**New Jersey Department of Children and Families**

**Risk Assessment Tool for Local Implementing Agencies (LIA)**

**of Evidence-Based Home Visitation (EBHV) Services**

This assessment should be completed by someone in the organization who is knowledgeable about the EBHV program and the accounting system, for example the Director and/or Chief Financial Officer.

The purpose of this assessment is to ensure the process for evaluating the LIA’s risk of noncompliance with statutes, regulations, and the terms and conditions of the grant/sub-grant and how monitoring activities may be enhanced based upon the risk assessment. Completion of this form also meets state and federal requirements.

A separate assessment must be completed annually for each individual EBHV program

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| State Fiscal Year: Choose an item. | | | |
| Organization Name: Click or tap here to enter text. | | | |
| Organization’s Mailing Address: Click or tap here to enter text. | | | |
|  | | | |
| DCF Contract Number: Click or tap here to enter text. | | | |
| Unique Entity ID *(12 character ID as assigned by SAM.gov):* Click or tap here to enter text. | | | |
| Is your organization registered in SAM.gov and searchable? | Yes | No | Not Sure |
|  | | | |
| EBHV Program Model for Which this Risk Assessment is Applicable to:  Choose an item. | | | |
| County Served: Choose an item. | | | |

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| **Funding of Organization** | | | | | | |
| 1. For the state fiscal year identified above, indicate the total anticipated award amount from DCF for this program. | | | Click or tap here to enter text. | | | |
| 1. Of the total award, list the award amount per funding source and the number of positions funded by the award. | | | | | | |
| **MIECHV**  APU: 1630-044  N/A  Click or tap here to enter text. | **TANF Kids Needs**  APU: 1630-039  N/A  Click or tap here to enter text. | **TANF TIP**  APU: 1630-040  N/A  Click or tap here to enter text. | **PSSF IV-B**  APU: 1610-062  N/A  Click or tap here to enter text. | **Universal HV**  APU: 1630-100  N/A  Click or tap here to enter text. | **DFCP/Grants in Aid**  APU: 1630-010  N/A  Click or tap here to enter text. | **Other: Specify**  N/A  Click or tap here to enter text. |
| Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. | Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. | Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. | Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. | Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. | Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. | Full Time = Click or tap here to enter text.  Part Time = Click or tap here to enter text. |

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| **Accounting System** | | | |
| 1. Which best describes your organization’s accounting system. | Automated | Manual | Combination |
| 1. Does your organization have an accounting system that will allow you to track the receipt and disbursements of funds related to this award? | Yes | No |  |

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| **Organization’s Information: Management and Fiscal** | **Yes** | **No** |
| 1. Has your organization been in existence for more than 10 years   Please indicate the number of years: Click or tap here to enter text. |  |  |
| 1. Is this the first time your organization has received this award from the Department of Children and Families? |  |  |
| 1. Does your organization have prior experience with similar programs? |  |  |
| 1. Does your organization sub-contract part of the award?   If so, list amount: Click or tap here to enter text. |  |  |
| 1. Does your organization have a way to determine who is a contractor vs. subrecipient? |  |  |
| 1. Are you required to match federal funds with your entity’s non-federal funds?   If so, will your organization be able to meet match/cost share amounts? |  |  |
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| 1. Does your organization’s financial and programmatic staff who oversee this grant have more than one-year of prior federal grant experience? |  |  |
| 1. Does your organization assign personnel to monitor award budget so the award ceiling and/or administrative caps are not exceeded? |  |  |
| 1. Does your organization have a system in place which can track employee time spent on multiple programs? |  |  |
| 1. Does your organization have a procurement system or procedures in place that meet the minimum federal requirements for procurement? |  |  |
| 1. Does your organization have internal controls and monitoring in place? |  |  |
| 1. Does your organization have a federally approved indirect cost rate?   If yes, please list the current rate: Click or tap here to enter text. |  |  |
| 1. Does your organization have fiscal policies to ensure braided budgets and contracts?\* |  |  |
| 1. Does your organization have a capital management system that meets the minimum federal requirements for equipment management? |  |  |
| 1. Does your organization have an annual audit?   Please list any unresolved audit findings: Click or tap here to enter text. |  |  |
| 1. Does your organization have one or more audit findings from the last single audit? |  |  |
| 1. Has your organization incurred any debt in the past year? |  |  |
| 1. Has the organization had any lawsuits or compliance issues? |  |  |
| **Organization’s Information: Programmatic** |  |  |
| 1. Does your organization have adequate technology to meet the grant requirements? |  |  |
| 1. Within the last 12 months, has your organization had staff turnover within the EBHV program?   If so, please list the positions: Click or tap here to enter text. |  |  |
| 1. Does your organization have policies on staff training and professional development? |  |  |
| 1. As of June 30th, is the EBHV program operating within compliance of the expected Level of Service (LOS)? *Defined as at least 85% of expected LOS*   List the percentage of LOS utilization for the past 12 months: |  |  |
| **MIECHV Funded Organizations Only** | **Yes** | **No** |
| 1. Is the program in compliance with the HRSA scope of work and requirements? |  |  |
| 1. Is the program funded by this grant currently meeting HRSA deliverables?   If not, please add a note: Click or tap here to enter text. |  |  |
| 1. Does your organization maintain policies which include procedures for assuring compliance with the terms of this funding? |  |  |

\* *Braided funding pools multiple funding streams toward one purpose while separately tracking and reporting on each source of funding. Blended funding combines, or “comingles,” multiple funding streams for one purpose without continuing to differentiate or track individual sources.*

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| *I declare and affirm that all the information listed in this risk assessment is true and accurate to the best of my knowledge.* |
| Printed Name: Click or tap here to enter text. |
| Signature: |
| Title: Click or tap here to enter text. |
| Phone: Click or tap here to enter text. |
| Email: Click or tap here to enter text. |
| Date: Click or tap to enter a date. |

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| NJ DCF Use Only |
| Date Risk Assessment Received: Click or tap to enter a date. |
| Name of DCF Reviewers: Click or tap here to enter text. |
| Risk Assessment Score: Choose an item. |
| Date Risk Assessment Score Shared with LIA: Click or tap to enter a date. |

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| NJ DOH Use Only (if applicable) |
| Date Risk Assessment Received: Click or tap to enter a date. |
| DOH Staff Person: Click or tap here to enter text. |