Florida Network for Youth and Family Services
Compliance Monitoring Report for

Bethel Community Foundation Inc.

2901 54th Avenue South
St, Petersburg, Florida 33712

February 7, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

On February 7, 2024, Forefront LLC conducted a joint Quality Improvement (QI) monitoring and Compliance Monitoring onsite visit on behalf of the Florida Network of Youth and Family Services (FNYFS) at the Bether Community Foundation for the FY 2023-2024. The BCF program office is located at 2901 54th Avenue South St. Petersburg, Florida 33712. 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. BCF is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The program review was conducted by Keith Carr, Consultant for Forefront LLC and Marvin Bliss, Central Region Monitor, Florida Department of Juvenile Justice and Kayrinah Hunter, LMHC Clinical Director, Hillsborough County Childrens Services Department. Agency representatives from BCF present for the entrance interview were: Vinson Lison, Executive Director and Lena Moody, Program Specialist. The last onsite QI visit was conducted December 20, 2022.

In general, the reviewer found that Bethel Community Foundation agency is in compliance with compliance monitoring contract requirements. **Bethel Community Foundation received an overall compliance rating of 100% for achieving full compliance with 13 out of 14 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions and recommendations cited 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 2-7-2023-2024

Agency Name: Bethel Community Foundation	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 2901 54th Avenue South St. Petersburg, 33712**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 7, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	I and D – The agency has a total of two staff members trained as Quality Improvement Peer Reviewers prepared to participate in a minimum of 2 onsite Qi program reviews.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	D – At the time of this on-site program review, the agency has an additional contract with the Pinellas County Juvenile Welfare Board to operate the Truancy Intervention Program Services (TIPS). BCF has an additional contract with Pinellas County Schools - Human Services Funding for $75,000 for FY 2022-2024.	
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	☐	☐	☒	☐	☐	D – General Liability through United States Liability Insurance Company. The General Liability limits include coverage for $1,000,000 each/$2,000,000 aggregate;	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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**						$1,000,000 personal injury; $100,000 damage to rented property, $2,000,000 products-comp/op AGG; Insurance is effective and provided through United States Liability Insurance Company with combined single limits of $1,000,000, effective 09/1/2023-09/1/2024. Workers Compensation and Employers' Liability is provided by Technology Insurance Company, Inc and includes $500,000 each accident, $500,000 per each employee; and $500,000 for policy limitations. Effective dates are 4/22/23-4/23/24. The Florida Network is listed as certificate holder on the insurance certificate.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	I – At the time of this on-site program review, the agency is not under a Corrective Action Plan for an external funding source.	

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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**	☐	☐	☒	☐	☐	D – A copy of the agency's policies and procedures were provided onsite. A review these documented found no change in policies from the previous year. The policies were reviewed and signed by the Executive Director on October 5, 2023. The Accounting Policies and Procedures documentation was reviewed and appears to include generally accepted financial provisions which provide for basic fiscal tracking and controls.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	D – General Ledger (GL) for Periods: July 1, 2023 – February 2024. BCF maintains a detailed general ledger with corresponding source documents. The General Ledger is organized to document funding sources and it does contain a separate GL for the CINS/FINS program. Categories include Type; Date; Number; Name; Memo; Split; Amount; and Balance.	

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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**	☐	☐	☐	☐	☒	D –The agency does have a policy and procedures for handling petty cash. The at the time of this review had no Petty Cash. It is the agency policy not to either utilize or have petty cash on hand.	
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**	☐	☐	☒	☐	☐	D – The agency provided banking statements and reconciliation documents. The documents reviewed reflect BB&T Bank activity for the period July 2023-Decemeber 2024. Reconciliations are being executed within 4-6 weeks. Agency invoices are processed by the Program Specialist and Executive Director prior to submission to the FNYFS office for payment on a monthly basis. All invoices have been submitted and processed in the last 6 months. BCF has a general filing system to organize all vendor files. The agency maintains an individual vendor file for each vendor by the fiscal year in the file room in secure file cabinets.	

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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) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	D – The agency provided documentation of the current Asset Inventory list of all current property utilized by the agency. The inventory list tracks the Inventory ID, Asset/Item Location, Description, Unit Price, Funding Source, Date Purchased. Items listed include computers, monitors, printers and office furniture.	
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**	☐	☐	☒	☐	☐	D – The agency provided a Payroll Detail document for the period July 2023 through January 2024 showing bi-weekly Payroll Tax Payments for all staff members. The documentation provided include the date, description, hours, rate, amount, tax amount, deductions amount, Net Pay, and liability amount.	

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	D- BCF provided a Budget vs. Actual statement for all Florida Network funds from July 2023 through February 5, 2024. The Bethel Community Foundation Profit & Loss Budget vs. Actual – FN show program budget and variances. The Executive Director reported being responsible for overseeing the budget and all associated Variances in budget Profit and Loss Budget versus Actuals.	
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**	☐	☐	☒	☐	☐	D – An audit was conducted by Clifton, Larson, Allen LLP (CLA) for the year ending December 31, 2022. CLA issued a report on June 22, 2023. A CLA Management letter was issued and did not have any financial improprieties. However, CLA cited findings related to Accounting Policies, Accounting Estimates and Financial Disclosures. The communication was for information purposes and for use by the Board of Directors and management of BCF.	

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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**	☐	☐	☒	☐	☐	D- The agency provide a copy of the current Confidentiality policy. The policy's last date of revision is documented as October 5, 2023. The utilizes password to limit access to all major data files. BCF maintains back-up copies of electronic data files in a secure, fire protected environment and additional back-up offsite. The agency also has Cyber Security Insurance.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	D – The agency provided proof of both the FNYFS contract amendment with additional funds for staff salary increases and payroll information which verifies amount of staff member earning records. Staff member salaries increased on October 1, 2023.	

CONCLUSION

Bethel Community Foundation has met the requirements for the CINS/FINS contract as a result of full compliance with --- applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. A total of two out of 14 indicators were not applicable because the agency does not utilize Petty Cash. Consequently, **the overall compliance rate for this contract monitoring visit is 100% across all applicable indicators.** There are no corrective actions or recommendations 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 described in the report's findings.

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 deemed 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 Bethel Community Foundation - St. Petersburg
CINS/FINS Program

Date: February 7, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	**Satisfactory**
1.02 Provision of an Abuse Free Environment	**Satisfactory**
1.03 Incident Reporting	**Satisfactory**
1.04 Training Requirements	**Satisfactory**
1.05 Analyzing and Reporting Information	**Satisfactory**
1.06 Client Transportation	**Satisfactory**
1.07 Outreach Services	**Satisfactory**

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Marvin Bliss – Central Regional Monitor, Florida Department of Juvenile Justice
Kayrinah Hunter – Clinical Manager, Hillsborough County Children's Services Department

Methodology

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

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	2	# Case Managers
X	Executive Director	X	Direct – Care Full time		# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	2	# Other (listed Office Manager, Admin. Asst.
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
	CCC Reports	X	Grievance Process/Records		# Health Records
	Logbooks		Key Control Log		# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	6	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
X	Contract Scope of Services		Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans		Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	2	# Other: ___
X	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

X	Intake	X	Posting of Abuse Hotline		Staff Supervision of Youth
X	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
	Recreation		Toxic Item Inventory & Storage	X	First Aid Kit(s)
	Searches		Discharge		Group
	Security Video Tapes	X	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

Bethel Community Foundation (BCF) operates in the Bethel Community Baptist Church Building that houses four (4) programs. These four programs include:
1) Children in Need of Services/ Families in Need of Services (CINS/FINS) Prevention Program
2) Truancy Intervention Program Services (TIPS)
3) Private School for elementary to middle school youth
4) Pre-School for children ages one through five

BCF reported that their families have in-house educational resources, which are immediately accessible to parents during the intake assessment process, for children ages one through fourteen. The K-8 school that is operated onsite offers a small, faith-based private school setting as an alternative for youth that are experiencing challenges in the public school system. Scholarships available to parents include State of Florida McKay and Step-Up for Students. Pre-School scholarships are available through Coordinated Childcare.

The agency reported the TIPS program was funded in 2011 through Pinellas County's Juvenile Welfare Board Children's Services Council. This program is now in its 13th year of service to truant youth who are detained and transported by police officers to BCF's site. Currently, BCF is the lone Truancy Center in Pinellas County. Upon campus arrival, youth in the TIPS program undergo a comprehensive screening and assessment, including substances abuse and suicide risk screenings. Navigators inform parents of BCF services upon pick-up of the truant youth. School Social Workers, Law Enforcement and Truancy Court are the most significant referral sources for youth enrolled in the CINS/FINS TIPS programs.

For the eighth year, BCF reported it is maintaining supervision and case management responsibility for Truancy Court cases that result in Case Staffing's and CINS/FINS petitions. The residential CINS/FINS provider, Family Resources, has transitioned these responsibilities to BCF Navigators who have been trained by the DJJ Attorney regarding filing CINS petitions.

The following programmatic updates were provided by the agency:

BCF continues a written memorandum of agreement with the Pinellas County School Board that allows Navigators on-line access to student records. This permits staff to have real time client school history data for completion of Needs Assessment and Service Plans as well as daily monitoring of academic, attendance and discipline progress.

BCF CINS/FINS program continues to provide comprehensive family support services, including Anger Management, Youth Resiliency and Active Parenting classes. Additionally, the agency reports in-house mental health evaluations and individual/family counseling are provided, either on-site or at the school, by a sub-contracted licensed therapist (LMHC) and clinical technicians under the LMHC's supervision. At the time of this onsite Quality Improvement (QI) program review, BCF employs five (5) Navigators to provide case management, including weekly coaching to parents and mentoring to youth. Counseling and life skills classes are offered Monday – Thursday until 7:00 p.m. Youth Resiliency classes have replaced gender specific classes (Manhood Development and Female Life Skills) to ensure all youth, regardless of sexual orientation or identification, feel both welcomed and supported. Youth Resiliency classes are continuing to use the evidence based "Why Try" curriculum and are taught in a group setting by two Navigators every Wednesday at 6:00 pm. The Anger Management class uses an evidenced based Mindfulness stress reduction curriculum, designed to overcome anger and aggression using Dialectical Behavior Therapy (DBT). An evidence based Active Parenting curriculum is used for parents.

For the third straight year, BCF reported that it has secured a contract through Pinellas County Social Action Funding to further expand in-house individual and family counseling. This additional funding allows BCF to target psychosocial issues contributing more aggressively to habitual truancy, such as anxiety and depression. New Vision Behavioral Health, BCF's sub-contracted mental health provider, continues to offer services in the immediate neighborhood and therefore eliminates transportation as a barrier. Offering mental health services in the school further reduces the transportation barrier and improves access to mental health services. The Social Action Funding grant also allows BCF to increase the salaries of direct care staff (Navigators) to ensure higher retention rates. Currently, BCF has no vacancies and has not encountered any significant changes in personnel over the past year.

The BCF Foundation's current Juvenile Welfare Board (JWB) contract has been approved for an additional year and includes a slight increase from last year's award. The JWB contract increase, along with the Social Action Funding grant, elevates the BCF agency's total budget. The new operating budget is a milestone in the Foundation's history.

Lastly, BCF reported it has renewed its community partnership with Gulf Coast Jewish Family & Community Center's Community Assistance & Life Liaison Program (CALL). The CALL program is a non-emergency dispatch center, through the St. Petersburg Police Department, that aids families who call regarding non-violent issues such as teens exhibiting ungovernable behaviors and truancy. The CALL Center has become a valuable BCF referral source as it ensures that families are contacted during their moment of crisis with no waiting time for services.

Narrative Summary

BCF is under the leadership of an Executive Director who oversees the CINS/FINS program. Program staff includes and Officer Manager; Program Specialist; a Contracted Therapist and Licensed Mental health Counselor; and five Navigators. There were no vacant positions at the time of the onsite visit. The program has not reported any major challenges, incidents, administrative review, or current external investigation.

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

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

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

Standard 4: There is one applicable indicator for Community Counseling in Standard 4. Indicator 4.02 is rated **Satisfactory with an Exception.**

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:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The agency has a policy number QA 1.01 and is titled Background Screening. Policy was reviewed and approved by the Agency Executive Director on October 31, 2023.	

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

Total number of New Hire Employee/Intern/Volunteer Files: No new hires
Total number of 5 Year Re-screen Employee Files: No 5 yr. rescreenings
Staff Position(s) Interviewed *(No Staff Names)*: **No new hires**
Type of Documentation(s) Reviewed: Background screenings
Describe any Observations: No items for review.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**No eligible items for review**	The agency reported no new employees or contractors since the last Quality Improvement (QI) program review.	
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**	The agency reported no new employees or contractors since the last Quality Improvement (QI) program review.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The agency reported no new employees or contractors with a break in service for 18 months or more sine the last QI program review.	
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. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**No eligible items for review**	The agency reported no new employees or contractors who required an exemption with a break in service for 90 days or less sine the last QI program review.	

Five-year re-screening is completed every 5 years from the date of last screening.	**No eligible items for review**	The agency reported no new employees, volunteers or Intern files or contractors since the last Quality Improvement (QI) program review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency sent the required email to the Department of Juvenile Justice on January 30, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	A comprehensive review of eight employees was completed. The assigned Reviewer found all employee personnel files contained evidence of E-Verify confirmation except of one employee who was hired prior to the E-Verify requirement. All eight employees had current printed compiles of E-Verify confirmation on record.	
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		**YES** If NO, explain here: The agency has a policy number QA 1.02 and is titled Provision of Abuse Free Environment. Policy was reviewed and approved by the Agency CEO on October 31, 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.*			
Type of Documentation(s) Reviewed: Policy			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has an employee Code of Conduct policy numbers 104 and is titled Ethics and Conduct and 701 Employee Conduct and Work Rules. Policy was reviewed and approved by the Agency CEO on October 31, 2023.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a practice of ensuring that Abuse Calls if made are documented. The Abuse Hotline Registry form used by the agency listed the telephone number and captures information related to the call which includes Incident Date/Time, Call date/time, Youth Name, Abuse Report Number, BCF Staff Name, Incident Type, Reporter Type and Agent ID Number. As of the date of this onsite QI program review, the agency did not have any called reported and documented to the Abuse Hotline.	
Youth were informed of the Abuse and Contact Number	**Compliance**	All clients are informed of the Abuse Registry hotline contact number during the orientation process. No reportable incidents were made to the DCF Abuse Hotline.	

Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The agency has a detailed grievance policy. The policy includes the procedures for clients and staff members to report relevant problems to the attention of the BCF management. Once notified, the agency then initiates a review of the reported issues/complaint within 72 hours of less. The agency's response is also completed in writing. It additional time is needed resolve the issue, the agency notifies the parties involved. The agency has a youth grievances form that captures Youth Name, Grievance Date Received, Investigation Initiated - 2 Days, Grievance - 10 Day Response.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	Not applicable to Community Counseling Programs.	
Shelter only: 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**	Not applicable to Community Counseling Programs.	
Shelter only: 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**	Not applicable to Community Counseling Programs.	
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Not Applicable**	Not applicable to Community Counseling Programs.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy number QA 1.03 and is titled Incident Reporting. Policy was reviewed and approved by the Agency Executive Director on October 31, 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)* **: Executive Director.** **Type of Documentation(s) Reviewed: No incidents reported.**			
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	**Compliance**	A search of the Florida Department of Juvenile Justice Central Communications Center data base was conducted to find any documented reportable incidents in the last year. No incidents of Medical Incidents, Mental Health and Substance Abuse, Complaints Against Staff, Youth Behaviors were found as being reported.	

The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**	The agency had no record of documented reportable incidents in the last 12 months.	
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**	The agency had no record of documented reportable incidents in the last 12 months.	
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**	The agency had no record of documented reportable incidents in the last 12 months.	
All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**	The agency had no record of documented reportable incidents in the last 12 months.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy number QA 1.04 and is titled Training. Policy was reviewed and approved by the Agency Executive Director on October 31, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: Zero **Total number of Annual In-Service Staff Files: Six** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: Current training year is July 1 through June 30.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Officer Manager.** **Type of Documentation(s) Reviewed: Staff member training files.**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**No eligible items for review**	The agency reported no new employees or contractors have been hired since the last Quality Improvement (QI) program review.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**No eligible items for review**	No new staff members were hired to assess this requirement.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**No eligible items for review**	No new staff members were hired to assess this requirement.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**No eligible items for review**	No new staff members were hired to assess this requirement.	

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	No new staff members were hired to assess this requirement.	
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 members were hired to assess this 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).	**Not Applicable**	Not applicable to Community Counseling Programs.	
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).*	**Compliance**	A total of six staff member training files were reviewed to determine if all staff met the annual minimum 24 hours training requirement. All six staff members have evidence of meeting the requirement of obtaining 24 hours of annual training hours per year.	
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 agency provided documentation of an annual training plan. The current plan includes listing of all required training topics including training that specifies requirements for both pre-service and in-service staff members.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency's Program Specialist is the designated staff member responsible for overseeing the training files and completed routine tracking and management of all staff training file requirements.	
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**	A review of the agency's process for tracking and maintaining training courses completed by each staff member was conducted. The agency provided evidence of each staff member's training log and file. Each training log captures training course provided by the Florida Network, DJJ and internal agency training courses.	

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

1.05 - Analyzing and Reporting Information		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	**YES** If NO, explain here: The agency has a policy number QA 1.05 and is titled Analyzing and Reporting. Policy was reviewed and approved by the agency Executive Director on October 31, 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)* **: Executive Director**
Type of Documentation(s) Reviewed: Quality Assurance Reports, Team Meeting Minutes, Quarterly Peer Record Reviews.

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The agency provided documentation that case record reviews are conducted with a designated sample size. The case file record reviews are conducted by the Executive Director The review is conducted with a QA Review Form that assesses NIRVANA, Service Plan, Case Notes, Therapists Notes, Client and Family Contacts, and additional elements related to service delivery.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency has forms for incidents, grievances for client and staff, accidents and injuries if applicable. All the aforementioned items are reviewed monthly by the program leadership.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Customer services is review at discharge for youth and parent. The Executive Dire reviews Satisfaction surveys with the Board. Evidence is documented in Board Meeting minutes.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The agency reviews the FNYFS extract on a monthly basis. The Executive Director conducts a quarterly review of the prior 3 months data on a quarterly basis to both Board and staff members. This is evidenced in the Board Meeting minutes.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency has a policy on analyzing and reporting. The Executive Director conducts a review of the newly assembled client file and how data is entered into NetMIS.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The agency reviews case file records, incidents, accidents and grievances, Satisfactions Surveys and Program Performance Review on a monthly basis. The Executive Director is responsible for reviewing outcome data and monitors agency performance monthly internally and with the Board on a quarterly basis.	

There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The agency has documented evidence listed in the Board of Directors Meeting minutes every 2-3 months. The agency provided documented minutes for prior six months. The agency provided Governance Board meeting minutes were provided for January 2024, October 2023 and July 2023. Internal team meeting minutes were provided for January 2024, October 2023 and August 2023.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency reported utilizing an internal process of client file reviews. The Executive Director gathers a random sample and conducts quality control checks on major service delivery requirements for each Navigator's caseload. When a deficiency is observed it is documented and all necessary training and other corrective action methods are implemented by the Executive Director. The files are then placed back on a review schedule to determine if the corrections have been addressed as required. The agency provided Board Of Directors and staff member meeting minutes for the last six months. These minutes document the Executive Director providing an update on staff performance on client file case review and any associated corrective actions and service delivery improvements.	
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		**YES** If NO, explain here: The agency has a policy number QA 1.05 and is titled Analyzing and Reporting. Policy was reviewed and approved by the agency Executive Director on October 31, 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.*			
Dates or Timeframe Reviewed: Not Applicable. **Describe any Observations:** Due to liability insurance costs and concerns, it is the policy of Bethel Community Foundation to not transport clients under any circumstances. Staff may not use their personal vehicle to transport a singular client and are subject to disciplinary action if observed or found doing so.			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Not Applicable**	The agency's transportation policy indicates that the program will only transport clients in emergency situations. The policy delineates what constitutes an emergency situation. The policy indicates the program provides daily bus passes for families needing assistance with transportation.	
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			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy number QA 1.07 and is titled Outreach Services. Policy was reviewed and approved by the agency Executive Director on October 31, 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)* **: Executive Director.** **Type of Documentation(s) Reviewed: NetMIS Outreach Report, FSI Meeting Agenda, Community Outreach Events -GHS.**			

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.	**Compliance**	Position title of lead staff reviewed: Lead positions conducting Outreach primarily conducted by 3 Navigators. Each Navigator has differently roles. One Navigator works with Pinellas County School Board. One Navigator is the lead person for Family Services Initiative (FSI) community meetings and helping people with crisis issues. One Navigator is lead person that work truancy cases with the Truancy Judge and courts. The agency also attend Community Discussion Meetings at Gibbs High School on a quarterly basis. GHS documented events on the following dates of 1/17/2024; 11/15/2023; and 9/13/2023. Documentation was provided for Juvenile Welfare Board Meetings were conducted on July 2023 - January 2024.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Agreements with Community Assistance and Life Liaison Program (CALL) /911 resource center to act as referral source for family issues, Pinellas County School Board, and Vision Behavior.	
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**	Outreach forms capture the following categories Title of Event; Activity Date; Duration Hours; Zip Code; Location Description; Target Audiences; Estimated People Reached; Modality; Topics; and Staff Present.	
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: Executive Director and three program Navigators performance the majority of all outreach activities.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.2.01 Screening and Intake which was last reviewed on 10/31/2023 by the Executive Director.	
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: 5 open youth Community Counseling **Total number of Closed (Residential & Community) Files: 5 closed youth Community Counseling** **Staff Position(s) Interviewed** *(No Staff Names)* **: Executive Director** **Type of Documentation(s) Reviewed: Youth Files**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Not Applicable**	Not applicable to Community Counseling.	

Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	Eight of 10 client files reviewed has screening forms completed within Three business days of receiving referral.	Two out of the 10 client files reviewed have screenings completed outside 3 business day period after initial referral was received.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All 10 client files documented data entry in Netmis within Seventy-Two hours.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All 10 files documented obtained youth and parent/guardian signatures of receiving available service options along with the rights and responsibilities	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All 10 client files had documented information regarding possible interventions through CINS/FINS services and Grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All 10 files documented youth were screened for suicidality. Two of the ten files documented youth answering yes to suicide risk assessment questions.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.2.02 Needs Assessment which was last reviewed on 10/31/2023 by the Executive Director.	
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: 5 open youth Community Counseling **Total number of Closed (Residential & Community) Files: 5 closed youth Community Counseling** **Staff Position(s) Interviewed (No Staff Names): Executive Director** **Type of Documentation(s) Reviewed: Youth Files**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	Not applicable to Community Counseling.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All 10 client files documented the NIRVANA assessment was initiated and completed at intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All 10 client files contained supervisor signatures for completed NIRVANA assessments	

(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 to Community Counseling.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Five out of five closed client files contained NIRVANA Post-Assessments completed at time of discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Nine out of 10 client files required a NIRVAN Re-assessment after every 90 days of service.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All 10 client files included printed and completed NIRVANA assessment.	
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		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.2.03 Case/Service Plan. which was last reviewed on 10/31/2023 by the Executive Director.	
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: 5 open youth Community Counseling **Total number of Closed (Residential & Community) Files: 5 closed youth Community Counseling** **Staff Position(s) Interviewed (No Staff Names): Executive Director** **Type of Documentation(s) Reviewed: Youth Files**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All 10 client files had service plans developed based on information gathered from screening, intake, and the NIRVANA assessment.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All 10 client files contained service plans developed within seven days of NIRVANA assessment.	
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**	All 10 client files provided goals, service type, frequency, location, person responsible, target dates, signatures and date service plan was initiated. three out of ten charts had actual completion dates.	Three of the five closed client files did not have evidence of completion dates documented in the client file.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	All 10 client files documented case service plans were reviewed every thirty days for the first three months and every six months after.	
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		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.2.04 Case Management and Service Delivery which was last reviewed on 10/31/2023 by the Executive Director.	
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: 5 open youth Community Counseling **Total number of Closed (Residential & Community) Files: 5 closed youth Community Counseling** **Staff Position(s) Interviewed (No Staff Names): Executive Director** **Type of Documentation(s) Reviewed: Youth Files**			
Counselor/Case Manager is assigned	**Compliance**	All 10 client files contained evidence of documented assigned counselors/navigators all files reviewed.	
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 progress of 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 post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	Seven of the 10 client files documented appropriate referrals made to New Vision Behavioral Health based on all completed intakes and assessments. Ten client files displayed service plan coordination and monitoring youth/family's progress. One of the ten client files included case notes due to truancy involvement and court order directives. No case staffings referrals have been made or youth referred to the shelter. Five of Five of discharged client files had documented termination notes. Three of the five closed charts provided proof of 30 day follow ups. One of the five closed charts provided evidence of 60 day follow ups. Seven of the 10 charts were not applicable for 30 and 60 day post discharge follow--ups.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency has policies and procedures that include a referral source and process with community partners to assist with suicide prevention after youth respond yes to questions on suicide risk assessment.	
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		**YES**	
		If NO, explain here:	
		Agency has written policy and procedure titled Q.A.2.05 Mental Health & Substance Abuse Counseling Services which was last reviewed on 10/31/2023 by the Executive Director.	
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: 5 open youth Community Counseling **Total number of Closed (Residential & Community) Files: 5 closed youth Community Counseling** **Staff Position(s) Interviewed (No Staff Names): Executive Director** **Type of Documentation(s) Reviewed: Youth Files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	Not applicable to Community Counseling.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**	Not applicable to Community Counseling.	
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 to Community Counseling.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**	Not applicable to Community Counseling.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	All 10 client files documented services were provided in the youths home, community location, and at local provider's counseling office or virtually.	

Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	All 10 client files have documentation of file reviews in accordance between presenting problems, service plan, service plan reviews, assessments, case management, and follow up services.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All 10 client files adhere to all laws of confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All 10 client files have evidence of progress notes, contact notes, case notes, service plan reviews to document youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	All 10 client files had documented supervisor's review of files.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**Not Applicable**	All 10 client files documented intakes were completed with client and parent/guardian in the home.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.2.06 Adjudication/Petition which was last reviewed on 10/31/2023 by the Executive Director.	
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: No eligible items for review. **Total number of Closed (Residential & Community) Files: No eligible items for review.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	At the time of this on QI program review, the agency did not have any adjudication or petition cases eligible for review. In the event the agency does have cases in adjudication and petition status the agency has processes in place to conduct all aspects of case staffing including conducting meeting with the proper members required to execute the process.	
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	**Compliance**	At the time of this on QI program review, the agency did not have any adjudication or petition cases eligible for review. In the event the agency does have cases in adjudication and petition status the agency has processes in place to conduct all aspects of case staffing including conducting meeting with the proper members required to execute the process.	

The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The agency has procedures in place to assemble members and the ability to properly manage communicating with all parties required for the proper execution of the Case Staffing process.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The agency has procedures in place to assemble members and facilitate all parties required for the proper execution of the Case Staffing process.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The agency did not have any eligible files to review that meets this criteria at the time of review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The agency did not have any eligible files to review that meet this criteria at the time of review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The agency did not have any eligible files to review that meets this criteria at the time of review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency did not have any eligible files to review that meets this criteria at the time of review.	
Additional Comments: **There are no additional comments for this indicator.**			
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: Agency has written policy and procedure titled Q.A.2.07 Youth Records which was last reviewed on 10/31/2023 by the Executive Director.	
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: 5 open youth Community Counseling **Total number of Closed (Residential & Community) Files: 5 closed youth Community Counseling** **Staff Position(s) Interviewed (No Staff Names): Executive Director** **Type of Documentation(s) Reviewed: Youth Files**			
All records are clearly marked 'confidential'.	**Compliance**	All 10 client files reviewed were marked "Confidential".	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	Files were stored in locked room. Counselors with open files have files secured in metal file cabinet with a locking mechanism in each of their respective offices. Client closed files are stored in a secondary building adjacent to the agency office. The building houses all closed client files in locked metal cabinets in a secure storage room which is marked confidential.	

When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Counselors transport files in locked travel case with a combination lock.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All client files reviewed onsite are secured and organized. All client files included a file format sheet. All files were legible and did not have torn or ripped pages.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.2.08 Specialized Additional Program Services which was last reviewed on 10/31/2023 by the Executive Director.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for review.			
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**	Not applicable to Community Counseling Programs.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Not Applicable**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**Not Applicable**		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**Not Applicable**		
Agency provides a written report for any court proceedings regarding the youth's progress	**Not Applicable**		
Domestic Minor Sex Trafficking (DMST)			

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for review. **Total number of Closed Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			
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**	Not applicable to Community Counseling Programs.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**Not Applicable**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**Not Applicable**		
Services provided to these youth specifically designated services designed to serve DMST youth	**Not Applicable**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**Not Applicable**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**Not Applicable**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**Not Applicable**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for review. **Total number of Closed Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			

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**	Not applicable to Community Counseling Programs.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Not Applicable**		
Data entry into NetMIS within (3) business days of intake and discharge	**Not Applicable**		
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Not Applicable**		
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Not Applicable**		
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for review. **Total number of Closed Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			
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**	Not applicable to Community Counseling Programs.	
All probation respite referrals are submitted to the Florida Network.	**Not Applicable**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Not Applicable**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Not Applicable**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Not Applicable**		
All case management and counseling needs have been considered and addressed	**Not Applicable**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		

Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for review. **Total number of Closed Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			
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**	The agency is not contracted to provide this service.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for review. **Total number of Closed Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			

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**	The agency does not have a contract with the FNYFS to provide Family and Youth Respite Aftercare Services (FYRAC).	
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.	**Not Applicable**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Not Applicable**		
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.	**Not Applicable**		
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.	**Not Applicable**		

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.	**Not Applicable**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**Not Applicable**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Not Applicable**		
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	**Not Applicable**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Not Applicable**		
All data entry in NetMIS is completed within 3 business days as required.	**Not Applicable**		
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: The agency does not have a policy specific to SNAP because the agency does not have a SNAP contract.	
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			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: Agency has written policy and procedure titled Q.A.4.02 Suicide Prevention which was last reviewed on 10/31/2023 by the Executive Director.	
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: Not Applicable. **Total number of Closed (Residential & Community) Files: Closed residential files.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Executive Director.** **Type of Documentation(s) Reviewed: Client Case files.**			
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.	**Compliance**	Two closed non-residential client files included risk screening questions which indicated at least one positive response to the suicide risk screening questions.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Exception**	The agency reported that the FNYFS approved their use of the current suicide risk assessment. The current risk assessment tool does not include language consistent with the risk screening questions listed in the most recent policy and procedures manual.	The current risk assessment tool does not include the same risk screening questions in the FNYFS suicide risk evaluation policy. Agency addressed this onsite and updated screening instrument to ensure it is consisted with FNYFS suicide prevention policy.
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**		
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.	**Compliance**	A review of agency client files resulted in two clients files which indicated the youth reported a yes response to one of the suicide risk screening questions on the suicide prevention screening instruments.	
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**	A review of two client files which indicated a positive on the suicide risk screening instrument was found to have evidence of referrals being made to local mental health receiving facilities.	Agency referral sheet was completed and indicates referral being made. One of two client files did not have evidence of the referral date documented in the client file when the youth was referred to a local mental health facility.
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.	**Compliance**	The review of the two applicable client files found evidence of referrals placed with a local mental health receiving facility by the agency Counselor and located in both client files.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Both client files have documented evidence confirming parent/guarding being notified of the client stating yes in response to suicide risk screening questions.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	Both screening were conducted outside of schools hours and not on school property. As a result, no school authorities were required to be notified.	
Additional Comments: **There are no additional comments for this indicator.**			