Refer at least 15 women to behavioral health or substance use recovery programs, with follow-up documented.	2 (Avg)
10.	Maternal Child Health-Postpartum Services	Number of women provided breastfeeding education or support	Include breastfeeding education during each trimester and offer virtual or in-person lactation support postpartum.	4 (Avg)

			Provide breastfeeding education to at least 50 women, tracked via class rosters and postpartum check-ins.	
11.	Maternal Child Health-Postpartum Services	Number of women referred to breastfeeding education or support	Referral to certified lactation consultants or community-based breastfeeding support groups. Refer at least 30 women to breastfeeding support services, with referrals logged and confirmed by service providers.	3 (Avg)
12.	Maternal Child Health-Postpartum Services	Number of families referred to pediatric care	Assist families in selecting a pediatric provider and making the first well-baby appointment. Refer at least 50 families to pediatric care providers before delivery or within 2 weeks postpartum, documented in care plans.	4 (Avg)
13.	Maternal Child Health-Postpartum Services	Number of people provided with parenting classes/education	Offer trimester-specific parenting modules and postpartum education, including newborn care and safe sleep. Provide parenting education to at least 75 individuals, tracked through attendance logs and course completions.	7 (Avg)
14.	Maternal Child Health-Health And Safety Services	Number of people provided safe sleep education	Safe sleep training is incorporated into prenatal education in the third trimester and reinforced postpartum. Deliver safe sleep education to at least 75 participants, confirmed through sign-in sheets and educational material distribution.	7 (Avg)
15.	Maternal Child Health-Community Assistance	Number of referrals to housing supports or resources	Screen participants for housing insecurity and connect them to emergency housing, shelters, or long-term support.	3 (Avg)

			Refer at least 30 families to housing resources, with documentation included in referral logs and follow-up notes.	
16.	Maternal Child Health-Community Assistance	Number of families referred to home visiting services	Participants are referred to Nurse-Family Partnership, Healthy Families, or other home visiting programs based on eligibility. Refer at least 50 families to home visiting programs, tracked via secure referral systems	4 (Avg)
17.	Maternal Child Health-Contraception	Number of people provided contraceptive education	Offer education on postpartum contraception options during third trimester and again at postpartum check-ins. Deliverable: Provide contraceptive education to at least 90 individuals, with documentation in EMR and case manager education logs.	8 (Avg)
18.	Maternal Child Health-Food and Nutrition	Number of women referred to WIC	All eligible participants are referred to WIC at intake or during first trimester. Refer at least 90 women to WIC, tracked through referral forms and confirmation from WIC liaisons.	8 (Avg)
19.	Maternal Child Health-Food and Nutrition	Number of families referred or connected to local food pantries	Families facing food insecurity are referred to local food pantries or mobile food distribution partners. Refer or connect at least 50 families to food pantries, with logs maintained in the referral database.	4 (Avg)

Item	KPI	Metric	Deliverable	Value

				(Monthly)
1.	Access and Linkage to Clinical Care-Screening and referrals	Number of people screened for high blood pressure through local health department or partners	During the intake process or at clinic visits, all participants are offered blood pressure screening using digital monitors. Blood pressure is a routine prenatal measure, and abnormal results trigger a referral for clinical follow-up. Tracking Method: Blood pressure values are recorded in the secure Electronic Medical Record (EMR) or intake form. Abnormal values are flagged for follow-up. Screen at least 90 participants for high blood pressure; data tracked through intake documentation and community health partner logs	8 (Avg)
2.	Access and Linkage to Clinical Care-Screening and referrals	Number of people screened for diabetes risk factors through local health department or partners	All participants are screened for diabetes risk factors (e.g., family history, BMI) during their initial health history intake or through labs ordered by their OB provider. Risk factors are assessed using standardized screening tools and documented in the EMR or prenatal care intake record. Screen at least 90 participants for diabetes risk factors and document results and referrals through EMR or case manager notes.	8 (Avg)
3.	Access and Linkage to Clinical Care-Screening and referrals	Number of people referred to or enrolled in a diabetes prevention program	Participants identified as high risk for type 2 diabetes or gestational diabetes are referred to local Diabetes Prevention Programs (DPPs) in partnership with local clinics, FQHCs, or community-based organizations.	2 (Avg)

			Referrals are logged in case manager files with follow-up confirmation calls or documentation from the partner agency. Refer or enroll at least 25 participants in a DPP or diabetes education resource; referrals verified through documented follow-up.	
4.	Access and Linkage to Clinical Care-Screening and referrals	Number of people screening positive for food insecurity	A validated two-question food insecurity screening tool (The hunger vital sign) is included in the intake packet and administered by maternal health advocates. Responses are recorded in the EMR or database. A "positive" screen (yes to one or more questions) is automatically flagged for referral. Screen all enrolled participants; track those who screen positive; results entered into case tracking system.	8 (Avg)
5.	Access and Linkage to Clinical Care-Screening and referrals	Number of people referred to a food assistance program	Participants who screen positive for food insecurity are referred to WIC, local food pantries, or enrolled in Early Connect's bi-weekly pregnancy nutrition food box program. Referrals are logged and followed up through case notes and confirmations from community partners. Refer at least 50 individuals or families to a food assistance program; track through referral logs and food box delivery records.	4 (Avg)
6..	Access and Linkage to Clinical Care-	Number of adults participating in nutrition and physical	All enrolled participants receiving bi-weekly food boxes are invited to	2 (Avg)

	Programming	activity education programming	monthly virtual or in-person classes on healthy pregnancy nutrition, physical activity, and postpartum wellness. Attendance is logged manually or electronically through registration forms or virtual participation logs. Engage at least 20 adults in structured nutrition and physical activity education; attendance and participation recorded by program educators.	

[1] Reports are to be sent directly to Denice Trulley at trulldj@lakecountyin.org.

8. PERFORMANCE EVALUATIONS.
   8.1. Performance will be determined by the LCHD based on performance reports from the Grantee; and the results of the evaluations will be discussed with the Grantee as needed or upon request.

9. ROLES, RESPONSIBILITIES, AND STATUS OF PARTIES
   9.1. Roles.

      9.1.1. The Grantee's role shall be that of educating at-risk population of Lake County, Indiana and a healthy community coalition with a comprehensive, evidence-based program that addresses obesity and obesity-related disease prevention.

      9.1.2. To adequately satisfy the roles of this Agreement, Grantee shall have the required appropriate level of education and experience, as required by each specific area where Services are provided.

      9.1.3. Grantee understands the LCHD utilizes an electronic records system; and further agrees and acknowledges that all records shall be the sole and proprietary property of the LCHD and shall in no way be construed as the property of the Grantee or any of its staff or employees.

      9.1.4. The grantee shall provide adequate workspace, equipment, computers, electronic records systems, and supplies required to deliver the contracted services. Additionally, the Grantee shall provide sufficient security and other staff needed to accomplish required and contracted responsibilities. LCHD shall also provide other support resources that may be required as mutually agreed.

9.1.5. Grantee shall have sole discretion to determine hours and schedules of their staff.

9.2. Responsibilities.

9.2.1. Grantee will review and recommend to LCHD in the development of policies, procedures, protocols, guidelines, quality assurance and improvement processes and reports, health care services and resource utilization processes and reports as needed to ensure effective and efficient delivery of Services.

9.2.2. The Grantee shall be responsible for performance and deliverables as outlined below.

9.2.3. The Grantee shall be responsible for reporting and evaluating (see Section 4) the progress of the project metrics. The Grantee shall submit reports on the progression of the project, following the measures and indicators listed in the proposal.

9.3. Independent Relationship.

9.3.1. LCHD and the Grantee are and shall remain independent contractors with respect to each other. The persons provided by Grantee to perform the services shall be Grantee's employees and shall be wider the sole and exclusive direction and control of Grantee. They shall not be considered employees of the LCHD for any purpose. Grantee shall be responsible for compliance with all laws, rules, and regulations involving, but not limited to, employment of labor, hours of labor, health and safety, working conditions, and payment of wages with respect to such persons. Grantee shall also be responsible for payment of taxes, including federal, state, and municipal taxes chargeable or assessed with respect to its employees, such as Social Security, unemployment, Workers' Compensation, disability insurance, and federal and state withholding. The grantee shall also be responsible for providing reasonable accommodations, including auxiliary aids and services, as may be required under the Americans with Disabilities Act. Supplier agrees to defend, indemnify, and bold harmless LCHD from and against any loss, cost, claim, liability, damage, or expense (including attorney's fees) that may be sustained by reason of Contractor's failure to comply with this paragraph. In any case, LCHD acknowledges that Grantee's indemnification obligation may be limited in substance by laws designed to protect and limit the exposure and liability of Grantee as an instrumentality of the State of Indiana (e.g., actions and conditions as to which Grantee is immunized by the Indiana Tort Claims Act, dollar limits stated in such Act, exemption from punitive damages, and the continued ability to defeat a claim by reason of contributory negligence for fault of the claimant), so that Grantee's liability to indemnify, protect, and/or hold harmless may not exceed what might have been its liability to claimant if sued directly by claimant in Indiana, and all appropriate defenses had been raised by Grantee.

9.3.2. Acting in Individual Capacity. Both parties hereto, in the performance of the Agreement, will act in their individual capacities and not as agents, employees, partners, joint ventures, or associates of one another. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

9.3.3. Ownership. The ownership and right of control of all reports, records, and supporting documents prepared by Grantee pursuant to the Services provided under this Agreement ("Records") shall vest in LCHD and Grantee, and Grantee shall comply with all state, federal, and HIPAA laws and regulations concerning or related to the collection, recording, storage, and release of any and all health care records and/or information.

10. RESOURCES AND FUNDING

10.1. LCHD hereby agrees to provide Grantee with a grant in the amount listed under Section 3. FINANCIAL TERMS, above from its Health First Indiana funding from the State of Indiana to:

10.1.1. Perform the services enumerated in the section above called PERFORMANCE AND DELIVERABLES.

10.1.2. Collect the metrics enumerated in the section above called PERFORMANCE AND DELIVERABLES.

10.1.3. Report on all metrics as required in the section above called PERFORMANCE AND DELIVERABLES.

10.2. Use of funds. Grantee may use the grant funds for the purchase of supplies, certain services (such as printing and other activity-related and pre-approved services), equipment, and staffing FTEs associated with carrying out the above-mentioned services in this contract agreement. The grant funds may not be used for the following per the State of Indiana (this may not be an exhaustive list):

10.2.1. Personal Items,

10.2.2. Items not related to IC 16-46-10-3 (*pursuant to changes made during the 2023 legislative session),

10.2.3. Alcoholic Beverages,

10.2.4. Duplicate Payments and Overpayments,

10.2.5. Capital expenses not permitted by IC 16-46-10-3(c) (such as vehicles, motorized items, trailers, buildings/structures, renovations, etc.),

10.2.6. Scholarships,

10.2.7. Donations,

10.2.8. State or Federal Lobbying,

10.2.9. Political Activity,

10.2.10. Food/Beverages, except those purchased for food demonstrations

10.2.11. Any unallowable expenditure as determined by the Indiana State Board of Accounts,

10.2.12. Any expenditure not allowed by State Law,

10.2.13. Incentives (unless educational or a protective public health measure in nature and with prior approval by the LCHD), or

10.2.14. Other activities or purchases deemed inappropriate by the LCHD.

10.3. Unexpended Funds and Carryover. Any funds provided under this Agreement that remain unexpended at the end of the contract term shall, unless otherwise approved in writing by the Lake County Health Department ("HFI"), either:

10.3.1. be applied to the subsequent contract period for the same program or service if renewed or extended, subject to written approval by LCHD BOH; or

10.3.2. be refunded to Lake County Health Department ("HFI"), within thirty (30) days after the expiration or termination of this Agreement, or at the parties otherwise agree.

10.4. The Grantee shall provide a final expenditure report identifying any remaining balance. Any rollover of funds shall not be automatic and must comply with applicable State Board of Accounts and Indiana Department of Health fiscal policies and procedures.

11. CONFIDENTIALITYAND DATA PROTECTION

11.1. Confidentiality of Materials. Grantee will not disclose to others, either during the term of this Agreement or subsequent to termination, any data, forms, reports, systems or other materials containing confidential information specific to LCHD without the prior written consent.

11.2. Data Protection

11.2.1. The Grantee understands and agrees that data, materials, and information disclosed to the Grantee may contain confidential and protected information. The Grantee covenants that data, material, and information gathered, based upon or disclosed to the Grantee, which is marked as 'confidential' or 'proprietary' for the purpose of this Contract will not be disclosed to or discussed with third parties without the prior written consent of the LCHD.

11.2.2. The parties acknowledge that the services to be performed by Grantee for the LCHD under this Contract may require or allow access to data, materials, and information containing Social Security numbers maintained by the LCHD in its computer system or other records. In addition to the covenant made above in this section and pursuant to 10 IAC 5-3-1(4), the Grantee and the LCHD agree to comply with the provisions of IC § 4-1-10 and IC § 4-1-11. If any Social Security number(s) is/are disclosed by Grantee, and Grantee agrees to

pay the cost of the notice of disclosure of a breach of the security of the system in addition to any other claims and expenses for which it is liable under the terms of this contract.

12. RESIDENCY REQUIREMENT

12.1. As a condition of eligibility for participation in any programs, services, or benefits funded or provided under this Contract, all recipients must be residents of the State of Indiana. The Contractor shall implement and maintain procedures reasonably designed to verify the Indiana residency of each individual recipient prior to the provision of services. Acceptable documentation or methods of verification shall be determined in accordance with applicable state or program-specific guidelines. Failure to comply with this residency requirement may result in disallowance of expenditures, corrective action, or termination of this Contract.

13. DISPUTE RESOLUTION

13.1. Should any disputes arise regarding this Contract, the Grantee and the LCHD agree to act immediately to resolve them. Time is of the essence in dispute resolution.

13.2. The Grantee agrees that the existence of a dispute notwithstanding, it will continue without delay to carry out all of its responsibilities under this Contract that are not affected by the dispute. Should the Grantee fail to continue to perform its responsibilities regarding all non-disputed work, without delay, any additional costs incurred by the LCHD or the Grantee as a result of such failure to proceed shall be borne by the Grantee, and the Grantee shall make no claim against the LCHD for such costs.

13.3. If the parties are unable to resolve a contract dispute between them after good faith attempts to do so, a dissatisfied party shall submit the dispute to the Commissioner of the Indiana Department of Administration for resolution. The dissatisfied party shall give the Commissioner and the other party written notice. The notice shall include (1) a description of the disputed issues, (2) the efforts made to resolve the dispute, and (3) a proposed resolution. The Commissioner shall promptly issue a Notice setting out documents and materials to be submitted to the Commissioner to resolve the dispute; the Notice may also allow the parties to make presentations and enter into further negotiations. Within thirty (30) business days of the conclusion of the final presentations, the Commissioner shall issue a written decision and furnish it to both parties. The Commissioner's decision shall be the final and conclusive administrative decision unless either party serves on the Commissioner and the other party, within ten (10) business days after receipt of the Commissioner's decision, a written request for reconsideration and modification of the written decision. If the Commissioner does not modify the written decision within thirty (30) business days, either party may take such other action helpful to resolving the dispute, including submitting the dispute to an Indiana court of competent jurisdiction. If the parties accept the Commissioner's decision, it may be memorialized as a written Amendment to this Contract if appropriate.

13.4. LCHD may withhold payments on disputed items pending resolution of the dispute. The unintentional nonpayment by the LCHD to the Grantee of one or more invoices not in dispute in accordance with the terms of this Contract will not be cause for the Grantee to

terminate this Contract, and the Grantee may bring suit to collect these amounts without following the disputes procedure contained herein.

13.5. With the written approval of the Commissioner of the Indiana Department of Administration, the parties may agree to forego the process described in subdivision C. relating to the submission of the dispute to the Commissioner.

13.6. This paragraph shall not be construed to abrogate provisions of IC § 4-6-2-11 in situations where dispute resolution efforts compromise claims in favor of the LCHD as described in that statute.

14. INSURANCE AND INDEMNIFICATION

14.1. Insurance. Throughout the term of this Agreement, Grantee and LCHD shall each maintain appropriate commercial and other liability coverage consistent with the limits required thereunder.

14.2. Indemnification. Grantee shall indemnify, defend, and hold harmless LCHD and its agents, Board members, officers, and employees from and against all claims, losses, costs, damages, and expenses (including reasonable attorneys' fees) relating to injury or death of any person which results from or arises in connection with (1) any breach of the Agreement; or (2) any gross negligence or willful act or omission by any Consultant in performing the Services. LCHD shall indemnify, defend, and hold harmless Grantee and its agents, managers, members, officers, and employees from and against all claims, losses, costs, damages, and expenses (including reasonable attorneys' fees) which result from or arises in connection with (1) any breach of the Agreement by Client; or (2) any negligent or willful act or omission by LCHD's personnel. This Section shall survive the termination or expiration of this Agreement. In any case, LCHD acknowledges that Grantee's indemnification obligation may be limited in substance by laws designed to protect and limit the exposure and liability of Grantee as an instrumentality of the State of Indiana (e.g., actions and conditions as to which Grantee is immunized by the Indiana Tort Claims Act, dollar limits stated in such Act, exemption from punitive damages, and the continued ability to defeat a claim by reason of contributory negligence for fault of the claimant), so that Grantee's liability to indemnify, protect, and/or hold harmless may not exceed what might have been its liability to claimant if sued directly by claimant in Indiana, and all appropriate defenses had been raised by Grantee.

14.3. Representations and Warranties. The parties represent and warrant to one another that they have full corporate power and authority to enter into this Agreement and to carry out their obligations hereunder, and this Agreement has been duly authorized by all necessary action on their part. THE FOREGOING WARRANTIES AND OTHERS PROVIDED IN THIS AGREEMENT BY EACH PARTY ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, WITH RESPECT TO THIS AGREEMENT.

14.4. Limitation of Liability. TO THE EXTENT ALLOWED BY APPLICABLE LAW, IN NO EVENT SHALL THE LIABILITY OF EITHER PARTY TO THE OTHER FOR A GIVEN YEAR DURING THE TERM OF THIS AGREEMENT ON ALL CLAIMS OF

ANY KIND, WHETHER IN CONTRACT, WARRANTY, INDEMNITY, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY, OR OTHERWISE, ARISING OUT OF THE PERFORMANCE, NON-PERFORMANCE OR BREACH OF THIS AGREEMENT EXCEED THE TOTAL COMPENSATION RECEIVED OR PAID, AS APPLICABLE, FOR SUCH YEAR. FURTHERMORE, TO THE EXTENT ALLOWED BY APPLICABLE AND EXCEPT FOR THIRD-PARTY CLAIMS, IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, EXEMPLARY, PUNITIVE, CONSEQUENTIAL, OR SIMILAR DAMAGES.

15. COMPLIANCE AND LEGAL REQUIREMENTS

15.1. Compliance. Grantees shall always operate their respective services in compliance with applicable federal, state, and local laws, rules, and regulations, the policies, rules, and professional standards of care, bylaws, and all currently accepted and approved methods and practices of each service area. HIPAA Compliance. The parties agree they will comply in all material respects with all applicable federal and state-mandated regulations, rules or orders applicable to privacy, security, and electronic transactions, including, without limitation, regulations promulgated under Title II Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191) ("HIPAA"). If within thirty (30) days of either party first providing notice to the other of the need to amend the Agreement to comply with Laws, the parties, acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to meet the requirements are not feasible, then either party may terminate this Agreement upon thirty (30) days prior written notice.

15.2. Records. LCHD shall keep and maintain any records relating to the services of this Agreement rendered hereunder as may be required by any federal, state, or local law. Grantee agrees to make its records concerning any of LCHD's patients available to LCHD upon request.

15.3. Equal Opportunity and Affirmative Action. The Grantee agrees by the execution of this Agreement that in regard to its operations, it will fully comply with Lake County Ordinances and Policies providing:

15.3.1. No person shall, on the grounds of race, color, national origin, sex, or sexual orientation (LGBT or lesbian, gay, bisexual, or transgender), be excluded from participation, be denied the benefits of, or be subject to discrimination.

15.3.2. The principles of equal opportunity in employment of delivery of services are applicable and commit to a policy and practice of nondiscrimination and affirmative action based upon age, military service, ancestry, color, national origin, physical handicap, political affiliation, race, religion, and sex or sexual orientation (LGBT or lesbian, gay, bisexual or transgender).

15.3.3. The provisions of the Affirmative Action Program adopted by the Board of Commissioners of the County of Lake on May 31, 1977, and as amended, as applicable, are incorporated by reference as part of this agreement.

15.3.4. The provisions of all Federal Civil Rights laws and Indiana Civil Rights laws, as applicable, are incorporated by reference as part of this agreement.

15.3.5. Breach of any of the equal opportunity and/or nondiscrimination provisions of the Agreement may result in any remedy available to the County in respect to such breach or default.

15.3.6. Where applicable, non-discriminatory and affirmative action clauses shall be part of any agreement, contract, or lease between the Grantee and any organization, corporation, subcontractor, or other legal entity that benefits from the funds paid out by this Agreement.

15.4. Indiana Open Records Law. Information that is the property of LCHD shall be made available in accordance with the Indiana Open Records Law, LC. S-15-5.1-1 et seq. Grantee and LCHD recognize and acknowledge that in some course of performing the services provided hereunder, it may have access to certain confidential or proprietary information and the LCHD's business and computer operations. Grantee hereby agrees that it will not, at any time during or after the term of this agreement, disclose any such confidential or proprietary information to any person unless required by law upon obtaining the prior written consent.

16. ENTIRE AGREEMENT; AMENDMENTS

16.1. Entire Agreement. This Agreement supersedes all previous contracts between Grantee and LCHD related to the subject matter contained herein and constitutes the entire agreement between the parties. Neither Grantee nor LCHD shall be entitled to any benefits other than those specified.

16.2. Termination of Prior Agreements. This Agreement constitutes the sole and entire agreement between the Parties with respect to the subject matter described herein and terminates, cancels, and supersedes any and all prior or existing agreements, contracts, memoranda of understanding, or other arrangements between the Parties related to the same program, project, or services funded under this Agreement. No rights or obligations shall survive from any prior agreement unless expressly restated herein.

16.3. Amendments. No modification or amendment of the provisions hereof shall be effective unless in writing and signed by authorized representatives of the parties hereto. The parties hereto expressly reserve the right to modify this Agreement, from time to time, by mutual agreement and in writing.

17. GOVERNING LAW

17.1. Governing Law.

17.1.1. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed per the laws of the State of Indiana without regard to the choice of law rules.

17.1.2. In the event of litigation between the parties regarding this Agreement, reasonable attorneys' fees of the prevailing Party will be paid by the non-prevailing Party.

17.2. Severability. If any provision of the Agreement is found to be illegal, invalid or unenforceable pursuant to judicial decree or decision, the remainder of the Agreement shall remain valid and enforceable according to its terms so long as the economic or legal substance of the transactions contemplated by this Agreement is not affected in any manner materially adverse to any party. Upon such decree or decision, the parties shall negotiate in good faith to modify this Agreement to affect the parties' original intent as closely as possible in an acceptable manner to the end that the transactions contemplated hereby are consummated to the fullest extent possible.

18. GENERAL PROVISIONS

18.1. Assignment. No assignment of this Agreement will be valid without the specific written consent of the other party, which consent will not be unreasonably withheld.

18.2. Waiver of Breach. Either party's waiver of a breach of any provision of this Agreement will not operate as, or be construed to be, a waiver of any subsequent breach.

18.3. Notices. All notices, requests, demands, and other communications under this Agreement (collectively a "notice") shall be in writing and shall be deemed to have been duly given if delivered by hand, mailed by United States mail, or sent via electronic mail if properly addressed as follows or such other respective addresses as may be specified herein or as either party may, from time to time, designate in writing:

Prenatal Well
Early Connect
235 W. 75th Ave
Merrillville, Indiana 46410
Attn: Dr. Maya Dominique
mdominique@prenatalwell.org

Lake County Health Department
Administrator Sheila Paul
2900 West 93rd Ave.,
Crown Point, IN 46307
paulsl@lakecountyin.org

18.4. Cancellation. The LCHD may at any time cancel this agreement in whole or in part for its sole convenience upon written notice to Grantee, and Grantee shall stop performing the services on the date specified in such notice. The LCHD shall have no liability as a result of such cancellation, except that the LCHD will pay the Grantee for completed

services accepted by the LCHD and the actual incurred cost to the Grantee for services in progress.

18.5. Executory Agreement. This Agreement will not be considered valid until signed by both parties.

18.6. All Information Matter of Public Record. All information gathered during the process of submitting for, being approved for, submitting reports for, or communicating about this grant, award, or subsequent data or financial reporting is a matter of public record unless otherwise precluded from release by Indiana or other law. By signing this contract, you are indicating that you understand this in its entirety and that you realize information about this award or your entity as gathered by the Lake County Department of Health will be reported as required to other governmental agencies on the LCHD website, or in other related reports. Further, it means that if information about this grant program and its awardees is requested by a public records request, all submitted information may be released as required under Indiana law.

18.7. Execution. This Agreement and any amendments may be executed in the original, by facsimile or by any generally accepted electronic means (including transmission of a .pdf file containing an executed signature page) in one or more copies on behalf of Grantee or LCHD, each of which shall constitute an original and all of which together shall constitute one and the same instrument.

18.8. Force Majeure. LCHD shall not be liable or deemed in default for any delay or failure in performance under this Agreement or interruption of the Services resulting, directly or indirectly, from circumstances beyond its control, including without limitation, acts of government, acts of God, fires, floods, explosions, riots, civil disturbances, strikes, insurrections, terrorism, earthquakes, wars, rebellion, and epidemics. Grantee shall use reasonable efforts to notify LCHD of any factor, occurrence or event that may cause any such delay or failure.

*** * *SIGNATURE PAGE FOLLOWS* * ***

Prenatal Well

By: _____ Date:_____
Otis Dominique, Director of Operations

BOARD OF HEALTH FOR LAKE COUNTY HEALTH DEPARTMENT

BY: _____ Date: _____
Chiedu Nchekwube, M.D.
President, Board of Health for Lake County Health Department

The Board of Health for Lake County Health Department, Indiana, hereby recommends this contract to the Lake County Board of Commissioners, Indiana.

LAKE COUNTY BOARD OF COMMISSIONERS

_____
Kyle Allen, Sr., 1st District

_____
Jerry Tippy, 2nd District

_____
Michael C. Repay, 3rd District