Florida Network for Youth and Family Services
Compliance Monitoring Report for

Nehemiah Educational and Economic Development (N. E. E. D.)

611 N. Wymore Rd, Suite #203
Winter Park, 32789

December 14, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Nehemiah Educational and Economic Development (NEED) for the FY 2023-2024 at its program office located at 611 N. Wymore Road, Suite 203, Winter Park, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Nehemiah Educational and Economic Development is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from NEED present for the entrance interview were: Venus Highsmith, Director of Youth Services; Dr. John Robinson, Clinical Psychologist; and Data Specialist Minnie Jackson. The last onsite QI visit was conducted January 25, 2023.

In general, the Reviewer found that NEED is not in compliance with some of the contract requirements. **NEED received an overall compliance rating of 40% for achieving full compliance with only four of ten applicable indicators** of the CINS/FINS Monitoring Tool. There are four corrective actions as a result of the monitoring visit and two recommendations made for indicators rated as conditionally acceptable.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-25-2023-2024

Agency Name: Nehemiah Educational and Economic Development (N.E.E.D.)	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 611 N. Wymore Rd., Suite 209, Winter Park,**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 25, 2023**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☒	☐	☐	☐	The program currently has one staff, Minnie Thompson, who is currently qualified to participate as a peer. Javis Mays was previously certified but is in need of refresher training prior to participating as a peer. Terrence Middleton need refresher training,	**Corrective Action:1)** Provider must maintain at least two staff members who have been trained and qualify as QI peers.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☐	☐	☒	NEED does not have any additional funding sources.	**No recommendation or Corrective Action.**
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of	☐	☒	☐	☐	☐	Documentation: The agency is insured for General Liability by Underwriters at Lloyd's, London at $1,000,000 each/$3,000,000 aggregate, $50,000 damage to rented premises, and $5,000 medical	**Corrective Action:2)** The provider needs to submit renewal insurance documentation for coverages that expired 10/30/2023.

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
$500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						expenses. The policy is effective 10/30/2022 – 10/30/2023. Professional Liability by Underwriters at Lloyds, London at $1,000,000 each/$3,000,000 aggregate, effective 10/30/2022 – 10/30/2023. The Florida Network is listed as Certificate Holder upon request.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	NEED does not have any corrective actions cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are maintained in the agency's Accounting Policies and Procedures Manual that are general and provide for limited internal controls. The Accounting	**No recommendation or Corrective Action.**

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Policies and Procedures were last reviewed March 2022.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☒	☐	☐	☐	☐	Interview Per interview with the executive director, the agency had technical issues with QuickBooks, its bookkeeping software, and was unable to furnish an accurate copy of its general ledger. Efforts are underway to correct the issue.	**Corrective Action: 1)** Agency must submit a general ledger that is set up for the CINS/FINS program and ensure the ledger is an accurate accounting of grant funds.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in petty cash practice was reported for the agency. The agency has a petty cash system for program clients and staff/team members for occasional program events and outings. The request for cash is a form-based justification process and is required to be processed in advance via a check request or official cash request. As of the date of the review, there were no examples of the program	**No recommendation or Corrective Action.**

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						utilizing a petty cash request for the current fiscal year.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☒	☐	☐	☐	☐	Interview Per interview with the executive director, the agency had technical issues with QuickBooks, its bookkeeping software, and was unable to furnish an accurate report of bank reconciliations for the review period. Efforts are underway to correct the issue.	**Corrective Action: 2)** Agency must submit bank statements and corresponding bank reconciliations for the past six months demonstrating bank statements are compared (or reconciled) with the items that are entered in the agency's general ledger.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Interview Per interview with the program director, the program has not purchased any items with FNYFS funds during the past year.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☒	☐	☐	☐	☐	No documentation submitted.	**Corrective Action: 3)** Agency must submit proof of payroll tax payments/deposits, Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms.

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☒	☐	☐	☐	☐	No documentation submitted. Per interview with the executive director, the agency had technical issues with QuickBooks, its bookkeeping software, and was unable to furnish a budget to actual report.	**Corrective Action: 4)** Agency must submit Budget to actual report for the current fiscal year to date to compare the program's predicted budget to the amount actually expensed in order to find the variance and identify unusual spending activities.
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☐	☐	☒	Interview Per interview with the program director, the annual expense for NEED is not greater than $750,000. The agency is not required to submit an annual Single audit from an outside agency. No Management Letter is applicable or required.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation reviewed included policy and procedures regarding confidentiality, record storage and data security and disposal contained in policy #2.07, Youth Records and Storage and Laptop Security Policy.	**No recommendation or Corrective Action.**
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. ON SITE	☐	☐	☒	☐	☐	Interview and documentation; A review of consultant contract, and written documentation states contracted staff is paid at minimum $19 per hour for training and above that for services provided to youth/family.	**No recommendation or Corrective Action.**

CONCLUSION

NEED has not met the requirements for the CINS/FINS contract as a result of lack of compliance with six of ten applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Four of the fourteen indicators were not applicable because: 1) the agency does not have any additional funders; 2) there are no corrective actions with external funders; 3) no new inventory has been purchased with Florida Network funds; and 4) the agency is not required to complete a single audit because its annual expense for NEED is not greater than $750,000. Consequently, **the overall compliance rate for this contract monitoring visit is 40%.** There are six corrective actions cited as a result of the contract monitoring visit. Overall, the provider does not demonstrate satisfactory performance in meeting the fiscal and administrative terms of its contract.

SUMMARY OF CORRECTIVE ACTIONS

Corrective Action: 1) Agency must submit a general ledger that is set up for the CINS/FINS program and ensure the ledger is an accurate accounting of grant funds.

Corrective Action: 2) Agency must submit bank statements and corresponding bank reconciliations for the past six months demonstrating bank statements are compared (or reconciled) with the items that are entered in the agency's general ledger.

Corrective Action: 3) Agency must submit proof of payroll tax payments/deposits, Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms.

Corrective Action: 4) Agency must submit Budget to actual report for the current fiscal year to date to compare the program's predicted budget to the amount actually expensed in order to find the variance and identify unusual spending activities.

Corrective Action: 5) The provider must maintain at least two staff members who have been trained and qualify as QI peers.

Corrective Action: 6) The provider needs to submit renewal insurance documentation for coverages that expired 10/30/2023.

The provider must submit a corrective action plan to address four corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Nehemiah Educational and Economical Development (NEED)
Orlando, Florida
Community Counseling Program

December 14, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Not Applicable
1.07 Outreach Services	Limited

Percent of indicators rated Satisfactory: 85.71 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Not Applicable

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 94.12 %
Percent of indicators rated Limited: 5.88 %
Percent of indicators rated Failed: 0 %

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Heather Molinario– Regional Monitor, Department of Juvenile Justice
Shashondalyn Upson – Orange County Youth and Family Services
Paulette Hinton (Shadowing) – Orange County Youth and Family Services

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2023).

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director		Direct – Care Full time		# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	1	# Other (listed by title): Data Specialist
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan		Youth Handbook
	CCC Reports		Grievance Process/Records		# Health Records
	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	3	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans		Program Schedules	7	# Youth Records (Open)
	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline		Staff Supervision of Youth
	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
	Recreation		Toxic Item Inventory & Storage		First Aid Kit(s)
	Searches		Discharge		Group
	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration		Staff Interactions with Youth		Census Board

Surveys

0	# of Youth	2	# of Direct Staff		# of Other

Comments

A Quality Improvement Program Review was conducted for FY 2023-2024.

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Strengths and Innovative Approaches

Nehemiah Educational and Economical Development, Inc. (NEED) is a non-profit, human services agency located in Winter Park, Florida. NEED contracts with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) community counseling services to youth and families in Orange County at large and target areas Pine Hills, West Orlando, and Eatonville. NEED serves the community by providing medical case management, housing and transportation services, and programs specifically designed to assist those at-risk socially and physically. With a special focus on youth and elderly members of the community, NEED, Inc. teaches valuable self-sufficiency skills and provides resources to help those at-risk overcome difficult situations. In addition to CINS/FINS, NEED is also contracted with the Florida Network to provide Family Youth Respite Aftercare Services (FYRAC) services to youth charged with domestic violence (DV) or at risk of violating their probation (Probation Respite).

The following programmatic updates were provided by the agency:

Staffing

During the current review period, the executive management structure for NEED remains intact with no change in key leadership positions such as the Executive Director, Youth Services Director, contracted licensed Psychologist, four part time CINS/FINS Case Managers, and two part time FYRAC case managers. All Case Managers have a bachelor's degree or master's degree. The program is also supported by two administrative assistants/data specialists. One of the data specialists works remotely as of November 2024. The data team communicate and work well together to ensure the program continues to meet its contract deliverables.

Program updates

The program offices are located at 611 N. Wymore Rd., Suite 203, Winter Park FL 32789, serving Orange County, Circuit 9. The service practice model is in-home services, school visits, and virtual services if requested by parent/guardian. Youth files are maintained in paper form and stored in file folders. NEED is contracted to serve CINS/FINS and FYRAC DV/Probation population.

Other Programmatic Features

Majority of case management staff have Bachelor level or above degrees. The program recognizes and shows appreciation to staff in an effort to retain them in face of nationwide staff shortages. NEED has continued its partnership with ACE School, thereby allowing staff to continue to receive referrals when there was a slowdown of referrals statewide. The program focuses on outreach and services in the target areas , Pine Hills, West Orlando, and Eatonville. Currently, NEED has exceeded its contract benchmarks for youth served, 161, which represented 103% of our contract and achieved 100% Overall on Annual Agency Report Card from the Florida Network for 2022-2023.

Major Challenges

There are currently no major challenges. The program addressed its corrective action plan resulting from the last Annual QI review for the Florida Network in last fiscal year.

Narrative Summary

NEED is under the leadership of an Executive Director and a Youth Development Director who oversees the CINS/FINS and FYRAC DV/Probation programs. Program staff includes: a contracted licensed Psychologist, four part time case managers, a mentor, and two administrative assistants/data specialists. As previously mentioned, the data specialists participated in the testing of NetMIS 3 client information system and are fully trained and prepared for data entry in both NetMIS and JJIS. There were no vacant positions at the time of the onsite visit. The program has not reported any major challenges, incidents, administrative review, or current external investigation.

The overall findings for the program QI Review are summarized as follows:

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**, Indicator 1.03 Incident Reporting was rated **Satisfactory**, Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory,** Indicator 1.06 Client Transportation is **Not Applicable**, and Indicator 1.07 Outreach Services was rated **Limited.**

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory**, Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception**, Indicator 2.03 Case/Service Plan was rated **Satisfactory**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**, Indicator 2.05 Counseling Services was rated **Satisfactory**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**, and Indicator 2.09 Stop Now and Plan (SNAP) is **Not Applicable**.

Standard 4: There are five indicators for Standard 4 but only one is applicable to community counseling providers. Indicator 4.02 was rated **Satisfactory.**

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

Standard 1:
Indicator 1.07 - Limited
No evidence was provided to support Director of Youth Services and/or Program President's attendance to all of the DJJ advisory board meetings held during the past six months.

No new interagency agreements were initiated since 2018. Five of the current agreements are outdated with prior local political or elected leaders no longer in their positions.

Documentation to support outreach activities is incomplete. Four of five reviewed outreach activities were missing at least one required documentation element. Some outreach information documented is inaccurate. Netmis report included outreach activity documented 12.21.2023; documentation is for 11.21.2023. Activity for 10.25.2023 in Netmis indicates an individual meeting with one DJJ supervisor; documentation for same date has a meeting with 10 DJJ employees and there is no sign-in sheet.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** Narrative guidelines: The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**NO**	
	If NO, explain here: Current policy and procedure is missing requirement for submission of the Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) to the DJJ Background Screening Unit by January 31st of each year. It is also missing elements for retaking the pre-employment assessment if a passing score in not obtained as well as rehiring of staff with break in service less than 180 days.	
	The program has a policy #1.01 Background Screening that was reviewed and approved by the Director of Youth Services on 12/11/2023. The policy was updated 12/14/2023 to reflect the missing information.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Total number of New Hire Employee/Intern/Volunteer Files: 1 new hire file
Total number of 5 Year Re-screen Employee Files: 2, 5-year rescreened staff files
Staff Position(s) Interviewed *(No Staff Names)*: **Program Director**
Staff roster, Department of Juvenile Justice Background Screening results, Avatar Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	NEED uses the Avatar pre-employment assessment tool. During the QI period, the Avatar was administered prior to hiring one new staff and the staff received a passing score.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	One applicable staff who completed the suitability assessment received a passing score.	

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The one applicable new hire is not a prior employees.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	Background screening for one applicable new hire was initiated prior to hire/start date with eligibility documented on the DJJ background screening results. There were no exemptions required. There were no new interns/volunteers utilized during the review period.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Compliance**	The program had two applicable rescreened employees during the review period. Both employees were observed to have valid retained prints on their DJJ Background screenings.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	Provider emailed the Annual Affidavit of Compliance with Level 2 Screening to DJJ Background Screening Unit on 1/24/2023 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for the one new hire.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**NO**	
		If NO, explain here: Current policy approved 1/3/23 does not address the program's grievance process (must have an accessible and responsive process) for youth to provide feedback and address complaints. In addition, the policy does not include the program's procedure for reporting and documenting abuse calls.	
		The program has a policy #1.02 Abuse Reporting/Abuse Free Environment that was reviewed and approved by the Director of Youth Services on 1/3/2023. The policy was updated 12/14/2023 to reflect the missing information.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Program Director **Type of Documentation(s) Reviewed: Code of Ethics, program brochure, grievance policy** **Describe any Observations: Abuse Hotline posting**			

Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Code of conduct is discussed with staff during orientation and documented on the program's Self Study Training certification form which includes the signature of the staff and instructor. Training is in process but not yet completed for one staff who was recently hired. The director also reviews DJJ's State Employment Policies code of ethics with new hires during orientation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Exception**	Per the director of youth services, the program has not made any calls to the abuse hotline since the last QI review. The current protocol in place for reporting and documenting abuse calls was assessed. Reviewer did not observe where the program had a specific form for documenting the call to the hotline or a log that is used to document calls made.	The current process in place for reporting abuse calls does not include documenting the call on a reporting form and maintaining a log of calls made.
Youth were informed of the Abuse and Contact Number	**Exception**	The program director indicated youth and parent/guardian receives a packet of information about the program and services to be provided. However, no documentation was provided to support youth are informed about the abuse hotline and contact number.	There is no evidence youth are informed about the abuse hotline during intake.
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The program director has a log for tracking grievances. The log indicates zero grievances for the past year. Per interview with the program director, youth receive information about the grievance procedures during intake. All 10 records reviewed included a form signed by youth acknowledging receipt of the grievance procedures. No grievances were reported during the review period.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Not Applicable**	NEED is not a residential provider.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Not Applicable**	NEED is not a residential provider.	
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**No eligible items for review**	No grievances were reported by the program for the past year.	

1.03: Incident Reporting			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The program has the required policy #1.03 Incident Reporting that was reviewed and approved by the Director of Youth Services on 12/14/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Policy and Procedures, DJJ CCC Incident Detail Report**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**No eligible items for review**	Per DJJ CCC Incident Detail Report and the program director, the program had no reportable CCC incidents since the last QI review.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**		
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**No eligible items for review**		
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**		
All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**		
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The program has the required policy #1.04 Training, that was reviewed and approved by the Director of Youth Services on December 11, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: 1 **Total number of Annual In-Service Staff Files: 5** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 0** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: first 90-days; annually from date of hire every year thereafter** **Type of Documentation(s) Reviewed: Staff training records, annual training plans, policy**			

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**No eligible items for review**	The program hired one new staff during the annual review period. The new staff was hired ten days prior to the annual compliance review. The new staff is in the process of completing pre-service training and has completed eleven hours of training since the date of hire.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**No eligible items for review**	Date of hire for one new staff is 12/4/2023. Staff is still within the 30 day period for completing the DOJ Civil Rights training.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**No eligible items for review**	One new staff is still within the first full year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**No eligible items for review**	One new staff is still within the first 90 days of employment.	
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	One new hire is a case manager who is still in training and has not yet been assigned cases.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	One new staff is still within the first full year of employment.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Not Applicable**	NEED is not a residential provider.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	A review of five staff training records was conducted for in-service training. Three of five staff have completed more than the required twenty-four hours of in-service training; the remaining two records are still within the year for training. The program sets the staff training year from the date of hire. Four of five staff records have completed all mandatory annual training.	One of five in-service staff record contained documentation of the CPR/First Aid certifications which expired in April 2023 and no valid certificate is on file.
N/A			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program does have a training plan for pre-service and in-service staff.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The program does have a single clerical staff who is responsible for maintaining staff training records.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Exception**	The program maintains individual staff training records and utilizes a training log in accordance with the policy and standard; however, the Florida Network Training Logs appear to be different for all staff reviewed. Each staff log was missing several contractually required trainings; therefore completed trainings may not be captured.	The training log utilized by the program allows for trainings to go undocumented, or missed, as it is not a standardized Florida Network training log with all required trainings. Each training log is created as the staff completes training; adding the completed training to the log in list form, rather than having the required training listed and documenting completion.
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	**YES**		
	If NO, explain here:		
	The program has a policy 1.07 Analyzing and reporting Information, reviewed and approved by the Director of Youth Services on December 14, 2023.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: NetMIS, letter to Board of Director after last year's Annual Compliance Review** **Describe any Observations: Good attempts being made at documentation of data and trends; however, there is a lack of chronological data collection and storage to review.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The program documents case record reviews within each case management record, and the reviews are conducted on a quarterly basis, or more frequently.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The program utilizes a monthly log to document incidents, accidents and grievances made. The program did not have any of these to document during this annual compliance period.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The program utilizes youth and parent surveys at the conclusion of services to obtain customer satisfaction data. Survey results requiring attention are addressed by the program director with staff at staff meetings.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**Compliance**	The program director utilizes NetMIS reports, on a monthly basis, to review outcome data regarding service delivery. This data is discussed and provided to the program's president on a monthly basis. The program's president is responsible for communicating the data to the Board of Directors.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program's process to review and reconcile data is to discuss the outcomes under 100% with staff and the program director. Identified improvements will be placed into practice. This practice was described by the program director in an informal interview. The program also has two data specialist who are responsible for ensuring NetMIS data is entered accurately and reconciles any incorrect data when such is communicated by the Florida Network.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The program director reviews NetMIS reports and data trends, on a monthly basis and communicates this information to staff during staff meetings as well as to the agency's president who informs other stakeholders.	

There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The program does provide, in writing, to the Board of Director all annual compliance review findings and ratings. A copy of the letter sent to the Board of Director after last year's Annual Compliance review was reviewed.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The program director schedules regular meetings with staff to address program outcomes and compliance issues to ensure corrective action is taken for any issues identified.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**N/A** If NO, explain here: NEED CINS/FINS program does not transport youth.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Not Applicable**	NEED CINS/FINS program does not transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Not Applicable**		
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Not Applicable**		
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Not Applicable**		
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Not Applicable**		
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Not Applicable**		

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The program has a policy 1.05 Outreach Services and 1.05A Linkage To Local Community Services, reviewed and approved by the Director of Youth Services on December 11, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: NetMIS Outreach Report,**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Exception**	The program has two position titles, Director of Youth Services and Program President, who are responsible for involvement and attendance to community meetings and boards. There was no position description or written policy to review which details the responsibilities of these positions and mandated attendance to which meetings and boards. A job description for the case manager position was provided that includes outreach activities as one of the duties; however, these individuals are not mandated to attend DJJ advisory meetings.	No evidence was provided to support Director of Youth Services and/or Program President's attendance to all of the DJJ advisory board meetings held during the past six months.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Exception**	The program had documentation for eleven signed agreements with community partners from 2015 and one agreement from 2018; however, five of twelve agreements were with elected or political leaders in the community who may not currently be holding those positions. There was no evidence of any additional or more recent agreements with community partners or service providers. One of twelve agreements is with a service provider, who is still active with the program.	No new interagency agreements were initiated since 2018. Five of the current agreements are outdated with prior local political or elected leaders no longer in their positions.

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Exception**	The program has a policy and procedure outlining the required documentation method and data to be collected for each outreach event or community meeting attended. The program had outreach events entered into NetMIS; however, community meetings were not entered. The program utilizes an outreach log to store documentation of each outreach event. One of five reviewed outreach events had all required documentation to include a sign-in sheet, event documentation and a staff narrative of activities; the remaining four reviewed outreach events were missing at least one required documentation element.	Documentation to support outreach activities is incomplete. Four of five reviewed outreach activities were missing at least one required documentation element. Some outreach information documented is inaccurate. Netmis report included outreach activity documented 12.21.2023; documentation is for 11.21.2023. Activity for 10.25.2023 in Netmis indicates an individual meeting with 1 DJJ supervisor; documentation for same date has a meeting with 10 DJJ employees and there is no sign-in sheet.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has a position title of Case Manager- FYRAC Program/ Outreach Coordinator, who is responsible for outreach in the community. This position description was reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The Program has the required policy #2.01 Screening and Intake that was reviewed and approved by the Director of Youth Services on 12/11/2023	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Community) Files: five open client files **Total number of Closed (Community) Files: five closed client files** **Type of Documentation(s) Reviewed: Client Files** **Describe any Observations: 10 client files were reviewed**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Not Applicable**	NEED is not a residential provider.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All ten records confirmed the eligibility screening is completed within 3 business days of the referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten records confirmed all referrals for service were screened for eligibility and logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	Youth and parent/guardians receive the Program Handbook which included: Available services options, and Rights and responsibilities of youth and parents/guardians. All ten files confirmed receipt of these documents were signed by the parent/guardian and placed in the file.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	Youth and parent/guardians receive the Program Handbook which included: Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication), and grievance procedures. All ten files confirmed receipt of these documents were signed by the parent/guardian and placed in the file.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	All ten records were screened for suicidality and assessed as required during intake.	
Additional Comments: **There are no additional comments for this indicator.**			

2.02 - Needs Assessment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02	**YES**		
	If NO, explain here:		
	The program has the required policies #2.02 Nirvana Assessment that was reviewed and approved by the Director of Youth Services on 12/11/2023.		

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *10 Client Files were reviewed. NIRVANA assessments were initiated at intake and completed within two to three contacts following the initial intake date into services for all 10 client files. All 10 client had a printed NIRVANA in their file.*

Total number of Open (Community) Files: 5 open client files
Total number of Closed (Community) Files: 5 closed client files
Type of Documentation(s) Reviewed: Client Files
Describe any Observations: NIRVANA assessments in 10 client Files were reviewed.

Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	NEED is not a residential provider.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All ten records confirmed NIRVANA Assessments were initiated at intake and had consistent documentation that they were completed within two to three face to contacts after the initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All ten records included a Supervisor's signature on the completed NIRVANA.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Not Applicable**	NEED is not a residential provider.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Post assessments were completed for five closed files at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	NIRVANA re-assessments were completed for five closed youth records who were in care for 90 days or more.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	Each youth file included the interview guide and printed NIRVANA	

Additional Comments: **All current staff possess a BA/MA degree, and completed the NIRVANA and MI training.**

2.03 - Case/Service Plan			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The program has the required policy #2.03 Service Plan that was reviewed and approved by the Director of Youth Services on 12/11/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *10 Client Files were reviewed. NIRVANA were developed on the provider's form and entered into NetMIS within 7 working days.*			
Total number of Open (Community) Files: 5 open client files **Total number of Closed (Community) Files: 5 closed client files** **Type of Documentation(s) Reviewed: Client Files** **Describe any Observations: 10 client files reviewed**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All 10 client files reviewed included evidence that case plans were developed using the provider's approved form.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Each youth's case/service plan was developed within seven working days of NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	All 10 case plans reviewed contained evidence of all required elements including individualized and prioritized needs and goals identified by the NIRVANA, the service type, frequency, and location, target dates for completion and actual completion dates, signatures of the youth, counselor, and supervisor, and the date the plan was initiated. The program supervisor reviewed each client record within seven days of the initial case plan development. The clinical supervisor reviewed and signed all service plans within the 30 days after the service plan was initiated in all 10 client files. Each client had a target and completion date within 90 days.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	In all 10 client files reviewed, the service plans were reviewed for progress/revision by the counselor every 30 days during the clients' service delivery.	
Additional Comments:			

2.04 - Case Management and Service Delivery		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04	**YES** If NO, explain here: The program has the required policy #2.04 Case Management and Service Delivery, that was reviewed and approved by the Director of Youth Services on 12/11/2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Community) Files: 5 open client files **Total number of Closed (Community) Files: 5 closed client files** **Type of Documentation(s) Reviewed: Client Files** **Describe any Observations: 10 client files reviewed**			
Counselor/Case Manager is assigned	**Compliance**	All 10 files reviewed, 5 open, 5 closed, confirmed a case manager was assigned during the intake.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	**Compliance**	The case manager established referral needs and coordinated the implementation of the service plan for each youth and family. Youth progress was monitored, and provided family support. There were no case staffing referrals nor accompanying youth/parent to court hearings and related appointments. Referrals were made for mentoring and tutoring. The case manager provided case termination documentation, as well as 30 and 60 day follow up documentation as required for the five closed files. Two of the files noted three unsuccessful attempts to contact the youth/family.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program utilizes a consent form as well as a referral form that lists community resources, and a variety of community partners. Informal agreements are in place for agencies listed as resources for youth/parents to consider.	
Additional Comments:			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	**YES**		
	If NO, explain here:		
	The program has the required policy #2.05 Counseling Services that was reviewed and approved by the Director of Youth Services on 12/11/2023.		

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Community) Files: 5 Opens Client Files **Total number of Closed (Community) Files: 5 Closed Client files** **Type of Documentation(s) Reviewed: Client Files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	NEED is not a residential provider.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**		
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Not Applicable**		
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**		
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	All 10 client files reviewed provided evidence of youth and family receiving individual and family counseling that is relevant to the youth's service plan. Each file shows chronological case notes on the youths progress, identified the needs of the family, and all services were documented at the appropriate locations, such as youth home, school, or program office.	
Counseling Services			
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	**Compliance**	All 10 client files reflect coordination between presenting problems, needs assessment, case plans and reviews, case management and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All 10 files included individual folders, stamped with the word confidential, and adhere to all laws regarding confidentiality.	

Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	All 10 files maintained case notes for all counseling services provided and show documentation of youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	All 10 client files contained documentation of case managers' chronological notes that are signed and reviewed by the case manager and clinical supervisor.	
Additional Comments: **There are no additional comments for this indicator**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The program has the required policy #2.06 Adjudication/Petition Process that was reviewed and approved by the Director of Youth Services on 12/11/2023	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**No eligible items for review**	Per interview with Director of Youth Services, there were no adjudication/petition filed or staffing during the review period.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**No eligible items for review**		
The program has an established case staffing committee, and has regular communication with committee members	**No eligible items for review**		
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	No case staffing requests were made during the annual review period; however, the policy states a clear process for conveying and commencing any case staffing request.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**		
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**		

If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**		
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**		
Additional Comments:			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The program has the required policy #2.07- Youth Records, that was reviewed and approved by the Director of Youth Services on 12/11/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Community) Files: 5 open client files **Total number of Closed (Community) Files: 5 closed client files** **Staff Position(s) Interviewed (No Staff Names): Program Director**			
All records are clearly marked 'confidential'.	**Compliance**	All 10 clients files were marked confidential	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	The program has a secured room for storage of all program files. Files are stored in a locked file cabinet that is marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program has a policy in place for transporting files. Reviewer observed a locked opaque container marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All 10 client files reviewed were neat, and orderly arranged, identifying each section and its supporting documents.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The program has a policy in place titled 2.09 Family and Youth Respite Aftercare Services (FYRAC), that was approved by the Director of Youth Services on 12/11/2023. This is the only special population service provided by this program, so the other special populations covered under this indicator are not applicable.	
Staff Secure			

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**Not Applicable**	NEED is not a residential provider.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Not Applicable**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**Not Applicable**		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**Not Applicable**		
Agency provides a written report for any court proceedings regarding the youth's progress	**Not Applicable**		
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	NEED is not a residential provider.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**Not Applicable**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**Not Applicable**		
Services provided to these youth specifically designated services designed to serve DMST youth	**Not Applicable**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**Not Applicable**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**Not Applicable**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**Not Applicable**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	NEED is not a residential provider.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Not Applicable**		
Data entry into NetMIS within (3) business days of intake and discharge	**Not Applicable**		

Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Not Applicable**		
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Not Applicable**		
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	NEED is not a residential provider.	
All probation respite referrals are submitted to the Florida Network.	**Not Applicable**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Not Applicable**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Not Applicable**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Not Applicable**		
All case management and counseling needs have been considered and addressed	**Not Applicable**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Intensive Case Management (ICM)			

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	NEED is not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 open FYRAC Probation Respite files **Total number of Closed Files: 1 closed FYRAC Probation Respite file** **Type of Documentation(s) Reviewed:**			

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**Compliance**	All three files documented the youth were referred by DJJ and were on probation.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	The program director provided email evidence from the Florida Network documenting each FYRAC referral was approved by the Network office.	
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**Compliance**	All intake and initial assessment sessions were completed face-to-face and included a gathering of family history and demographic information. All files documented the youth and parent were provided an orientation to the program during this initial visit. The Service Plan was also developed at the same time and signed by the youth and parent/guardian.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**Compliance**	Each youth documented Life Management sessions at the youth's home with the youth, case manager, and any family members present. These sessions were an hour in length each time and focused on identifying strengths and needs of the youth and family to help improve family functioning.	
Individual Sessions: a.The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**Compliance**	Each youth documented staff conducted individual sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. Issues covered during the sessions included coping skills, emotional triggers, and anger management.	

Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**Not Applicable**	The program does not conduct group sessions.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	Evidence of 30 and 60 day follow-ups were documented in NetMIS following case discharge for one applicable closed case. Both follow-ups were not successfully completed as three attempts were made and documented for each.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**Compliance**	Two of the cases are open and youth are still participating in services. The one closed case was discharged prior to 90 days because the JPO requested case closure earlier. Youth and family participated in eight sessions prior to the early discharge.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Not Applicable**	All services were provided face-to face for all three youth.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	NetMIS data entry was completed within three business days of intake for all three youth records and within three business days of discharge for one applicable closed case.	
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)		Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	**N/A** If NO, explain here: NEED does not provide SNAP services, so this indicator is not applicable.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	NEED is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		

There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**		
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		

The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The program has a policy 3.03 Identification of Suicide Risk in Community Counseling Programs, reviewed and approved by the Director of Youth Services on December 11, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Community) Files: 0 **Total number of Closed (Community) Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**No eligible items for review**	The program has not served any youth, since the last annual review, who were identified as suicide risk.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**		
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Not Applicable**	NEED is not a residential provider.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Not Applicable**		
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Not Applicable**		

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Not Applicable**		
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Not Applicable**		
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**		
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**		
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**		
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**		
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			