Florida Network for Youth and Family Services
Compliance Monitoring Report for

Tampa Housing Authority

5301 West Cypress St
Tampa, FL 33607

November 13, 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 Tampa Housing Authority for the FY 2024-2025 at its program office located at 5301 West Cypress Avenue, Tampa, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Tampa Housing Authority 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 2024 through June 30, 2025.

The compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from Tampa Housing Authority present for the entrance interview were: Matthew Dickey, Program Manager, Natisha Johnson, Treatment Supervisor, Elizabeth Carrasquillo, Treatment Supervisor, and Tampa Housing Community Counseling and Administrative staff members. The last onsite QI visit was conducted on November 15, 2023.

In general, the Reviewer found that the Tampa Housing Authority is in compliance with specific contract requirements. **Tampa Housing Authority received an overall compliance rating of 73% for achieving full compliance with seven applicable indicators** of the CINS/FINS Monitoring Tool. 1)There were no recommendations as a result of the monitoring visit. However, there were three corrective action items identified 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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-13-2024-2025

Agency Name: Tampa Housing Authority						Monitor Name: Keith Carr, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 5301 W. Cypress Ave., Tampa, FL 33607	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): November 13, 2024	
	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently the agency does not have two staff members certified as DJJ QI Peer reviewers: Natisha Johnson and Elizabeth Carrasquillo. Neither has participated as a peer reviewer to date but will be scheduled for the current FY.	**No recommendation of corrective action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The THA provided a list, titled PPS Grant Summary, of multiple contracts for FY2024-2025. The list includes: the name of grant, funding source, contract period, description of funding, and contract amount.	**No recommendation of corrective action.**
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person;	☒	☐	☐	☐	☐	Documentation: Commercial Liability Insurance is secured through HAI Group. The policy included $1,000,000 per occurrence; Fire Damage limits $50,000; Sports Liability limits $250,000. Personal and Advertising Injury Liability is set at $1,000,000; wrongful act -law enforcement is $500,000 and for public officials is $1,000,000; and Mold, Other Fungi or Bacteria Liability Claim is set at limits of $100,000. Policy is effective 10/01/2024 10/01/2025.	**Corrective Action: 1)** Re-submit the current insurance certificate of insurance to ensure that it lists the Florida Network of Youth and Family Services. Update accordingly and provide a copy of the revised document.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						Auto Insurance is provided through the Auto-Owners Insurance automobile insurance company. Coverage includes combined liability for $1million, PIP for $10,000 each person, medical limited to $2,500, and uninsured motorist coverage for $10,000/person and $20,000/accident. Policy is effective 03/01/2024 03/01/2025. Workers Compensation and Employers Liability Insurance is provided through The Zenith. The policy coverage includes $1,000,000 in Bodily injury for each Accident; $1,000,000 in Bodily Injury for each Disease policy limit; and $1,000,000 in Bodily injury for each Disease each employee. The policy is effective 07/01/2024-07/01/2025. The certificate of insurance does not list the Florida Network as additional insured.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by other funding sources.	**No recommendation of corrective action.**

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Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a copy of its current fiscal policy titled Standard Operating Procedures for Critical Financial Functions. This document explains the agency's major fiscal procedures which include Case Receipts and Disbursements, Investments, Petty Cash, Accounts Payable, Hiring and Payroll, Fixed Assets, Revenue and Receivables and Budget. Agency has organized vendor files as required.	**No recommendation of corrective action.**
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: General ledger (GL) for Periods: July 2024-September 2024. The agency maintains a detailed general ledger with corresponding source documents as required. The agency's general ledger also lists CINS/FINS funding separately from other funding sources by category.	**No recommendation of corrective action.**
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☐	☐	☒	Interview: A petty cash ledger system is not a part of the agency's fiscal policy and procedures for any CINS/FINS funded programs.	**No recommendation of corrective action.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures.	☒	☐	☐	☐	☐	Documentation: The agency's fiscal department processes all financial documents. No evidence of reconciled bank statements was provided by the agency.	**Corrective Action: 2)** Provide copies of bank statements reconciled over the past six months (June 2024-November 2024).

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(Disbursements/invoices are approved & monitored by management). **ON SITE**							
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**	☐	☐	☐	☐	☒	Documentation: The agency does not purchase property over $1000 with FNYFS funds.	**No recommendation or corrective action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provide documented evidence of submitting payroll taxes for the period from April 2024 – September 2024.	**No recommendation or corrective action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☒	☐	☐	☐	☐	Documentation: The agency provided as Job Cost Summary which listed funding from the initial start of the current period of July. The agency did not provide an actual FY 2024-2025 budget. The program budget was not included in the report because zero values are shown on the program budget line items.	**Corrective action: 3)** **The provider must resubmit a budget to actual report showing line item CINS/FINS expenditures approved in this FY budget and demonstrate any related variances.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The annual single audit was conducted by Berman Hopkins CPA & Associates LLP for the year ended March 31, 2023, in a letter dated December 29, 2023. Per the audit report, there were no audit findings that needed to be reported or any questioned costs.	**No recommendation or corrective action.**

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Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided copies of its THA Public Records Retention Policy -2023. The policy addresses the following areas including Record Retention Policy, Records Maintenance, Physical Records, Maintenance of Electronic Records, Records Inventory, Records Destruction, Document Disposition Schedules.	**No recommendation or corrective action.**
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 agency provided evidence of compensation for funded positions for staff members providing direct care for CINS/FINS programming. All contract positions meet or exceed the mini hourly rate of $19.00 per hour.	**No recommendation or corrective action.**

CONCLUSION

Tampa Housing Authority has met the requirements for the CINS/FINS contract as a result of full compliance with eight applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the indicators were not applicable because: 1) the provider does not have any outstanding corrective actions with external funders; 2) the program does not utilize petty cash; and 3) no new inventory was purchased with Florida Network funds.

Consequently, **the overall compliance rate for this contract monitoring visit is 73%.** There are three corrective actions that are required to be addressed by the agency as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner that meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

Corrective Action: 1) Re-submit the current insurance certificate of insurance to ensure that it lists the Florida Network of Youth and Family Services. Update accordingly and provide a copy of the revised document.

Corrective Action: 2) Provide copies of bank statements reconciled over the past six months (June 2024-November 2024).

Corrective Action: 3) The provider must resubmit a budget to actual report showing line item CINS/FINS expenditures approved in this FY budget and demonstrate any related variances.

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 Tampa Housing Authority - Tampa
CINS/FINS Program

11/13/2024

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	Limited
1.05 Analyzing and Reporting Information	Failed
1.06 Client Transportation	Not Applicable
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	Limited
2.03 Case/Service Plan	Limited
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Not Applicable

Percent of Indicators rated Satisfactory: 77.78 %
Percent of Indicators rated Limited: 22.22 %
Percent of Indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Failed

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 70.59 %
Percent of indicators rated Limited: 17.65 %
Percent of indicators rated Failed: 11.76 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Jeremy Curvan – Regional Monitor, Department of Juvenile Justice
Teresa Clove – Chief Executive Officer, Thaise Education and Exposure Tours

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, 2024).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	10	# Health Records
	Logbooks		Key Control Log	10	# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services		Precautionary Observation Logs	10	# Youth Records (Closed)
X	Egress Plans		Program Schedules	3	# Youth Records (Open)
	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline		Staff Supervision of Youth
X	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
	Recreation		Toxic Item Inventory & Storage		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	2	# of Direct Staff		# of Other		

Comments

A Quality Improvement Program Review was conducted for FY 2024-2025.

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 community counseling services.

Narrative Summary

Tampa Housing Authority (THA) provides individual, case management, and family services for youth and their families in Circuit 13, Hillsborough County. The CINS/FINS program is managed by a program manager who oversees two treatment supervisors, a subcontracted part-time therapist, and six local university interns. The agency also contracts a licensed clinical social worker (LCSW) and employs a data manager who assists on a part-time basis with data entry for the CINS/FINS program. The program experienced significant staffing changes over the past year. At the time of the last QI review, the program manager's position was filled in April 2024 and the treatment supervisor positions were occupied in April and May of 2024. There is a Ph.D. clinician who is contracted to provide the entire staff with clinical supervision.
At the time of this onsite Quality Improvement program review, the agency does not have any vacancies. The THA is currently working to develop new and re-established partnerships with the local schools. The THA has recently created a partnership with the University of West Florida for interns.

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 with Exception.**
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 **Limited**.
Indicator 1.05 Analyzing and Reporting Information was rated **Failed**.
Indicator 1.06 Client Transportation was rated **Not Applicable.**
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 **Limited.**
Indicator 2.03 Case/Service Plan was rated **Limited**.
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory.**
Indicator 2.05 Counseling Services was rated **Satisfactory.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory with Exception.**
Indicator 2.07 Youth Records was rated **Satisfactory**.
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**.
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

Standard 4: There is one applicable indicator for Standard 4.
Indicator 4.02 Suicide Prevention was rated **Failed.**

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

Standard 1:

Indicator 1.04 Limited

Seven of the eight reviewed staff member files did not have one of the required pre-service trainings; CCC and Incident Reporting training. One staff member's file was also missing Child Abuse Report pre-service training. Seven of the eight training files did not contain all the required training within the 90-day timeframe; one staff file was missing Child Abuse Recognition, Reporting, and Prevention (Skill Pro), and one staff member's file was missing Civil Rights and Federal Funds (Skill Pro). There was no evidence that the FL Statute 984 CINS Petition Training had been provided to the agency by the local DJJ Attorney for any of the staff files reviewed. At the time of this review, the agency does not have a designated individual responsible for managing individual training files or all staff members.

Indicator 1.05 Failed

The program does not formally conduct case record reviews. There was no evidence of this being conducted on a quarterly basis. The program has no evidence of any review of customer satisfaction data. No evidence of the program conducting an annual review of customer satisfaction data. The agency does not have a process in place to review and improve the accuracy of data entry and collection. No evidence of documentation that findings and performance are regularly reviewed by management and communicated to staff members (meeting minutes) stakeholders and the Board of Directors. There was no evidence that strengths and weaknesses were identified, improvements were implemented or modified, or that staff were informed and involved throughout the process.

Standard 2:

Indicator 2.02 Limited

All 10 files did not have evidence of the supervisor's signature on the Nirvana Assessment forms after the counselor completed the assessment. Two out of the three closed cases did not have a Post Nirvana Assessment completed at discharge as required.

Indicator 2.03 Limited

Two out of the 10 electronic case files were missing the guardian signatures. None of the 10 electronic case files had the supervisor's signatures on the case/service plans.

Standard 4:

Indicator 4.02 Failed

None of the files contained evidence of the suicide screening indicating the documents were reviewed and signed by the supervisor and documented in each youth’s case file. Each case did not have direct clinical supervision regarding youth identified with suicide risk. The assessments did not contain proof of supervisor's or clinician's review immediately following the identification of suicide risk. No evidence of immediate action being taken by the agency following the youth's identification of suicide risk to be referred for necessary suicide prevention assistance. No evidence of documentation of available resources in the community being documented as given to the youth and their families for necessary suicide prevention assistance. There was no documented evidence in the file that school authorities were notified when youth screened positive for suicide risk while on school property during school hours.

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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has a policy number 1.01 and is called Background Screening of Employees/Volunteers. The policy meets the requirements of the general indicator. The policy was reviewed and approved by the organization's Program Manager October 2024.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Eight staff member files were reviewed which consisted of six interns and two full time staff. The six intern staff member files were not applicable. As of the date of this onsite program review, none of intern staff were assigned to provide direct care service to clients. The two full time staff members completed their 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.	**Not Applicable**	No staff members were applicable for review of this item.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**Not Applicable**	No staff members were applicable for review of this item.	
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**	Eight staff members files were reviewed and confirmed a background screening was completed prior to the date of hire.	

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**Not Applicable**	No staff members were applicable for review of this item.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Exception**	The program manager submitted the Annual Affidavit of Compliance on November 4th, 2024. This is evidenced by an email sent to the Florida Department of Juvenile Justice (DJJ) Background Screening Unit on November 4, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Two staff member files reviewed were appliable, and both had proof of E-verify 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 policy is 1.02 and called Abuse Free Environment. The policy meets the requirements of the general indicator except for a code of conduct for staff to review an agency Code of Conduct document. The policy was reviewed and approved by the organization's Program Manager in October 2024.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Exception**	An interview with the Program Manager was conducted regarding the agency's Code of Conduct. The agency provided power point presentation of the agency's Code of Conduct. Each staff receive this during their initial orientation training provided by the Human Resources Department.	The agency was not able to provide evidence of each staff member receiving Code of Conduct training include the date and name of staff who received the training.
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency reported two child abuse calls in the last six months. One abuse call was reported on August 13, 2014 (medical neglect). The second abuse call was reported on August 16, 2014 (verbal abuse and possible child endangerment). A Treatment Supervisor called in both abuse calls to the call center.	
Youth were informed of the Abuse and Contact Number	**Compliance**	All youth receive a client safety agreement during the Intake process with the parent and child.	
Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	**Compliance**	The agency has a Tampa Housing Authority Youth and Family Services Client/Family Grievance Policy form. The youth and family is given information and instructions on how to report a grievance.	

Shelter only: Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	Not applicable for community counseling programs.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Not Applicable**	Not applicable for community counseling programs.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	**Not Applicable**	Not applicable for community counseling programs.	
Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	**Not Applicable**	Not applicable for community counseling programs.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency policy is 1.03 and called Incident Reporting. The policy meets the overall requirements of the indicator. The policy was reviewed and approved by the organization's Program Manager October 2024.	
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**No eligible items for review**	During the past 6 months, the program has not reported any incidents to the DJJ Central Communication Center (CCC).	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**	There were no applicable items for the review of this indicator.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**No eligible items for review**	There were no applicable items for the review of this indicator.	
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**	There were no applicable items for the review of this indicator.	
All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**	There were no applicable items for the review of this indicator.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency policy is 1.04 and its titled Training. The policy meets the overall requirements of the indicator. It was reviewed and approved by the organization's Program Manager in October 2024.	
First Year Direct Care Staff			
All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following: • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties.	**Exception**	Eight staff member files were reviewed during the annual compliance review.	Seven of the eight files reviewed did not have training completed for the DJJ CCC & Incident Reporting during pre-service training. One staff member file reviewed did not have training completed for Child Abuse reporting during pre-service training.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Seven of the eight files reviewed provided evidence the United Stated Department of Justice (DOJ) Civil Rights and Federal Funds training was completed within thirty days from the date of hire.	One file reviewed did not show evidence the training was completed within the required timeframe.
All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	**Not Applicable**	A review of eight staff member files was conducted. None of the staff files reviewed have been employed for a full year. All staff members are still within their first year of employment and have adequate time to complete the remaining required training hours.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A review of eight staff member files was conducted. One staff member file contained evidence of receiving CCC and Incident reporting training.	Seven of the eight reviewed staff member files did not have CCC and Incident Reporting training. One staff member's file was missing Child Abuse Report training. One staff member file was missing Child Abuse Recognition, Reporting, and Prevention (Skill Pro). One staff member's file was missing Civil Rights and Federal Funds (Skill Pro).
Non Licensed Staff Assisting with Medication Distribution			
Any staff without a medical license that assists with Medication Distribution received in-person training from a Registered Nurse prior to administering medication to a shelter youth.	**Not Applicable**	None of the staff member files reviewed administer medication to shelter youth.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Not Applicable**	None of the staff member files reviewed utilize NETMIS.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).*	**Exception**	All eight staff member files reviewed confirmed there was no documentation FL Statute 984 CINS Petition Training by a local DJJ Attorney had been completed.	No evidence that the FL Statute 984 CINS Petition Training has been provided to the agency by the 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**	The agency operates a non-residential program. This indicator is not applicable.	

In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	**Not Applicable**	The agency operates a non-residential program. This indicator is not applicable.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Not Applicable**	All current non-residential direct service staff have been employed less than a year.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(E.g. the program has a DCF child caring license).*	**Not Applicable**	The agency operates a non-residential program. This indicator is not applicable.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency provides training across three methods of delivery which include DJJ Skill Pro, Florida Network Bridge, and in-house training provided by the Tampa Housing Authority for all pre-service and in-service training requirements.	
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 manager is responsible for managing all employee's individuals receiving training. The program manager compiled a spreadsheet for pre service trainings, skill pro trainings and bridge trainings. However, it is evident the program manager is not accurately tracking and reviewing staff files because of the number of missing trainings.	At the time of this review, the agency does not have a designated individual responsible for managing individual training files or all staff members.
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains training files for each staff member. Each training file contained a Florida Network training log with all required categories including topic, hours, certificates, agendas, and sign-in sheets. There is evidence certificates of completion or training for completed training courses**.**	
All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:		At the time of this onsite program review, two employee files reviewed confirmed the treatment supervisors had completed the training. However, the six interns had not because the program doesn't administer Naloxone.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency policy is 1.05 and titled Analyzing and Reporting Information. The policy meets the general requirements of the indicator. The policy was reviewed and approved by the organization's Program Manager October 2024.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. *(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)*	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice during the period of review.	The program does not currently conduct routine case record reviews to assess the accuracy, completion and evaluation to determine if cases meet minimum requirements.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	At the time of this review, the agency reported there have been no incidents, accidents or grievances. The agency does have a process in place to ensure the aforementioned occurrences are documented and reviewed on a quarterly basis.	
The program conducts an annual review of customer satisfaction data	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice.	The program has no evidence of any review of customer satisfaction data.
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice.	No evidence of program conducting an annual review of customer End of Month data report.
The program has a process in place to review and improve accuracy of data entry & collection	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice.	The agency does not have a process in place to review and improve accuracy of data entry and collection.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice.	The agency does not have a process for providing proof of service delivery findings are regularly reviewed by management or communicated to staff 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.	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice.	No evidence of documentation that limited and failed report results are regularly reviewed by management and communicated to 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.	**Exception**	At the time of this onsite program review, the agency did not have evidence of any practice related to this indicator.	There was no evidence that strengths and weaknesses are identified, improvements are implemented or modified, or that staff are informed and involved throughout the process.
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency policy does not operate transportation services or provide transportation for clients.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Not Applicable**	The agency's CINS/FINS program does not transport clients.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Not Applicable**		
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Not Applicable**		
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Not Applicable**		
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Not Applicable**		
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Not Applicable**		
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			

1.07 - Outreach Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency policy is 1.07 and called Outreach. The policy meets the general requirements of the indicator. The policy was reviewed and approved by the organization's Program Manager October 2024.	
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The agency's Treatment Supervisors are primarily conducting outreach events. The agency is affiliated with the Circuit 13 Juvenile Justice Advisory Committee. A Treatment Supervisor provided evidence of attending one meeting. Evidence of attending a September 2024 meeting and training were provided onsite.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Agency provided and email dated October 15, 2024, from Chrysalis Health stating thank you for referring clients to their agency. The agency provided numerous written Memorandums of Agreement and partnership letters from various local area schools, system partners and community-base organizations. Information was provided via uploaded documents to document request portal.	
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 most recent meeting the agency provided proof of attending the September 20, 2024. Next meeting is scheduled for November 20, 2024. Community Outreach dates documented by the agency include 10/29/2024, 10/22/2024, 10/1/2024, 9/16/2024, 9/16/2024, 9/2/2024, and 8/9/2024.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Agency does have staff members conducting outreach events and activities. The agency does have evidence of proof that staff members are conducting outreach events and have this duty listed in their job description. The agency provided a sample of eight outreach events to demonstrate practice in this area.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The policy number is 2.01 and is called Screening and Intake. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	

Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Not Applicable**	The agency is does not provide residential services.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	A total of 10 client cases were reviewed. Of these files, six were open and four were closed cases. The eligibility form for the closed case was completed within 4 days of the referral and the eligibility for the opened cases was completed within 8 days of the referral.	Of the 10 cases, two cases were not completed within three days of confirmation of the referral.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	There were evidence from the screening log and electronic file that all cases were logged in within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	There is evidence on all the 10 electronic case files reviewed that the youth and parent signed a form acknowledging that they receive a written copy of the available service options, rights and responsibilities.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	There were evidence on all the 10 electronic case files reviewed that the youth and parent signed a form acknowledging that they receive a written copy of the possible action occurring through involvement with CINS/FINS services and information on the grievance procedure.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Exception**	There were 10 electronic case files reviewed for suicide at intake. There were two case files which answered yes to one of the five suicide questions indicating suicide risk. The agency is not using the updated Florida Network Suicide form. They are using an old Intake form that was updated with the five suicide questions. The agency uses this form to ask the suicide questions. Although, the Intake form had the five questions on it, it was not the Suicide Screening Form. On the two (2) case files that had a risk of suicide they used a National Institute of Mental Health Suicide Screening Tool that asked five different suicide questions. The screening form did not have the correct suicide questions on the form that Florida Network required the programs to use. The staff was given a copy of the new suicide screening form onsite and the new Intake form from Florida Network Partner Portal.	The current screening form being used by the agency did not have the correct suicide questions on the form that Florida Network required the programs to use. The agency must review the FNYFS policy and update the current suicide risk prevention tool with the correct suicide risk questions.
Additional Comments: **There are no additional comments for this indicator.**			

2.02 - Needs Assessment			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The policy number is 2.02 and is called Needs Assessment. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	The agency does not provide residential services.	
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**	There were 10 electronic case files reviewed, 6 opened and 4 closed. Of the 10 cases, all the Nirvana Assessment were completed within 2 to 3 face to face contact with the family as evident by the date and signature of the counselor on the Nirvana Assessment form.	
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.	**Exception**	There were 10 electronic case files reviewed. The supervisor did not sign any of the Nirvana Assessment forms after the counselor completed the assessment.	All 10 files did not have evidence of the supervisor's signature on the Nirvana Assessment forms after the counselor completed the assessment.
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Not Applicable**	The agency does not provide residential services.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Exception**	Of the 10 electronic case files reviewed, there were four closed cases. One out of the four closed cases had a Post Nirvana Assessment completed at discharge. One was not completed due to the client leaving town before services began, therefore the Post Nirvana Assessment was left blank in the electronic case file.	Two out the three closed cases did not have a Post Nirvana Assessment completed at discharge.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Out of the 10 electronic case files reviewed, there were no Nirvana Re-Assessments completed due to all the cases being opened and closed prior to 90 days. Therefore, no Nirvana Re-Assessment were required.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	The 10 electronic case files had a printed Nirvana Assessment in all the electronic case files.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The policy number is 2.03 and is called Case Service Plan. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
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**	After reviewing 10 electronic case files all the case/service plan were developed on the local provider's form that were based on information gathered from the screening, intake and Nirvana Assessment as evidence by the information on these aforementioned forms.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All 10 electronic case files that were reviewed had the Case /Service plans generated within seven days of completing the Nirvana Assessment. Seven out of 10 completed them on the same day and two were completed within two days of the Nirvana Assessment and one was completed within three days of the Nirvana Assessment.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Eight out of the 10 electronic case files contained evidence of the guardian signatures. All the electronic case files case/service plans were individualized, the needs were prioritized, and the goals were identified as it was described on the Nirvana Assessment. The Case/Service Plans included the service type, frequency, location, person responsible, target dates of completions and actual completion dates for those that had completed. The Case/Service Plan included the youth and counselor's signatures and it included the date the plan was initiated.	Two out of the 10 electronic case files were missing the guardian signatures. The treatment supervisor stated that she discussed the case/ service plan over the phone with the guardians, however, there was no evidence of notes indicating the counselor had a discussion regarding the case/service plan with the guardian. None of the 10 electronic case files had the supervisor's signatures on the case/service plans.
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**	The case/service plans were reviewed for progress every 30 days as required for the first three months as seen on the case/service plan reviews. There were no cases held open over three months.	
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 Case Management and Service Delivery. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
Counselor/Case Manager is assigned	**Compliance**	There were 10 electronic case files reviewed and all the case files were assigned a counselor/Treatment Supervisor as evidence by the counselor's name and signature listed on the case file forms and case notes.	
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	**Compliance**	The electronic case files indicated in the progress notes and discharge summary that the counselors were implementing and coordinating services, monitoring the youth/family progress, providing support to the family and providing termination notes at discharge. There were no court ordered youth, no youth that were referred to case staffing, and no families referred for additional service. There were no 30 or 60 day follow-ups due for the 4 closed cases.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency provided proof of an extensive list of partnership agreements from local service providers located throughout the Tampa area during the audit. The agency submitted more than a dozen agreements as evidence of their existing partnerships with local agencies and organizations.	
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 and is titled Counseling Services. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
Shelter Program			
Shelter programs provides individual and family counseling	**Not Applicable**	Not applicable for community counseling programs.	
Group counseling sessions held a minimum of five days per week	**Not Applicable**	Not applicable for community counseling programs.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Not Applicable**	Not applicable for community counseling programs.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Not Applicable**	Not applicable for community counseling programs.	
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**	There were 10 electronic case files reviewed, 6 opened and 4 closed. All the case files provided community-based services to the client and their families designed to provide intervention services in order to stabilize the family as indicated in the case notes and case files. The services were provided in the home, in school and in the community as evidence by the case notes and the service plan where it indicated the location of the services.	
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**	There were clinical notations indicating the Treatment Supervisors were meeting with the clinical staff weekly addressing presenting problems, assessments, reviews, and case management.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All case files are securely maintained electronically in an one drive on the agency's tablet. Access is password protected and backed up.	

Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All electronic case files reviewed contained evidence notes with proof of the current status of progress of the case and all services provided or challenges associated with working with youth and family.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	There were clinical notations indicating the Treatment Supervisors were meeting with the clinical staff weekly to discuss the case records and performance.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	None of the 10 electronic case files were completed virtually as evidence by the case notes, and youth/guardian signatures.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy 2.06 and is titled Adjudication/Petition Process. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The agency reported no clients were required case staffing services in the last six months. The agency is prepared to refer clients in need of this service to other CINS/FINS programs in the service area.	
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 agency reported no clients were required case staffing services in the last six months. The agency is prepared to refer clients in need of this service to other CINS/FINS programs in the service area.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	There were no youth staff for case staffings as reported by the counselors/Treatment Supervisors. There were no case staffing committee meetings attended nor do the staff have regular communication with the committee as reported by the counselors/Treatment Supervisor/Program Manager.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Exception**	The agency has an internal procedure for the case staffing process to refer to Hillsborough County Children Services but currently does not have a schedule to attend committee meetings.	The agency does not have a plan in place for addressing requests for case staffings. The agency does not have a staff person who has been trained and is familiar with the identification of youth who qualify for this service.
The youth and family are provided a new or revised plan for services	**No eligible items for review**	There were no revised plan for service to review due to not having a case to staff with the case staffing committee.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The agency reported no clients were applicable for a case staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The agency reported no clients were applicable for a case staffing.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency reported no clients were applicable for a case staffing.	
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 and is titled Youth Records. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
All records are clearly marked 'confidential'.	**Not Applicable**	All case files are kept electronically in a one drive on the agency's tablet.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Not Applicable**	All case files are kept electronically in a one drive on the agency's tablet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The agency reported that there is a process when files are transported outside of the office. The agency reported they have a locking case which is marked confidential and is used when files are needed outside of the office.	
All records are maintained in a neat and orderly manner	**Compliance**	The agency's records are maintained and are neat and orderly on an electronic case file.	

SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Not Applicable**	Not applicable for community counseling programs.	
COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	**Compliance**	The Community Counseling files contain the table of contents with all the required documents.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Compliance**	The records that are kept electronically are maintained securely and were made immediately available to the auditors onsite upon request.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	The counselor's/Treatment Supervisor's reported and showed proof that the records are kept as required by the contract.	
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 and is titled Specialized Additional Program. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
Staff Secure			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**Not Applicable**	The Agency does not have an Additional Specialized Program Services.	

Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Not Applicable**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**Not Applicable**		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**Not Applicable**		
Agency provides a written report for any court proceedings regarding the youth's progress	**Not Applicable**		
Domestic Minor Sex Trafficking (DMST)			
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**	Tampa Housing Authority is not contracted to provide Domestic Minor Sex Trafficking services.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**Not Applicable**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**Not Applicable**		
Services provided to these youth specifically designated services designed to serve DMST youth	**Not Applicable**		

Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**Not Applicable**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**Not Applicable**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**Not Applicable**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Domestic Violence			
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**	Tampa Housing Authority is not contracted to provide Domestic Violence services.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Not Applicable**		
Data entry into NetMIS within (3) business days of intake and discharge	**Not Applicable**		
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Not Applicable**		
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Not Applicable**		
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		

Probation Respite			
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**	Tampa Housing is not contracted to provide Probation Respite services.	
All probation respite referrals are submitted to the Florida Network.	**Not Applicable**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Not Applicable**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Not Applicable**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Not Applicable**		
All case management and counseling needs have been considered and addressed	**Not Applicable**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		
Intensive Case Management (ICM)			
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**	Tampa Housing reported there were no applicable client cases available for review for intensive Case Management.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		

Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	Tampa Housing did not serve youth under FYRAC services during the period of review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		
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**		

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**		
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**		
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**		
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**		
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**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)			Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: Agency does not have a SNAP Program.	
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	**Not Applicable**		
All files contain **each** of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**		
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**		
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet (*This may be in progress for open files but is required for all closed files.*)	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**		
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**Not Applicable**		

The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	**Not Applicable**		
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**		
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Not Applicable**		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.	**Not Applicable**		
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Failed
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 and is titled Suicide Prevention. The policy meets the general requirements of the indicator. The updated policy was reviewed and approved in October 2024 by the agency's Program Manager.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Exception**	A review was conducted for all cases in the last six months that indicated positive for suicide risk during the intake process. The agency provided evidence of two closed community counseling cases. None of the cases had evidence of supervisor reviews.	None of the files contained evidence of the suicide screening indicating the documents were reviewed and signed by the supervisor and documented in each youth's case file.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency reported it has not made any changes to its current suicide risk assessment documents and forms which would require approval from the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Not Applicable**	Not applicable for community counseling programs.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Not Applicable**	Not applicable for community counseling programs.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Not Applicable**	Not applicable for community counseling programs.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Not Applicable**	Not applicable for community counseling programs.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Not Applicable**	Not applicable for community counseling programs.	

Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Exception**	A review of two files screened for suicide risk indicated both were positive for suicide. Screening results were conducted on school property and required notification to clinical authorities. There is evidence of only the parent being notified following youth indicating positive for suicide risk. Counselors consulted the clinician on the status of the youth and sought guidance on how to proceed.	Each case did not have direct clinical supervision regarding youth identified with suicide risk. The assessments did not contain proof of supervisor's or clinician's review immediately following the identification of suicide risk.
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Exception**	Following the completion of the suicide risk screening, the parents of both youth were notified of the suicide risk finding. However, at a later time, staff members were instructed by clinician to go to the home on youth and then assist child in being admitted to a local mental receiving facility. The youth was then Baker Acted and immediately admitted to the facility.	No evidence of immediate action being taken by the agency following the youth's identification of suicide risk to be referred for necessary suicide prevention assistance.
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.	**Exception**	No evidence of information resources in the local community related to suicide prevention being provided to youth, parent and families were found in the client file.	No evidence of documentation of available resources in the community being documented as given to the youth and their families for necessary suicide prevention assistance.
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	In both cases reviewed, parents were notified as required.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Exception**	In one of the two cases, the youth was screened positive for suicide on school property and evidence of school officials being notified were not documented.	There was no documented evidence in the file that school authorities were notified when youth screened positive for suicide risk while on school property during school hours.
Additional Comments: **There are no additional comments for this indicator.**			