 Exhibit “G”

Subrecipients

Continuous Quality Improvement

Monthly Reporting

Program Name:

Month/ Year:

Grant Number:

# PROGRAM HIGHLIGHTS AND INFORMATION SUMMARY

# Palm Beach Delegate Agency:

# Goals and Objectives

**Program Goal 1:**

**Objective:**

**Objective:**

**Objective:**

**Objective:**

**Objective:**

**Program Goal 2:**

**Objective:**

**Objective:**

**Objective:**

**Objective:**

**Program Goal 3:**

**Objective:**

**Objective:**

**Program Goal 4:**

**Objective:**

**Objective:**

**Program Goal 5:**

**Objective:**

# COMMUNITY OUTREACH AND EVENTS

Please identify the full name of community events and what you learn from events

LUTHERAN SERVICES FLORIDA, INC. HEAD START POLICY COUNCILS Date of Meeting, Policy Council meeting approved the following actions items

**LSF HEAD START**

# CHILDREN WITH DISABILITIES

|  |  |  |
| --- | --- | --- |
| **Year to Date Children with Disabilities** |  |  |
| **Programs** | **Head Start** | **Early Head Start** | **Program Total** | **The number of referrals** | **The cumulative number of referrals** |
| **Delegate:**  |  |  |  |  |  |

**If the disabilities is below 10%, please write plan of action in 2 sentences.**

**Plan of action**: **(2 sentences required)**

# ENROLLMENT

|  |
| --- |
| **Current Enrollment (CE) VS Funded Enrollment (FE)** |
| **Programs** | **CE Head Start** | **FE Head Start** | **CE Early Head Start** | **FE Early Head Start** |
| **Delegate**  |  |  |  |  |

**If the current enrollment is below funded enrollment, please write plan of action in 2 sentences.**

**Plan of action: (2 sentences required)**

**TOTAL CHILDREN SERVED**

|  |
| --- |
| **Year-to-Date Total Participation of Children** |
| **Programs** | **Head Start** | **Early Head Start** |
| **Delegate** |  |  |

# VOLUNTARY PRE-KINDERGARTEN (VPK):

|  |  |  |
| --- | --- | --- |
| Programs | Current VPK Enrollment | VPK Supposed to be |
| **Delegate** |  |  |

# AVERAGE DAILY ATTENDANCE

|  |
| --- |
| **Average Daily Attendance (ADA)** |
| **Programs** | **Head Start** | **Early Head Start** |
| **Delegate** |  |  |

**If the current ADA is below 85%, please write plan of action in 2 sentences.**

**Plan of action: (2 sentences required)**

# WAITING LIST

|  |
| --- |
| **Number of Children on Head Start/Early Head Start Waiting List** |
| **Programs** | **Head Start** | **Early Head Start** |
| **Delegate** |  |  |

# If your waiting list goes down from previous month, please send the plan of action.

# Plan of action: (2 sentences required)

# PROGRAM MEAL COUNT

|  |
| --- |
| **MEAL COUNT** |
| **Programs** | **BREAKFAST** | **LUNCH** | **SNACK**  | **TOTAL** |
| **Delegate** |  |  |  |  |

# *NOTE: Please remember to attach all supporting documentations.*