Florida Network for Youth and Family Services
Compliance Monitoring Report for

Tampa Housing Authority, Tampa

5301 West Cypress Avenue
Tampa, Florida 33607

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Tampa Housing Authority for the FY 2023-2024 at its program office located at 5301 West Cypress Avenue, Tampa, 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. Tampa Housing Authority 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 for July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from Tampa Housing Authority present for the entrance interview were: Jessy Kingman, Program Manager, and Latisha Anderson, Treatment Coordinator. The last onsite QI visit was conducted February 1, 2023.

In general, the Reviewer found that Tampa Housing Authority is in compliance with specific contract requirements. **Tampa Housing Authority received an overall compliance rating of 80% for achieving full compliance with eight out of ten applicable indicators** of the CINS/FINS Monitoring Tool. There was one corrective action and one recommendation made as a result of the monitoring visit.

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 11-15-2023-2024

Agency Name: Tampa Housing Authority	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 5301 W. Cypress Ave., Tampa, FL 33607**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 15, 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 program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has two staff members certified as DJJ QI Peer reviewers: Jessy Kingman, and Latisha Anderson. Neither has participated as a peer reviewer to date but will be scheduled for the current FY.	
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 listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list, titled PPS Grant Summary, of 14 additional contracts for FY2023-2024. The list includes: the name of grant, funding source, contract period, description of funding, and contract amount.	
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	☐	☒	☐	☐	☐	Documentation: Commercial Liability Insurance is secured through HAI Group. The policy included $1,000,000 per	**Recommendation: 1)** As required, provider must request and list the Florida Network as additional insured on the certificate of insurance.

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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 $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**						Occurrence; Fire Damage limits $50,000; Sports Liability limits $250,000. Personal and Advertising Injury Liability is set at $1,000,000; wrongful act -law enforcement is $500,000 and for public officials is $1,000,000; and Mold, Other Fungi or Bacteria Liability Claim is set at limits of $100,000. Policy is effective 10/01/2023-10/01/2024. Auto Insurance is provided through the Auto-Owners Insurance automobile insurance company. Coverage includes combined liability for $1million, PIP for $10,000 each person, medical limited to $2,500, and uninsured motorist coverage for $10,000/person and $20,000/accident. Policy is effective 03/01/2023-03/01/2024. Workers Compensation and Employers Liability Insurance is	

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Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:**
						provided through The Zenith. The policy coverage includes $1,000,000 in Bodily injury for each Accident; $1,000,000 in Bodily Injury for each Disease policy limit; and $1,000,000 in Bodily injury for each Disease each employee. The policy is effective 07/01/2023-07/01/2024. The certificate of insurance does not list the Florida Network as additional insured.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
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**	☐	☐	☒	☐	☐	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 policy manual, titled Operating Procedures – Accounting – Finance, was last	

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						reviewed March 1, 2022. The manual covers standard operating procedures for critical financial functions.	
b. Agency maintains a general ledger and the corresponding source documents. 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**	☐	☐	☒	☐	☐	Documentation: General ledger (GL) for Periods: July-October 2023. The agency maintains a detailed general ledger with corresponding source documents. The General Ledger documents and tracks CINS/FINS funding separately from other funding sources by category.	
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**	☐	☐	☐	☐	☒	Interview: The provider does not utilize a petty cash system for occasional program outings. The request for cash is required to be placed in advanced via a check request.	

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	Explain Rating						
Major Programmatic Requirements	**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:**
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**	☐	☐	☒	☐	☐	Documentation: All program invoices are processed for payment by the agency's fiscal department. Purchase order forms are completed by the program for all purchases. The designated purchase is then processed or ordered through the agency's fiscal department. A basic filing system is maintained at the CINS/FINS program office. Request for purchases generally include acquisition of certain local supplies or services for the operation of the program. Reviewed Bank Statements and Bank Reconciliations for the period April – October 2023 for one account held with Wells Fargo. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any equipment with FNYFS monies since the last time on-site.	
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**	☐	☐	☒	☐	☐	Documentation: Copies 941s for the 2nd and 3rd quarter of 2023 were provided. The agency submits payroll taxes to the appropriate authority as required.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☒	☐	☐	☐	☐	Documentation: Agency provided a financial document for the period July-October 2023, with budget to actual comparison for the current FY. A review of these documents was conducted but the report has the actual expenditures entered but zero values are shown on the program budget line items. Consequently, a budget to actual variance cannot be conducted without the budget statement.	**Corrective Action: 1)** Provider submitted a budget to actual report showing CINS/FINS program expenses to date and a column for program budget; however, an actual FY program budget was not included in the report because zero values are shown on the program budget line items. The provider needs to resubmit a budget to actual report showing approved FY budget and demonstrate how variances are investigated and addressed.

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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**	☐	☐	☒	☐	☐	Documentation: The annual single audit was conducted by Berman Hopkins CPA & Associates LLP for the year ended 3/31/22 in a letter dated December 28, 2022. Per the audit report, there were no audit findings that needed to be reported or any questioned costs.	
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**	☐	☐	☒	☐	☐	Procedures relating to confidentiality and data backup are found in the Records Retention Policy Manual last approved February 2023. The policies were reviewed and appear to provide for sound internal control. The agency has an IT department that maintains strict control over the security of all computers and laptops.	

CONCLUSION

Tampa Housing Authority has met the requirements for the CINS/FINS contract as a result of full compliance with eight out of ten applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the indicators were not applicable because: 1) the provider does not have any outstanding corrective actions with external funders; 2) the program does not utilize petty cash; and 3) no new inventory was purchased with Florida Network funds. Consequently, **the overall compliance rate for this contract monitoring visit is 80%.** There is one corrective action cited and one recommendation made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF CORRECTIVE ACTION

Corrective Action: 1)
Provider submitted a budget to actual report showing CINS/FINS program expenses to date and column for program budget; however, an actual FY program budget was not included in the report because zero values are shown on the program budget line items. The provider needs to resubmit a budget to actual report showing approved FY budget and demonstrate how variances are investigated and addressed.

SUMMARY OF RECOMMENDATION

Recommendation: 1)
The certificate reviewed during the contract monitoring visit did not include the Florida Network as additional insured. As required, the provider must list the Florida Network on the certificate of insurance as additional insured.

If required, the provider must submit a corrective action plan to address 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 Tampa Housing Authority - Tampa
Community Counseling Program

November 15, 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	Failed
1.06 Client Transportation	Not Applicable
1.07 Outreach Services	Limited

Percent of indicators rated Satisfactory: 83.33 %
Percent of indicators rated Limited: 16.67 %
Percent of indicators rated Failed: 16.67 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Limited
2.02 Needs Assessment	Limited
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: 75 %
Percent of indicators rated Limited: 25 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Failed

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 80 %
Percent of indicators rated Limited: 20 %
Percent of indicators rated Failed: 13.33 %

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
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
Kara Brown – Regional Monitor, Department of Juvenile Justice
Nicole Leslie– Family Resources, Inc.

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	X	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
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	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
X	CCC Reports		Grievance Process/Records		# Health Records
	Logbooks		Key Control Log	X	# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	2	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	2	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	5	# Youth Records (Closed)
	Egress Plans		Program Schedules	5	# 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

Tampa Housing Authority (THA) provides individual, case management, and family services to clients who live in rural areas and have minimal access to much needed therapeutic treatment. The CINS/FINS program is managed by a program manager who oversees a treatment coordinator, a subcontracted part-time therapist, and four local college interns. The agency also contracts with a licensed clinical social worker (LCSW) and employs a data manager who assists on a part time basis with data entry for the CINS/FINS program.

The program experienced significant turnover during the last two years. At the time of the last QI review, the Program Manager's position was vacant but was filled in February 2023 by the former Treatment Coordinator who was relatively new in her position prior to transitioning to the manager's position.

The following programmatic updates were provided by the agency:

Staffing

Jessy Kingman was promoted from Treatment Coordinator to Program Manager position in February 2023. The program hired a new treatment coordinator on 3/20/2023. One contract therapist position remains vacant. Both the program manager and treatment coordinator have earned a master's degree. Dr. Carrion is the LCSW who is contracted to provide licensed supervision and services requiring oversight by a licensed professional.

Program Updates

The program operates out of the Tampa Housing building located at 5301 W Cypress Street, Tampa. No new initiatives were undertaken in the past year. Services to youth are provided in groups, individual, and family, and conducted in homes or in schools. Youth records are maintained electronically. THA serves youth ages 6-17 in the entire Hillsborough County area.

Governance and Community

The program entered into a new community partnership with Brooker Elementary school to host group counseling. Additionally, it is in the process of a new partnership with Barry University for intern placements.

Narrative Summary

Tampa Housing Authority provides community-based CINS/FINS services for youth and their families in Circuit 13, Hillsborough County. The program provides centralized screening and intake services during regular business hours. The program accepts referrals from established referral partners and local elementary, middle, and high schools. The program also receives referrals from youth, parents/guardians, and local community-based organizations. At the time of the QI review, services were being provided by a treatment coordinator and four local college interns. All staff and interns are overseen by the youth program manager. Clinical services are subcontracted to a licensed clinical social worker. The program has one vacancy for a part time contract therapist.

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

Standard 1: There are seven indicators for Standard 1. One indicator, Indicator 1.06 Client Transportation is not applicable because the program does not transport youth. Indicator 1.02 Provision of an Abuse Free Environment and Indicator 1.03 Incident Reporting were rated **Satisfactory.** Indicator 1.01 Background Screening of Employees/Volunteers and Indicator 1.04 Training Requirements were rated **Satisfactory with exceptions.** Indicator 1.07 Outreach Services **was rated Limited.** Indicator 1.05 Analyzing and Reporting Information received a **Failed rating.**

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake and Indicator 2.02 Needs Assessment were rated **Limited.** Indicator 2.03 Case/Service Plan and Indicator 2.06 Adjudication/Petition Process were rated **Satisfactory with exceptions.** Indicator 2.04 Case Management and Service Delivery, Indicator 2.05 Counseling Services, Indicator 2.07 Youth Records, and Indicator 2.08 Specialized Additional Program Services were rated **Satisfactory with no exceptions.** Indicator 2.09 Stop Now and Plan (SNAP) is not applicable because THA is not a SNAP provider.

Standard 4: There are five indicators for Standard 4 but only one is applicable to community counseling providers. Indicator 4.02 received a **Failed** rating.

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

Standard 1:

Indicator 1.05 - Failed

There was no evidence of quarterly case record reviews. The program did not have any incident, accidents or grievances during the review period though the program manager reported there was not a formal review process or procedure for monitoring these if they occur. There was no annual review of customer satisfaction or outcome data. Monthly review of statewide EOM reports were not evident or demonstrated, and there was not a quality improvement process in place to review accuracy of data entry and collection. Lastly, previous QI Report included two Limited and one Failed rating. The QI Report with these indicators was not sent to or reviewed with the Board of Directors as required.

Indicator 1.07 - Limited

The program does not have a lead staff member designated to participate in local DJJ Board, Circuit, and Council meetings. There was no attendance at these meetings for the full review period. The program manager reported that these meetings conflicted with truancy court, and the program staff attend truancy court only, not DJJ meetings. The program does not currently maintain written agreements with community providers.

Standard 2:

Indicator 2.01 - Limited

Six of ten initial screening forms were completed more than three business days after the youth's referral. Eight of ten youth were logged in NetMIS beyond 72 hours of screening completion. One form was not signed by the youth indicating they received available service options and rights and responsibilities information; however, it was signed by the parent/guardian and counselor. One form was not signed by the youth indicating they information regarding possible actions occurring through involvement with CINS/FINS services and grievance procedures; however, it was signed by the parent/guardian and counselor. One youth had hits on the suicide risk screening but was not assessed as required. The youth was screened for suicidality six days after their intake.

Indicator 2.02 - Limited

Two youth's NIRVANAs were not initiated within 72 hours of admission. One youth's NIRVANA was not signed by the supervisor. Four youth were applicable for 90 day NIRVANA Re-Assessments. A re-assessment was not completed for any of the four youth. The remaining six youth were not in services beyond 90 days.

Standard 4:

Indicator 4.02 - Failed

Results of the initial screening and follow up screenings were not signed for months by the licensed supervisor and there was no documentation regarding the review taking place outside of the delayed signature. When interviewed, the Program Manager was unaware of this requirement, as she reported she was given the risk questions and safety plan when she started her role and thought this met the requirement.

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:** E.g. Any item marked as 'Yes' in the worksheet would need to be summarized for the indicator.	**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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**NO**	
	If NO, explain here: The program's policy and procedure 1.01 was not updated to include changes to Indicator 1.01 regarding protocol for staff who score low/do not pass the suitability assessment and re-employment of employees in good standing without an additional suitability assessment or background screening if the break is less than 90 days eighteen (18) months.	
	The provider has a policy and procedure 1.00, entitled Background Screening, that was approved April 2023 by the youth program manager.	

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: One new staff hired and three interns.
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Berke 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.	**Exception**	The program implemented use of the Berke pre-employment assessment tool on March 31, 2023. One new staff was hired March 20, 2023 prior to the program's implementation of a pre-employment assessment. The tool was administered with the new staff on April 4, 2023 but a passing score was not achieved. A letter of approval for hire by the supervisor is on file.	One new hire, DOH 3/20/23, did not complete a pre-employment assessment because the agency did not have a suitability assessment tool in place and opened the account with Berke on 3/31/23.
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**	No new staff were hired after effective date of QI policy.	

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**	No new staff were hired after effective date of QI policy.	
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	**Exception**	Background screenings for one applicable new hire and two of three interns were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required.	Start date for one of three interns in the program is 8/28/23, prior to receipt of an eligible bacground screening that was completed on 8/29/23.
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**No eligible items for review**	The program does not have any eligible 5-year re-screens for the review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit January 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 one new hire.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**NO**	
		If NO, explain here: Policy 1.02 has not been updated and is missing language regarding program's grievance procedures. Additionally, the current grievance policy needs to be updated with contact information for the program manager	
		The provider has a policy and procedure 1.01, entitled Abuse Reporting, that was approved April 2023 by the youth program manager.	
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): Youth Program Manager **Type of Documentation(s) Reviewed: Standards of Conduct Policy 400**			

Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The provider's personnel policies and procedures include a section for standards of conduct, policy 405, that prohibits unacceptable behavior and conduct. The personnel policies and procedures manual is given to staff at hire and reviewed during orientation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The provider has a process in place for reporting and documenting abuse hotline calls. The hotline number is posted in the program offices. Abuse calls are documented on the hotline abuse reporting form and the form and a note documenting the call to the hotline is noted in the youth's record. One call involving parent/care giver was made during the review period; the call was not accepted by the abuse hotline.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The abuse hotline number is included on the consent form signed by youth/family during intake.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**No eligible items for review**	No grievances were reported by the program for the past year.	
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**	Tampa Housing 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**	Tampa Housing 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	**NO**		
	If NO, explain here: The agency's policy was last reviewed in April 2023 but does not reflect updates to Florida Network policy made last FY, to include transports for Baker Act as a CCC reportable incident.		
	The provider has a policy and procedure 1.02, entitled Incident Reporting, that was approved April 2023 by the youth program manager.		
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)* **: Youth Program Manager** **Type of Documentation(s) Reviewed: FLORIDA DEPARTMENT OF JUVENILE JUSTICE, CENTRAL COMMUNICATIONS CENTER, Incidents 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 CCC Incidents Detail Report, there were no incidents reported to CCC by the program 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	**NO**	
	If NO, explain here: Policy 1.05 was last updated in April 2023 and does not include changes made to the indicator 1.04 effective 7/1/2023 with regards to training topics, time frames, and training plan.	
	The provider has a policy and procedure 1.05, entitled Training, that was approved April 2023 by the youth program manager.	

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: 2
Annual Training Plan Timeframe (Program timeframe for annual trainings): anniversary of hire date
Staff Position(s) Interviewed (No Staff Names): Youth Program Manager
Type of Documentation(s) Reviewed: Training files, training certificates, training reports from Bridge, SkillPro

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Two new hire training files reviewed. One of the staff, date of hire (DOH) 3/20/2023, is still within the first year of employment and has adequate time to complete all required training hours.	One of two first year new hires completed the Motivational Interviewing training 11/3/22 beyond the 90 day required timeframe.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Two new hires completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	
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.	**Compliance**	One of the staff, date of hire (DOH) 3/20/2023, is still within the first year of employment and has adequate time to complete the remaining 32 training hours.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Two new hires completed all mandatory training required during 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.	**Compliance**	The three new case management staff completed the NIRVANA assessment training prior to case assignment.	

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**	No new staff were hired after 7/1/2023, the effective date of the requirement.	
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).	**No eligible items for review**	Tampa Housing 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).*	**No eligible items for review**	The two current program staff are both new hires.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program provides training across two different platforms including DJJ Skill Pro and Florida Network Bridge, in addition to using local training providers. The training plan for both staff included all mandatory pre-and in-service training topics required.	
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**	Each employee maintains their own training log and is responsible for recording all completed training with completion dates and uploading the certificate and log to the agency's shared drive. To ensure compliance, the program manager monitors each employee's log on a regular basis.	
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.	**Compliance**	The program provided training files for each employee selected for review. Each training file contained a Florida Network training log with all required information. Certificates of completion or training transcripts were present for all trainings completed.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	**NO**		
	If NO, explain here: Policy 1.06 was last reviewed in April 2023 and is missing updated Florida Network policy language regarding program having a quality improvement process in place as well as final reports with a Limited or Failed rating being sent to the Board of Directors for review		
	The provider has a policy and procedure 1.06, entitled Analyzing and Reporting Data, that was approved April 2023 by the youth program manager.		
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)* **: Youth Program Manager** **Type of Documentation(s) Reviewed: Policy, Emails, and Board Reports.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Exception**	The program manager shared sporadic emails regarding her reminding staff of the next step following an intake. She reported she looks through files periodically but does not document this in any formal way.	The program does not formally conduct case record reviews. There was no evidence of this occurring quarterly.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Exception**	The program did not have any grievances, accidents or incident reports for this review period.	Program manager reported no process in place to review incidents, accidents, and grievances should these occur.
The program conducts an annual review of customer satisfaction data	**Exception**	No practice observed.	The program has no evidence of any review of customer satisfaction data.
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.	**Exception**	No practice observed.	The program has no evidence of an annual review of outcome data or any possible reconciliation that occurs through communication with the Florida Network.
The program has a process in place to review and improve accuracy of data entry & collection	**Exception**	No practice observed.	The program does not have a process in place to review and improve accuracy of data entry and collection.

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Exception**	No practice observed.	There was no documentation that any findings, including those from previous QI Report in February 2023, were regularly reviewed by management or communicated to staff and 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.	**Exception**	No practice observed.	There was no documentation that the program shares critical data reports with the board of directors. The previous QI report (February 2023) included 2 Limited and 1 Failed ratings, and therefore was required to be shared with the board of directors, which evidence could not be produced to show that this occurred.
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Exception**	No practice observed.	There was no evidence that strengths and weaknesses are identified, improvements are implemented or modified, or that staff are informed and involved throughout the process.
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: Tampa Housing Authority CINS/FINS program does not transport.	
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)* **: Youth Program Manager**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Not Applicable**	Tampa Housing Authority CINS/FINS program does not transport.	
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 provider has the required policy and procedure 1.07, entitled Outreach Services, that was approved April 2023 by the youth program manager.	
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 Manager** **Type of Documentation(s) Reviewed: Policy, NetMIS outreach data/export report, Outreach binder on site, Job Description, Calendars (DJJ, truancy court, and program manager)**			

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 manager reported that truancy court is changing their days beginning in November and therefore the program will be sending someone to these meetings moving forward. The program manager was able to show evidence of table events where outreach occurs, as evidenced by NetMIS data entry/reporting.	The program does not have a lead staff member designated to participate in local DJJ Board, Circuit, and Council meetings. There was no attendance at these meetings for the full review period. The program manager reported that these meetings conflicted with truancy court, and the program staff attend truancy court only, not DJJ meetings.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Exception**	The new program manager was not able to locate agreements that were used and/or in place in the past.	The program does not currently maintain written agreements with community providers.
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.	**Compliance**	The program is entering required info for outreach events into NetMIS, including the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Include all position(s) and name of position title for staff reviewed: The program manager has outreach listed as a required task on her job description. Program manager reported that all program staff are responsible for completing outreach as needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**NO** Policy is not current and is missing language which was included in the July 2023 updates. The agency has policies 2.00 Screening and Eligibility, 2.01 Admission Process, 2.03 Identification of Suicide Risk in Community Counseling which were reviewed by the program manager in April, 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 (Residential & Community) Files: Five open community counseling files **Total number of Closed (Residential & Community) Files: Five closed community counseling files** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Youth files- referrals, screening forms, intake forms, parent brochure**			

Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Not Applicable**	Not applicable for community counseling programs.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	Four of ten reviewed youth's initial screening forms were completed within three business days of referral by a trained staff member.	Six of ten initial screening forms were completed more than three business days after the youth's referral.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	Two of ten youth were logged in NetMIS within 72 hours of screening completion.	Eight of ten youth were logged in NetMIS beyond 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	**Exception**	Signed documentation in nine reviewed files found the youth and parents/guardians received available service options and rights and responsibilities of youth and parents/guardians.	One form was not signed by the youth indicating they received available service options and rights and responsibilities information; however, it was signed by the parent/guardian and counselor.
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	**Exception**	Signed documentation in nine reviewed files found the youth and parents/guardians received information regarding possible actions occurring through involvement with CINS/FINS services and grievance procedures.	One form was not signed by the youth indicating they information regarding possible actions occurring through involvement with CINS/FINS services and grievance procedures; however, it was signed by the parent/guardian and counselor.
During intake, all youth were screened for suicidality and assessed as required if needed.	**Exception**	Nine reviewed youth were screened for suicidality during intake.	One youth had hits on the suicide risk screening but was not assessed as required. The youth was screened for suicidality six days after their intake.
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**NO**	
		Policy is not current and is missing language which was included in the July 2023 updates.	
		The agency has a policy, 2.04 Needs Assessment, which was reviewed by the program manager in April 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 (Residential & Community) Files: Five open community counseling files
Total number of Closed (Residential & Community) Files: five closed community counseling files
Type of Documentation(s) Reviewed: Youth files- NIRVANAs, interview guides, NetMIS admit dates

Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	Not applicable for community counseling programs.	
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	**Exception**	Eight youth's NIRVANAs were initiated and completed during intake.	Two youth's NIRVANAs were not initiated within 72 hours of admission.
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.	**Exception**	Nine youth's completed NIRVANA assessments included the interview guide, as well as the supervisor's signature.	One youth's NIRVANA was not signed by the supervisor.
(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**	Not applicable for community counseling programs.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Four of five closed youth files were applicable for a NIRVANA Post-Assessment being completed at discharge. A NIRVANA Post-Assessment was completed for all four youth. The remaining youth was not applicable, as the youth and family were not compliant with services.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Four of five closed youth files were applicable for a NIRVANA Re-Assessment. The remaining youth was not applicable, as the youth and family were not compliant with services.	Four youth were applicable for 90 day NIRVANA Re-Assessments. A re-assessment was not completed for any for the four youth. The remaining six youth were not in services beyond 90 days.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	Each youth file included the interview guide and printed NIRVANA.	

Additional Comments: **There are no additional comments for this indicator.**

2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**NO** Policy is not current and is missing language which was included in the July 2023 updates. The agency has a policy, 2.06 Case Service Plan, which was reviewed by the program manager in April 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 (Residential & Community) Files: Five open community counseling files **Total number of Closed (Residential & Community) Files: Five closed community counseling files.** **Type of Documentation(s) Reviewed: Youth files- Case Service Plans**			
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 ten youth had a Case/Service Plan developed on an appropriate form based on information gathered during the initial screening, intake, and NIRVANA.	
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	**Exception**	Each youth's Case/Service Plan included 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. Nine youth's Case/Service plans included the parent/guardian signature. The remaining Case/Service Plan documents verbal consent by the parent/guardian. Nine youth's Case/Service Plans included the person responsible for each goal.	One youth's Case/Service Plan did not include the person responsible for completing one of four goals included on the plan.
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	**Exception**	Five reviewed youth files included Case/Service Plans which were reviewed for progress/revised by the counselor and parent/guardian (if available) every thirty days for the first three months.	Five reviewed youth files included Case/Service Plans in which the thirty day reviews/revisions were beyond thirty days. One youth had a 22 day late and 33 day late review, two youth had two reviews each which were one day late, one youth had one review which was five days late, and one youth had one review which was 12 days late.
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**NO** Policy is not current and is missing language which was included in the July 2023 updates. The agency has a policy, 2.07 Case Management Services, which was reviewed by the program manager in April 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 (Residential & Community) Files: Five Open Community Counseling files **Total number of Closed (Residential & Community) Files: Five closed community counseling files.** **Type of Documentation(s) Reviewed: Ten youth files- Case/Service Plans, Case Notes, Referrals, Case Termination Notes, Follow-Up Forms**			
Counselor/Case Manager is assigned	**Compliance**	All ten reviewed youth were assigned to a counselor.	
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 counselor for each youth established referral needs and coordinated referrals for services based upon the on-going assessment of the youth's/families problems and needs, coordinated service plan implementation, monitored the youth/families progress in services and provided support for the families. None of the youth were court ordered to a shelter, required referrals to the case staffing committee, were recommended for judicial intervention, or had court orders which required review. One youth had a court hearing and the counselor accompanied them to the court hearing. One youth required additional services and a referral was completed. Only one youth had exited the program at least 30 days before the review, and follow-up was attempted after 30 days and after 6 days of their exit.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program has access to a comprehensive referral process backed by the agency that includes local specialty service providers which target youth's specific needs. These specialty providers have already been vetted and approved by the Tampa Housing Authority. Appointments for youth are gained by utilizing the program's referral form. None of the reviewed youth required a referral to a community partner.	

Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**NO** Policy is not current and is missing language which was included in the July 2023 updates. The agency has a policy, 2.05 Community Counseling Sessions, which was reviewed by the program manager in April 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 (Residential & Community) Files: Five open community counseling files **Total number of Closed (Residential & Community) Files: Five closed community counseling files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager** **Type of Documentation(s) Reviewed: Ten youth files- Case Notes, NIRVANAs, Case/Service Plans**			
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	Not applicable for community counseling programs.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**	Not applicable for community counseling programs.	
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**	Not applicable for community counseling programs.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**	Not applicable for community counseling programs.	
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**	Documentation in each youth's file found services were provided in the youth's home, a community location, or the local provider's counseling office. The program indicated they do not conduct any services virtually.	

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**	Each youth's file reflected case coordination between presenting problems and the NIRVANA , Case/Service Plan, Case/Service Plan reviews, case management, and follow-ups.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	Each youth had an individual electronic file, which was confidential.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Each youth's file included case notes documenting the youth's progress for each counseling session held.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	The program manager indicated they conduct reviews of case records weekly.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policies, 2.08 Adjudication Services and 2.09 CINS Petition Process which were reviewed by the program manager in April 2024.	
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 (Residential & Community) Files: Five open community counseling files **Total number of Closed (Residential & Community) Files: Five closed community counseling files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**No eligible items for review**	No youth were applicable for a case staffing.	
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**	No youth were applicable for a case staffing.	
The program has an established case staffing committee, and has regular communication with committee members	**No eligible items for review**	If a youth were to need a case staffing, another nearby CINS/FINS agency would host the staffing.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Exception**	If a youth were to need a case staffing, another agency would conduct the staffing; however, the current program's policy and procedure does not include any guidance for referral of youth to case staffing if a request is made.	No current protocol in place for holding a case staffing if a request is made.
The youth and family are provided a new or revised plan for services	**No eligible items for review**	No youth were applicable for a case staffing.	
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**	No youth were applicable for a case staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	No youth were applicable for a case staffing.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No youth were applicable for a case staffing.	
Additional Comments: **There is no current protocol in place for conducting a case staffing if a request is made.**			
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 agency has a policy, 2.10 E-File Youth Records, which was reviewed by the program manager in April 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 Manager** **Type of Documentation(s) Reviewed: Youth files**			
All records are clearly marked 'confidential'.	**Not Applicable**	This is not applicable, as all records are electronic in the OneDrive system. The only individual's who can access OneDrive are the program manager, intake coordinator, data clerk, and interns. OneDrive is password protected and the interns do not have the password, a staff member must log them in.	

All records are kept in a secure room or locked in a file cabinet that is marked “confidential”	**Not Applicable**	This is not applicable, as all records are electronic in the OneDrive system. The only individual's who can access OneDrive are the program manager, intake coordinator, data clerk, and interns. OneDrive is password protected and the interns do not have the password, a staff member must log them in.	
When in transport, all records are locked in an opaque container marked “confidential”	**Compliance**	The program indicated they never transport any records. The program manager indicated they have a locking case they would utilize and mark "confidential" if they ever needed to for any reason.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are maintained electronically in an orderly manner. Staff have access to the electronic records.	
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		**NO**	
		If NO, explain here: Per Florida Network, the program is contracted to provide Family/Youth Respite Aftercare Services (FYRAC) Community Counseling Services; however, a current policy is missing for that population.	
		The agency has a policy, 6.01 Specialized Additional Program Services which was reviewed by the program manager in April 2023. Policy is not current and is missing language included in the July 2023 updates.	
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.*			
N/A			

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**	Tampa Housing 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.*			
N/A			
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")	**No eligible items for review**	Tampa Housing has not received any referral for FYRAC services since the last QI review.	
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.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
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.	**No eligible items for review**		
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.	**No eligible items for review**		

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.	**No eligible items for review**		
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	**No eligible items for review**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
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	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
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: Tampa Housing does not have a contract to provide SNAP services.	

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.*

N/A

SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	Not Applicable		
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			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has the required policy, 2.03 Identification of Suicide Risk in Community Counseling Programs, which was reviewed by the program manager in April 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 Files: 1 open youth record, agency forms, agency policy. **Staff Position(s) Interviewed (No Staff Names): Youth 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.	**Exception**	Youth answered the six suicide risk screening questions at intake.	Results of the initial screening and follow up screenings were not signed for months by the licensed supervisor and there was no documentation regarding the review taking place outside of the delayed signature.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Exception**	The program manager is not aware of the suicide risk assessment that was approved by the Florida Network.	When interviewed, the Program Manager was unaware of this requirement, as she reported she was given the risk questions and safety plan when she started her role and thought this met the requirement.
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**	Not applicable for community counseling programs.	
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.	**Exception**	Program does not have a licensed clinician as part of the staff, however, they contract with a licensed clinician who reportedly reviews and signs off on suicide forms remotely.	One youth was identified as at risk for suicide during this review period. The youth completed the initial six questions and after having a positive screening, completed the initial contact screener (previous form which was no longer required as of Fall 2022) with their counselor. Youth never received a suicide risk assessment, as the program does not have one. Additionally, there were no notes regarding consultation with a licensed clinician and the licensed staff signed off on the initial contact screener several months after the completion of the form.
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.	**Exception**	This was not evidenced in the one file applicable during the review period. There was no documentation regarding conversation taking place with the parent/guardian and the youth never received an assessment.	No referral for an assessment of suicide risk was found in the youth record.
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.	**Exception**	No evidence of practice was observed in the youth record.	This was not evidenced in the one file applicable during the review period.
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Exception**	No evidence of practice was observed in the youth record.	This was not evidenced in the one file applicable during the review period.
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	Screening was competed in the youth's home.	
Additional Comments: **There are no additional comments for this indicator.**			