



**Florida Network for Youth and Family Services
Compliance Monitoring Report for**

Thaise Educational & Exposure Tours – Jacksonville

728 Blanche St, Jacksonville, FL 32204

April 2, 2025

Compliance Monitoring Services Provided by



EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Thaise Educational & Exposure Tours (Thaise Jacksonville) for the FY 2024-2025 at its program office located at 728 Blanche St, Jacksonville, FL 32204. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Thaise Jacksonville is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 1, 2024 through June 30, 2025.

The compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from Thaise Jacksonville present for the entrance interview included Teresa Clove, MS, Chief Executive Officer; and Blondell Clove; Administrative Assistant. The last onsite QI visit was conducted on April 11, 2024.

In general, the Reviewer found that the Thaise Jacksonville program is in compliance with specific contract requirements. Thaise Jacksonville received **an overall compliance rating of 100% for achieving full compliance** with 10 applicable indicators of the CINS/FINS Monitoring Tool. There are no corrective actions cited or recommendations made as a result of the contract 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 4-02-2024-2025

Agency Name: Thaise Educational & Exposure Tour (Jacksonville)					Monitor Name: Keith Carr, Lead Reviewer						
Contract Type : CINS/FINS					Region/Office: 728 Blanche St, Jacksonville, FL 32204						
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): April 2, 2025						
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.					<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The Thaise agency has four certified peer reviewers in total. The certified peer reviewers for the Thaise Jacksonville program location are: Teresa Clove who is a floater for all three locations and Cyntoria Thomas. Two of the two peer reviews have participated in reviews this season.	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					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Documentation: At the time of this on-site program review, the agency reported two additional contracts (county and state). The list included: awarding entity, award amount, description of services, and contract start & end dates.	Not Applicable. 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					<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: United States Liability Insurance Company provides commercial liability. The coverage limits are \$1,000,000 per occurrence, personal & advertising injury limit	No recommendation of corrective action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

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Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation/Interview: The agency uses an external bookkeeper to maintain fiscal practice. Procedures are maintained in the agency's Accounting Policies and Procedures Manual which are general and provide for limited internal controls. The Accounting Policies and Procedures were dated as last reviewed during FY December 2023.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation/Interview: The agency maintains a detailed general ledger with corresponding source documents. The agency's general ledger is structured to rack all funding sources. The agency also provided a statement of assets, liabilities, and a statement of revenue and expenses. Documents submitted by the agency included the General ledger (GL) for Periods: from September 2024 through February 2025.	No recommendation of corrective action.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Documentation: Per the agency policy, Petty Cash Fund, the program states	Not Applicable. No recommendation of corrective action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – ON SITE						they do not have a petty cash ledger system at this time. The policy was last reviewed January 7, 2025 and signed by the Board.	
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. (Disbursements/invoices are approved & monitored by management). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation/Interview: The agency maintains bank reconciliation documents. The bank documents track all expenditures for the last six months. Documents submitted by the agency include the organization's actual expenses for Periods: August 2024 through February 2025.	No recommendation of corrective action.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interview: The agency's CEO reported that Thaise has not made any purchases over \$1000.00.	No recommendation of corrective action.
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: A review of the past year of quarterly tax returns was conducted of Quarter three and four of 2024 (July, August, September, October, November and December).	No recommendation of corrective action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS							
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency has policies named record storage and retention disposal. The policy addresses the security of all client files and computers. and disposal of records. Personal information is not easily accessible, and the agency maintains a backup system in case of accidental loss of financial information. The agency's policy lists record retention timeframes and states disposal protocol will be according to the granting agency's requirements. The policy was reviewed and approved on August 21, 2024, and reviewed and approved again in the board meeting on January 7, 2025	No recommendation of corrective action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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CONCLUSION

Thaise St Jacksonville has met the requirements for the CINS/FINS contract as a result of full compliance with seven out of ten applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Four out of fourteen compliance indicators were not applicable which included: Additional Contracts; External/Outside Contract Compliance; Petty Cash System; and Annual Audit. There are no corrective actions cited as a result of the contract monitoring visit. Overall, **the agency is performing at a 100% compliance rating in meeting the fiscal and administrative terms of its contract.** In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report's findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

None.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.



Florida Network of Youth and Family Services Quality Improvement Program Report

Thaise Educational and Exposure Tours - Jacksonville
CINS/FINS Program

Date: April 2, 2025

Compliance Monitoring Services Provided by

 FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Not Applicable
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
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Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 100 %

Percent of indicators rated Limited: 0 %

Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
LeAnn Gruentzel – Regional Monitor, Department of Juvenile Justice
Christina Baker, LCSW, Residential Counselor, Lutheran Services Florida Northwest

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

<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Chief Executive Officer Chief Financial Officer Chief Operating Officer Executive Director Program Director Program Manager Program Coordinator Clinical Director Counselor Licensed 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Case Manager Counselor Non-Licensed Advocate Direct – Care Full time Direct – Part time Direct – Care On-Call Intern Volunteer Human Resources 	<ul style="list-style-type: none"> Nurse – Full time Nurse – Part time # Case Managers # Program Supervisors # Food Service Personnel # Healthcare Staff # Maintenance Personnel 1 # Other (listed Administrative Assistant)
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Documents Reviewed

<ul style="list-style-type: none"> Accreditation Reports <input checked="" type="checkbox"/> Affidavit of Good Moral Character CCC Reports Logbooks Continuity of Operation Plan <input checked="" type="checkbox"/> Contract Monitoring Reports <input checked="" type="checkbox"/> Contract Scope of Services <input checked="" type="checkbox"/> Egress Plans Fire Inspection Report Exposure Control Plan 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Table of Organization Fire Prevention Plan Grievance Process/Records Key Control Log Fire Drill Log Medical and Mental Health Alerts Precautionary Observation Logs Program Schedules List of Supplemental Contracts Vehicle Inspection Reports 	<ul style="list-style-type: none"> Visitation Logs <input checked="" type="checkbox"/> Youth Handbook # Health Records # MH/SA Records 4 # Personnel /Volunteer Records 4 # Training Records # Youth Records (Closed) # Youth Records (Open) # Other: ___
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Observations During Review

<ul style="list-style-type: none"> Intake Program Activities Recreation Searches Security Video Tapes Social Skill Modeling by Staff Medication Administration 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Posting of Abuse Hotline Tool Inventory and Storage Toxic Item Inventory & Storage Discharge Treatment Team Meetings Youth Movement and Counts Staff Interactions with Youth 	<ul style="list-style-type: none"> Staff Supervision of Youth Facility and Grounds <input checked="" type="checkbox"/> First Aid Kit(s) Group Meals <input checked="" type="checkbox"/> Signage that all youth welcome Census Board
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Surveys

<ul style="list-style-type: none"> 0 # of Youth 	<ul style="list-style-type: none"> 2 # of Direct Staff 	<ul style="list-style-type: none"> # of Other
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April 2, 2025

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

The Thaise Educational & Exposure Tours agency has three locations across the state of Florida including Jacksonville, Orlando, and St. Petersburg. The North Florida program (Thaise Jacksonville) is located on 927 South Goldwyn Avenue, Orlando. The central Florida program (Thaise Jacksonville) is located at 728 Blanche St, Jacksonville, FL 32204. The agency is managed by a Executive Director and there are two Case Managers, one Intern and Data Clerk employed at this site. Thaise Jacksonville currently has no vacancies at the time of the review. The agency's Executive Director oversees the operations at a total of three (3) Thaise locations. The Thaise Jacksonville program ensures that level 2 background screening is a mandatory requirement for all employees and volunteers, working with direct access to youth, to guarantee they meet statutory requirements of good moral character as required in s.435.05, F.S. The Thaise Jacksonville program has partnerships with several local community-based and system organizations.

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

Standard 1: There are seven indicators for Standard 1.

Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**.

Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory**.

Indicator 1.03 Incident Reporting was rated **Satisfactory**.

Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**

Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**.

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/Satisfactory**.

Indicator 2.02 Needs Assessment was rated **Satisfactory**.

Indicator 2.03 Case/Service Plan was rated **Satisfactory**.

Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**.

Indicator 2.05 Counseling Services was rated **Satisfactory/Satisfactory**.

Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.

Indicator 2.07 Youth Records was rated **Satisfactory**.

Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**.

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 **Satisfactory**.

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

Not Applicable.

CINS/FINS QUALITY IMPROVEMENT TOOL		
Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability		
1.01: Background Screening of Employees, Contractors and Volunteers		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	YES	
	If NO, explain here:	
	The agency has a policy titled 1.01 Background Screening of Employees/Volunteers. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	Compliance	The program has a policy and procedure requiring all staff members to pass a pre-assessment tool, which score for suitability. The program utilizes the tool HR Avatar. Two applicable staff member records confirmed the both staff passed the pre-employment suitability assessment.
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	Both applicable staff members successfully passed the initial suitability assessment, therefore did not need to complete a retake.
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	None of the reviewed staff records indicated a break in serviced for eighteen months or more.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. <i>(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.)</i>	Compliance	The program hired two new staff members since the last annual compliance review . Both staff members received an initial background screening prior to hire date.

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	Compliance	The program had one staff eligible for a five-year background rescreening during the annual compliance review period. The reviewed staff record confirmed the staff had a five-year rescreening completed as required	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	Compliance	The program completed and submitted the Annual Affidavit of Compliance on February 24, 2025, within the required timeframe.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	Compliance	Two applicable reviewed staff member records confirmed the program obtained an E-verify for both staff.	
Additional Comments: There are no additional comments for this indicator.			
1.02: Provision of an Abuse Free Environment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	YES		
	If NO, explain here:		
	The agency has a policy titled 1.02 Provision of an Abuse Free Environment. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	Compliance	The program has a policy and procedure for code of conduct for staff members to follow. One policy is required for staff members to be reviewed and sign the day of hire during onboarding. A review of two new hires confirmed the program reviews the code of conduct during new staff orientation as well as staff signing a code of conduct.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	The program has a policy and procedure in place for reporting and documenting child abuse calls to the Florida Abuse Hotline. The program did not have any calls made to the abuse hotline nor were any reviewed documentation found of a need for the program to report any abuse. The program maintains a log , if needed, for abuse and incident calls.	
Youth were informed of the Abuse and Contact Number	Compliance	The program provides youth with a handbook which has the Florida Abuse Hotline number. This information is reviewed with the youth during orientation.	
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 program has a policy and procedure which outlines the grievance process for youth. The program maintains a log , if needed, for youth grievances. The interviewed CEO stated the youth have access to grievance forms, if needed, and a grievance box is located in the administration office. The program also completes surveys which are used to gauge any possible grievances from staff, legal guardians, and/or youth.	

Shelter only: Grievances are maintained on file at minimum for 1 year.	Not Applicable	This program is a non-residential community program, therefore not applicable.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	Not Applicable	This program is a non-residential community program, therefore not applicable.	
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	This program is a non-residential community program, therefore not applicable.	
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	This program is a non-residential community program, therefore not applicable.	
1.03: Incident Reporting			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	YES		
	If NO, explain here: The agency has a policy titled 1.03 Incident Reporting. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	No eligible items for review	The program has a policy and procedure to contact the Department's Central Communication Center for any reportable incident. The program did not have any incidents which required a call to the CCC for the annual review compliance period, therefore not applicable.	
The program completes follow-up communication tasks/special instructions as required by the CCC	No eligible items for review	The program did not have any incidents which required a call to the CCC for the annual review compliance period, therefore not applicable.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	No eligible items for review	The program did not have any incidents which required a call to the CCC for the annual review compliance period, therefore not applicable.	
Incidents are documented in the program logs and on incident reporting forms	No eligible items for review	The program did not have any incidents which required a call to the CCC for the annual review compliance period, therefore not applicable.	

All incident reports are reviewed and signed by program supervisors/ directors	No eligible items for review	The program did not have any incidents which required a call to the CCC for the annual review compliance period, therefore not applicable.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	YES		
	If NO, explain here:		
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: 1.04; CEO Clove; reviewed 2/5/24; approval 1/7/25.		
First Year Direct Care Staff			
<p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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. 	Compliance	Two training records were applicable for review during the annual compliance review period. One training record was for a staff member and the other was for an intern. Both records indicated both team members received and completed all required orientation training courses in the required timeframes.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	Compliance	Both applicable staff members completed the Civil Rights and Federal Funding training within thirty days of being hired.	

<p>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.</p>	<p>Not Applicable</p>	<p>Neither staff member has been hired for a full year, therefore not applicable for completing the minimum number of hours. One staff has completed fifty-eight and a half hours and the other sixty-seven and a half hours in the six months of hire. No other staff was applicable for review.</p>	
<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p>Exception</p>	<p>Two applicable staff were reviewed for mandatory training during the first ninety days of hire. One staff completed all required trainings within ninety days. The other staff was an intern and the education program states students are not allowed to be on-site when school is not in session. There was a break from December 3, 2025 to January 13, 2025, therefore the ninety-days was extended to February 3, 2025. Due to this, the only two trainings which would be considered late would be Understanding Diversity, being twenty-four days late, and Administration of Naloxone (Narcan), being fifty-six days late.</p>	<p>One staff was missing Understanding Diversity and Administration of Naloxone (Narcan).</p>
<p>Non Licensed Staff Assisting with Medication Distribution</p>			
<p>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.</p>	<p>Not Applicable</p>	<p>The reviewed program is a non-residential community program which does not administer medication, therefore not applicable.</p>	
<p>Staff that are Utilizing NETMIS</p>			
<p>Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.</p>	<p>Compliance</p>	<p>Only one reviewed training record was applicable for NETMIS training. The one staff is in the process of completing the training. Reviewed documentation confirmed only staff who have completed NETMIS training, as verified by evidence in their training record, are utilizing NETMIS.</p>	
<p>Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)</p>			
<p>Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney <u>within 1 year of employment or no later than 7/1/24 if hired before 7/1/23.</u> (Policy went into effect 7/1/23).</p>	<p>Not Applicable</p>	<p>Neither reviewed pre-service training records were applicable for completion of the Petition Training for they are both are still within a year of being hired.</p>	
<p>Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)</p>			
<p>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).</p>	<p>Not Applicable</p>	<p>The reviewed program is a non-residential community program which does not require mental health staff members.</p>	

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.	Compliance	A review of the program's staff roster found only two staff are applicable for in-service or on-going staff member training. Both in-services or on-going staff members had all required in-service annual or two-year mandatory trainings within the required timeframes.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	Compliance	Both reviewed staff members completed over twenty-four hours of mandatory trainings, with one staff completing forty-nine and a half hours and the other staff completing forty and a half hours.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually (<i>E.g. the program has a DCF child caring license</i>).	Not Applicable	The reviewed program is a non-residential community program, therefore 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	Reviewed both pre-service and in-service staff member training plans and each included all required training topics.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	Compliance	The program's CEO is the designated staff member responsible for maintaining all employee's individual training records and completes routine tracking and reviews of staff records to ensure compliance.	
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	Both reviewed training records included a training log and certifications. The training log tracked the staff training hours.	
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:		Both reviewed staff members have completed the Naloxone training.	
Additional Comments: There are no additional comments for this indicator.			
1.05 - Analyzing and Reporting Information			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	YES		
	If NO, explain here:		
	The agency has a policy titled 1.05 Analyzing and Reporting. The policy meets the general requirements. The policy was last reviewed and approved by the Executive Director and the Thaise Board of Directors on January 7, 2025.		

<p>Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(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.)</i></p>	<p>Compliance</p>	<p>The reviewer interviewed the CEO/ED for information on this indicator. The agency reported the administrative assistant reviews the client files to ensure that all forms are completed as required and includes all forms screening, NIRVANA, and case file format list. The form used to complete this review is called Supervisor and peer case file Review. The results of this review are staffed with the program Managers (2) and the staff person that is assigned the case. The CEO conducts supervision sessions with each Case Manager/Mentors and then also discusses findings and recommendations during monthly staff meeting. The review includes a review of case file records session with each Case Manager. Findings on grievances or incidents are discussed on a monthly basis. A summary of the case file review report results is reviewed with staff members on a monthly basis.</p>	
<p>The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum</p>	<p>Compliance</p>	<p>The agency reported there were no formal grievances or incidents reported by the CEO. In the event that the agency has findings, the agency would conduct a review of the issues cited in the monthly program managers meeting. Each program manager then discusses issues with all direct service staff. All findings on grievances or incidents are discussed on a monthly basis.</p>	
<p>The program conducts an annual review of customer satisfaction data</p>	<p>Compliance</p>	<p>The agency conducts reviews of customer service data responses on a monthly basis. The agency asks about services, grievances and incidents each month. The CEO reported that this is discussed monthly. The agency provided proof with copies of these discussions from October 2024-March 2025.</p>	
<p>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.</p>	<p>Compliance</p>	<p>The agency's CEO was interviewed and reported that EOMs from the FNYFS are reviewed monthly. The agency provided evidence of review of reviewing the EOM data on a monthly for all PMs. The agency then requires all PM to meet with their to discuss performance observations from meetings with CEO/ED and communicates those discussions with direct service staff at their monthly meetings.</p>	
<p>The program has a process in place to review and improve accuracy of data entry & collection</p>	<p>Compliance</p>	<p>The agency CEO reported that the agency reviews the NetMIS dashboard to see if their data is below the required minimum. The agency looks 30 Days, Intakes w/in 3days, Discharges, Screenings w/in 3 days, Satisfactory surveys, Follow Ups 30 and 60 days categories. The dashboard is the major method in which the agency monitors its performance and any areas of data entry that are below the standard.</p>	

<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p>Compliance</p>	<p>All agency program performance reports are regularly reviewed by the CEO and communicated to staff members and Board members. All major performance ratings less than Satisfactory are discussed and shared with staff members at regular staff meetings.</p>	
<p>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.</p>	<p>Compliance</p>	<p>All board member received Official Notice of the QI and then the report and any CAP responses.</p>	
<p>There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.</p>	<p>Compliance</p>	<p>Last year's April corrective action regarding QI indicator 2.01 from the THAISE Orlando site 2024 report. This report found an issue related to the screening for suicide that was present at one three Thaise program sites. As a result, the CEO required all three sites to address screening practices.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>1.06: Client Transportation</p>			<p>Not Applicable</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.06</p>		<p>YES If NO, explain here: The agency has a policy titled 1.06 Client Transportation. The policy meets the general requirements. The policy was last reviewed and approved by the Executive Director and the Thaise Board of Directors on January 7, 2025.</p>	
<p>Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle</p>	<p>Not Applicable</p>	<p>The agency does not transport clients as a part of the services provided to clients and families. All staff members are not allowed and strictly prohibited from transporting clients.</p>	
<p>Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy</p>	<p>Not Applicable</p>		
<p>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</p>	<p>Not Applicable</p>		
<p>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</p>	<p>Not Applicable</p>		
<p>The 3rd party is an approved volunteer, intern, agency staff, or other youth</p>	<p>Not Applicable</p>		

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	Not Applicable		
When transporting a single client in a vehicle, there was evidence documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals (as stated in policy) with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	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:		
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: 1.07; CEO Clove; reviewed 12/17/2023; approval 1/7/25.		
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 CEO/ED reported that she is the head staff member required to conduct outreach for the agency. All staff members are required to perform general outreach duties.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	Compliance	The agency provided copies of current Partnership Agreements.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	Compliance	All board members received Official Notice of the QI and then the report and any CAP responses. See NetMIS documents.	
The program has designated staff that conducts outreach which is defined in their job description.	Compliance	The agency requires that all program managers and case managers members perform general outreach duties. The CEO of the agency also utilizes case managers and the data clerk to conduct outreach only as a back up on an as needed basis.	
Additional Comments: There are no additional comments for this indicator.			

Standard Two – Intervention and Case Management		
2.01 - Screening and Intake		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01	YES	
	If NO, explain here:	
	The agency has a policy and procedure that meets the requirement for Indicator titled 2.01 Screening and Intake. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	Not Applicable	Not applicable.
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files had evidence that eligibility screenings were completed with 24 hours of receiving a referral.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files had evidence that eligibility screenings were logged in NetMIS within 72 hours of completion.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files had evidence that youth and parents/guardians received (in writing) service options available as well as rights and responsibilities of youth and parents/guardians.
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence that possible actions occurring through CINS/FINS involvement as well as the grievance procedures were made available to the youth and parent/guardians.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence that the youth were screened for suicidality and further assessed of required.
Additional Comments: There are no additional comments for this indicator.		

2.02 - Needs Assessment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02	YES	
	If NO, explain here:	
	The agency has a policy and procedure that meets the requirement for Indicator 2.02 titled 2.2 Network Inventory of Risks, Victories and Needs Assessment. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	Not Applicable	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake OR updated, if most recent assessment is over 6 months old	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence that the Nirvana is initiated at intake and completed within 2-3 face-to-face contacts.
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of supervisor signature on all completed Nirvana assessments.
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Not Applicable	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of a Nirvana post-assessment being completed at discharge on cases open more than 30 days.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	Not Applicable	Ten (10) files were reviewed, seven (7) closed and three (3) open. Three of 10 files had a NIRVANA Re-Assessment completed every 90 days excluding files for youth receiving SNAP services.
All files include the interview guide and/or printed NIRVANA.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of a printed copy of the completed Nirvana assessment.
Additional Comments: There are no additional comments for this indicator.		

2.03 - Case/Service Plan		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03	YES	
	If NO, explain here:	
	The agency has a policy and procedure that meets the requirement for indicator 2.03. The policy is titled 2.3 Case/Service Plan. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.	
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of a service plan developed on a provider-approved form with information gathered during the screening, intake, or Nirvana.
Case/Service plan is developed within 7 working days of NIRVANA	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of a service plan being developed with seven working days.
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of service plan including individualized goals identified by the Nirvana. Each of the ten files had service plans that included service type, frequency, and location; person responsible; target and actual completion dates; signature of youth, parent/guardian, counselor, and supervisor; date plan was initiated.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	Compliance	The reviewer reviewed 7 closed and 3 open files. Each of the ten files had evidence that service plans were reviewed for progress and revised as necessary every 30 days for the first 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 and procedure that meets the requirement for Indicator titled 2.04 Case Management and Service Delivery. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.	

Counselor/Case Manager is assigned	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of counselor or case manager being assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of referrals given (if applicable), coordination of service plan, monitoring of progress, support for families, case monitoring, termination notes, 30/60 day follow-up post discharge.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	Compliance	The agency's CEO/ED was interviewed and provided evidence of the written agreements and referral processes the agency has in place with community partners.	
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 and procedure that meets the requirement for Indicator titled 2.05 Counseling Services. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.		
Shelter Program			
Shelter programs provides individual and family counseling	Not Applicable	This does not apply to Community Counseling services.	
Group counseling sessions held a minimum of five days per week	Not Applicable		

<p>Groups are conducted by staff, youth, or guests and group counseling sessions consist of :</p> <ol style="list-style-type: none"> 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer 	<p>Not Applicable</p>		
<p>Documentation of groups must include date and time, a list of participants, length of time, and topic.</p>	<p>Not Applicable</p>		
<p>Community Counseling</p>			
<p>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.</p>	<p>Compliance</p>	<p>The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence that therapeutic community-based services are being provided in a variety of settings including: the youth's home, community locations, the provider's office, or virtually (if necessary and documentation explaining why virtual services are in the best interest of the child).</p>	
<p>Counseling Services</p>			
<p>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.</p>	<p>Compliance</p>	<p>The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence that the program reviews case files for coordination between presenting problem(s), psychosocial assessment, service plan, case management, and follow-ups..</p>	
<p>Maintain individual case files on all youth and adhere to all laws regarding confidentiality.</p>	<p>Compliance</p>	<p>The reviewer reviewed 7 closed and 3 open files. All ten files had confidentiality stamps on each side and all files are stored in the CEO/ED's locked office in locked filing cabinets labeled "confidential".</p>	
<p>Case notes maintained for all counseling services provided and documents youth's progress.</p>	<p>Compliance</p>	<p>The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of case notes documenting counseling services and the youth's progress.</p>	
<p>On-going internal process that ensures clinical reviews of case records and staff performance.</p>	<p>Compliance</p>	<p>The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of an internal process of clinical reviews being conducted on case records as well as staff performance.</p>	

<p>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.</p>	<p>Compliance</p>	<p>The reviewer reviewed seven closed and three open files. Of the ten files, five showed intakes were conducted virtually. All five of those files contained evidence of documentation describing the reason a virtual intake was in the best interest of the child..</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.06 - Adjudication/Petition Process</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.06</p>		<p>YES If NO, explain here: The agency has a policy and procedure that meets the requirement for Indicator 2.06 titled 2.6 Adjudication/Petition. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.</p>	
<p>Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative</p>	<p>Compliance</p>	<p>The agency has a policy that requires a case staffing committee to be convened within seven working days from receipt of a written request from the parent/guardian. The staffing committee includes the agency's case manager and the local school district. At the time of this onsite program review, the agency had no adjudication/petition cases in the past six months or back to the date of the last QI review.</p>	
<p>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</p>	<p>No eligible items for review</p>	<p>There were no files that met the criteria during the period of review.</p>	
<p>The program has an established case staffing committee, and has regular communication with committee members</p>	<p>Compliance</p>	<p>The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review. The agency has the required process to participate in case staffings with case staffing committee members as required.</p>	
<p>The program has an internal procedure for the case staffing process, including a schedule for committee meetings</p>	<p>Compliance</p>	<p>The agency has the required process to participate in case staffing committee meetings as required.</p>	
<p>The youth and family are provided a new or revised plan for services</p>	<p>No eligible items for review</p>	<p>The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.</p>	

Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	No eligible items for review	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	The agency has no adjudication/petition cases in the past six months or back to the date of the last QI review.	
Additional Comments: There are no additional comments for this indicator.			
2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	YES		
	If NO, explain here:		
	The agency has a policy and procedure that meets the requirements for Indicator titled 2.07 Youth Records. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.		
All records are clearly marked 'confidential'.	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files contained "confidential" stamps on the front and back sides.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	The reviewer interviewed the CEO/ED and was shown that case records are kept in a locked filing cabinet marked "confidential". The filing cabinet is located in the locked office of the CEO/ED.	
When in transport, all records are locked in an opaque container marked "confidential"	Compliance	The reviewer interviewed the CEO/ED and was shown that case records are transported using a lock box marked "confidential".	
All records are maintained in a neat and orderly manner	Compliance	The reviewer reviewed 7 closed and 3 open files. All ten files were neat and well organized..	

<p>SHELTER FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> •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 	<p>Not Applicable</p>		
<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> • 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 	<p>Compliance</p>	<p>The reviewer reviewed 7 closed and 3 open files. All ten files contained evidence of a table of contents that outlined all the program required documents in each section.</p>	
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Not Applicable</p>	<p>Records are not kept electronically.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p>Compliance</p>	<p>The reviewer interviewed the CEO/ED and it was explained that records are kept for a minimum of 7 years.</p>	

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 written policy and procedure that meets the requirements for Indicator 2.08 titled Family/Youth Respite Aftercare Services . The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.		
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	Not Applicable -The agency is not contracted for Staff Secure 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	Not Applicable -The agency is not contracted for DMST 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 <input type="checkbox"/>			
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	Not Applicable -The agency is not contracted for 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		

<p>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.</p>	<p>Not Applicable</p>		
<p>Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home</p>	<p>Not Applicable</p>		
<p>All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements</p>	<p>Not Applicable</p>		
<p>Probation Respite</p>			
<p>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")</p>	<p>Not Applicable</p>	<p>Not Applicable -The agency is not contracted for Probation Respite services.</p>	
<p>All probation respite referrals are submitted to the Florida Network.</p>	<p>Not Applicable</p>		
<p>All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.</p>	<p>Not Applicable</p>		
<p>Data entry into NetMIS and JJIS within (3) business days of intake and discharge</p>	<p>Not Applicable</p>		
<p>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.</p>	<p>Not Applicable</p>		
<p>All case management and counseling needs have been considered and addressed</p>	<p>Not Applicable</p>		
<p>All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements</p>	<p>Not Applicable</p>		
<p>Intensive Case Management (ICM)</p>			
<p>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")</p>	<p>Not Applicable</p>	<p>Not Applicable -The agency is not contracted for ICM services.</p>	

<p>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.</p>	<p>Not Applicable</p>		
<p>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.</p>	<p>Not Applicable</p>		
<p>Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements</p>	<p>Not Applicable</p>		
<p>Service/case plan demonstrates a strength-based, trauma-informed focus</p>	<p>Not Applicable</p>		
<p>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</p>	<p>Not Applicable</p>		
<p>Family and Youth Respite Aftercare Services (FYRAC)</p>			
<p>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")</p>	<p>Yes</p>	<p>The reviewer reviewed 3 closed FYRAC files.</p>	
<p>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.</p>	<p>Compliance</p>	<p>The reviewer reviewed 3 closed FYRAC files and all 3 contained evidence of a DJJ referral due to domestic violence on a family member or the youth was on probation.</p>	
<p>Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office</p>	<p>Compliance</p>	<p>Reviewer reviewed 3 FYRAC files and each contained emails to Florida Network with approval for services.</p>	

<p>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.</p>	<p>Compliance</p>	<p>All three FYRAC files have evidence that 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.</p>	
<p>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.</p>	<p>Compliance</p>	<p>All three FYRAC files included evidence that life management sessions met 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.</p>	
<p>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.</p>	<p>Compliance</p>	<p>All three FYRAC files contained documentation of individual sessions that met the following criteria: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify the 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.</p>	
<p>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</p>	<p>Not Applicable</p>	<p>The reviewer reviewed 3 closed FYRAC files and none of the files contained group sessions however; in these cases groups were not necessary.</p>	

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	Compliance	All three FYRAC files contained documentation of 30/60 day follow ups. The reviewer interviewed the CEO/ED and was shown the follow ups in NetMIS.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	Compliance	The reviewer reviewed 3 closed FYRAC files. All 3 files show documentation of less than 13 sessions and less than 90 consecutive days of services. However; the FYRAC contract was stopped at the end of December. After interviewing the CEO/ED and reading correspondence emails with DJJ it was determined that programs were informed to discharge clients nearing the end of services.	
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	Based on an interview with CEO, there have been no cases during the review period that needed virtual services.	
All data entry in NetMIS is completed within 3 business days as required.	Compliance	All 3 FYRAC files contained evidenced that data entry was entered into NetMIS withing 3 business days.	
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	YES		
	If NO, explain here:		
	The agency is not a current SNAP provider.		
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	Not Applicable -The agency is not contracted for SNAP services.	
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 <i>(This may be in progress for open files but is required for all closed files.)</i>	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	Not Applicable -The agency is not contracted for SNAP services.	
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	Not Applicable -The agency is not contracted for SNAP services.	
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. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	Not Applicable	Not Applicable -The agency is not contracted for SNAP services.	
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.			
Standard Four – Mental Health/Health Services			
4.02 - Suicide Prevention			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	YES		
	If NO, explain here:		
	The agency has a written policy and procedure that meets the requirement titled 3.02.01 Identification of Suicide Risk in Community Counseling Mentoring Programs. The policy was last reviewed and approved by the Executive Director and the Board of Directors on January 7, 2025.		
Suicide Risk Screening and Approval (Residential and Community Counseling)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	Compliance	At the time to this onsite program review, there were no files reviewed involving youth who were identified for suicide risk during intake. The program does have a policy and practices to refer youth to community partners if they require further assessment. The program does not admit youth with any identified suicidal concerns.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	The program reports the suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk (Shelter Only)			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	Not Applicable	The indicator is not applicable. The agency is a community counseling services provider and does not provide shelter/residential services.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	Not Applicable		

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		
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		
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		
Youth with Suicide Risk (Community Counseling Only)			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	No eligible items for review	This indicator is not applicable. At the time to this onsite program review, there were no files reviewed involving youth who were identified for suicide risk during intake. However, the program does have a policy and practices to refer youth to community partners if they are in need of further assessment. The program does not admit youth with any identified suicidal concerns.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	No eligible items for review	The agency had no youth identified for suicide risk during intake over the past six months.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	No eligible items for review	The agency had no youth identified for suicide risk during intake over the past six months.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	No eligible items for review	The agency had no youth identified for suicide risk during intake over the past six months.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	No eligible items for review	The agency had no youth identified for suicide risk during intake over the past six months.	
Additional Comments: There are no additional comments for this indicator.			