Florida Network for Youth and Family Services
Compliance Monitoring Report for

<u>Thaise Educational and Exposure Tours, Inc.</u>

1111 18TH AVE. SOUTH
ST. PETERSBURG, FL 33705

MARCH 20, 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, Inc. (St. Petersburg) for the FY 2023-2024 at its program office located at 1111 18th Ave. St. Petersburg, Florida 33705. 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, Inc. (St. Petersburg) is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Andrea Haugabook, Consultant for Forefront LLC, and Kara Brown, Pacherrah Faulkner, Justin Terziu. Agency representatives from Thaise Educational and Exposure Tours, Inc. (St. Petersburg) present for the entrance interview were: Theresa Clove, Dennis Clove, Shanna Baker, Cynthia Rogers. The last onsite QI visit was conducted on January 25, 2023.

In general, the Reviewer found that Thaise Educational and Exposure Tours, Inc. (St. Petersburg) is in compliance with specific contract requirements. Thaise Educational and Exposure Tours, Inc. (St. Petersburg) **received an overall compliance rating of 100% for achieving full compliance with nine indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-20232024

Agency Name: Thaise Educational and Exposure Tours, Inc.						Monitor Name: Andrea Haugabook, Lead Reviewer	
Contract Type: CINS/FINS						Region/Office: 1111 18th Ave. South St. Petersburg, FL 33705	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): March 20, 2024	
	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:
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.	☐	☐	☒	☐	☐	Interview with the Chief Executive Officer (CEO)/ Executive Director (ED) indicated that Thaise Educational and Exposure Tours has two certified peer reviewers, and the program has participated in reviews during this contract period.	
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**	☐	☐	☐	☐	☒	Interview with the CEO/ ED indicated the agency does not have additional contracts or funding sources. The program is only supported by the Florida Network of Youth and Family Services.	
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	☐	☐	☒	☐	☐	The CEO/ ED provided renewal certificates from United States Liability Insurance Company which contained the declaration page for coverage of commercial liability from 03/01/2024 - 03/01/2025. The coverage limits are $1,000,000 per occurrence, personal & advertising injury limit $1,000,000,	

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$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						medical expense $5,000 (any one person), damages to rented premises $100,000, general aggregate $2,000,000, professional E&O$1,000,000 (each accident and $2,000,000 (aggregate), abuse and molestation $100,000 (each claim) $200,000 (aggregate). Automobile Liability coverage from 03/01/2024 - 03/07/2025 with a limit of $1,000,000 for bodily injury and property damage, $1,000,000 for uninsured motorists, $10,000 (per person) bodily injury without work comp – named insured only, $5,000 medical payments. Florida Network is listed as an additional insured.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	There are no corrective action plans due to no additional funders for the agency.	

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Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20, 2024**

Major Programmatic Requirements	**Explain Rating** Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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**	☐	☐	☒	☐	☐	The agency has employee and fiscal policies that comply with GAAP and provides sound internal controls. The agency uses an external bookkeeper (American Accounting Service) to maintain fiscal records and is not required to submit an annual audit.	
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**	☐	☐	☒	☐	☐	The agency's general ledger is only set up to track funds from the Florida Network of Youth and Family Services for the CINS/ FINS services. Financial Statements are prepared monthly from the general ledger and provided to the CEO/ ED for presentation to the board of directors.	
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 with the CEO/ ED indicated the program does not utilize petty cash.	
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.	☐	☐	☒	☐	☐	Financial records were reviewed from January-December 2023. The bank reconciliations and general ledger are handled by a 3rd party accountant. Bank statements are given to the	

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(Disbursements/invoices are approved & monitored by management). **ON SITE**						accountant upon receipt (at beginning of each month and returned to the CFO with the reconciliation worksheet, general ledger, statement of assets liabilities and equity, and statement of revenue and expenses by the end of the following month. Vendor invoices are paid monthly by the CFO and all invoices are approved and monitored by the CEO.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Interview with the CEO/ ED indicated that Thaise has not made any purchases over $1000.00 requiring DJJ property inventory tag number or equipment requiring an informational resources request. The agency does maintain an inventory list of all assets. CEO. ED confirmed that everything in inventory is valued under $1000 and not purchased with Florida Network of Youth and Family Services Funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and	☐	☐	☒	☐	☐	A review of the last six months of quarterly tax returns was conducted. All payroll tax returns, payments and deposits are managed by the	

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Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						agency's payroll provider, Freedom Payroll services.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Budget to actual reports are prepared by the CFO and reviewed by the CEO. Variances are discussed between the CFO and CEO. The CEO sends the board members the financial reports electronically every month and explains variances. The board receives hard copies of the financials in months when face to face board meetings occur.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☐	☐	☒	Interview with the CEO/ ED reports that the agency does not meet the requirements to have an annual audit because expenses are not greater than $750,000.	

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency has policies named record storage and retention disposal. The policy addresses the security of all client files and computers. and disposal of records. Personal information is not easily accessible, and the agency maintains a backup system in case of accidental loss of financial information. The agency's policy lists record retention timeframes and states disposal protocol will be according to the granting agency's requirements.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Interview with CEO/ ED indicated that all staff members are paid at least $19.00 per hour. Board meeting minutes from December 17, 2023, reported that everyone's salary that was below $19.00 per hour was raised to $19.00 per hour as of October 1, 2023.	

CONCLUSION

Thaise Educational and Exposure Tours, Inc. (St. Petersburg) has met the requirements for the CINS/FINS contract as a result of full compliance with nine applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Five of the fourteen indicators were not applicable because: 1 The agency has no additional contracts or funds other than the Florida Network of Youth and Family Services, 2. The program has no corrective action plans from external funders, 3. The program does not use petty cash, 4. The program has no inventory with a valuation of more than $1000 or purchased computer equipment requiring a DJJ IRR request, and 5. The program does not meet the financial threshold to complete an audit. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited. 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

Recommendation (1)
None

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 - St. Petersburg
CINS/FINS Program

Date: March 20, 2024

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 100 %

Percent of indicators rated Limited: 0 %

Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Kara Brown – Regional Monitor, Department of Juvenile Justice
Justin Terziu – Regional Monitor, Department of Juvenile Justice
Pacherrah Faulkner – Bethel Community Foundation

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan		Youth Handbook
	CCC Reports	X	Grievance Process/Records		# Health Records
	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	4	# Personnel /Volunteer Records
	Contract Monitoring Reports		Medical and Mental Health Alerts	4	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	5	# Youth Records (Closed)
	Egress Plans		Program Schedules	5	# Youth Records (Open)
	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

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

Comments

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

Monitoring Purpose

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

Strengths and Innovative Approaches

Thaise Educational and Exposure Tours (Thaise - St. Pete) Program continues to provide in-home, in-school and community based services. The Enrichment Program has been halted since COVID but plans to start up during the summer of 2024. The program is scheduling a college tour for this summer. All services are delivered in person.

The following programmatic updates were provided by the agency:

Thaise St. Pete program is currently governed by a three member Board of Directors. Since the date of the last QI review, the program has a new program director who runs the day to day operations in St. Petersburg. There is a total of four employees in the program and they serve 92 clients per year. Client sessions are conducted: in person, in home, in school and in the community. All files are maintained in a paper format in a locked file cabinet in the administrative office located at 1111 18th Ave. South, Suite #7, St. Petersburg, FL 33705.

Thaise has been involved with the local community in St. Petersburg and actively participates in the monthly Campbell Park community meetings. The program has an agreement with the Pinellas County school district which enables them to visit youth on school campuses. Currently, there are partnerships with Bay Kids Cohort of Champions and Woodlawn Elementary School. Mental Health agreements are held with Family Resources, Suncoast Mental Health, and Pinnacle ADHD Counseling Services. The program staff attends the local Department of Juvenile Justice (DJJ) Circuit Advisory Board (CAB) meetings. Meetings are still being held virtually.

Narrative Summary

Thaise Educational and Exposure Tours is located at 1111 18th Ave South, Suite #7, St. Petersburg, Florida 33705. Thaise program serves youth on the north and south sides of St. Petersburg, FL. Program referrals come from: schools, other programs, parents/ family members, or friends, law enforcement and word of mouth. The program currently serves 92 youth annually in the St. Petersburg location. Thaise halted all tours since covid, however plan to resume in this summer. The agency holds no accreditations.

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

Standard 1: There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory.**
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory.**
Indicator 1.03 Incident Reporting was rated **Satisfactory.**
Indicator 1.04 Training Requirements was rated **Satisfactory with Exception.**
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exception.**
Indicator 1.06 Client Transportation was rated **Satisfactory.**
Indicator 1.07 Outreach Services was rated **Satisfactory.**

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

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: There is a policy in place, 5.03 Background Screening, that addresses the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board of Directors.	

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: Zero
Total number of 5 Year Re-screen Employee Files: One
Staff Position(s) Interviewed *(No Staff Names)* ***: None***
Type of Documentation(s) Reviewed: Background Screenings, Policy, Email indicating assessment was implemented, Email with Annual Affidavit of Level 2 Screening Standard

Item	Result	Summary/Narrative Findings	Deficiencies/Exceptions
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**No eligible items for review**	The agency did not have any new hires who would have been applicable to complete a pre-employment suitability assessment since the last review.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	The agency did not have any new hires who would have been applicable to complete a pre-employment suitability assessment since the last review.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The agency did not have any new hires who had a break in service for 18 months or more and has not changed the suitability assessment tool used since the last review.	

Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**No eligible items for review**	The agency did not have any new hires applicable for a background screening since the last review.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	The agency had one employee applicable for a five-year re-screening since the last review. A review of the staff file found a five year re-screening was conducted on February 1, 2024, which was within five years of their last screening.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	A copy of an email was provided verifying an Affidavit of Annual Compliance with Level 2 Screening Standard form was completed and submitted to the Department's Background Screening Unit (BSU) on January 23, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**No eligible items for review**	The agency did not have any new employees since the last review.	
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: There are three policies in place, 5.02 Abuse Reporting, HR 4.04 Code of Conduct and Behavior Background Screening, and HR 5.01 Grievances, which address the requirements of this indicator. The policies were last reviewed on December 17, 2023 by the Board of Directors.	
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)* **: One Staff Survey** **Type of Documentation(s) Reviewed: Policies, Grievance Log, Incident Report Log, Signed Code of Conduct Forms** **Describe any Observations: Abuse Hotline and CCC phone numbers in office**			
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 policy in place. Documentation was reviewed showing each staff signed the code of conduct policy upon hire.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a policy indicating they must report all abuse. The program has an Incident Report form where they would document any reports of abuse. The agency has not had any abuse calls since the last review. One staff completed a survey and confirmed there have been no incidents where abuse needed to be reported.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The Florida Abuse Hotline and Department's Central Communications Center (CCC) phone numbers were observed hanging in the staff office.	
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 program has a grievance process which is provided to the youth and family at admission. Grievance forms are available for youth to complete and a grievance box is present in the staff office, where the grievance can be placed for the program director to review.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	This a community counseling program only; therefore, this 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**	This a community counseling program only; therefore, this 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**	This a community counseling program only; therefore, this 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**	This a community counseling program only; therefore, this 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: There is a policy in place, 5.01 Incident Reporting, which address the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board of Directors.	
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)* **: CEO/ ED, DJJ reviewer** **Type of Documentation(s) Reviewed: NONE** **Describe any Observations: There were no CCC reports or internal incident reports back to the date of the last review.**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**No eligible items for review**	The agency did not have any incidents which required reporting to the Department's Central Communications Center (CCC) since the last review.	
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 incidents which required reporting to the Department's Central Communications Center (CCC) since the last review.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**No eligible items for review**	The agency did not have any incidents which required reporting to the Department's Central Communications Center (CCC) since the last review.	
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**	The agency did not have any incidents which required reporting to the Department's Central Communications Center (CCC) since the last review.	
All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**	There were no incidents reported for review period.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: There is a policy in place, 6.04 Training, which address the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board of Directors.	
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: One **Total number of Annual In-Service Staff Files: Three** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: None** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: 2023** **Staff Position(s) Interviewed** *(No Staff Names)***: CEO/ED** **Type of Documentation(s) Reviewed: Training Plans, SkillPro Reports, Training Certificates, Training Sign-In Sheets** **Describe any Observations:**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	One staff training record was reviewed for pre-service training. Documentation found all new hire pre-service training requirements were met for safety and supervision.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	One staff training record was reviewed for pre-service training. Documentation found the staff completed Civil Rights and Federal Funds within 30 days of hire, as required.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**No eligible items for review**	The agency did not have any staff member that recently completed their first full year of employment. One staff member was within the first 90 days of employment and three staff members were evaluated for in-service training hours beyond the first full year of employment.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	One staff training record was reviewed for pre-service training. The staff was still within their initial 90 days of employment in their current position; however, all mandatory trainings within the initial ninety days were completed. The staff was already employed by the agency; however, they were not in a direct care position, so pre-service training was required.	
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**	Three in-service and one pre-service staff record found each staff completed the required trainings required to enter NIRVANA and other information in the Department's Juvenile Justice Information System (JJIS).	
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**	The one reviewed pre-service staff was still within their first year of employment.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Not Applicable**	This a community counseling program only; therefore, this is not applicable.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Three reviewed staff records found each staff completed at least 24 total hours of training annually. Two of three reviewed records completed all required annual trainings. The remaining staff did not complete all required trainings.	One of three reviewed staff did not complete Human Trafficking, PREA part 1 or PREA part 2, or Trauma Informed Care in 2023 as required. Human Trafficking is required annually. PREA and Trauma Informed Care is required every two years; however, they were not completed in 2022 either.
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 has a training plan which lists all required training topics for pre-service and in-service training.	

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 agencies CEO/ED indicated they are responsible for managing and tracking each staff's training record.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	A review of one pre-service and three in-service staff training records found each staff had an individual training file as well as a Florida Network Training Log which included annual training hours, and related documentation including training certificates and sign-in sheets.	

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

1.05 - Analyzing and Reporting Information	**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	**YES** If NO, explain here: There is a policy in place, 1.05 Analyzing and Reporting Information, which address the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board of Directors.

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)* **: CEO/ ED**
Type of Documentation(s) Reviewed: Program Manager's Monthly Meeting Minutes, Staff Meeting Agendas, Board Members Meeting Agenda Minutes.

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The agency utilizes review forms to document the review of each youth's case record. Reviews are conducted monthly and the forms are kept in each youth's record.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency did not have any incidents, accidents, or grievances during the review period; however, reviewed meeting minutes and agendas showed this information is shared during program manager meetings, staff meetings, and board member meetings.	
The program conducts an annual review of customer satisfaction data	**Exception**	Reviewed meeting minutes and agendas indicated customer satisfaction surveys are being sent out; however, no documentation was located indicated an annual review of the data collected from the surveys.	No documentation was located indicating there is an annual review of customer satisfaction data.

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 Program Manager conducts monthly meetings to review the statewide End-of-Month report generated by the Florida Network Office. A review of the most recent six months of meeting agendas indicated that incidents, accidents and grievances were reviewed at each meeting. Meeting minutes also include monthly data, year data, benchmarks, screening, report card measures, and follow-up reporting measures.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	A review of data found on program manager's monthly meeting agendas found the program is consistently meeting their goal on accuracy of data entry and collections. They discuss their goals and where they are at during the monthly meetings and discuss ways to improve and encouraging staff to continue doing well.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	A review of monthly program manager meeting agendas and staff meeting agendas found findings are reviewed by management and communicated to staff regularly.	
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**	A review of Board Members Meeting Agenda minutes found program performance is routinely communicated with the board of directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	A review of Staff Meeting Agendas found strengths and weaknesses are discussed, as well as things which can be improved.	

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

1.06: Client Transportation		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06	**YES** If NO, explain here: There is a policy in place, 5.07 Transportation of Youth, which address the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board of Directors.	

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: Previous six months
Staff Position(s) Interviewed (No Staff Names): CEO/ ED
Type of Documentation(s) Reviewed: Drivers List, Driver's License Checks, Policy, Insurance Information
Describe any Observations: The program only provides transportation for educational and exposure tours.

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency has a list of approved driver's and was able to provide completed driver's license checks for the individuals on the list. The agency did not complete any transports in the last year; however, their practice is to rent a vehicle when they do.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency provided a copy of their insurance policy, which listed all approved drivers on their driver's list.	
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	**Compliance**	The agency's transportation policy indicates at least two staff should be present for all transports. The policy includes information on what to do if a third party is not present.	
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 agency did not have any transports during the review period. The agency's policy indicates if they have a transport without a third party, the supervisor or managerial personnel would consider the clients' history, evaluation, and recent provider.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**No eligible items for review**	The agency did not have any transports during the 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 agency did not have any transports during the 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 agency did not have any transports during the review period; however, they do have a log sheet which includes all required information.	

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:	
	There is a policy in place, 1.01 Outreach Services, which address the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board of Directors.	

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)* **: CEO/ED**
Type of Documentation(s) Reviewed: Policy, Outreach Binder, NETMIS, Board and Council Meeting Binder, Partner Binder

Indicator	Rating	Findings	
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 agency's policy indicates the program manager is the lead staff member designated to participate in DJJ Board, Circuit, and Council meetings. The CEO/ED indicated she and the program director are the main individuals involved in outreach; however, all staff have participated in events. A review of event minutes found the agency participates in board and council meetings.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains a binder which includes their agreements with community partners.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The program maintains a binder with documentation of outreach participation. A sample of five outreach events were selected from the program's outreach binder. Five of five events selected for review coincided with NetMIS entries corroborating the event. Entries into NetMIS included the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	A review of the program manager's job description found it included outreach activities.	

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

2.01 - Screening and Intake		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01	**YES**	
	If NO, explain here:	
	There is a policy in place titled 2.01, Screening and Intake. The policy was last reviewed on December 17, 2023 by the Board Members and CEO.	

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: There were five Community files reviewed.
Total number of Closed (Residential & Community) Files: There were five Community closed files reviewed.
Staff Position(s) Interviewed (No Staff Names): CEO/ED
Type of Documentation(s) Reviewed: Case files were reviewed
Describe any Observations: Ten youth records were reviewed, five open and five closed files. Each file contained proper screening and intake paperwork. The intake occurred within three days of the screening process in all ten files.

Standard	Rating	Findings	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	Not Applicable	This agency is a community counseling provider.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	Compliance	Ten youth files were reviewed and each file contained the eligibility screening forms and all ten were completed within three business days of the 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	There is evidence in the NetMIS system that was provided by the agency's CEO/ED to confirm that all eligible referrals for service were logged in NetMIS within 72 hours of screenings' completion. The dates were confirmed for all ten youth files reviewed.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	Compliance	Youth and parents/guardians receive in writing the available service options provided by the agency as well as the rights and responsibilities of the youth and parents/guardians. The youth and parents/guardians are provided with brochures and additional material that specify the available services and rights and responsibilities and a signature from the youth and parent are required on a form in the file to confirm receipt of said documents.	
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	The CINS/FINS services and grievance procedures are discussed during the intake process and the youth and parent(s)/guardian(s) signature(s) are required on the appropriate form in the file, to confirm receipt. All ten files reviewed contained the signatures from the youth and parent(s)/guardian(s).	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	Compliance	Ten files were reviewed, five open and five closed files and all ten files proved that the youth were screened for suicidality. No further assessment was required in all ten files. The agency has a process in place to accommodate if additional screening/assessments are required. This information was confirmed by the agency's CEO/ED.	

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: This agency has a written policy and procedure in place that meets the requirements for indicator 2.02 titled Network of Risks, Victories and Needs Assessment NIRVANA. This was reviewed on December 17, 2023 by the Board Members and CEO.	
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: A total number of five open Community files were reviewed. **Total number of Closed (Residential & Community) Files: A total number of five closed Community files were reviewed.** **Staff Position(s) Interviewed** *(No Staff Names)* **: CEO/ED** **Type of Documentation(s) Reviewed: Case files were reviewed.** **Describe any Observations: A total number of ten case files were reviewed; five open and five closed.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	Not Applicable	This agency is a community counseling provider.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	Compliance	Ten case files were reviewed. The NIRVANA was initiated at intake and completed within two to three face to face contacts after the initial intake, in all ten files.	
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	The supervisor's signature is documented for all completed NIRVANA assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Not Applicable	This agency is a community counseling provider.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	Compliance	A NIRVANA Post-Assessment was completed in all five of the closed files reviewed.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	Not Applicable	The five closed files that were reviewed were closed within the 90 day period.	
All files include the interview guide and/or printed NIRVANA.	Compliance	All ten files included the printed NIRVANA.	

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

2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: There is a policy in place titled 4.03 Case/Service Plan that addresses the requirements of this indicator. The policy was reviewed on December 17, 2023 by the Board Members and CEO.	

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: A total of five Community files were reviewed.
Total number of Closed (Residential & Community) Files: A total of five closed Community files were reviewed.
Staff Position(s) Interviewed *(No Staff Names)* **: CEO/ED**
Type of Documentation(s) Reviewed: Client case files were reviewed.
Describe any Observations: A total of ten youth files were reviewed; five open and five closed.

Requirement	Rating	Findings	
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**	The program policy states that a Case/Service Plan will be developed for every youth admitted to a program for CINS/FINS services. A Case/Service Plan will consist of a written document developed with the youth and parent(s)/guardian(s) that identifies needs, measurable goals and outcomes, proposed actions and time frames for completion of actions. Ten youth records, five open and five closed files were reviewed. All ten contained Case/Service Plans that were developed within seven working days of completion of assessment. All ten were completed as required.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten files' Case/Service Plans were developed within seven working days of NIRVANA, as required by the agency's policy and standard.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Ten youth files were reviewed and each files' Case/Service Plan contained: individualized and prioritized need(s) and goal(s) identified on each youth's NIRVANA; service type, frequency and location; the persons responsible; target dates for completion; signature of youth, parent(s)/guardian(s) and supervisor and the date the plan was initiated.	

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	Ten youth files were reviewed and all of the youths serviced had Case/Service Plans that were reviewed for progress every thirty days as required and outlined in the contract; with the exception of one of the five open case files because the file was not yet due for the thirty day review since the file was opened on 2/28/24.	

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: There is a policy in place titled 4.04, Case Management Services that addresses the requirements of this indicator. The policy was last reviewed on December 17, 2023 by the Board Members and CEO.	

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: A total number of five open Community files were reviewed.
Total number of Closed (Residential & Community) Files: A total number of five closed Community files were reviewed.
Staff Position(s) Interviewed *(No Staff Names)*: **CEO/ED**
Type of Documentation(s) Reviewed: Ten case files were reviewed.
Describe any Observations: A total of ten youth files were reviewed; five open and five closed.

Counselor/Case Manager is assigned	**Compliance**	Ten case files were reviewed (five open and five closed) and each youth's case file was assigned to a case manager upon admission to the program.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	The program coordinates referrals based upon the initial intake assessment and ongoing assessment of the youth and family's needs. All ten youth's case notes contained monitoring of the youth's ongoing services. The Case/Service Plans indicated if the youth and their families were in need of additional support and if referrals were initiated. None of the five closed files were referred for additional services upon discharge. In addition, since no follow up was recommended for the youth whose files were closed; the youth did not receive follow up care. There were no case staffing referrals nor accompanying of youth or family members to court hearings and related appointments.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program maintains written agreements with other community partners that include services provided and a comprehensive referral process as was documented in each youth record.	

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

2.05 - Counseling Services		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	**YES** If NO, explain here: The provider has a written policy and procedure that meets the requirement for Indicator 2.05 titled Counseling Services. The policy was reviewed by the Board of Directors and CEO on 12/17/23.	

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: There was a total of five open files reviewed.
Total number of Closed (Residential & Community) Files: There was a total of five closed files reviewed.
Staff Position(s) Interviewed (No Staff Names): CEO/ED
Type of Documentation(s) Reviewed: Ten case files were reviewed.
Describe any Observations: A total of ten case files were reviewed; five open and five closed.

Shelter Program

Shelter programs provides individual and family counseling	Not Applicable	This is not applicable because this agency is only a community counseling provider.	
Group counseling sessions held a minimum of five days per week	Not Applicable	This is not applicable because this agency is only a community counseling provider.	
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	This is not applicable because this agency is only a community counseling provider.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Not Applicable	This is not applicable because this agency is only a community counseling provider.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	Compliance	All ten files reviewed contained evidence of services designed to provide necessary interventions to stabilize the family. Thaise provides services on school campuses. No virtual services were being conducted.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	Compliance	All ten files were reviewed and all ten youth's progress were notated during the thirty day review periods; with the exception of one of the five open files that was not eligible for the thirty day review since the case file was opened on 2/28/24.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	Compliance	All ten files reviewed adhered to all laws regarding confidentiality. All ten files were clearly marked, "Confidential" and stored in locked file cabinets when not in use.	
Case notes maintained for all counseling services provided and documents youth's progress.	Compliance	Case management services are well documented through progress notes, in ten of ten files reviewed. Youth are referred to counseling services as needed or upon request. Five of the open files reviewed, documented no need or request for counseling, therefore no counseling case notes were necessary in the youth's file. Five of the five closed youth files reviewed, had documentation of a referral for counseling services during the exit process.	,

On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The program manager conducts monthly reviews of case records and documents the review in the youth's record. Review of 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.	**Not Applicable**	This program is not conducting intakes through virtual means.	

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

2.06 - Adjudication/Petition Process		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES** If NO, explain here: The provider has a written policy and procedure that meets the requirement for Indicator 2.06 titled Adjudication/ Petition Process. The policy was reviewed by the Board of Directors and CEO on 12/17/23.	

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: ZERO
Total number of Closed (Residential & Community) Files: ZERO
Staff Position(s) Interviewed *(No Staff Names)* **: CEO/ ED**
Type of Documentation(s) Reviewed: None
Describe any Observations:

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The agency has a policy, 2.06 Adjudication/ Petition Process. According to the agency's policy, a case staffing committee is convened within seven working days from receipt of a written request from the parent/guardian. The staffing committee includes the agency's case manager and the local school district. The agency had no adjudication/petition cases in the past six months or back to the date of the last QI review.	

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	**Exception**	The agency's policy indicates that the agency works with the circuit court for judicial intervention for the youth or family, as recommended by the case staffing committee, in accordance with the procedures outlined in Florida Statute and the Florida Network's policy and procedure manual. The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	There was no documentation presented that other members such as: 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, are included in the case staffing committee meetings.
The program has an established case staffing committee, and has regular communication with committee members	**Exception**	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	The program does not have an established case staffing committee, and regular communication with committee members.
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Exception**	The program's internal procedure for the case staffing process is described in the agency's policy.	The program does not have a schedule for committee meetings.
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI 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, 2.07 Youth Records, last reviewed 12/17/2023 by the board of directors.	

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)*: **CEO/ ED**
Type of Documentation(s) Reviewed: None
Describe any Observations: Locked file cabinet in staff office where files are stored, opaque container used for transporting files.

All records are clearly marked 'confidential'.	**Compliance**	All records observed to be clearly marked 'confidential'.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records are kept in a secure room (staff office) and locked in a file cabinet that is marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	A locked opaque container marked "confidential" was observed for use of transporting records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are maintained in a neat and orderly manner and are quickly and easily accessible by the staff.	

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

2.08 - Specialized Additional Program Services		**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	**YES** If NO, explain here: The provider has a written policy and procedure that meets the requirement for Indicator 2.08 titled Specialized Additional Program Services. The policy was reviewed by the Board of Directors and CEO on 12/17/23.	

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.*

Staff Position(s) Interviewed (No Staff Names): CEO/ ED
Type of Documentation(s) Reviewed: N/A

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	This agency is not contracted to provide intensive case management services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**	This agency is not contracted to provide intensive case management services.	

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 is not contracted to provide intensive case management services.	
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 is not contracted to provide intensive case management services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**	This agency is not contracted to provide intensive case management services.	
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 is not contracted to provide intensive case management services.	
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: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: CEO/ ED** **Type of Documentation(s) Reviewed: N/A**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	

Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	No eligible items for review	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	No eligible items for review	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
All data entry in NetMIS is completed within 3 business days as required.	No eligible items for review	The agency has no cases of FYRAC in the past six months or back to the date of the last QI review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: 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.*			
Staff Position(s) Interviewed (No Staff Names): CEO/ ED			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	Not Applicable	This agency is not a contracted SNAP provider.	
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable	This agency is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable	This agency is not a contracted SNAP provider.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Not Applicable	This agency is not a contracted SNAP provider.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Not Applicable	This agency is not a contracted SNAP provider.	

SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Not Applicable	This agency is not a contracted SNAP provider.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	Not Applicable	This agency is not a contracted SNAP provider.	
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable	This agency is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
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 is not a contracted SNAP provider.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	Not Applicable	This agency is not a contracted SNAP provider.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Not Applicable	This agency is not a contracted SNAP provider.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Not Applicable	This agency is not a contracted SNAP provider.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	Not Applicable	This agency is not a contracted SNAP provider.	

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

4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has a written policy and procedure that meets the requirement for Indicator 2.01, titled, 2.01 Screening and Intake. The policy was reviewed by the Board of Directors and CEO on 12/17/23.	
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: A total of five Community files were reviewed. **Total number of Closed (Residential & Community) Files: A total of five closed Community files were reviewed.** **Staff Position(s) Interviewed** *(No Staff Names)* **: CEO/ED** **Type of Documentation(s) Reviewed: Client case files were reviewed.** **Describe any Observations: A total of ten youth files were reviewed; five open and five closed.**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Ten of ten youth files reviewed contained suicide risk screenings that occurred during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program uses a suicide risk assessment that has been approved by the Florida Network of Youth and Family Services.	
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**	The agency only provides community counseling services.	
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**	The agency only provides community counseling services.	
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**	The agency only provides community counseling services.	
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**	The agency only provides community counseling services.	

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**	The agency only provides community counseling services.	
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's policy states, staff should complete a suicide assessment immediately and the parents and supervisor notified of the results. There have been no occurrences of suicide assessments in the past six months or back to the date of the last QI review.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	The agency's policy states, if the appropriate staff is not available, the parent or guardian must be notified that suicide risk findings were disclosed during screening and that an assessment of suicide risk should be completed as soon as possible by a licensed mental health professional or a non-licensed professional working under the direct supervision of a licensed mental health professional. There have been no occurrences in the past six months or since the date of the last QI review.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	The agency's policy states, information on resources available in the community for further assessment shall be provided.	
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's policy states, if the parent/guardian cannot be contacted, all efforts to contact them should be documented in the case file. If the parent/guardian is notified by telephone, a written follow-up notification should be sent by certified mail. There have been no occurrences in the past six months or since the date of the last QI review.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The agency's policy states, if the screening was completed on school property during school hours, the appropriate school authorities should also be notified. If at any point during or after the screening staff believes or youth presents as an immediate threat to themselves or others, staff will immediately call 911 and/or follow Baker Act procedures. The results of the screening must be reviewed and signed by the supervisor and placed in the youth's case file. There are no cases of suicide assessment in the past six months or back to the date of the last QI review.	
Additional Comments: **There are no additional comments for this indicator.**			