

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

June 8, 2022



RE: Request to use the MAPP planning process for developing IPLAN



The Illinois Department of Public Health (IDPH) has approved your request to use the Mobilizing for Action through Planning and Partnership (MAPP) planning process as an equivalent to the Illinois Project for Local Assessment of Needs (IPLAN) process to develop your IPLAN. Please be advised that your MAPP IPLAN submission shall comply with the requirements of Section 600.400 and Section 600.410 of the Certified Local Health Department Code. Please find enclosed the "IPLAN Standards and MAPP Crosswalk," which provides a detailed outline of how MAPP components correlate with these requirements and other items you may need to achieve a substantial compliance. Note that the IDPH's approval of MAPP process as an equivalent to the IPLAN process is based on the expectation that the local health department and its community partners are committed to the planning process and will complete all four MAPP assessments, maintaining fidelity to the MAPP model.

Please feel free to contact the IPLAN Administrator JoAnne Bardwell me at 217-782-0847 or <u>DPH.IPLAN@illinois.gov</u>, should you have any questions regarding this communication.

Sincerely,

Jennifer Epstein

Jennifer Epstein Deputy Director

On behalf of JoAnne Bardwell IPLAN Administrator Office of Policy, Planning, and Statistics Division of Health Data and Policy

Enclosure

cc: Mark Stevens. Regional Health Officer, Marion Region

IPLAN File



July 11th, 2023,

IPLAN Administrator
Division of Health Policy
Illinois Department of Public Health
525 West Jefferson Street
Springfield, Illinois 627

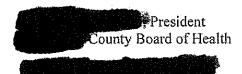
To whom it may concern:

At its May 8th, 2023 meeting, the County Board of Health approved the County Community Organizational Capacity Assessment.

At its July 10th, 2023 meeting, the county Board of Health approved the County Health Department IPLAN.

The Board applauds the efforts of the Effingham County Health Coalition and looks forward to seeing the results of their community health improvement efforts.

Sincerely,





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May 2, 2022

Mark Stevens Marion Regional Office 2309 West Main Street Marion, Illinois 62959

Dear Mr. Stevens:

The Illinois Department of Public Health (IDPH) has verified that the qualification requirements for the position of Public Health Administrator under the Certified Local Health Department Code (77 Ill. Adm. Code 600). Therefore, I am pleased to notify you that I have approved as the Public Health Administrator for the County Health Department.

Please feel free to contact the IDPH Office of Policy, Planning and Statistics at 217-782-0847, should you have any questions.

Very truly yours,

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Amaal V.E. Tokars

Acting Director

cc: IPLAN File

LOCAL HEALTH DEPARTMENTS ARE REQUIRED TO HAVE AN AFFIRMATIVE ACTION PROGRAM THAT PROHIBITS DISCRIMINATION IN EMPLOYMENT PRACTICES ON THE BASIS OF RACE, SEX, COLOR, RELIGION, NATIONAL, ORIGIN, PHYSICAL OR MENTAL HANDICAP.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH PERSONNEL INFORMATION FORM

THE PURPOSE OF THIS FORM IS TO ADVISE THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH OF ALL PERSONS HIRED OR TO BE HIRED BY LOCAL HEALTH DEPARTMENTS AS AN EXECUTIVE OFFICER FOR WHICH A MINIMUM PERSONNEL QUALIFICATION STANDARD HAS BEEN ESTABLISHED. A DETERMINATION AS TO WHETHER THE APPLICANT MEETS ALL APPLICABLE EDUCATIONAL AND EXPERIENTIAL QUALIFICATIONS WILL BE MADE AND RETURNED TO THE ORIGINATOR WITHIN 45 DAYS OF RECEIPT OF COMPLETED FORMS. SUBMIT THIS FORM AND ALL ATTACHMENTS IN DUPLICATE. MAIL TO: ILLINOIS DEPARTMENT OF PUBLIC HEALTH, IPLAN ADMINISTRATOR, 525 WEST JEFFERSON STREET, 2ND FLOOR, SPRINGFIELD, IL 62761.

			PLEAS	SE PRINT	T OR TYPE					
Local Health Dept:						Date:				
Applicant's Name:										
Position: ☐ Public Health Administrator ☐ Medical Health Officer						Date of Hire:(or to be hired)				
College Transcripts Attached: □Ye	s ⊡No		Copy of	Applical	ble Certificates o	or Licenses At	tached: □Y	es □No		
Signature of Board of Health President	dent or Auth	orized Des	ignee:							
			APPLIC	ANT INF	ORMATION					
LAST NAME		MIDDLE			MAIDEN					
STREET ADDRESS	CITY	COUNTY		ZIP CODE		PHONE #				
				EDUCAT	<u>TION</u>					
NAME AND ADDRESS OF INSTITUTION	CREDITS EARNED		NAME OF MAJOR		NAME OF MINOR	DATES ATTENDED		TYPE OF DEGREE EARNED	DATE ISSUED	
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PROFESSIONAL LICENSE NUMBER OR CERTIFICATION		STA		ATE IN WHICH ISSUED	DATE ISSUED		DATE APPLIED FOR			
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I SIGNIFY THAT THE INFORMATION REALIZE THAT MISREPRESENTATE APPLICATION. SIGNATURE OF APPLICANT	TION OF THI	IS INFORM	ATION A	AT ANY	TIME MAY BE C					

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