Florida Network for Youth and Family Services
Compliance Monitoring Report for

Thaise Educational and Exposure Tours - Jacksonville

728 Blanche Ave., Suites 115 and 117
Jacksonville, Florida 32204

April 11, 2024

Compliance Monitoring Services Provided by

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 Thaise Educational and Exposure Tours – Jacksonville for the FY 2023-2024 at its program office located at 728 Blanche Avenue, Suites 115 and 117, Jacksonville, FL 32204. 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. Thaise Educational and Exposure Tours (TEET) – Jacksonville 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 compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from Thaise Educational and Exposure Tours – Jacksonville present for the entrance interview were: Teresa Clove MS – CEO/Program Manager and Blondell Clove – Data Clerk/Office Assistant. The last onsite QI visit was conducted November 9, 2022.

In general, the Reviewer found that Thaise Educational and Exposure Tours – Jacksonville is in compliance with specific contract requirements. Thaise Educational and Exposure Tours – Jacksonville **received an overall compliance rating of 100% for achieving full compliance on ten out of fourteen compliance monitoring indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations based on the results 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 4-11-2023-2024

Agency Name: Thaise Educational and Exposure Tours (TEET) - Jacksonville	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 728 Blanche Street, Jacksonville, FL 32204**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 11, 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.	☐	☐	☒	☐	☐	Documentation: The TEET - Jacksonville program currently has two staff members certified as DJJ QI Peer reviewers. The following peer reviewer include Teresa Clove MS – CEO/Program Manager and Cyntoria Thomas, BS/MS – Case Manager. The agency has completed the request to participate in onsite Quality Improvement Peer Reviews during the FY 2023-2024.	**No recommendation or corrective action.**
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**	☐	☐	☒	☐	☐	Documentation: At the time of this on-site program review, the agency reported two additional contracts (county and state). The list included: awarding entity, award amount, description of services, and contract start & end dates.	**No recommendation or corrective action.**

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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;	☐	☐	☒	☐	☐	Documentation: The agency is insured for General Liability through United States Liability Company. The limits include coverage of $1,000,000 each occurrence; $2,000,000 aggregate; $1,000,000 personal injury; $100,000 Damage to Rented Property; $5,000 medical expenses (any one person); $100,000/200,000 Abuse Coverage Occ/Agg; effective 03/01/2024 03/01/2025 Professional Liability through United	**No recommendation or corrective action.**

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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**						States Liability Company. The limits include coverage of $1,000,000/2,000,000 Occurrence/Aggregate; effective dates 02/05/2024- 02/05/2025. Auto Insurance is provided through Progressive Express Ins. Company, with combined single limit coverage for Bodily Injury $250,00 per person; $500,00 each accident; Property Damage $100,000 each accident; effective 03/07/2024 -03/07/2025. The Florida Network of Youth and Family Services is listed as the 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**	☐	☐	☐	☐	☒	N/A: The agency reported that the at the time of this compliance monitoring review, there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or corrective action.**

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Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: General Program, Fiscal Policies and Procedures are maintained in the agency's Accounting Policies and Procedures Manual. The policies include general financial terms and for the agency to operate generally acceptable internal controls. The Accounting Policies and Procedures were last reviewed by the CEO and Board in 2023.	**No recommendation or corrective action.**
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**	☐	☐	☒	☐	☐	Documentation: General ledger (GL) for Periods: July 1, 2023 through February 29, 2024. The agency maintains a detailed general ledger with corresponding source documents. The agency's general ledger is structured to track all funding sources. The agency also provided statement of assets, liabilities, and statement of revenue and expenses.	**No recommendation or corrective action.**

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c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☐	☐	☒	Interview and Documentation: The agency does not utilize a petty cash system for program related purchases. Procedures for petty cash are contained in the Fiscal Policies and Procedures Manual.	**No recommendation or corrective action.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency conducts bank reconciliations for the current fiscal year from July 2023 through August 2021 for one account held with Wells Fargo. Accounts Payable Reconciliations are signed monthly by the Accountant, within 2-4 weeks of receipt, and approved by the Executive Director.	**No recommendation or corrective action.**
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**	☐	☐	☐	☐	☒	N/A: The agency has not purchased any property or inventory items with FNYFS funds since the last program review.	**No recommendation or corrective action.**

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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: The agency files 941s for the third and fourth Quarters of 2023. The agency has evidence of providing an electronic fund transfer process system Batch Provider Payment Inquiry Report. The agency demonstrates that it is submitting payroll taxes to the appropriate authority as required. A contracted company is directly responsible for submitting the W-3 and 1009 forms.	**No recommendation or corrective action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency income statements for the current year for months July 2023 – January 2024. The report shows an agency budget and variances with year to date net surplus. Variances in budget are monitored on a regular basis by management.	**No recommendation or corrective action.**

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h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☐	☐	☒	Documentation: The annual funding amount from FNYFS contracts for the agency are not greater than $750,000. The agency is not required to submit an annual Single Audit from an outside Agency.	**No recommendation or corrective action.**
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: The agency has updated policies in Storage and Retention, Confidentiality, and Record Retention Schedule. The agency also has related policies that address Storage and Disposal. The policies were last reviewed on October 10, 2021, by the Board of Directors and Executive Director.	**No recommendation or corrective action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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**	☐	☐	☒	☐	☐	Documentation/Interview: The agency's CEO reported all direct service staff members have a minimum of $19 per hour which became effective October 1, 2023.	**No recommendation or corrective action.**

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CONCLUSION

Thaise Educational and Exposure Tours – Jacksonville has met the requirements for the CINS/FINS contract as a result of full compliance with 10 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Four out of fourteen indicators were not applicable. Consequently, **the overall compliance rate for this contract monitoring visit is100%.** There are no corrective actions or recommendations cited 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.

SUMMARY OF RECOMMENDATIONS

No Recommendations or Corrections.

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

Thaise Educational and Exposure Tours - Jacksonville
728 Blanche Street
Jacksonville, Florida 32204

Date: April 11, 2024

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

Percent of indicators rated Satisfactory: 88.89 %
Percent of indicators rated Limited: 11.11 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Logan Farrelly - Chief Clinical Officer, Youth Crisis Center
Jeffery Honaker - Manager of Operations, SMA Healthcare, Inc.

Methodology

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

Persons Interviewed

X	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
	Executive Director		Direct – Care Full time		# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	1	# Other (listed Administrative staff member
	Counselor Licensed	X	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	X	Grievance Process/Records		# Health Records
	Logbooks		Key Control Log		# MH/SA Records
X	Continuity of Operation Plan		Fire Drill Log	5	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	5	# Training Records
X	Contract Scope of Services		Precautionary Observation Logs	4	# Youth Records (Closed)
X	Egress Plans		Program Schedules	6	# Youth Records (Open)
	Fire Inspection Report	X	List of Supplemental Contracts	4	# Other: ___
X	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

X	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		Group
	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration		Staff Interactions with Youth		Census Board

Surveys

0	# of Youth	1	# 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

The agency ensures that all staff members meet minimum professional credentials and are provided the necessary training to perform their job responsibilities. Individual training records are maintained in a binder for each staff that includes: training plan, individual certificates, and training hours. The provider has numerous partnership agreements throughout the local service area and conducts outreach to educate the community and market the program's services. The agency also attends DJJ Juvenile Advisory Board Meetings.

The following programmatic updates were provided by the agency:

The agency operates daily Monday-Friday with the following staff members including Teresa Clove, MS – CEO/Program Manager; Cyntoria Thomas, BS/MS – Case Manager; Sherrel Jackson ,BS – Case Manager; and Blondell Clove – Data Clerk/Office Assistant. Thaise Program is governed presently by the agency's Board of Directors with the CEO. At the time of this onsite program review, Teresa Clove, MS runs the day-to-day operations in Jacksonville as the Program Manager. She plans to hire a new Program Manager in the new fiscal year 2024-25. At the time of this onsite program review, the agency reports there are no staff member vacancies. The Data Clerk was brought up to $19.00 an hour this fiscal year.

Thaise has been involved with the community partners in Jacksonville. This year Thaise Program reported it has partnered with MAI Leadership Academy K-12. They have given us access to all their youth that need services. This charter school alone could meet our number of deliverables for the year. This school serves a high-risk population. Thaise Program has attended the DJJ CAB meetings virtually. They are still having meetings virtually. Thaise Program is continuing to provide in-home, in school and community based services. The Enrichment Program that involves tours of Colleges and Universities has been halted, but plans to start up during the summer of 2024. The agency reported they are scheduling a college tour for the summer. There have been no new mental health agreements. Presently the agency has existing agreements with YCC, Gateway Community Services, Community Rehabilitation Center, and River Regions Human Services.

Narrative Summary

The Thaise Educational and Exposure Tours (TEET) Jacksonville is located at 728 Blanche St, Suite 115b, Jacksonville, Florida. The TEET Jacksonville program is currently staffed by Teresa Clove, Executive Director at the time of this onsite program review. The TEET staff are trained to conduct screenings and assessment services to youth and families that meet the CINS/FINS criteria. The agency's Executive Director oversees the operations at a total of three (3) TEET locations. The TEET-Jacksonville program ensures that level 2 background screening is a mandatory requirement for all employees and volunteers, working with direct access to youth, to guarantee they meet statutory requirements of good moral character as required in s.435.05, F.S.

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, I**ndicator 1.03 Incident Reporting was rated **Satisfactory**, Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**, Indicator 1.06 Client Transportation 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 **Limited**, Indicator 2.02 Needs Assessment was rated **Satisfactory**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**, 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 with Exception**, and Indicator 2.09 Stop Now and Plan (SNAP) was **Not Applicable**.

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 with exception.**

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

Standard 2:

Indicator 2.01 - Limited: Nine of nine client files were not asked the five current FNYFS risk screening questions. At the time of the onsite program review, the agency is using a current method that includes seven suicide risk screening questions. The seven suicide risk screening questions used by the agency do include questions which are similar to those in the current policy, but are not exact. For example the FNYFS policy suicide risk screening asks, "Are you thinking about harming or killing yourself now or in the last 2 weeks?" in comparison to the agency screening question, "Are you thinking about killing yourself now?"

CINS/FINS QUALITY IMPROVEMENT TOOL

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

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers — **Satisfactory**

Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**
	If NO, explain here:
	The agency has a policy that is in place. Policy 5.03, Background Screening, and was reviewed by the Board of Directors on 12/17/2023.

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

Total number of New Hire Employee/Intern/Volunteer Files: 1 (New Hire)
Total number of 5 Year Re-screen Employee Files: 3
Staff Position(s) Interviewed *(No Staff Names)*: **Agency Chief Executive Officer(CEO).**
Type of Documentation(s) Reviewed: initial and five year screenings with dates.
Describe any Observations: Records were readily available and well organized with both historical and current year data.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	One applicable staff member was administered the suitability assessment. This staff member completed the suitability assessment prior to being hired.	
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.	**Not Applicable**	At the time of this onsite program review, the agency did not pass the initial suitability assessment.	
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.	**Not Applicable**	No employees have had a break in service during the current review period.	

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**	One applicable staff member (new employee) was reviewed for this indicator. The background screening was completed prior to the employee's, 10/3/2023 hire date.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	All required background screens were completed and in each employee's personnel file.	
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 was sent to Florida Department of Juvenile Justice (DJJ) Background Screening Unit (BSU) prior to 1/31/2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	The newly hired employee evidenced E-Verify approval prior to initial hire date of 10/03/2023.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy titled 5.2 Abuse Reporting. The policy was reviewed and signed by Board and the CEO on December 17, 2023. This date is documented as the most recent date the policy updated and reviewed.	
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)* **: Agency CEO.** **Type of Documentation(s) Reviewed: Agency policy.** **Describe any Observations: No internal issues or external abuse or neglect issues have been reported to the agency.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a code of conduct of policy and there is evidence that staff members are familiar with the agency's code of conduct.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. The agency's CEO reported there were no abuse calls reported by clients or agency staff members since the last onsite program review.	

Youth were informed of the Abuse and Contact Number	**Compliance**	The agency has a process for informing each youth and family. All youth files have evidence the each client was informed of the Abuse and contact number.	
Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The agency has a grievance process for youth to provide feedback and address complaints. The agency CEO has full access to and manage grievances unless it is towards themselves.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
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**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
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**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
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**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy titled 5.2 Abuse Reporting. The policy was reviewed and signed by Board and the CEO on December 17, 2023. This date is documented as the most recent date the policy updated and reviewed.	

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)* **: Agency CEO.**
Type of Documentation(s) Reviewed: None.
Describe any Observations: See report.

During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	The agency did not have a reportable incident submitted in the past six months to the Department's CCC (Central Communication Center).	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**	The agency did not have any reportable incidents submitted in the past six months to the Department's CCC.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**No eligible items for review**	The agency did not have any reportable incidents submitted in the past six months to the Department's CCC.	
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**	The agency did not have any reportable incidents submitted in the past six months to the Department's CCC. The agency does have an incident reporting binder to maintain all incidents when needed.	
All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**	The agency did not have any reportable incidents submitted in the past six months to the Department's CCC.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform*			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES**	
		If NO, explain here:	
		The agency has a policy titled 6.04 Training. The policy was reviewed and signed by Board and the CEO on December 17, 2023. This date is documented as the most recent date the policy updated and reviewed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: 1 **Total number of Annual In-Service Staff Files: 3** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: Not Applicable.** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: Anniversary date.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Agency CEO.** **Type of Documentation(s) Reviewed: Employee training files.**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	The newly hire staff person hired in October 2023 completed new hire pre-service training requirements for safety and supervision as required.	

All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	A new hired staff member completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	The first year CINS/FINS Counselor had evidence of demonstrating working towards completing the minimum of 80 hours of training for the first year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	The staff file reviewed showed that the staff member received mandatory training during the first 90 days of employment from the date of hire except for one required training.	The staff member did not complete "Equal Employment Opportunity" (Skill Pro) within the require time frame. The training was completed on 1/3/2024, which is two days beyond the 90 day time frame.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	The staff member completed required training for this standard/relevant NIRVNA training, which ensures accurate and complete data enter in the Fl JJIS system.	
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**	All direct care staff with contact with children have time to complete this training requirement deadline of July 1, 2024.	
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**	This program is community based non-residential and does not employ clinical staff members.	
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**	Three (3) staff member files were reviewed and all staff were found to have achieved in excess of the 24 hours of training required.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency provided a copy of its training plan. The training plan includes all of the required training topics including the pre-service and in-service.	

The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has a staff member that is assigned (Admin/Data Clerk) that monitors training compliance, as well as the staff members training files.	
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 organization has established an individual training file for each employee. Located in each file is a training log that captures each employees completed training and hours for each training.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policies titled 6.0 Data Collection and 6.01 Quality Improvement. The policies were reviewed and signed by Board and the CEO on December 17, 2023. This date is documented as the most recent date the policy updated and reviewed.	
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)* **: Agency CEO.** **Type of Documentation(s) Reviewed: Agency documents.** **Describe any Observations: See report.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The agency has evidence of a case record review process which reviews are conducted quarterly, at a minimum. The agency CEO or Program Manager reviews every case record on a monthly basis. These reviews were documented monthly in the Supervisors Notes of all six client case files reviewed. The results of the review are discussed with the respective Counselor and all staff at regular monthly meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency conducts reviews of incidents, accidents, and grievances on a monthly basis. The agency had no occurrence of incidents, accidents or grievances in the last six months.	

The program conducts an annual review of customer satisfaction data	**Compliance**	The agency currently has a process in which the agency performs a review of customer satisfaction data quarterly and at times on a monthly basis.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The agency has a process in which it performs a monthly review of the statewide End-of-Month ("EOM") report and other data extracts related to the agency's performance generated by the Florida Network Office. The major areas reviewed monthly by the agency include date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency has a dedicated staff member to enter NetMIS and other data entry requirements. The agency has a process in place to review the timeliness, accuracy and completeness of all data entered in order to improve overall data entry and collection.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	All official and formal performance reports are regularly reviewed by the CEO and Program Manager and communicated to staff and stakeholders. All major performance results are discussed and shared with staff at regular staff meetings.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The agency provided evidence of its current process to ensure that 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. The agency submits all reports to it Governance Board as required.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency has both performance improvement and corrective action processes as needed. The agency reviews its current practice and implements interventions related to its practices. The agency monitors all activities related to improving its performance with staff and provides necessary training, coaching and modeling to ensure that the modifications are implemented and successfully address the identified performance problem.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation			Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy titled 1.06 Client Transportation. The policy was reviewed and signed by Board and the CEO on December 17, 2023. This date is documented as the most recent date the policy updated and reviewed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Not Applicable. **Staff Position(s) Interviewed** *(No Staff Names)* **: Not Applicable.** **Type of Documentation(s) Reviewed: Not Applicable.** **Describe any Observations: See report.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**No eligible items for review**	This location (Thaise Jax) reported it does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**No eligible items for review**	The location does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	
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	**No eligible items for review**	The location does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	
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	**No eligible items for review**	The location does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**No eligible items for review**	The location does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**No eligible items for review**	The location does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	

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.	**No eligible items for review**	The location does not provide transportation as part of the services provided to clients. The program has not transported any youth during this review period.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy titled 1.01 Outreach Services. The policy was reviewed and signed by Board and the CEO on December 17, 2023. This date is documented as the most recent date the policy updated and reviewed.	
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)* **: Agency CEO.** **Type of Documentation(s) Reviewed: Outreach documents.** **Describe any Observations: See report.**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The position title of lead staff reviewed is primarily the agency CEO and Program Manager staff members designated to participate in local DJJ board, Circuit and Council meetings. The agency provided evidence that includes dates since the last program review of attendance at local meetings.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency has local partnership agreements with community-based organizations from mental health, schools, churches and community centers. The agency has a an established process for sending and receiving referrals with all partnership agreements.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The agency maintains and utilizes NetMIS for the purposes of documenting its outreach activities. The outreach entries generally include date, duration (hours), zip code, location description, estimated number of people reached, audience and topic.	

The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The staff members responsible for local outreach include the agency's CEO, Program Manager.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Two – Intervention and Case Management			
2.01 - Screening and Intake			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy titled 2.00 Centralized Intake. The policy was last reviewed and the Screening approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Staff Position(s) Interviewed (No Staff Names): CEO** **Type of Documentation(s) Reviewed: Reviewed physical files provided and policy and procedure manual** **Describe any Observations: See report.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Not Applicable**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. All screening forms were completed within 3 business days of referral by a trained staff using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. All youth and parents/guardians received the following in writing: a. available service options and b. rights and responsibilities of your and parents/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**	Nine (9) files were reviewed, five (5) open and four (4) closed. Youth and parents/guardians were provided information about possible actions occurring through involvement with CINS/FINS services and grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Exception**	Nine (9) files were reviewed, five (5) open and four (4) closed. Zero (0) of nine (9) files were screened for suicidality using the FNYFS five screening questions: 1. Have you recently been in a situation where you did not care whether you lived or died? 2. Have you felt continuously sad or hopeless to the point of wanting to die? 3. Do you feel like life is not worth living or wish you were dead? 4. Have you ever tried to harm or kill yourself? 5. Are you thinking about harming or killing yourself now or in the last 2 weeks? a. If yes, do you have a plan (specific method) to kill yourself?	Nine of nine client files were not asked the five current FNYFS risk screening questions. At the time of the onsite program review, the agency is using a current method that includes seven suicide risk screening questions. Each of the 9 files reviewed had two forms which indicated two separate suicide risk screening procedures. Each of the 9 files had an outdated intake form (unknown date), showing old suicide questions: 1. Have you ever attempted to kill yourself? 2. Are you thinking about killing yourself now? 3. Do you have a plan to kill yourself? 4. Do you feel like life is not worth living or wish you were dead? 5. Have you recently been in a situation if you did not care if you lived or died? 6. Have you felt consciously sad or hopeless? 7. Do you hear voices or see things that other people do not see or hear? The other intake form that was also in all 9 files was dated 08/2022. It indicated to use the "initial contact screener" for suicide risk procedures. The seven suicide risk screening questions used by the agency do include questions which are similar to those in the current policy, but are not exact. For example the FNYFS policy suicide risk screening asks, "Are you thinking about harming or killing yourself now or in the last 2 weeks?" in comparison to the agency screening question, "Are you thinking about killing yourself now?".
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 agency has a policy called 3.03 Network Inventory of Risks, Victories and Needs Assessment (NIRVANA) . The policy was reviewed and approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Staff Position(s) Interviewed (No Staff Names): CEO** **Type of Documentation(s) Reviewed: Reviewed physical files provided and policy and procedure manual** **Describe any Observations: See report.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had the NIRVANA 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.	
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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had supervisor signatures documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	
(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**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had a NIRVANA Post-Assessment completed at discharge for all youth who have a length of stay that is greater than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had a NIRVANA Re-Assessment completed every 90 days excluding files for youth receiving SNAP services.	

All files include the interview guide and/or printed NIRVANA.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had included the interview guide and/or printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy titled 4.03 Case/Service Plan. The policy was reviewed and approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Staff Position(s) Interviewed (No Staff Names): CEO** **Type of Documentation(s) Reviewed: Reviewed physical files provided and policy and procedure manual** **Describe any Observations: See report.**			
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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had 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.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had the Case/Service plan is developed within 7 working days of NIRVANA.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Nine (9) files were reviewed, five (5) open and four (4) closed. 4 of 9 files included a Case plan/service plan that 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 .	Five of nine files reviewed did not meet the indicator #5, signature of youth, parent/guardian, counselor, and supervisor. The agency is utilizing two forms called "Treatment/Service Plan" and one that resembles a more individualized service plan for each youth that has components 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) and 6. Date the plan was initiated. Component 5. Signature of youth, parent/guardian, counselor, and supervisor is on the "Treatment/Service Plan" form. In 5 of 9 files, this "Treatment/Service Plan" form was signed by all parties at the time of intake however, the individualized treatment plan was not initiated until a later date. Signature lines do not exist on the individualized treatment plan. Because the "Treatment/Service Plan" form predates the individualized treatment plan, the initiated date of the service plan is after the parties signed and therefor were signing for a treatment plan that did not exist.
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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had Case/service plans reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after.	
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy titled 4.04 Case Management Services. The policy was reviewed and approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Staff Position(s) Interviewed (No Staff Names): CEO** **Type of Documentation(s) Reviewed: Reviewed physical files provide, policy and procedure manual, partnership agreement binder** **Describe any Observations: See report.**			
Counselor/Case Manager is assigned	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had a counselor/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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files showed the Counselor/Case Manager completed 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"	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency's partnership agreement binder was reviewed. The binder consisted of MOUs that clearly showed written agreements with other community partners that include services provided and 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 agency has a policy called 4.02 Community Counseling/Mentoring Services. The policy was reviewed and approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Staff Position(s) Interviewed (No Staff Names): CEO** **Type of Documentation(s) Reviewed: Reviewed physical files provided and policy and procedure manual** **Describe any Observations: See report.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**	The agency is a Community Counseling service provider, therefore this measure is 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**	The agency is a Community Counseling service provider, therefore this measure is Not Applicable.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**	The agency is a Community Counseling service provider, therefore this measure is 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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files showed they provided 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.	
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**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files shows 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.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files were maintained in individual case files on all youth and adhere to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files had case notes maintained for all counseling services provided and documents youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files showed they had an on-going internal process that ensures clinical reviews of case records and staff performance.	
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.	**No eligible items for review**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files provided services face to face and not by virtual means.	
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: 4.05 Adjudication Services, 4.06 CINS Petition Process approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023	

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

Total number of Open (Residential & Community) Files: 5 open community counseling files
Total number of Closed (Residential & Community) Files: 4 closed community counseling files
Staff Position(s) Interviewed (No Staff Names): CEO
Type of Documentation(s) Reviewed: Reviewed physical files provided and policy and procedure manual
Describe any Observations: An interview was conducted with the agency's CEO who reported the agency refers eligible youth to YCC the local full-service CINS/FINS provider and attends meeting when scheduled.

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	This agency did not hold case staffings for the period of the review. The staffings include members such as the local DJJ Attorney and local Duval County School Board.	

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**	This agency did not hold case staffings for the period of the review. The staffings include members including State Attorney's Office, DCF, local mental health agencies, State Attorneys and others community resources as needed.	
The program has an established case staffing committee, and has regular communication with committee members	**No eligible items for review**	This agency did not hold case staffings for the period of the review.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**No eligible items for review**	This agency did not hold case staffings for the period of the review.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	This agency did not hold case staffings for the period of the 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**	This agency did not hold case staffings for the period of the review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	This agency did not hold case staffings for the period of the review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	This agency did not hold case staffings for the period of the review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy that is titled 2.07 Youth Records approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Staff Position(s) Interviewed (No Staff Names): CEO** **Type of Documentation(s) Reviewed: Reviewed physical files provided and policy and procedure manual** **Describe any Observations: Toured office**			
All records are clearly marked 'confidential'.	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All files are secured. The office door was always locked and entry only by request. Once in office, locking file cabinets were displayed and organized by case manager.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The agency reports they do not take any records offsite; however, it was indicated that if they needed to, they have locking, rolling boxes that are marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	Nine (9) files were reviewed, five (5) open and four (4) closed. 9 of 9 files were neat and orderly. Filing cabinets were also neat and orderly.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policies titled 4.07 Specialized and Additional Program Services 4.07.06 Family/Youth Respite Aftercare Services (FYRAC). the policies were reviewed and approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.	
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.*			
Not Applicable			
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**	This agency does not provide Intensive Case Management.	
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**	This agency does not provide Intensive Case Management.	

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**	This agency does not provide Intensive Case Management.	
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**	This agency does not provide Intensive Case Management.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**	This agency does not provide Intensive Case Management.	
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**	This agency does not provide Intensive Case Management.	
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 open FYRAC **Total number of Closed Files: 3 closed FYRAC** **Staff Position(s) Interviewed** *(No Staff Names)* **: CEO** **Type of Documentation(s) Reviewed: Entire case record** **Describe any Observations: See report.**			
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**	Five (5) files were reviewed, two (2) open and three(3) closed.	
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**	Five files showed youth are 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.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	Five files showed evidence that all FYRAC referrals have documented approval from the Florida Network office.	

Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**Compliance**	Five of five files showed Intake and initial assessment session met the following criteria a which included: 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.	
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.	**Exception**	Four of five files provided showed that 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.	One of five client files provided did not have sessions that were face-to-face, sixty (60) minutes in length. In 1 of the 3 closed files, session lengths were as follows for the dates: 11/20/23 45 minutes, 11/17/23 48 minutes, and 11/22/23 30 minutes.
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**	Five of five files showed that during 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.	

Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency did not provide any group sessions during this time period.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	Five of five files showed evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	
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**	Five of five files showed the 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.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**	The agency did not provide any virtual sessions during this time period.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	Five of five files showed all data entry in NetMIS is completed within 3 business days as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: N/A	
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: Not applicable.			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	This agency does not provide SNAP.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	This agency does not provide SNAP.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**	This agency does not provide SNAP.	

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

Additional Comments: **There are no additional comments for this indicator.**			
Standard Four – Mental Health and Health Services			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	**YES** If NO, explain here: 3.02.01 Identification of Suicide Risk in Community Counseling Programs approved by Board President Quintin Clark and Teresa Clove CEO 12/17/2023.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 open community counseling files **Total number of Closed (Residential & Community) Files: 4 closed community counseling files** **Describe any Observations: See report.**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Exception**	At the time of this review, the agency has a process which requires all clients to be screened for suicide risk utilizing risk screening questions. The sample of clients screened did include a total of seven suicide risk questions. The seven questions used to screen youth for suicidality, which are reviewed and signed by the supervisor. The files reviewed did not have any youth that responded positive with a yes on any of the suicide risk questions.	At the time of the onsite program review, all nine client files reviewed were not asked the current risk screening questions. Each of the 9 files reviewed had two forms which indicated two separate suicide risk screening procedures.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	A review of the agency's suicide risk screening process was conducted. The agency's CEO reported that the agency is using a previously approved suicide risk assessment and has not changed its suicide risk assessment practices since the last program review.	
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 to Community Counseling.	
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 to Community Counseling.	

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 to Community Counseling.	
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 to Community Counseling.	
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 to Community Counseling.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	The agency did not provide any files that indicated a "yes" on the suicide risk questions.	
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**	The agency did not provide any files that indicated a "yes" on the suicide risk questions.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	The agency did not provide any files that indicated a "yes" on the suicide risk questions.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The agency did not provide any files that indicated a "yes" on the suicide risk questions.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The agency did not provide any files that indicated a "yes" on the suicide risk questions.	
Additional Comments: **There are no additional comments for this indicator.**			