Florida Network for Youth and Family Services
Compliance Monitoring Report for

PREVENTION CENTRAL

1100 W Sunrise Boulevard
Fort Lauderdale, FL 33311

March 22, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Prevention Central for FY 2023-2024 at its program office located at 1100 W. Sunrise Boulevard, Fort Lauderdale, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Prevention Central is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers Rosa Flores, Department of Juvenile Justice, and Ivonne Fusco, Lutheran Services Florida Southeast. Agency representatives from Prevention Central present for the entrance interview were: Tierra Smith, Executive Director; Kwankila Corbin, Director of Operations; Ivonne Medrano, Lead for CINS/FINS; Latoya Robinson, FYRAC Director; and Jandra Alexander, SNAP Coordinator. The last onsite QI visit was conducted on May 10, 2023.

In general, the Reviewer found that Prevention Central is in compliance with specific contract requirements. **Prevention Central received an overall compliance rating of 100% for achieving full compliance with 11 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions cited or recommendations made as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 03-22-2023-2024

Agency Name: Prevention Central	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1100 W Sunrise Blvd, Fort Lauderdale, FL 33311**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 22,2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. 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 - The provider currently has three certified QI Peer Reviewers: Tierra Smith, Ivonne Medrano, and Latoya Robinson. All three peer reviewers participated in a QI Peer Review during the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	D - The agency maintains a list of funders that includes one additional contract other than the Florida Network for FY 2023-2024. The list includes contract name, funder, amount funded, service provided, and contract term dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All agreements reviewed during the QI visit had current contract/agreement dates.	

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Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $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**	☐	☐	☐	☒	☐	D – Prevention Central provided a certificate of liability insurance that included: Commercial Liability Insurance with Western World Insurance Company with a limit of $1,000,000 per occurrence (exceeds minimum), and $2,000,000 policy aggregate (exceeds minimum), effective 7/26/2023-7/26/2024 Automobile Liability Insurance through Western World Insurance Company with combined single limits of $1,000,000 effective 7/26/2023-7/26/2024 Workers Compensation Insurance through Ascendant Commercial Insurance Company Inc. with a $100,000 limit per accident /per employee and $500,000 policy limit, and $100,000 each employee by	

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						disease, effective 1/11/2024-1/11/2025. The Florida Network is listed on the Certificate of Liability Insurance as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	I - During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	D - The agency maintains accounting policies and procedures in place for FY 2023-2024, revised July 2023. The manual includes procedures for Chart accounts and general ledger, cash receipts, inter-account bank transfers, cash disbursements and expense allocations, credit card policy and charges, accruals, bank account reconciliations, property and equipment, personnel records, payroll processing, end of month and FY end close, financial reports, and fiscal	

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						policy statements. The procedures reviewed appear to be consistent with GAAP and provide for sound internal 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- The General Ledger for the CINS/FINS program for FY 2023-2024 as of January 2024 was provided. The general ledger (GL) is structured to track all funding sources and there is a separate GL for the CINS/FINS program which uses a chart of accounts that includes the type of transaction, date, Invoice #, Payee, description, debit/credit amount, and balance. Specific expenditures related to the CINS/FINS program were reviewed on the GL and were found to be consistent with standard program expenditures.	
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**	☐	☐	☐	☐	☒	I – Prevention Central CINS/FINS program does not use Petty cash	

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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- Prevention Central provided Bank of America bank reconciliations for the period July 2023-February 2024. All reconciliation reports reviewed showed reconciliation dates within 6 weeks of receipt of the bank statement (5 were completed within three weeks). The provider completes a Reconciliation Report for each month listing the statement period ending dates, dates reconciled, beginning balance, cleared balance, register balance, and ending balance. The printed copies include the name of the person who completed the reconciliation.	
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- Per statement provided by the Executive Director, the program has not purchased any FN inventory or item amounting to more than $1000 since the last QI visit.	

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f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation and Interview: Agency provided a copy of payroll liability for the current FY to date. The monthly report documents the amount of federal and state income tax withheld and contributed by the agency for each pay period as well as the corresponding Bank of America debit transaction to verify payment made. The agency contracts with ADP for payroll services. The agency has a new agreement with the IRS for the delinquent payroll taxes from (2012-2015) to expedite the payoff. There are no current tax delinquencies. As of Fall 2021, Prevention Central is contracted with CBK Pros, LLC accounting firm to provide fiscal oversight.	

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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**	☐	☐	☒	☐	☐	Documentation: Agency provided budget to actual year-to-date reports for FY 2023-2024. The report shows actual year-to-date expenditures, budgeted amounts, and variance. A review of these documents was conducted. Variances in budget are monitored on a regular basis and are discussed with the Board.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2023 was completed by BAS Partners LLC, Certified Public Accountant, per audit letter dated January 30, 2024. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor.	

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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**	☐	☐	☒	☐	☐	Documentation: Review of the agency's Record Retention and Confidentiality policies and procedures that address secure and confidential storage, retention timeframe, and access to records. The policy is applicable to youth, personnel, and financial records. Agency maintains quarterly back-up of files which is kept in a safe. Cloud storage is used for daily back up of files.	
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 provider submitted payroll information for each direct care staff with salary information to support each staff has a minimum hourly salary of at least $19/hour.	

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CONCLUSION

Prevention Central has met the requirements for the CINS/FINS contract as a result of full compliance with 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the fourteen indicators were not applicable because 1) the provider does not have any corrective actions with any external funder; 2) no new inventory was purchased with Florida Network funds in the past year; and 3) the CINS/FINS program does not use petty cash. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendation made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report 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 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 Prevention Central - Fort Lauderdale
Community Counseling Program

March 22, 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	Not Applicable
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	Satisfactory
2.09 Stop Now and Plan (SNAP)	Satisfactory

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

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Rosa Flores – Regional Monitor, Department of Juvenile Justice
Ivonne Fusco – Lutheran Services Florida Southeast

Methodology

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

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	2	# Case Managers
X	Executive Director		Direct – Care Full time	1	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
	CCC Reports		Grievance Process/Records		# Health Records
	Logbooks		Key Control Log	X	# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	2	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans		Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

0	# of Youth	4	# 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

Prevention Central, formerly Mount Bethel Human Services Corporation (MBHSC), is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to provide non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program in Broward County. The program is located at 1100 W. Sunrise Boulevard, Fort Lauderdale, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Family and Youth Respite Aftercare Services (FYRAC) and is also contracted to provide SNAP U12, SNAP Clinical Group (ages 12-17), and SNAP in School programs.

The following programmatic updates were provided by the agency:

Staffing

Prevention Central has been under the executive leadership of Tierra Smith since February 2021. Recently, the program hired Ms. Kwankila Corbin as Director of Programs to supervise all programs operated by the agency. In addition to Ms. Corbin, the CINS/FINS program is led by Ivonne Medrano, the SNAP program's coordinator is Jandra Alexander, and the FYRAC program director is LaToya Robinson. Staff vacancies include a CINS/FINS director and case manager, and a SNAP case manager.

Program Update

Prevention Central CINS/FINS offices are located in a high risk zip code of Fort Lauderdale and services are provided throughout the entire Broward County. The executive director reported two new program initiatives since the last QI review. The agency is in the process of rebranding and adopting a more active social media presence. Additionally, a new partnership was fostered with Endeavor Primary of Fort Lauderdale as a local enrichment center partnership.

The program conducts face-to-face services in-home, at schools, or in the community, but offers virtual services to parent/guardians if requested for those not able or willing to allow in-home services. Files are maintained in file folders but some forms are completed electronically. Other non-CINS service that complements the CINS program is the SNAP Tier Transfer program and Fatherhood programs, that provides high-risk youth and their parents with a model to help them stay in school and out of trouble by making better choices throughout the program, and a Family Resource Center.

The facility is also used by the program as a food pantry that distributes food to the community on a weekly basis. The food pantry is a natural outreach activity that provides a valuable food service to the local community and brings awareness to the agency and program services.

Facility

The program has not made any significant improvement to the program offices in the past year as these improvements were already completed the prior year resulting in increased office space, remodeled office areas, a reception area, additional cubicles for staff, a staff cafe, and improved staging/storage area for the food pantry. Planned facility upgrades for the future includes the lease of additional suite/property and expansion of programs to the Treasure Coast.

Funding/Finance

Since the last onsite visit, the agency received new funding for the SNAP FATHER program, a resource for incarcerated or previously incarcerated fathers. The agency's annual fiscal audit with BAS Partners was completed and no management letter with corrective actions was required.

Governance and Community

New engagements within the last year includes the following community partnerships (non-profit and corporate): Endeavor Primary Learning Center, Chrysalis Health, and Rock Academy. There were no Board of Director changes since the last QI Review.

External Corrective Action Plans

The agency did not report any external corrective action plans or major challenges for the review period.

Major Challenges

Staffing and workforce continues to be one of the challenges faced by the agency.

Narrative Summary

Prevention Central is under the leadership of an Executive Director, a Director of Programs, a CINS/FINS Lead who supervises a senior multi-lingual case manager and another fulltime case manager, a FYRAC director supervising one case manager, and a SNAP Coordinator who operates the SNAP staffed by two part time SNAP contractors. The CINS/FINS case manager's duties include intake and assessment, development of case plans, providing case management services, and linking youth and families to community services. Through the screening and intake process, trained staff can assess youth and families for eligibility of services. Case management, substance abuse prevention education, and parenting group education are available as well. Aftercare planning includes referral of youth and families to other agency programs or to external community resources.

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 with Exception,** Indicator 1.06 Client Transportation was rated **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 was rated **Satisfactory**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with Exception.**

Standard 4: There are five indicators for Standard 4. There are four indicators that are Not Applicable for Community Counseling Programs; Indicator 4.01, 4.03, 4.04 and 4.05 are all Not Applicable. Indicator 4.02 was rated **Satisfactory.**

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

None of the indicators were rated Limited or Failed rating.

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 provider has the required policy and procedure, PC1.01 - Background Screening of Employees/Volunteers, that was reviewed by the Executive Director (ED) on 2/2/2024	

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

Total number of New Hire Employee/Intern/Volunteer Files: Two new staff hired.
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Avatar Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	The provider uses the HR Avatar pre-employment suitability assessment which was implemented in September 2018. The Avatar was administered prior to hiring two new direct care staff who received scores above the agency's established passing rate of 70%.	
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 two new staff received passing scores on the HR Avatar.	
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 two new staff were not previously employed by the agency.	

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.)*	**Compliance**	Two eligible background screening files were reviewed for two new staff hired since the last onsite QI review. The background screenings were submitted prior to hire date for both staff. No volunteers meeting the criteria for background screening were utilized by the agency during the annual review period.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**No eligible items for review**	The provider did not have any eligible for 5-year re-screenings during the review period	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department of Juvenile Justice Background Screening Unit on December 21, 2023 via email prior to the January 31, 2024 deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	E-verify and proof of employment authorization from the Department of Homeland Security is on file for the two new hires.	
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 provider has the required policy and procedures, PC 1.02 - Provision of an Abuse Free Environment, that was reviewed by the Executive Director on 2/2/24	
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)* **: Director of Programs** **Type of Documentation(s) Reviewed: Employee/Contractor Code of Conduct signed by employee on personnel file, client handbook,** **Describe any Observations: Posting of abuse hotline telephone number**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The provider has an Employee/Contractor Code of Conduct reviewed by new employees during hiring process.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The policy and procedure outlines the protocol for reporting and documenting abuse hotline calls. If the case manager is aware of any allegation of child abuse, they will notify their supervisor and then will make the call to the abuse hotline. There were no abuse hotline calls reported during the annual review. The program has a log to document abuse calls in the event calls are made.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Florida Child Abuse Hotline is included in the Client Handbook that is given to clients during intake and reviewed with the youth and family.	
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**	During intake clients are informed of the program's grievance procedure and sign a form acknowledging receipt of the information. Signed grievance procedure acknowledgement forms were evident in the youth records reviewed.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	Not applicable for 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 for 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 for 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 for 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 provider has the required policy and procedure PC1.03 - Incident Reporting, that was reviewed by the Executive Director on 2/2/24	
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)* **: Director of Programs** **Type of Documentation(s) Reviewed: CCC Reporting Binder,** **Describe any Observations: Posted CCC phone number in several places around the office**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**No eligible items for review**	The provider does not have any reportable CCC incidents since the last annual QI review. A review of the provider's Incident Report binder showed there were three calls made to CCC; however, all three incidents were noted as non-reportable by CCC.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**		
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**No eligible items for review**		
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	The program maintains a program log with complete detail of incidents reported.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The three non-reportable incidents reviewed were signed by the program director.	
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**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The program has the required policy and procedure, PC1.04 - Training Requirement, that was reviewed by the Executive Director on 2/2/24	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of New Hire Staff Files: 2
Total number of Annual In-Service Staff Files: 5
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: Fiscal year 7/1 - 6/30**
Staff Position(s) Interviewed *(No Staff Names)* **: Executive Director and Director of Programs**
Type of Documentation(s) Reviewed: Training binders

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Training records for two new staff were reviewed to assess compliance with pre-service training requirements. All two staff completed mandatory pre-service trainings prior to working independently with youth.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Two new staff completed the required DOJ Civil Rights & Federal Funds within 30 days of hire	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**No eligible items for review**	Two new hires still have time to complete missing trainings: MI, CINS Petition, CINS/FINS Core; one was hired 1/3/24 and the other 2/5/24	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**No eligible items for review**	Two new hires still have time to complete missing trainings: MI, CINS Petition, CINS/FINS Core; one was hired 1/3/24 and the other 2/5/24	
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Training documentation reviews verified the two new hires completed the required NIRVANA training.	
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**	Two new hires are still within the required time to complete the FL Statute 984 CINS Petition Training.	
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 for community counseling program	
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**	Five in-service training records were reviewed. The five in-service staff completed all mandatory annual training topics and exceeded the annually required 24 hours training.	

Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program has a Training Plan for FY 2023-2024 which includes pre-service and in-service training requirements. The training plan is included in each training file.	
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 person in charge and responsible to manage training files is the Executive Director but each staff maintains their individual training record.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains individual training files for each employee. All seven training files reviewed included a training log and training certificates to support trainings completed.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	**NO**	
	If NO, explain here: The provider's policy and procedure PC1.05 duplicates the language of indicator 1.05; however, specific procedures are not documented to describe the program's activities that will address each element of the indicator.	
	The provider has a policy and procedure PC1.05 Analyzing and Reporting Information that was reviewed by the Executive Director on 2/2/24.	

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: quarterly risk management score card reports, Stakeholder Involvement Team (SIT) reviews consumer satisfaction surveys board of director meeting minutes, program committee/staff meeting agendas/minutes, and NetMIS data reports.

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Exception**	Peer record reviews are conducted by the supervisor randomly for new intakes and discharged records as well as monthly by each staff who participates by bringing two records to be reviewed. A form is used to capture the record review for each file that is placed in the youth's record.	The program documents the number of files reviewed monthly at staff meetings; however, a summary of overall findings or trends to be addressed as a result of the record reviews is not maintained to support monitoring and implementation of corrective actions.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Incidents, accidents, and grievance data is collected and reviewed monthly at staff meetings by the program staff. Staff meeting agenda items include a review of incidents, accidents, grievances. Verification of monthly meetings was evidenced by staff meeting agendas, minutes, and staff attendance.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Satisfaction surveys are collected and entered into NetMIS on a regular basis and are reviewed at staff meetings periodically. The program also conducted an annual review of satisfaction surveys at it's staff meeting June 30, 2023. A report of the 87 surveys was included in the minutes for the meeting.	
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**	EOM reports are reviewed by the ED and director of programs and also reviewed with management staff at Monday huddle meetings. The EOM report is also a standing staff meeting agenda item to demonstrate discussion of the program's performance with staff and evidence is supported by monthly meeting agendas and minutes for the review period.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Program staff is responsible for entering and ensuring Netmis data entry is accurate. However, the program supervisor ensures communication from the Florida Network is addressed and responded to promptly. Evidence of data communications with the Florida Network was reviewed onsite.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	As evidenced by meeting agendas and minutes with leadership staff and program staff, there is documentation to support findings are reviewed regularly and communicated effectively.	

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 ED attends the agency's Board of Director's meetings to keep the Board informed of program performance. No reporting of Limited or Failed ratings were applicable as the program received all Satisfactory ratings during the previous QI review.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Monthly staff meetings were found to document discussion of QI activities, reports, and areas identified as needing improvements resulting from analysis of data collected.	
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 provider has a policy and procedure PC1.06 Client Transportation, that was reviewed by the Executive Director on 2/2/24.	
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 PC1.06			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Not Applicable**	Per the agency's policy PC1.06, Prevention Central does not provide transportation for clients and transportation by agency staff is strictly prohibited.	
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 provider has the required policy and procedure PC1.07-Outreach Services, that was reviewed by the Executive Director on 2/2/24	
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 Activity Log 10/1/23-3/11/24, MOU Agreements binder, Lead Case Manager job description**			
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/responsibilities of lead staff was reviewed: Executive Director, Lead Case Manager, or Director of Programs are designees who attend local DJJ board meetings.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Program maintains MOU Agreements binder with several community partners like Feeding Florida, Urban League, Parks & Recreation Ft. Lauderdale, etc. All agreements reviewed were current and up-to-date.	
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**	All outreach activities are entered into NetMIS Outreach Activity. Activities for the review period from 10/1/23 - 3/11/24 were reviewed and evidenced the program is actively offering community awareness, information and educational services to youth and families.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Primary outreach staff includes the Lead Case Manager and Director of Programs. However, program staff also attends and participates in outreach activities as needed.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.01 Screening and Intake that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.			
Total number of Open (Residential & Community) Files: 5 **Total number of Closed (Residential & Community) Files: 5** **Type of Documentation(s) Reviewed: Case management files**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Not Applicable**	Prevention Central is not a residential program.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	A review of five open and five closed records, indicated each record contained an eligibility screening form completed within three days of referral by a trained staff using the Florida Network form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Each reviewed record indicate all referrals for service were screened for eligibility and logged in NetMIS within 72 hours of the screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	Each reviewed record confirmed the parent/guardians received written information regarding the available service options, rights and responsibilities of youth and parent/guardians.	
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**	Each reviewed record confirmed the youth and parent/guardian were provided with the possible actions and involvement with CIN/FINS services and the Grievance Procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	A review of five open and five closed records confirmed each youth was screened and assessed for suicidality during intake.	

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

2.02 - Needs Assessment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.02 Nirvana, that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 **Total number of Closed (Residential & Community) Files: 5** **Type of Documentation(s) Reviewed: Case management files**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	Prevention Central is not a residential program.	
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**	A review of five open and five closed records, confirmed each youth had a completed NIRVANA 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 ten records reviewed contained a completed NIRVANA assessment and interview guide, and each assessment contained the supervisor signatures	
(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**	Prevention Central is not a residential program.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	A review of five closed records, reflected a NIRVANA Post-Assessment was completed at discharge for each applicable closed records.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	None of the closed cases received services for over 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	Each of the reviewed client record confirmed each contained a completed NIRVANA and interview guide.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.04 Case Service Plan, that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 **Total number of Closed (Residential & Community) Files: 5** **Type of Documentation(s) Reviewed: Case management 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**	A review of five open and five closed records, confirmed each service plan was developed on the program's approved form. Additionally, each case plan indicated the required information was gathered during the initial screening, intake and NIRVANA. The case plans in all ten records reviewed were observed to include all elements required by the indicator. The youth signatures and parent/guardian signatures were verified in nine of the ten records reviewed, and one youth did not contain a parent/guardian signature as the youth was eighteen years of age.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	The case plans in all ten records reviewed were observed to have been developed within seven working days of the completion of the 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	**Compliance**	The case plans in all ten records reviewed were observed to include all elements required by the indicator. Each service plan contained the youth's individualized need/goal as identified by the NIRVANA assessment, the service type, frequency, location, person responsible, youth's signature, parent/guardian signature, counselor signature, supervisor signature and the date of when the plan was initiated.	

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**	A review of each of the ten service plans, confirmed all plans were reviewed for progress/revised by the counselor and parent (if available), at least every thirty days for the first three months as required.	
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: The provider has the required policy and procedure PC 2.05 Case Management and Service Delivery, that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 **Total number of Closed (Residential & Community) Files: 5** **Type of Documentation(s) Reviewed: Case management files**			
Counselor/Case Manager is assigned	**Compliance**	A review of five open and five closed youth records was conducted. Each of the case plans in all ten records reviewed were observed to have a case manager assigned.	
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**	The case plans in all ten records reviewed were observed to include all elements required by the indicator. As observed in the case files, the case managers established referrals and coordinated referrals based on the needs of the family, implemented and coordinated the service plans, provided support for the families, monitored the youth and family progress and documented it in the case notes, and provided case termination notes in the discharge summary and in the case notes for the clients that were terminated.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	A review of the program's policy and procedures and review of records confirm, the program maintains written agreements with other community partners, which provide services to the youth the program serves and contains a comprehensive referral process,	
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: The provider has the required policy and procedure PC 2.06 Counseling Services, that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 **Total number of Closed (Residential & Community) Files: 5** **Type of Documentation(s) Reviewed: Case management files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	Prevention Central is not a residential program.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**		
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Not Applicable**		
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**		

Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	A review of ten records verify the program provides services and interventions, which are accessible to youth in the community, youth's home, the local providers counseling office, or available virtually, with written documentation.	
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**	A review of five open and five closed records, confirmed each case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	A review of five open and five closed records, confirmed each case file was maintained confidentially and in adherence to all laws.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	A review of five open and five closed records, confirmed each case files contained case notes for counseling services, which documented the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	A review of five open and five closed records, indicated the program has an internal process and procedures, and documentation verified the program's practice. Record reviews were completed on a form that is maintained in the youth's file and was evident during the review of records.	
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.	**Compliance**	A review of five open and five closed records, confirmed four case files were conducted virtually. Each applicable record documented consent and confirm supervisory/case review.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.07 Adjudication/Petition Process, that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 0 **Total number of Closed (Residential & Community) Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Executive Director and Case Manager Supervisor** **Type of Documentation(s) Reviewed: The program's policy and procedures.** **Describe any Observations: The program did not have any applicable records for review.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The program refers and utilizes Lutheran services of Florida southeast for any case staffing committee meetings.	
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**	According to the Executive Director, all pertinent persons will attend the committee meetings, which are directed and held by Lutheran Services.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program attends the case staffing meetings which are held by the Lutheran Services that has established committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program has an internal procedure for the case staffing process that is contained in its policy and procedures.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	Per interview with the community counseling Program Director, Prevention Central has not received any case staffing requests since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**		

If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**		
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator. Informal interview with the programs Executive Director indicates, the program has not had any case committee staffing since the last annual review. In the event the program does, the youth is referred to Lutheran services, to complete the case staffing committee.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.08 Youth Services, that was reviewed by the Executive Director 2/2/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Executive Director and Case Manager Supervisor** **Type of Documentation(s) Reviewed: Case management records** **Describe any Observations: Records were observed to be in compliance with this indicator.**			
All records are clearly marked 'confidential'.	**Compliance**	A review of five closed and five open records was conducted. Each reviewed records were observed to be marked 'confidential'.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All reviewed records were observed to be securely maintained and kept confidentially. The files are kept in locked file cabinets with confidential marked on the file cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program has a locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	Each reviewed record was maintained in a orderly and chronological order, for quick access and review.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.09 Family Youth Respite Aftercare Services (FYRAC), that was reviewed by the Executive Director 2/2/2024.	
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: 0 **Total number of Closed Files: 0**			
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**	Prevention Central is not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		

Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 open **Total number of Closed Files: 2 closed** **Type of Documentation(s) Reviewed: Youth records**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	A total of four youth records were reviewed for two open and two closed FYRAC youth served during the review period.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**Compliance**	Domestic Violence charge is documented on the DJJ Face Sheet in each of the 4 youth records reviewed and the referral/screening form indicates the youth were referred by DJJ Juvenile Probation Officer (JPO).	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	Florida Network approval for each youth was present in the files.	
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**Compliance**	The initial intake assessment was conducted face-to-face for two of the four youth. Two of the youth had virtual intakes because one of the youth was on house arrest and the JPO requested virtual services for the other youth due to transportation issues. The requests for virtual services were clearly documented in each record. All services were documented in the progress notes and applicable signatures were obtained.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**Compliance**	Documentation of Life Management sessions and topics is maintained in each youth record. The sessions are at least 60 minutes long and include topics to improve family functioning.	

Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**Compliance**	Life Management sessions are conducted individually with each youth and family and focuses on the issues identified from the intake and goals to assist the youth to understand and deal with emotional triggers, anger management, and family coping skills.	
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**	Program conducts Life Management sessions in lieu of group sessions.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	Thirty and sixty-day follow ups were completed for the two closed records reviewed.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**Compliance**	Two applicable closed records reviewed demonstrated one of the two youth received 13 sessions and the other youth completed 10 sessions but the three missed sessions due to personal/family scheduling conflicts were made up in other sessions completed.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Compliance**	The requests for virtual services were clearly documented in the two applicable record. All services were documented in the progress notes and applicable signatures were obtained.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	NetMIS data entry lag report was reviewed and revealed no lags in data entry for the four records reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The provider has the required policy and procedure PC 2.10 Stop Now and Plan (SNAP), that was reviewed by the Executive Director 2/2/2024.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 open U12, 1 open SNAP Clinical youth **Total number of Closed Files: 1 closed U12 and 2 closed SNAP Clinical youth; two full cycle SNAP in Schools Group sessions.** **Staff Position(s) Interviewed** *(No Staff Names)* **: SNAP Coordinator**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	All three youth were screened using NetMIS and Brief SNAP screening forms to determine eligibility.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Each youth record contained a printed NIRVANA assessment that was completed at intake.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	All three youth records included evidence of completed CBCLs completed by the parent/guardian at intake and one applicable closed record included the post-CBCL.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Compliance**	TRFs were completed by the teachers for two of the three youth. There was a signed form in the closed record indicating the teacher refused to sign both pre/post TRF.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	The TOPSE assessments were completed for all three youth at intake and for one applicable closed record at discharge.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Evidence of SNAP Discharge Report was located in one applicable closed record.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Exception**	One applicable closed record was reviewed.	No evidence of SNAP Boys/SNAP Girls Child Group Evaluation Form was located in the file.
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Exception**	One applicable closed record was reviewed.	No evidence of SNAP Boys/SNAP Girls Parent Evaluation Form was located in the file.

SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Compliance**	All three youth were screened using NetMIS and Brief SNAP screening forms to determine eligibility.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Compliance**	Each youth record contained a Consent to Treatment and Participation in Research Form that was completed and located within the file.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Each youth record contained a printed NIRVANA assessment that was completed at intake.	
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.	**Compliance**	Each youth record contained the completed "How I Think Questionnaire" (HIT) form located within the file.	
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.	**Compliance**	There was evidence of the Social Skills Improvement System (SSIS) Student form documented in each record.	
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.	**Compliance**	There was evidence of staff's request for the teacher to complete the Social Skills Improvement System (SSIS) Teacher/Adult form; however, the teachers declined to participate and signed refusal by the teachers were documented for each record.	
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*)	**Compliance**	A total of 13 attendance sheets for a full cycle demonstrated evidence of the required attendance for all youth participating in two groups in schools completed during the review period.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Each of the two groups maintained evidence of a completed Class Goal document.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Evidence of pre and post MoCE were located in each of the two full cycle groups reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Evidence of pre and post evaluations were located in each of the two full cycle groups reviewed.	

There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Evidence of the fidelity adherence checklist was located in each of the two full cycle groups reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The program has the required policy and procedures PC 2.03 Suicide Prevention that was reviewed by Executive Director on 2/2/24	
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: 0 **Total number of Closed (Residential & Community) Files: 1 closed community counseling file** **Type of Documentation(s) Reviewed: Youth record**			
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**	The program reported only one applicable youth who was screened as a suicide risk during the annual review. The risk screening occurred during the initial intake and the screening result was reviewed and signed by the Supervisor and documented in the youth record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program suicide risk assessment is approved by the Florida Network.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Not Applicable**	Not applicable for community counseling programs	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Not Applicable**	Not applicable for community counseling programs	
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**	Not applicable for community counseling programs	

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**	Not applicable for community counseling programs	
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**	Not applicable for community counseling programs	
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**	The provider had one youth during this fiscal year that is applicable to suicide risk, during intake youth was identified as a suicide risk by the case manager and parents and supervisor were notified of the results immediately	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	Youth was already receiving Counseling services, they called CCC same day and was not accepted, then Counselor referred client to Chrysalis	
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**	Youth was already receiving Counseling services once a week, and was referred to Chrysalis	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	Parent was notified	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	Screening was not completed at school	
Additional Comments: **There are no additional comments for this indicator.**			