Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth Advocate Programs, Inc.

3016 N US Hwy 301, Ste. 550
Tampa, FL 33619

April 3, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Youth Advocate Programs, Inc. for the FY 2023-2024 at its program office located at 3016 N US Hwy 301, Ste. 550 Tampa, FL 33619. 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. Youth Advocate Programs, Inc. 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 Theresa Clove and Melissa Johnson. Agency representatives from Youth Advocate Programs, Inc. present for the entrance interview were: Felicia Wells, Sheryl Kincy, Ophilia Ciesicki and Laur'Tina Johnson. The last onsite QI visit was conducted January 1, 2023.

In general, the Reviewer found that Youth Advocate Programs, Inc. is in compliance with specific contract requirements. **Youth Advocate Programs, Inc. received an overall compliance rating of 100% for achieving full compliance with 11 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions 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 04-03-2024

Agency Name: Youth Advocate Program, Inc.	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3016 N US Hwy 301, Ste. 550 Tampa, FL 33619**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The agency has four certified peer reviewers.	
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**	☐	☐	☐	☐	☒	The Regional Director reported there are no additional contracts. The Florida Network of Youth and Family Services is the only funding source for the CINS/ FINS community counseling program.	
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	☐	☐	☒	☐	☐	A review of the certificate of insurance dated 01/11/2024 indicted the agency maintains the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance (01/21/2024-01/24/2025) with limits of $1,000,000 per accident, $1,000,000	

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$500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						per employee and $1,000,000 per policy aggregate. Commercial General Liability (08/15/2023-08/15/2024) with a limit of $1,000,000 per occurrence, $1,000,000 for damages to rented premises, $20,000 med expenses, $1,000,000 personal and advance injury, $3,000,000 general aggregate and $3,000,000 products aggregate. Automobile Liability Insurance (08/15/2023-08/15/2024) with a $1,000,000 combined single limit. Umbrella liability (08/15/2024-08/15/2024) $5,000,000 per occurrence and aggregate. Additional coverages include Cyber/ Privacy Liability (07/01/2023-07/01/2024) $2,000,000 per claim/ aggregate, Professional Liability and Sexual Abuse and Molestation (08/15/223-08/15/2024) $1,000,000 per claim/ $3,000,000 aggregate. The policies are produced by E.K. McConkey &	

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						Co., Ins with Philadelphia Indemnity Insurance, Chater Oak Fire Insurance and Company, and Travelers Casualty and Surety listed as insurers affording coverage. The Florida Network of Youth and Family Services is listed as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview with the Regional Director reported there are no other external corrective action items cited by any external funding sources.	
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**	☐	☐	☒	☐	☐	A review of the agency's accounting manual contained a policy entitled Accounting Guidelines which complies with GAAP and gives sound internal controls. The agency's fiscal files are maintained in accounting software and are audit ready.	
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**	☐	☐	☒	☐	☐	A review of the general ledger for the most recent six months shows the ledger is set up to track the activity of the grant separately from all other revenue and expenses. The CFO	

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						sends a monthly income statement to the Regional Director and the Regional Director compares and verifies the report with the program income and expenses for accuracy and compliance.	
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**	☐	☐	☐	☐	☒	The Regional Director reported that the program does not use any 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. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	The most recent six months of reconciled bank statements were provided for review. Bank statements are reconciled by the Finance Department. Invoices are submitted to the accounts payable and paid the following week. Check requests are submitted weekly to the assistant director and require two signatures, then to Regional Director for up to $200 and then VP (Vice President) if over $200.	

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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**	☐	☐	☐	☐	☒	The Regional Director reported the program does not make any purchases over $1,000 with FNYFS funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	The most recent six months of payroll tax deposits was provided for review. The agency submits payroll taxes and deposits and retirement deposits, as applicable.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Actual reports are sent from the CFO to the Regional Director on a monthly basis for review. The Regional Director along with the Assistant Director review the reports for accuracy and completeness in comparison to the invoice and expense reports submitted to the Florida Network.	

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h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	A single audit was performed December 27, 2023 by Bakertilly. There were no findings cited in the audit report requiring the submission of a corrective action plan. The annual financial audit was completed within 120 days after the previous fiscal year/ calendar year.	
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 written policies and procedures to ensure the security and privacy of all employee and client data. All personal information is maintained in an electronic format, not easily accessible. The program does have a back-up system in case of accidental loss of financial information. The program does have procedures in place to protect laptops.	

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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**	☐	☐	☒	☐	☐	The Regional Director provided compensation summaries for all direct care staff. A review of all compensation summary reports for all direct care staff indicates each direct care staff is being paid $19.00 per hour.	

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CONCLUSION

Youth Advocate Programs, Inc. has met the requirements for the CINS/FINS contract as a result of full compliance with 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the fourteen indicators were not applicable because the program has no additional contracts, the program does not use petty cash, and there is not inventory purchased with funds from the Florida Network of Youth and Family Services or Department of Juvenile Justice, **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

Review of Youth Advocacy Program
CINS/FINS Program

Date: April 3, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 14.29 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 88.24 %
Percent of indicators rated Limited: 5.88 %
Percent of indicators rated Failed: 5.88 %

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
Melissa Johnson – Regional Monitor, Department of Juvenile Justice
Theresa Clove – Thaise Educational and Exposure Tours, Inc.

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports		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	5	# 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	X	Program Schedules	5	# Youth Records (Open)
	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

0	# of Youth	11	# 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

Youth Advocate Program, Inc. (YAP) was awarded a contract with the Department of Children and Families (DCF) to expand services and include Hillsborough, Pinellas, Pasco, and Polk counties. The program has partnered with local restaurants, retail stores, and grocery stores to provide gift cards and meals for program participants and families.

YAP has updated its data entry system and now uses Evolv. The Evolv electronic record management system allows programs to upload individualized forms that are specific to their programs and funding agencies.

The following programmatic updates were provided by the agency:

Staffing:

Felicia Wells was promoted from Program Director to Florida Regional Director.

No staffing vacancies or concerns, Regional Director has implemented various activities to engage and encourage staff engagement through employee monthly recognition and Florida Fun Fact Trivia where staff can win $75 Amazon virtual gift cards.

Hillsborough county is now making referrals to Youth Advocate Program's Behavioral Health Program for “telehealth services” to eliminate youth being placed on local waiting lists for services. This service is not provided or funded under the Florida Network of Youth and Family Services CINS/ FINS contract.

Facility:

Youth Advocate Program, Inc. is renewing its lease in October of 2024 and is anticipating on acquiring a larger office area.

Governance and Community:

The Youth Advocate Program, Inc. has partnered with Arwood High School, Kenly Park, Brothers United Building Brothers Alliance (BUBBA), and Bridge Prep Academy, for recruitment of CINS/FINS, SNAP U12, and SNAP youth. The program has partnered with, Great Rooms Central for donations to celebrate youth accomplishments and Cheesecake Factory for gift cards for SNAP participants. The program has partnered with Integrity group homes to recruit FYRAC youth.

Hillsborough County hosted YAP's board meeting and provided a tour of one of the community partner's site in November 2023.

Narrative Summary

YAP continues to hold its accreditation through the Council On Accreditation through August 31, 2025. The program provides mentors to youth in the community. The program is a community counseling provider through contract with the Florida Network of Youth and Family Services and provide FYRAC and SNAP services as well. There is currently not external corrective action items outstanding for the program. The program tested a transportation system called "Trip Log", however the program was not successful in meeting the needs of the agency. YAP continues to work with vendors to find a program that is a more appropriate fit for the needs of the staff. The previous program director has been promoted to the Florida Regional Director and has implemented various activities to engage and encourage staff engagement through monthly employee recognition and Florida Fun Fact Trivia (where staff can win $75 amazon gift cards).

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 with Exception**,
Indicator 1.03 Incident Reporting was rated **Satisfactory**,
Indicator 1.04 Training Requirements was rated **Failed**,
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**,
Indicator 1.06 Client Transportation was rated **Limited**, and
Indicator 1.07 Outreach Services was rated **Satisfactory.**

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**,
Indicator 2.02 Needs Assessment was rated **Satisfactory**,
Indicator 2.03 Case/Service Plan was rated **Satisfactory**,
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory,**
Indicator 2.05 Counseling Services was rated **Satisfactory,**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**,
Indicator 2.07 Youth Records was rated **Satisfactory,**
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory,** and
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory**.

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

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

Standard 1:
Failed - Indicator 1.04 Training - One staff training file reviewed did not contain a training log with documentation of completed training. None of the three staff reviewed for annual training had completed the minimum of twenty-four hours of training for the year. Two staff had completed sixteen hours of training and one staff had completed twenty-two hours of training. None of the three staff members have completed the Florida Network Youth Suicide Prevention Training. There is no process in place for reviewing tracking of staff training files. All staff files were missing supporting documentation of trainings recorded on the training logs.

Limited - Indicator 1.06 Transportation - The program had 146 single transports and does not have a procedure in place to do check-ins at agreed upon intervals. The program does not maintain a log of transportation events. Transporting a client without maintaining at least one other person in the vehicle is common practice for the program. Additionally, in the event a 3rd party cannot be obtained, the agency's supervisor or managerial personnel is not considering the client's history, evaluation and recent behavior.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability		
1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES** If NO, explain here: The agency has a policy, 1.01 Policy for Background Screening, reviewed by the regional director 03/27/2024.	

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

Total number of New Hire Employee/Intern/Volunteer Files: Five
Total number of 5 Year Re-screen Employee Files: None
Staff Position(s) Interviewed (No Staff Names): Regional Director
Type of Documentation(s) Reviewed: Background Screening result from the Agency for Healthcare Administration, E-Verify confirmation from the Department of Homeland Security, and Pre-employment screening result.
Describe any Observations:

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Five of five new-hire staff files reviewed have successfully passed pre-employment suitability assessment on the initial attempt.	
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**	There were no applicants that did not pass the initial suitability assessment on the first attempt.	

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**	There were no employees who have had a break in service for 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Five of five employee files reviewed showed evidence of background screening completed prior to hire/start date.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**No eligible items for review**	There are currently no employees needing a 5 year rescreening during the dates of this review period or back to the date of the last review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency submitted the Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) via email to the Department of Juvenile Justice (DJJ) Background Screening Unit (BSU) prior to January 31st.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Five of five new-hire employee files reviewed showed evidence of proof of E-Verify for all new employees obtained from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy, 5.02 / Provision of an Abuse Free Environment reviewed by the regional director on 3/27/24.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Staff Position(s) Interviewed (No Staff Names): Regional Director and Director **Type of Documentation(s) Reviewed: Incident logbook** **Describe any Observations: Observed the COA certificate posted in the lobby**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	YAP, Inc acknowledgement of receipt of documents in the employee files, includes acknowledgement of the personnel policy manual which discusses the agency's code of conduct.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a procedure in place for reporting and documenting child abuse hotline calls. The agency has not had any child abuse calls made to the child abuse hotline in the last 6 months.	
Youth were informed of the Abuse and Contact Number	**Exception**	The client bill of rights and responsibilities / client grievance procedure, address the informal and formal grievance process and the corporate hotline number.	The client bill of rights and responsibilities/ client grievance procedure does not address the number to contact the Florida Abuse Hotline.
Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	Program director/supervisor will have access to and manage grievances unless it is toward themselves, then it will be handled by the regional director. Grievances will be resolved within 72 hours of being submitted and maintained by the agency for at least one year of submission. The program reported they did not have any grievances submitted during the review period.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	The program only provides community counseling services.	
<u>Shelter only:</u> There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Not Applicable**	The program only provides community counseling services.	
<u>Shelter only:</u> There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Not Applicable**	The program only provides community counseling services.	

Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Not Applicable**	The program only provides community counseling services.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy, 5.01/ Incident Reporting reviewed by the regional director on 3/27/24.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director and Director** **Type of Documentation(s) Reviewed: Incident Log Binder** **Describe any Observations:**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	The program maintains a binder for incident reports. A review of the incident log binder found no incidents were documented during the annual review period or back to the date of the last review. Interview with the regional director indicates there have been no reports to the CCC in the past six months or back to the date of the last review. The program has policies and procedures in place which addresses reporting incidents to the CCC within the required timeframe.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**	Interview with the regional director indicates there have been no reports to the CCC in the past six months or back to the date of the last review.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The agency has an internal incident reporting policy and procedure which includes documenting incidents on incident reporting forms and contacting the CCC on all reportable incidents.	
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**	The program is a community counseling program and not required to use a program logbook. The program does have internal incident report forms for documenting incidents.	

All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**	There were no incidents to review back to the date of the last QI review.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform*			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy 6.04/ Policy for Training Requirements, signed by the regional director 3/27/24.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: Four **Total number of Annual In-Service Staff Files: Three** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files:** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: One year from date of hire** **Staff Position(s) Interviewed** *(No Staff Names)* **: Director** **Type of Documentation(s) Reviewed: First year training plans**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Four new staff were reviewed. All three new staff were currently in their first year of employment so they still have time to complete training.	One staff did not have their training log available to review.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Four of four staff files reviewed showed complettion of the United States Department of Justice (DOJ) Civil Rights & Federal Funds training. Three files completed it within 30 days from the date of hire and one file completed the training on 06/07/2022, prior to the date of hire, due to being moved to this CINS/FINS position (05/15/2023) from another YAP program.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Four new staff were reviewed. Three new staff were currently in their first year of employment so they still have time to complete training. One staff did not have their training log available to review but is also still in their first year.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Three of the four completed this training.	One staff did not have their training log available to review.

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.	**Not Applicable**	None of the staff files reviewed are responsible to entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of 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*	**Compliance**	This training is applicable to two new-hire staff members hired after 07/01/2023. Two of two staff training records reviewed are within the first year of employment and still have time to complete the FL Statute 984 CINS Petition Training by their local DJJ Attorney.	
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 is a community counseling program and this indicator is not applicable to the staff.	
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 staff reviewed for annual training. Two staff had completed sixteen hours of training and one staff had completed twenty-two hours of training, the staff are still have time to complete the training.	None of the three staff reviewed for annual training had completed the minimum of twenty-four hours of training for the year. None of the three staff members have completed the Florida Network Youth Suicide Prevention Training.
Required Training Documentation			

The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Exception**	The agency has a training plan.	The training plan does not include all of the required training topics including the pre-service and in-service. The first year training log did not include all required trainings. The program did not appear to have an in-service training plan. Program staff indicated they would provide the review team copies of completed training in the Bridges system by each of the three staff. This documentation was not provided to the review team.
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.	**Exception**	The program director was responsible for managing all employee's individual training files.	There was no process in place to complete routine tracking and review of staff files.
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Exception**	The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form.	All training files were missing supporting documentation for completed training. The training files did not include trainings completed in electronic trainings systems such as Bridges.
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy, 6.00 Policy for Analyzing and Reporting Information signed by the regional director on 3/27/24.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Program Manager, Supervisor**
Type of Documentation(s) Reviewed: Staff meeting minutes
Describe any Observations:

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Case record reviews are conducted by the supervisor and discussed in staff meetings monthly.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Reviews of incidents, accidents and grievances are conducted bi-weekly by the program director.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The administrative manager collects various data. The program produces an annual report addressing the following YAP issues to the Board of Directors: YAP programs, demographics, entry information and outcomes, 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 Director indicated EOM report information is addressed in staff meetings under the agenda item called "FL Network Policy and Procedures Update". In reviewing the staff meeting minutes it appears this agenda item addresses different indicators in each meeting. There is also an agenda item "Quality Improvement". In reviewing the meeting minutes it appears report card results and information is shared with staff. Additional staff meeting agendas have the topic of "Network Reports CINS/FINS and SNAP. Feedback is shared during supervision.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The supervisor reviews the data collection completed by the program manager and discusses it with the staff weekly.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Various meeting minutes reviewed showed that findings are regularly reviewed by the supervisor and communicated to the regional director and stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The regional director indicates that all program performance is routinely reviewed with the board of directors. All final reports are submitted to 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**	The director indicated EOM report information is addressed in staff meetings under the agenda item called "FL Network Policy and Procedures Update". In reviewing the staff meeting minutes it appears this agenda item addresses different indicators in each meeting. There is also an agenda item "Quality Improvement". In reviewing the meeting minutes it appears report card results and information is shared with staff. Not all staff meeting agendas address these topics. Some staff meeting agendas have the topic of "Network Reports CINS/FINS and SNAP. Feedback is shared during supervision. The Administrative Manager collects various data monthly. Meet with Board of Directors quarterly (September and December 2023)	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy, 5.07 Policy on Client Transportation, reviewed by the regional director on 3/27/24.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: most recent six months **Staff Position(s) Interviewed (No Staff Names): Regional Director, Program Supervisor** **Type of Documentation(s) Reviewed: Staff weekly schedules, staff time sheets, written progress notes.** **Describe any Observations: The agency has a culture of encouraging advocates to build relationships with youth, including taking them out in the local community to support foster opportunities for community engagement.**			
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 drivers. All drivers operate their private vehicles for company use.	

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 certificate of insurance that covers all employees. Evidence of valid driver's licenses was present for all approved drivers.	
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	**Exception**	The agency has a policy on transportation. The agency encourages staff to take youth out into their local community and engage them with services, employment opportunities and public facilities that may be available in the area. One to one transportation is normal and acceptable in the role of the advocate.	The agency does not consider that transporting a client without maintaining at least one other passenger in the vehicle during the trip is prohibited and does not include exceptions in the event that a 3rd party is not present in the vehicle while transporting. There were a total of 146 single transports that took place in the last six month period.
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Exception**	One to one transportation is a standard practice in the role of the advocate and considered important in how the staff interact with the youth served by this program.	Interview with the program director confirmed that, in the event a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation and recent behavior, does not occur when conducting single transports. The staff are not required to check in at agreed upon intervals while transporting youth.
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Exception**	Single transports are a normal practice within the agency between the youth advocate and the youth. Youth advocates transport youth in their personal vehicles. Planned trips are approved by the supervisor on a weekly basis.	There is no presence of a 3rd party in 146 occurrences of single transports.
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The program director indicated the single youth transports are approved, prior to transporting youth, when the staff submits their weekly schedule. The schedule includes the name of the youth and the planned beginning and end time of the planned activity. The Director's approval is documented by their signature and date at the bottom of the weekly schedule. A review of staff's weekly schedules confirmed this practice. Confirmation of the trip was observed on the staff's weekly time sheet and in the chronological notes. The time sheet confirms all transportation events that have occurred and the chronological note provides additional details pertaining to those trips.	

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.	**Compliance**	The required information (name of driver, date and time, mileage, number of passengers, purpose of travel and location) was retrieved from the employees' time sheets, approved weekly schedules, and notes.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy, 1.07 Policy on Outreach Services, reviewed by the regional director on 3/27/24.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Program Director **Type of Documentation(s) Reviewed: Outreach Meeting minutes and agendas , NetMIS outreach entries.**			
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 program director is the designated staff member who attends DJJ Circuit Advisory Board (CAB) meetings. Evidence of attendance for the following CAB meetings was reviewed: 11/17/23 and 1/19/24. There was also evidence of attendance at the Hillsborough County Children's Committee Meeting 1/5/24, 2/2/24, 3/1/24, the Children's Advocacy Center - Child Advocate Peer Review meeting, 2/14/24, Circuit 13 Community Management Team Meeting 3/6/24.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Collaborative Agreements between Bridge Prep Academy, BAYS, and Tampa Connect Group (TCG) were reviewed and included services provided and a comprehensive referral process.	
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 provided documentation of outreach services that included the duration, zip code, location description, estimated number of people reached and target audience.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program director is the designated staff that conducts outreach and it is defined in their job description.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Two – Intervention and Case Management			

2.01 - Screening and Intake			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy, 2.01 Policy on Screening and Intake, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Opened Community Case Files **Total number of Closed (Residential & Community) Files: 4 Closed Community Case Files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Assistant Program Director and Program Coordinator** **Type of Documentation(s) Reviewed: Client Case Files** **Describe any Observations: All case files were orderly and neat in appearance.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Not Applicable**	The program provides community counseling services only.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Screening were completed within 3 business days for all community counseling youth by a trained staff using Florida Network screening forms as evident by the screening form date and time and the trained person name on the screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	All eight files reviewed contained evidence that referrals for service were screened for eligibility. Seven of eight screenings were logged into NETMIS within the 72 hours.	One out of the eight screenings was not logged into NETMIS within the 72 hours. The screening was logged in within 96 hours therefore was one day late.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All families received in writing the available service options, rights and responsibilities of youth and parents/guardian as evidence of their signatures on the forms in the case files.	
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**	Possible actions occurring through involvement with CINS/FINS services and Grievance procedures were also made available to the youth and family as evidence of the parent/guardian and youth signatures on the form in the case file.	

During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	During intakes all youth were screened for suicide and assessed if needed as evidence by the suicide form and signed by staff, supervisor and/or license staff. None of the clients indicated any suicidal tendencies on the form.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy, 2.02 Policy on Needs Assessment, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Opened Community Case Files **Total number of Closed (Residential & Community) Files: 4 Closed Community Case Files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Assistant Program Director and Program Coordinator** **Type of Documentation(s) Reviewed: Case files, Nirvana Assessment, and NETMIS System for Nirvana Assessment**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	The program provides community counseling services only.	
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**	The Nirvana Assessments were initiated at intake and completed within 2 to 3 face contacts as evidence on the date of the Nirvana form in the case file and in the NETMIS system.	
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 signatures were documented on all 8 Nirvana Assessments as seen on the Nirvana Assessment in the case file.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Not Applicable**	The program provides community counseling services only.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	All youth who had a stay greater than 30 days had a Post Nirvana Assessment completed and was placed in the case file and was entered into the NETMIS system.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	There were no Nirvana Re-Assessments completed on any of the 8 case files as there was none that required it.	

All files include the interview guide and/or printed NIRVANA.	**Compliance**	All 8 case files had the printed Nirvana Assessment in the case file.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy, 2.03 Policy on Case/ Service Plan, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Opened Community Case Files **Total number of Closed (Residential & Community) Files: 4 Closed Community Case Files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Assistant Program Director and Program Coordinator** **Type of Documentation(s) Reviewed: Youth Service Plans**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	The service plans are developed on a local provider-approve form and is based on information gathered during the screening, intake and Nirvana as evidence by the screening and intake form and Nirvana assessment evaluations in the case files.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All eight (8) Service Plans were developed within 7 working days of the Nirvana as indicated on the Service Plan located in the case file.	
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**	On all eight (8) case files the Service Plan included all that was required and was noted in the case file documentations.	
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**	Five (5) out of eight (8) service plans were reviewed for the 30 day case plan review. Evidence of completion was present in all five case files as observed by the review dates listed on the service plans along with the initials of the staff, client and parent initials. One (1) was not applicable due to closing before the 30 day review and the other two were too early for the review.	

Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy, 2.04 Policy on Case Management and Service Delivery, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Opened Community Case Files **Total number of Closed (Residential & Community) Files: 4 Closed Community Case Files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Assistant Program Director and Program Coordinator** **Type of Documentation(s) Reviewed: Case Files**			
Counselor/Case Manager is assigned	**Compliance**	Yes, counselors were assigned to all eight (8) clients as evidence of the counselors name and credentials listed in the case files.	
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**	Each case file reviewed contained evidence of the following: the counselor established and coordinated referrals based on the needs of the family, implemented and coordinated the service plans, provided support for the families, monitored the youth and family progress and documented it in the case notes, and provided case termination notes in the discharge summary and in the case notes for the clients that were terminated. No clients were referred for additional services. There were no court ordered cases out of the eight (8) reviewed therefore the counselor did not accompany the family to court hearings and related appointments nor did they provide court case monitoring and review court orders. Three (3) cases out of the eight (8) reviewed were due for a 30 day follow-up and they were completed as evidence of the follow-up in the follow-up book and documentations in the case notes. Two (2) out of the eight (8) were due for a 60-day follow-up and they were completed and was observed in the follow-up book, as well as the documentation in the case file.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	YAP maintains written agreements with community partners that allows them to refer their youth for additional services. They have a written process that allows them to refer to the community partners and they have written partnership agreements.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy, 2.05 Policy on Counseling Services, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: **Total number of Closed (Residential & Community) Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations:**			
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	The program provides community counseling services only.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**	The program provides community counseling services only.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Not Applicable**	The program provides community counseling services only.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**	The program provides community counseling services only.	
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**	The community counseling program provides therapeutic services designed to provide intervention needed to stabilize the family in the office, in the school or in the community and is documented in the case file notes. The case file reflects where the services were provided and the progress of the client and the family.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	It was documented throughout the case files that the presenting problems were reflected in the Nirvana Assessment, case service plan, case service plan reviews, case management and follow-ups.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	YAP maintain individual case files on each youth and adhered to the law regarding confidentiality. Each case file had confidential marked on the tab of each case file.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	The case file notes were observed in each case file and was noted that they documented the client progress or lack of progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	YAP has an internal process that ensures clinical reviews of case records and staff performance. The Assistant Program Director or the Program Coordinator meet with the case	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**Compliance**	No intakes were observed to be virtual.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy, 2.06 Policy on Adjudication/ Petition Process, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Zero **Total number of Closed (Residential & Community) Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager** **Type of Documentation(s) Reviewed: Agency Policy** **Describe any Observations: There were no case files that were referred to the Case Staffing Team.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The agency has a policy on the adjudication/ petition process. There is also regular attendance at the committee meetings which includes local school representatives.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	The program director is the designated staff member who attends DJJ Circuit Advisory Board (CAB) meetings. Evidence of attendance for the following CAB meetings was reviewed: 11/17/23 and 1/19/24. There was also evidence of attendance at the Hillsborough County Children's Committee Meeting 1/5/24, 2/2/24, 3/1/24, the Children's Advocacy Center - Child Advocate Peer Review meeting, 2/14/24, Circuit 13 Community Management Team Meeting 3/6/24 Hillsborough Case Staffing 9/12/23, 10/10/23, 11/14/23, 12/12/23, 1/23/24, 2/13/24, 2/29/24, 3/1/24	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	YAP attends Hillsborough County Case Staffing meeting on a monthly basis as evidence by the monthly attendance sheets.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	YAP has an internal procedure for the case staffing process which includes the monthly case staffing/supervision meetings with the Program Coordinator and/or the Assistant Program Director. If any cases need to be referred to the case staffing team the decision is made during the supervision meeting.	

The youth and family are provided a new or revised plan for services	**No eligible items for review**	The program had no adjudication/petition cases in the past six months or back to the date of the last review. The program demonstrates readiness to receive a youth under the CINS petition.	
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 program had no adjudication/petition cases in the past six months or back to the date of the last review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The program had no adjudication/petition cases in the past six months or back to the date of the last review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The program had no adjudication/petition cases in the past six months or back to the date of the last 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 Policy on Youth Records, reviewed by the regional director on 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Manager** **Type of Documentation(s) Reviewed: Youth Files, Agency's policy** **Describe any Observations: File cabinets are locked and marked confidential, opaque file containers are locked and marked confidential**			
All records are clearly marked 'confidential'.	**Compliance**	All eight (8) Community case files were mark confidential on the tab of the case file.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	A staff member took the peer auditor on a tour of the facility and showed this peer auditor where the case files are kept. They are kept in a secure room in a locked file cabinet with Confidential mark on the file cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	A YAP team member brought out a lock opaque container that had confidential mark on it. It was used to transport case files.	

All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All the case file was observed to be well maintained, neat and in an orderly manner.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policy, 2.08 Policy on Specialized Additional Program Services, reviewed by the regional director on 03/27/2024.	
Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: None** **Describe any Observations:**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	The agency is not contracted to provide 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**	The 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**	The 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**	The agency is not contracted to provide intensive case management services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**	The 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**	The 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: 2 Opened Community FRAC Cases **Total number of Closed Files: No Closed Community FYRAC Cases** **Staff Position(s) Interviewed (No Staff Names): Regional Director, Assistant Program Director and Program Coordinator** **Type of Documentation(s) Reviewed: Community FYRAC Case Files** **Describe any Observations:**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	There were 2 FYRAC cases during the last 6 months.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**Compliance**	The youth were referred by the JPO due to being on probation and referred for FYRAC services.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	The FYRAC case files have an approval email/letter from Florida Network approving the referrals.	

Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**Compliance**	All criteria were met during the intake and initial assessment as evidence of the documentation in the case file. The intake sessions were face to face for each case.	
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**	No life management sessions had been held as of yet. Both cases have been opened less than 30 days and efforts to engage families in services were documented in the youth files reviewed.	
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**	No individual sessions had been held as of yet. Both cases have been opened less than 30 days and efforts to engage families in services were documented in the youth files reviewed.	

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**	No group sessions had been held as of yet. Both cases have been opened less than 30 days and efforts to engage families in services were documented in the youth files reviewed.	
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**	No follow-ups were due.	
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 cases were at the beginning stages and there were no sessions initiated as of yet. The case managers were trying to contact the guardian to set up an initial session but was unable to schedule it at that time.	
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 program provides no virtual sessions.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	All data for the FYRAC cases were entered into NETMIS within 3 days	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has several policies, 4.11, 4.12, 4.13, 4.14 Policy for Stop Now And Plan, signed by the regional director 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Five **Total number of Closed Files: Three** **Staff Position(s) Interviewed (No Staff Names):** **Type of Documentation(s) Reviewed: SNAP Youth files** **Describe any Observations: Reviewed files for two completed SNAP in schools sessions.**			
SNAP Clinical Groups Under 12			

Youth are screened to determine eligibility of services.	**Compliance**	Four of four youth files reviewed contained evidence of a screening to determine eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	The NIRVANA was completed at initial intake, or within two sessions in four of four youth files reviewed.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	There was evidence of a completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within all four files reviewed.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Compliance**	Four of four youth files reviewed contained evidence of completed (pre and post) Teacher Report Forms (TRF) within the file.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	A completed (pre and post) TOPSE was present in four of four youth files reviewed.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Three of three closed SNAP clinical group files reviewed contained evidence of a completed SNAP discharge reports within the file.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form was located in three of three closed SNAP files reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form was located in all three closed SNAP files reviewed.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Compliance**	Four of four youth files reviewed contained evidence of screening to determine eligibility of services.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Compliance**	A completed consent to treatment and participation in research form is located in four of four youth files reviewed.	

The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	A NIRVANA completed at initial intake, or within two sessions was present in four of four SNAP files reviewed.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Compliance**	Evidence of a completed 'How I Think Questionnaire' (HIT) form was located in four of four files reviewed.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Compliance**	Evidence of completed Social Skills Improvement System (SSIS) Student forms were located in four of four files reviewed.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Compliance**	Evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form was located in four of four files reviewed.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	Completed weekly attendance sheets was present for 13 sessions in two of two SNAP in Schools files completed.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	There was evidence of a completed "Class Goal" document present in two of the two SNAP in Schools files reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Evidence of both completed pre and post Measure of Classroom Environment (MoCE) documents was present in both files for the classes reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Evidence of completed pre and post evaluation documents was present for both the classes reviewed.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Evidence of the fidelity adherence checklist was present in both files for each class reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Four – Mental Health and Health Services			

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 agency has a policy, 4.02 Policy for Suicide Prevention, signed by the regional director 03/27/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Five open community counseling files only **Total number of Closed (Residential & Community) Files: Five closed community counseling files only** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Suicide screening and referrals for assessment, if applicable.**			
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 files reviewed showed evidence of suicide risk screening being completed during the initial intake and screening process. The suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file for each youth file reviewed.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program is utilizing the suicide risk screening questions that have been approved by the Florida Network of Youth and Family Services. Youth are referred to local mental health providers for assessment if warranted per screening.	
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**	This program provides community counseling services only.	
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**	This program provides community counseling services only.	
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**	This program provides community counseling services only.	

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**	This program provides community counseling services only.	
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**	This program provides community counseling services only.	
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**	Ten of ten youth files reviewed were not identified for suicide risk during intake. There has not been a need to referred a youth for suicide assessment since the date of the last 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**	There have been no youth identified for suicide risk since the date of the last QI review. The program has policies and procedures in place to refer youth immediately and notify the parent/guardian of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional, in the event the youth is identified for suicide risk.	
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 program has information on resources available in the community for further assessment to provide to the parent/guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There are no cases of referral for suicide assessment back to the date of the last review.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	Evidence of notification to the appropriate school authorities was present in youth files when the screening was completed during school hours on school property.	
Additional Comments: **There are no additional comments for this indicator.**			