



**Florida Network for Youth and Family Services
Compliance Monitoring Report for FY 2025-2026**

Thaise Educational & Exposure Tours (Orlando)

927 South Goldwyn Avenue, Suite # 204
Orlando, FL 32805

November 25, 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 Orlando) for the FY 2025-2026 at its program office located at 927 South Goldwyn Avenue, # 204, Orlando, 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. Thaise Orlando 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 are funded with General Revenue Funds effective from July 2025 through June 30, 2026.

The compliance monitoring review was conducted by Marcia Tavares, Consultant for Forefront LLC. Agency representatives from Thaise Orlando present for the entrance interview were: Teresa Clove, Chief Executive Officer (via phone), Fatima Rodgers, Program Manager, and Amoni Allen, Data Clerk. The last onsite QI visit was conducted on February 5, 2025.

In general, the Reviewer found that Thaise Orlando is in compliance with specific contract requirements. **Thaise Orlando received an overall compliance rating of 100% for achieving full compliance with 12 applicable indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions required 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

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-25-2025-2026

Agency Name: Thaise Educational & Exposure Tour (Orlando)					Monitor Name: Marcia Tavares, Lead Reviewer		
Contract Type: CINS/FINS					Region/Office: 927 S. Goldwyn Avenue, #204 Orlando, FL 32805		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): November 25, 2025		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The Thaise agency has three certified peer reviewers in total. The certified peers for the Orlando location are Teresa Clove and Fatima Rodgers. Both peers have participated in a QI Review during the past fiscal year.	No recommendation or corrective action.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I: At the time of the onsite monitoring, the Executive Director reported not having any additional funding sources.	No recommendation or 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: United States Liability Insurance Company provides commercial liability. The coverage limits are \$1,000,000 per occurrence, personal injury limit \$1,000,000, medical expense \$5,000, damages to rented premises \$100,000, general aggregate \$2,000,000, professional liability	No recommendation or corrective action.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 11-25-2025-2026

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policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV							\$1,000,000 per accident and \$2,000,000 per aggregate, abuse coverage \$100,000 per claim and \$200,000 per aggregate. The policy is effective from 3/1/25- 3/1/26. Automobile Liability coverage is provided by Progressive Commercial Insurance with a limit of \$1,000,000 for bodily injury and property damage, \$1,000,000 for uninsured motorists, \$10,000 per person for personal injury, and \$5,000 for medical payments. The automobile policy was effective from 3/7/25-3/7/26.				
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I: Per the Executive Director, the agency does not have any corrective action items cited by an external funding source regarding their performance or any other matter.	No recommendation or corrective action.
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with					<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D,I: Fiscal policies and procedures are maintained in the agency's Fiscal Management Policy and Procedures Manual that are general and provide	No recommendation or corrective action.

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV						for limited internal controls. The procedures are reviewed annually and approved by the Board of Directors.	
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"/>	D, I: The agency maintains a detailed general ledger with corresponding source documents. The agency's general ledger is structured to track all funding sources. The general ledger provided a report of liabilities, revenue, and expenses. Documents submitted by the agency included the General ledger (GL) for the period January – October 2025.	No recommendation or 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	D: Per the agency's policy for Petty Cash Fund, Thaise does not currently use petty cash.	No recommendation or corrective action.
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D, I: The agency maintains bank reconciliation documents for account held with Wells Fargo Bank and provided bank reconciliation reports for the period May-October 2025. Monthly reconciliations are conducted by the	No recommendation or corrective action.

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(Disbursements/invoices are approved & monitored by management). ON SITE						Chief Financial Officer (CFO) and submitted to the accountant. The CEO and CFO review monthly invoices. Some invoices or bills are set for auto payment (i.e. rent, utilities, phone services, etc.) The CFO purchases the monthly supplies using credit cards for each location, and checks are rarely used. Disbursements and invoices are reviewed by the CFO and CEO.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I: The agency's CEO reported the program has not made any purchases over \$1000.00 since the last onsite review. Fiscal policies and procedures are maintained in the event that a qualifying purchase is made. The program maintains an updated list of its current inventory, dated November 14, 2025.	No recommendation or 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"/>	D: Documentation supported quarterly employer's Federal Tax Return Form 941 for the 2 nd and 3 rd quarters for 2025 were submitted.	No recommendation or corrective action.

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						All payroll tax returns and payments reviewed were observed to be submitted in a timely manner. Tax services are contracted through Jackson and Associates Bookkeeping, and Tax Services and payroll services are provided by Gusto Payroll.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency maintains monthly Statements of Activities for the current fiscal year. The report captures the current month and year-to-date distribution of income/expenditures. The provider conducts reviews of these financial statements at Board meetings, including a discussion of variances.	No recommendation or corrective action.
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not applicable to this agency due to funding being below the \$750,000 threshold.	No recommendation or corrective action.

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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"/>	D: The agency has policies for 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.	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					<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided a copy of an employee agreement, demonstrating salary of \$19/hour, for one new employee hired in July 2025.	No recommendation or corrective action.
Disaster Planning k. The agency has a written policy and procedure that includes a policy title/number, date of last review/revision, meets all of the requirements for the indicator that has					<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency has a written policy and procedures, policy 2.3 Disaster Planning, that was approved by the Executive Director and Board of Directors on 11/23/25. The agency also has an Emergency Disaster Plan	No recommendation or corrective action.

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been approved. The agency has a comprehensive Disaster Preparedness Plan that includes the following: o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. ON SITE						that outlines procedures for emergency evacuation, severe weather, hurricanes, and tornado procedures, flooding, bomb threats, riots, radioactive or chemical emergencies, fire, explosion, emergency drills, intruder/shooter, protocol for staff training, as well as Florida Network and DJJ notification requirements. The plan is evaluated annually by the Executive Director and the Board of Directors. Thaise Orlando is a community counseling provider and is not required to complete the Universal Agreement/Emergency Disaster Shelter document.	

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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CONCLUSION

Thaise Orlando has met the requirements for the CINS/FINS contract as a result of full compliance with eleven of twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the fifteen indicators were not applicable and included; 1) External/Outside Contract Compliance; 2) Petty Cash System; 3) Annual Financial Audit. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There were no corrective actions or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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 Thaise Educational & Exposure Tours - Orlando
CINS/FINS Program

Date: November 25, 2025

Compliance Monitoring Services Provided by



November 25, 2025

CINS/FINS Rating Profile

Domain 1: Background Screening and Compliance

1.0 Background Screening of Employees/Volunteers	Satisfactory
1.1 Annual Affidavit of Compliance with Good Moral Character Standards	Satisfactory
1.2 Provision of an Abuse Free Environment	Satisfactory
1.3 Incident Reporting	Satisfactory
1.4 Training Requirements	Satisfactory with Exception(s)
1.5 Data Entry & Collection	Satisfactory
1.6 Analyzing and Reporting	Satisfactory
1.7 Client Transportation	Not Applicable
1.8 Client Contact	Satisfactory
1.9 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 90 %

Percent of indicators rated Limited: 0 %

Percent of indicators rated Failed: 0 %

Domain 3: Screening, Assessment & Case Management

3.2 Admission Process	Satisfactory
3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)	Satisfactory
3.4 Case Management, Counseling & Non-Residential Services Policy	Satisfactory
3.5 Adjudication Services: Case Staffing	Satisfactory
3.6 Adjudication Services: CINS Petition Process	Satisfactory
3.7 Service Plan	Satisfactory with Exception(s)
3.8 Youth Records	Satisfactory
3.10 Discharge and Follow Up	Satisfactory with Exception(s)

Percent of indicators rated Satisfactory: 100 %

Percent of indicators rated Limited: 0 %

Percent of indicators rated Failed: 0 %

Domain 6: Medication Management

6.2 Suicide Prevention	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

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Jennifer Tummino – Regional Monitor, Department of Juvenile Justice
Cindi Lee - Crosswinds Youth Services

November 25, 2025

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of Domain (1) - Domain (6), which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2025).

Persons Interviewed

<input checked="" type="checkbox"/> Chief Executive Officer	<input type="checkbox"/> Case Manager	<input type="checkbox"/> Nurse – Full time
<input type="checkbox"/> Chief Financial Officer	<input type="checkbox"/> Counselor Non-Licensed	<input type="checkbox"/> Nurse – Part time
<input type="checkbox"/> Chief Operating Officer	<input type="checkbox"/> Advocate	<input type="checkbox"/> # Case Managers
<input type="checkbox"/> Executive Director	<input type="checkbox"/> Direct – Care Full time	<input type="checkbox"/> # Program Supervisors
<input type="checkbox"/> Program Director	<input type="checkbox"/> Direct – Part time	<input type="checkbox"/> # Food Service Personnel
<input checked="" type="checkbox"/> Program Manager	<input type="checkbox"/> Direct – Care On-Call	<input type="checkbox"/> # Healthcare Staff
<input type="checkbox"/> Program Coordinator	<input type="checkbox"/> Intern	<input type="checkbox"/> # Maintenance Personnel
<input type="checkbox"/> Clinical Director	<input type="checkbox"/> Volunteer	<input type="checkbox"/> 1 # Other (listec Data Clerk)
<input type="checkbox"/> Counselor Licensed	<input type="checkbox"/> Human Resources	

Documents Reviewed

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input checked="" type="checkbox"/> Fire Prevention Plan	<input type="checkbox"/> Youth Handbook
<input type="checkbox"/> CCC Reports	<input type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> # Health Records
<input type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	<input type="checkbox"/> 1 # MH/SA Records
<input checked="" type="checkbox"/> Continuity of Operation Plan	<input checked="" type="checkbox"/> Fire Drill Log	<input type="checkbox"/> 1 # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> 5 # Training Records
<input type="checkbox"/> Contract Scope of Services	<input type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> 4 # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input type="checkbox"/> Program Schedules	<input type="checkbox"/> 4 # Youth Records (Open)
<input type="checkbox"/> Fire Inspection Report	<input type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: ___
<input type="checkbox"/> Exposure Control Plan	<input type="checkbox"/> Vehicle Inspection Reports	___

Observations During Review

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

Surveys

<input type="checkbox"/> 0 # of Youth	<input type="checkbox"/> 2 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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November 25, 2025

Comments

A Quality Improvement Program Review was conducted for FY 2025-2026.

Monitoring Purpose

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

Narrative Summary

Thaise Educational & Exposure Tours agency has three locations across the state of Florida including Jacksonville, Orlando, and St. Petersburg. The central Florida program (Thaise Orlando) is located on 927 South Goldwyn Avenue, Orlando. Program referrals come from schools, other programs, parents/ family members, and churches in the Orlando area.

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

Domain 1: There are ten indicators for Domain 1.

Indicator 1.0 Background Screening of Employees/Volunteers was rated Satisfactory

Indicator 1.1 Annual Affidavit of Compliance with Good Moral Character Standards was Satisfactory

Indicator 1.2 Provision of an Abuse Free Environment was rated Satisfactory

Indicator 1.3 Incident Reporting was rated Satisfactory

Indicator 1.4 Training Requirements was rated Satisfactory with Exception(s)

Indicator 1.5 Data Entry & Collection was rated Satisfactory

Indicator 1.6 Risk Management/ Analyzing and Reporting Information was rated Satisfactory

Indicator 1.7 Client Transportation was rated Not Applicable

Indicator 1.8 Client Contact was rated Satisfactory

Indicator 1.9 Outreach Services was rated Satisfactory

Domain 3: There are eight indicators for Domain 3.

Indicator 3.2 Admission Process was rated Satisfactory

Indicator 3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment) was rated Satisfactory

Indicator 3.4 Case Management, Counseling & Non-Residential Services Policy was rated Satisfactory

Indicator 3.5 Adjudication Services: Case Staffing was rated Satisfactory

Indicator 3.6 Staffing and Youth Supervision was rated Satisfactory

Indicator 3.7 Service Plan was rated Satisfactory with Exception(s)

Indicator 3.8 Youth Records was rated Satisfactory

Indicator 3.10 Discharge and Follow Up was rated Satisfactory with Exception(s)

Domain 6: There is one applicable indicator for Domain 6.

Indicator 6.2 Suicide Prevention was rated Satisfactory

CINS/FINS QUALITY IMPROVEMENT TOOL		
<p>Quality Improvement Indicators and Results: Compliance: The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. Exception: The findings observed or reviewed indicate the practice is not aligned with the requirement(s) for the review item at the time of the review. Not Applicable: The item reviewed is not applicable for this review item(s) or the agency is not contracted to provide services related to the review item. E.g. If the agency has a policy that states they will not transport under any circumstance, Indicator 1.06 would be not applicable.</p>	<p>Summary/Narrative Findings: This column provides a comprehensive narrative summary of each assigned QI indicator. It highlights areas where the program demonstrated compliance, outlines the evidence supporting those determinations, and provides detailed explanations for any deficiencies or exceptions. Together, these findings offer clear justification for the specific domain ratings and present a balanced view of program performance.</p>	
Domain One		
1.0 - Background Screening		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.0	Yes	
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0	Yes	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 1.0 Background Screening that was last approved by the Executive Director on 11/23/25. Pre-assessment Tool: The agency utilizes the Avatar Suitability Assessment and has established a passing score of 60.	
A total of one file(s) were reviewed during this evaluation period. Of these, one new hire file(s) and zero 5-year rescreen file(s) were reviewed. The sample included one employee(s) and zero volunteer(s).		
Suitability Assessment		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	Compliance	All staff providing direct services to youth successfully passed the pre-employment suitability assessment on their initial attempt.
For any applicant that did NOT pass the initial suitability assessment: Applicant retook the assessment and passed within five (5) business days of the initial attempt, not to exceed three (3) attempt within thirty (30) days.	Not Applicable	One applicable staff successfully passed the suitability assessment on the initial attempt.

If the applicant did not pass on the initial attempt, the applicant passed the suitability assessment within the required timeframes.	Not Applicable	One applicable staff successfully passed the suitability assessment on the initial attempt.
Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.	Not Applicable	The provider has not re-hired any staff during the review period.
New Hire		
For New Hires-The background screening was completed and applicant determined eligible prior to date of hire.	Compliance	Background screenings for all new hires were completed, and eligibility was confirmed prior to each hire date.
For employee, contractor, volunteer, or intern who provide services for ten (10) or more hours per month-The background screening was completed and volunteer/mentor or intern determined eligible prior services being provided.	Not Applicable	The provider does not have any interns or volunteers who meet the criteria for background screening.
For those with ineligible background screenings, the exemption was obtained prior to working with youth.	Not Applicable	No ineligible background screenings were evident.
E-Verify		
The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	Compliance	All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.
5 Year Rescreening		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	Not Applicable	All current staff were observed to have valid retained fingerprint dates in the clearinghouse information reviewed.
Additional Comments: There are no additional comments for this indicator.		

1.1 - Annual Affidavit of Compliance with Good Moral Character Standards		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.1		Yes
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 1.1 Annual Affidavit of Compliance with Good Moral Character Standards that was last approved by the Executive Director on 11/23/25.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	Compliance	The Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) was completed and submitted to BSU by the required deadline of January 31.
Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	Compliance	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.
Additional Comments: There are no additional comments for this indicator.		
1.2 - Provision of an Abuse Free Environment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.2		Yes
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a written policy and procedures which meet the requirements and is titled 1.2 Provision of an Abuse-Free Environment. The policy was last reviewed and approved by the Chief Executive Officer and the Board of Directors on November 23, 2025.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation.	Compliance	The program maintains and enforces a written Code of Conduct that strictly prohibits physical abuse, profanity, threats, or intimidation. All staff demonstrate adherence to these standards.
The program has a process in place for reporting and documenting any child abuse hotline calls.	Compliance	The program has an established process for promptly reporting and documenting all child abuse hotline calls in accordance with state and agency policy. Staff are trained and compliant with reporting procedures.

Agency is an abuse free environment.	Compliance	No youth surveys are conducted in community counseling programs; however, staff surveys indicated working environment is safe and conditions were rated to be good.
Additional Comments: There are no additional comments for this indicator.		
1.3 - Incident Reporting	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 1.3	Yes	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a written policy and procedures which meet the requirements and is titled 1.3 Incident Reporting Policy. The policy was last reviewed and approved by the Chief Executive Officer and the Board of Directors on November 23, 2025.	
Data sources Reviewed	Dates Reviewed	Logbook Dates for Sample Size:
Incident reports CCC reports	Incident Report Logs and DJJ CCC Report 5/24/25 - 11/24/25 included no reportable incidents	This program type is not required to maintain a logbook.
The program notified the Department’s CCC and reportable incidents were consistently reported as required, no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	Not Applicable	DJJ Incident Report detail and the program's internal incident report log revealed there were no reportable incidents during the review period.
The program completes follow-up communication tasks/special instructions as required by the CCC.	Not Applicable	No eligible incident reports to review.
Incidents are documented in the program logs and CCC call is documented in the logbooks for Shelter programs	Not Applicable	No eligible incident reports to review.
All incident reports are reviewed and signed by program supervisors/directors.	Not Applicable	No eligible incident reports to review.
Additional Comments: There are no additional comments for this indicator.		

1.4 - Training Requirements		Satisfactory with Exception(s)
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.4</p>		<p>Yes</p> <p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a written policy and procedures which meet the requirements and is titled 1.4 Staff Training and Professional Development. The policy was last reviewed and approved by the Chief Executive Officer and the Board of Directors on November 23, 2025.</p>
<p>A total of zero first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. Two new hire staff and three annual staff file(s) were reviewed for compliance with training completed within the required timeframe(s).</p>		
<p>Policy & New Hire Training</p>		
<p>Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).</p>	<p>Compliance</p>	<p>All required trainings mandated by the Network and other funders are properly documented in each staff member's file and recorded on the FLN Training Log, including all required details such as staff information, training dates, hours, and completion records.</p>
<p>Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)</p>	<p>Compliance</p>	<p>All new staff completed Civil Rights & Federal Funds (U.S. Department of Justice) training within 30 days of hire, ensuring compliance with federal requirements.</p>
<p>Pre-Service Trainings</p>		
<p>Agency policies and procedures</p>	<p>Compliance</p>	<p>Training records for two non-direct service staff indicated training was completed on the first date of hire.</p>
<p>Building/Facility layout</p>	<p>Compliance</p>	<p>Staff received orientation to the building and facility layout.</p>
<p>File Documentation/Paperwork Requirements</p>	<p>Compliance</p>	<p>File documentation and paperwork requirement training was completed as required.</p>

Confidentiality (FYSB / DCF / Skill Pro)	Compliance	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	Exception	Training record for the licensed clinician hired 7/15/25 shows CCC/Incident Reporting training was completed late, one day past the required 90 days.
Child Abuse Reporting	Compliance	Child Abuse Reporting training was completed and verified in the staff record.
Client Intake & Screening	Compliance	Client Intake and Screening training was completed prior to independent case assignment.
Disaster Preparedness	Compliance	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	Compliance	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.
CPR/First Aid (By CPR Certified Instructor)	Compliance	CPR/First Aid training was completed by a certified instructor prior to independent duty.
CINS/FINS Core	Compliance	CINS/FINS Core training was completed and verified.
Florida Network Youth Suicide Prevention	Compliance	Florida Network Youth Suicide Prevention training was completed within the required timeframe.
Adolescent Development / Positive Youth Development	Compliance	Adolescent Development and Positive Youth Development training were completed and recorded.
Cultural Humility/Diversity (Specific training at the agencies discretion. Available sources Bridge / RHYTTAC)	Compliance	Cultural Humility and Diversity training was completed through an approved provider (Bridge or RHYTTAC).
Mental Health and Substance Abuse	Not Applicable	The two first year staff do no provide direct services to youth.
Skill Pro Required Trainings:		
Child Abuse: Recognition, Reporting and Prevention	Compliance	Staff completed Child Abuse: Recognition, Reporting, and Prevention training within the first 90 days of employment or service.
Equal Employment Opportunity	Compliance	Equal Employment Opportunity training was completed and documented within the first 90 days.
Human Trafficking Intervention for Direct Care Staff	Compliance	Human Trafficking Intervention for Direct Care Staff training was completed as required.
Information Security Awareness	Compliance	Information Security Awareness training was completed within the required timeframe.

Prison Rape Elimination Act (PREA) - Part 1	Compliance	Prison Rape Elimination Act (PREA) – Part 1 training was completed and documented in staff records.
Prison Rape Elimination Act (PREA) - Part 2	Compliance	Prison Rape Elimination Act (PREA) – Part 2 training was completed and verified in the staff file.
Sexual Harassment	Compliance	Sexual Harassment training was completed within the first 90 days of employment or service.
Trauma Responsive Practices	Compliance	Trauma Responsive Practices training was completed and documented as required.
Additional FL Network Required Trainings:		
Naloxone Training	Compliance	Naloxone training was completed and documented within the first 90 days of employment or service.
Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	Compliance	Adverse Childhood Experiences (ACEs) training was completed by all staff not participating in NIRVANA® training.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only)	Not Applicable	The two first year staff do no provide direct services to youth.
STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	Compliance	Staff requiring JJIS access completed Juvenile Justice Information System (JJIS) System Access training prior to entry or monitoring.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	Compliance	JJIS Data Entry staff completed JJIS Alerts – Part 1 training before accessing JJIS.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	Compliance	JJIS Data Entry staff completed JJIS Alerts – Part 2 training before accessing JJIS.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	Not Applicable	The two first year staff do no provide direct services to youth.
NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA) **Verify Date of Counselor or Case Manager's 1st case assignment with Lead**	Not Applicable	The two first year staff do no provide direct services to youth.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	Compliance	NetMIS users completed NetMIS training prior to being granted system access.

<p>NON-LICENSED CLINICAL STAFF ONLY Staff Suicide Assessment Training ** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person's personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)</p>	<p>Not Applicable</p>	<p>The two first year staff do no provide direct services to youth.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*</p>	<p>Not Applicable</p>	<p>The two first year staff do no provide direct services to youth.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY Mental health and substance-related disorders; Counseling theory and techniques; Group dynamics and therapy; Treatment and discharge planning. (Required for Bachelor's level non-licensed counseling staff without 2 years clinical experience assessing, counseling or treating youth with serious emotional disturbance or substance abuse problems) *To be completed during first year of employment*</p>	<p>Not Applicable</p>	<p>The two first year staff do no provide direct services to youth.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	<p>Compliance</p>	<p>When trainings were delayed, documentation of the reason and the scheduled completion date was maintained in the staff training file.</p>

<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	<p>Not Applicable</p>	<p>Neither of the two first year staff provide direct services to youth; however, one has completed all mandatory training required for all staff and required training hours. The other staff was hired in October and is on target to completing the required training and/or hours.</p>
<p>If there was a break in employment for less than six (6) months, the file contains documentation confirming the supervisor reviewed applicable prior training and verified completion.</p>	<p>Not Applicable</p>	<p>The program has not re-hired any staff during the review period.</p>
<p>If the agency finds that the instructor is not available for the instructor led course within the required timeframe, then document attempts in the staff training file.</p>	<p>Not Applicable</p>	<p>There were no courses reviewed where the instructor was not available.</p>
<p>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.</p>	<p>Compliance</p>	<p>The agency has a designated staff member responsible for managing all employee training files and routinely reviews them to ensure compliance.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	<p>Compliance</p>	<p>All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.</p>

Annual Training		
Trainings that are required by the Network must be documented in each individual training file or employee file as well as captured on the FLN Training Log or similar document with the minimum requirements (i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual), and Cumulative Total Training Hours)	Compliance	All Network-required trainings are documented in individual staff files and recorded on the FLN Training Log with all required details, including staff information, training hours, completion dates, and cumulative totals.
Child Abuse: Recognition, Reporting, and Prevention (Annually)	Compliance	Child Abuse: Recognition, Reporting, and Prevention training is completed annually and properly documented in staff training records.
Human Trafficking Intervention for Direct-Care Staff (Annually)	Compliance	Human Trafficking Intervention for Direct-Care Staff training is completed annually and supported by required documentation.
Information Security Awareness (Annually)	Compliance	Information Security Awareness training is completed annually and verified through certificates or attendance records.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	Compliance	Prison Rape Elimination Act (PREA) Part 1 training is completed every two years and properly documented in training files.
Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)	Compliance	Prison Rape Elimination Act (PREA) Part 2 training is completed every two years and supported by appropriate documentation.
Sexual Harassment (Every 2 Years)	Compliance	Sexual Harassment training is completed every two years and verified in staff files.
Trauma Responsive Practices (Every 2 Years)	Compliance	Trauma Responsive Practices training is completed every two years and documented on the FLN Training Log and in staff training files.
FL Network Annual Required Trainings REQUIRED for Staff Over 1 year		
Florida Network Youth Suicide Prevention (Required Annually)	Compliance	Florida Network Youth Suicide Prevention training is completed annually and documented in staff training files.
CPR (Every 2 Years - Check for current validity)	Compliance	CPR certification is current and renewed every two years in accordance with Network requirements.

First Aid (Every 2 Years - Check for current validity)	Compliance	First Aid certification is current and renewed every two years, with documentation maintained in the staff file.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	Not Applicable	None of the annual training records reviewed were missing required trainings.
All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training received for the year.	Compliance	All direct-care Community Counseling staff meet the annual minimum requirement of 24 total training hours.
Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	Compliance	Annual and biannual training schedules are tracked and completed based on the agency's established calendar or fiscal year cycle, not hire date.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	Compliance	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
Additional Comments: There are no additional comments for this indicator.		
1.5 - Data Entry & Collection	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 1.5	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 1.5 Data Entry and Collection that was last approved by the Executive Director on 11/23/25.	
The program has a quality improvement process in place to review and improve accuracy of data entry and collection.	Compliance	The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.
Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement (as reported on most recent End-of-Month ('EOM') report).	Compliance	Client and service data are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement, as verified in the most recent End-of-Month (EOM) report.
Monthly review of statewide End-of-Month ('EOM') reports is evidenced. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.	Compliance	Monthly review of statewide End-of-Month (EOM) reports is completed and documented, including analysis of monthly data, fiscal year-to-date data, benchmarks, screening metrics, report card measures, and follow-up reporting indicators
Additional Comments: There are no additional comments for this indicator.		

1.6 - Risk Management/ Analyzing and Reporting Information		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.6		Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 1.6 Analyzing and Reporting that was last approved by the Executive Director on 11/23/25.
Data sources Reviewed		Dates Reviewed
Interviewed Program Manager who provided copies of the monthly EOM reports, staff meeting minutes,		May-November 2025
The program provides reports of aggregated data and committee/workgroup minutes analyzing information.	Compliance	The program consistently compiles and maintains aggregated data reports and meeting minutes from committees and workgroups, demonstrating active analysis and ongoing program improvement.
The program conducts quarterly case record reviews. (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.)	Compliance	Quarterly case record reviews are conducted as required, with summary reports identifying compliance with CINS/FINS standards. Results are reviewed by management and communicated to staff on a quarterly basis.
The program reviews incidents, accidents, and grievances at least quarterly	Compliance	The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive measures.
The program reviews customer satisfaction data at least annually.	Compliance	Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.
The program reviews outcome data at least annually.	Compliance	Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	Compliance	Findings from reviews are consistently evaluated by management and effectively communicated to staff and stakeholders to ensure transparency and alignment.
The program demonstrates 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 provider's Executive Committee on the Board of Directors.	Compliance	Program performance is routinely presented to the Board of Directors. All final reports receiving a Limited or Failed rating are submitted to the Executive Committee electronically or by mail, as required.

Evidence shows strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process.	Compliance	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
Additional Comments: There are no additional comments for this indicator.		
1.7 - Client Transportation	Not Applicable	
Provider has a written policy and procedure that meets the requirement for Indicator 1.7	Yes	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a policy 1.7 Transportation of Youth, indicating Thaise does not transport youth that was last approved by the Executive Director on 11/23/25.	
Supervisors complete a quarterly review of transport documentation and provide written feedback or coaching when deficiencies are found.	Not Applicable	Thaise Orlando does not transport program youth.
The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.	Not Applicable	Thaise Orlando does not transport program youth.
All drivers have an approved driver’s license.	Not Applicable	Thaise Orlando does not transport program youth.
List of approved drivers eligible to drive client(s) for the agency or approved private vehicle that considers the driver’s work performance and history, indicating no inappropriate behavior is likely to occur.	Not Applicable	Thaise Orlando does not transport program youth.
The list of approved drivers are covered under the agency's automobile insurance.	Not Applicable	Thaise Orlando does not transport program youth.
There is documentation of use of a vehicle that notes the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location.	Not Applicable	Thaise Orlando does not transport program youth.
Two staff accompany youth on each transport.	Not Applicable	Thaise Orlando does not transport program youth.

<p>If a 2nd staff member cannot be obtained for transport, the necessity of transport, the client’s history, evaluation, and recent behavior is considered and documented. Signed parental consent is obtained in advance of any single transport *Note: Parental consent can be obtained at admission and is a one-time event.</p>	<p>Not Applicable</p>	<p>Thaise Orlando does not transport program youth.</p>
<p>If a single staff is transporting youth in a vehicle, there is evidence that the program supervisor approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.</p>	<p>Not Applicable</p>	<p>Thaise Orlando does not transport program youth.</p>
<p>If a 2nd staff member cannot be obtained for transport, there is evidence that the transporting employee completed a check-in by phone at agreed-upon intervals with the senior program leader or designee, upon departure and arrival. The employee check-ins must be documented by the manager or designee receiving the call.</p>	<p>Not Applicable</p>	<p>Thaise Orlando does not transport program youth.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.8 - Client Contact Policy</p>	<p>Satisfactory</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</p>	<p>Yes Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 1.8 Client Contact Policy that was last approved by the Executive Director on 11/23/25.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>		

1.9 - Community Referrals and Outreach Services		Satisfactory
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</p>		Yes
		<p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a written policy and procedures which meet the requirements and is titled 1.9 Community Referrals and Outreach Services. The policy was last reviewed and approved by the Chief Executive Officer and the Board of Directors on November 23, 2025.</p>
<p>Outreach activities include education about services offered and guidance on accessing those services.</p> <p>The following mandatory information of each outreach activity is entered into NETMIS: the title, date, duration (hours), zip code, location, description, estimated number of people reached, modality, target audience and topic. The activities include group presentations/discussions, individual meetings, short-term intervention groups, set up/display and distribution of materials at community events, conducting tours of facilities, and media events or interviews.</p>	<p>Compliance</p>	<p>The program’s outreach activities effectively educate the community about available services and provide clear guidance on how to access them. All required details, including title, date, duration, location, description, estimated attendance, modality, target audience, and topic, are accurately entered into NETMIS.</p>
<p>The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Documentation such as meeting minutes, sign-in sheets, and event summaries confirm active staff participation in all outreach activities.</p>
<p>The program has a lead staff member who conducts outreach, is designated to participate in local DJJ Board and council meetings and leads other outreach activities.</p>	<p>Compliance</p>	<p>A designated staff member serves as the program’s outreach lead, participates in local DJJ Board and council meetings, and coordinates all outreach efforts on behalf of the program.</p>
<p>This responsibility is specified in their job description.</p>	<p>Compliance</p>	<p>The outreach lead’s job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities.</p>

Full-Service agencies document meetings with local stakeholders (school districts, judges, and law enforcement) at least two times per year to discuss services available and needed improvements.	Compliance	Full-service agencies maintain ongoing collaboration with key stakeholders—including school districts, judges, and law enforcement—and meet at least twice per year to review services and discuss opportunities for improvement.
Outreach activities include education about services offered and guidance on accessing those services. The program has evidence that provides minutes of the event or other verification of staff participation.	Compliance	Outreach efforts include a variety of engagement methods such as group presentations, individual meetings, short-term intervention groups, informational displays at community events, facility tours, and media participation. These activities demonstrate strong community visibility and connection.
The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.	Compliance	The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.
Copies of agreements are forwarded to the Florida Network.	Compliance	Copies of all partnership agreements are submitted to the Florida Network as required, ensuring transparency and statewide coordination of services.

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

Domain Three

3.2 - Admission Process

Provider has a written policy and procedure that meets the requirement for Indicator 3.2	Satisfactory
	Yes Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy 3.2 Admissions. Last updated 11/23/2025 and approved by Director.

A total of eight file(s) were reviewed during this evaluation period. Of these, four were open and four were closed. Among the open file(s), zero residential (RES) and four community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and four community counseling file(s) were reviewed.

<p><u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.</p>	<p>Compliance</p>	<p>Initial screenings for Community Counseling Services were completed within three business days of referral by trained staff using the Florida Network screening form. All eligibility, crisis, and referral requirements were met.</p>
<p>Youth and parents/guardians receive the following in writing</p>		
<p>Youth and parents/guardians are provided available service options in writing.</p>	<p>Compliance</p>	<p>Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.</p>
<p>Youth and parents/guardians are provided “Rights and Responsibilities of Youth” in writing.</p>	<p>Compliance</p>	<p>Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.</p>
<p>Parents/guardians are provided “Rights and Responsibilities of Parents” and/or parent brochure.</p>	<p>Compliance</p>	<p>Parents and guardians were provided the “Rights and Responsibilities of Parents” brochure at intake, and signed acknowledgment forms were present in all records.</p>
<p>The following is also available to the youth and parents/guardians:</p>		
<p>Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).</p>	<p>Compliance</p>	<p>Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.</p>
<p>Youth and parents/guardians are provided information regarding the programs grievance procedures.</p>	<p>Compliance</p>	<p>All youth and parents/guardians were informed of the program’s grievance procedures, and documentation confirmed this information was reviewed and acknowledged.</p>
<p>If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.</p>	<p>Not Applicable</p>	<p>All eight records reviewed indicated youth/family participated in services offered.</p>

<p>The Intake took place in a setting that allows the client to feel safe and heard.</p>	<p>Compliance</p>	<p>Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.3</p>		<p>Yes Indicate policy number, authorized signee, date(s) of last review/revision/approval: 3.3/NIRVANA. Last updated October 15, 2025 and approved by Executive Director.</p>
<p>NIRVANA Assessment is initiated at intake and completed within one to two contacts following the initial intake date into services.</p>	<p>Compliance</p>	<p>All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.</p>
<p>NIRVANA Assessment was conducted by a bachelor's or master's degree staff who has completed the Florida Network NIRVANA training and has had Motivational Interviewing (MI).</p>	<p>Compliance</p>	<p>All assessments were completed by qualified bachelor's or master's level staff who successfully completed both NIRVANA and Motivational Interviewing training, verified through the staff roster.</p>
<p>All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.</p>	<p>Compliance</p>	<p>All completed NIRVANA Assessments were entered into NetMIS within three business days of service commencement, ensuring timely data submission and compliance with reporting standards.</p>
<p>The supervisor's signature is documented on the completed NIRVANA Assessment and/or the chronological note and/or the interview guide that is located in the youths' file within 7 business days.</p>	<p>Compliance</p>	<p>Supervisor signatures were documented within seven business days on all completed NIRVANA Assessments, confirming management review and approval.</p>
<p>A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.</p>	<p>Compliance</p>	<p>All youth with stays exceeding 30 days received a completed NIRVANA Post-Assessment at discharge to measure progress and outcomes.</p>
<p>A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.</p>	<p>Not Applicable</p>	<p>None of the records reviewed had service dates exceeding 90 days.</p>

<p>All files must have the interview guide and/or printed NIRVANA.</p>	<p>Compliance</p>	<p>Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.4 - Case Management, Counseling & Non-Residential Services Policy</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.4</p>		<p>Yes Indicate policy number, authorized signee, date(s) of last review/revision/approval: 3.7 Service Plan was last approved on 11/23/2025 by the Executive Director.</p>
<p>Each client is assigned a Counselor.</p>	<p>Compliance</p>	<p>Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.</p>
<p>The following is also available to the youth and parents/guardians:</p>		
<p>Community Counseling Program: Counseling sessions must be offered at a minimum once a week. (May include Individual, group, and family counseling, Crisis intervention, Parent training, Community-based mental health and substance abuse referrals, Case management, Prevention and diversion services, Skills training, tutorial/remedial services, Vocational, job training, or employment services, and Recreational services)</p>	<p>Compliance</p>	<p>In the Community Counseling Program, counseling sessions were offered weekly, meeting requirements for service frequency and modality, including individual, group, and family sessions as well as crisis intervention, skills training, and referrals.</p>
<p>The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.</p>	<p>Not Applicable</p>	<p>All eight records reviewed demonstrated weekly sessions were provided.</p>
<p>If case management needs extend beyond the counselor's role, a case manager is assigned.</p>	<p>Not Applicable</p>	<p>Thaise Orlando does not have separate case management staff. All counseling and case management services are provided by the assigned counselor.</p>
<p>Case Manager establishes appropriate referrals to services.</p>	<p>Not Applicable</p>	<p>Thaise Orlando does not have separate case management staff. Appropriate referrals were made by the assigned counselor.</p>

All counseling and case management sessions are documented in the youth’s file and NetMIS, including the reason for missed session/s.	Compliance	All counseling and case management sessions were documented in the youth’s file and entered into NetMIS, including explanations for any missed sessions.
If mental health or substance abuse needs, outside of the program’s capacity, are identified appropriate referrals are made and documented.	Not Applicable	None of the records reviewed were identified as needing substance abuse services outside of the scope of the program's offering.
Clients that do not receive services for 30 days or more have their case closed.	Compliance	Cases were closed for clients who had not received services for 30 days or more, in compliance with program standards.
Direct supervision is documented on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019) or on a program developed form which contains the same information.	Compliance	Direct supervision for Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals was documented on the MHSA 019 Supervision Log or equivalent program form containing all required information.
Additional Comments: There are no additional comments for this indicator.		
3.5 - Adjudication Services: Case Staffing	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 3.5	Yes	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 3.5 Adjudication Services: Case Staffing that was last approved by the Executive Director on 11/23/25.	

<p>A case staffing committee meeting is scheduled when one of the following occur (at minimum):</p> <ol style="list-style-type: none"> 1. the youth/family is not in agreement with services or treatment; 2. the youth/family will not participate in the services selected, 3. the youth’s referring problem has not shown substantial improvement within six weeks of initiating counseling. 4. the program receives a written request from the parent/guardian or any other member of the committee 	<p>Not Applicable</p>	<p>Thaise Orlando has not received any referrals for case staffing during the review period.</p>
<p>Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>Notification to family no less than 5 working days prior to staffing.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>Notification to committee no less than 5 working days prior to staffing date.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>At a minimum, the case staffing is attended by:</p>		
<p>Local school district representative</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>DJJ rep. or CINS/FINS provider</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>
<p>Other members may include:</p>		
<p>State Attorney’s Office</p>	<p>Not Applicable</p>	<p>No eligible items to review.</p>

Mental health representative	Not Applicable	No eligible items to review.
Substance abuse representative	Not Applicable	No eligible items to review.
Law enforcement representative	Not Applicable	No eligible items to review.
DCF representative	Not Applicable	No eligible items to review.
Others requested by youth/family	Not Applicable	No eligible items to review.
The program has an established case staffing committee, and has regular communication with committee members.	Not Applicable	No eligible items to review.
The program has an established case staffing committee, and has regular communication with committee members.	Not Applicable	No eligible items to review.
Additional Comments: There are no additional comments for this indicator.		
3.6 - Adjudication Services: CINS Petition Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.6		Yes
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 3.5 Adjudication Services: CINS Petition Process that was last approved by the Executive Director on 11/23/25.
If applicable, the program works with the circuit court for judicial intervention for the youth/family, as applicable, including required attendance at all court hearings without subpoena.	Not Applicable	Thaise Orlando has not processed any CINS petitions during the review period.
The Case Manager/Counselor completes a review summary prior to the court hearing.	Not Applicable	Thaise Orlando has not processed any CINS petitions during the review period.
Additional Comments: There are no additional comments for this indicator.		

3.7 - Service Plan		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.7		Yes Indicate policy number, authorized signee, date(s) of last review/revision/approval: 3.7 Service Plan was last approved on 11/23/2025 by the Executive Director.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA.	Compliance	The Case/Service Plan is completed within one contact of the NIRVANA, demonstrating prompt follow-up and coordination.
The plan is developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA.	Compliance	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.
Youth and parents/guardians receive the following in writing		
The Case/Service Plan reflects the individualized and prioritized need(s) and goal(s) identified during the assessment process including domains from the NIRVANA.	Compliance	Individualized and prioritized needs and goals are clearly identified based on the assessment process, incorporating all relevant domains from the NIRVANA.
Each plan clearly documents the type of service(s) to be provided, the frequency, and the location of services.	Compliance	Each plan clearly outlines the type, frequency, and location of services to ensure structured and consistent service delivery.
The plan identifies the person(s) responsible for implementing each service or action step.	Compliance	The plan specifies the person(s) responsible for implementing each service or action step, promoting accountability and effective follow-through.
The target date(s) for completion are documented in the service plan.	Compliance	Each plan includes clear target date(s) for goal completion, supporting timely progress monitoring and accountability.
The actual completion date(s) are documented in the service plan.	Compliance	Actual completion date(s) are consistently recorded, demonstrating effective tracking of service delivery and goal attainment.
The signature of the youth is documented in the service plan.	Compliance	Youth signatures are present on plans, confirming their participation and agreement with the identified goals and services.
The signature of the parent/guardian is documented in the service plan.	Compliance	Parent/guardian signatures are obtained, reflecting engagement and shared responsibility in the service planning process.

If unavailable, the absence is documented with a reason on the plan.	Not Applicable	All required signatures were evident in the youth records reviewed.
The signature of the counselor is documented in the service plan.	Compliance	Counselor signatures are included on all plans, verifying professional oversight and approval of service goals and actions.
The signature of the LMHP reviewing the plan is signed within seven (7) days of plan completion.	Exception	One record indicated the LMHP signed on the 8th day. Treatment plan was initiated on the 28th of October and LMHP signed on the 5th of November.
The date of plan initiation is clearly indicated.	Compliance	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.
The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s)		
At, 30 Days, following plan initiation.	Compliance	The Case/Service Plan is reviewed within 30 days of initiation in collaboration with the youth and parent/guardian, ensuring early progress monitoring and engagement.
At, 60 Days, following plan initiation.	Compliance	The Case/Service Plan is reviewed at 60 days with the youth and parent/guardian, reflecting continued collaboration and responsiveness to evolving needs.
At, 90 Days, following plan initiation.	Compliance	The Case/Service Plan is reviewed at 90 days with the youth and parent/guardian, demonstrating consistent follow-up and commitment to achieving identified goals.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	Not Applicable	None of the records reviewed had service dates exceeding six months.
Additional Comments: There are no additional comments for this indicator.		
3.8 - Youth Records	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 3.8	Yes	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has the required policy 3.8 Youth Records that was last approved by the Executive Director on 11/23/25.	

All records are marked "confidential".	Compliance	All youth records were clearly marked "Confidential," ensuring proper identification and adherence to privacy requirements.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential" and only accessible by staff.	Compliance	All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.
When in transport, all records are locked in an opaque container marked "confidential".	Compliance	When transported, all records were placed in locked, opaque containers marked "Confidential," maintaining privacy and data security.
All records are maintained in a neat and orderly manner.	Compliance	Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.
<p>COMMUNITY COUNSELING FILES</p> <ol style="list-style-type: none"> 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Community Counseling Intake Form 5. Suicide Assessment (if needed) 6. NIRVANA full Assessment 7. Plan of Service 8. Chronological case notes 9. Copies of referrals made (if needed) 10. Discharge summary once the case is closed 	Compliance	Each Community Counseling file included all required documents, including a table of contents, screening forms, informed consent, intake documentation, NIRVANA assessment, Plan of Service, chronological notes, referrals, and discharge summary.
If records are kept electronically, the records are maintained securely and can be made immediately available upon request for audit purposes.	Not Applicable	Thaise Orlando maintains paper copies of files.

Records are retained for five years after the termination date of the contract that is funding the youth’s service.	Compliance	Records were retained in compliance with policy for a minimum of five years following the termination date of the contract funding the youth’s services.
Additional Comments: There are no additional comments for this indicator.		
3.10 - Discharge and Follow Up	Satisfactory with Exception(s)	
Provider has a written policy and procedure that meets the requirement for Indicator 3.10	Yes	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy 3.10 Discharge and Follow	
The program provides a follow-up after 30 days post-discharge.	Exception	A thirty day follow up was not completed timely in one of eight files reviewed.
The program provides a follow-up after 60 days post-discharge.	Exception	A sixty day follow up was not completed timely in one of eight files reviewed.
Each file contains a discharge summary that describes the reason for termination.	Compliance	Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.
Each file contains a discharge summary that outlines the events of the case, services provided, and the progress of the youth and family.	Compliance	Each discharge summary outlined key case events, services provided, and measurable progress made by the youth and family throughout service delivery.
Each file contains a discharge summary that describes the living arrangements of the child at termination. If the child is not returned to the family at termination, the discharge summary contains the reason for the alternative placement, plans for the child’s living arrangement, and interim objectives set that will accomplish an eventual return, if possible and appropriate.	Compliance	All discharge summaries documented the youth’s living arrangements at termination. For youth not returning home, the file included the reasons for alternative placement, plans for ongoing stability, and goals supporting future reunification when appropriate.
Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.	Compliance	Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.

Each file contains a NIRVANA Post Assessment.	Compliance	Each file contained a completed NIRVANA Post-Assessment, documenting the youth’s progress and outcomes at discharge.
For cases that are referred for services by Truancy Court for FINS services, or to the case staffing committee for consideration of a CINS petition as a result of truancy related issues; youth having been deemed Truant by the Court, the Provider shall verify school attendance during 30- and 60-day follow-ups if the youth remains subject to compulsory education. If verification cannot be obtained, efforts are documented in the youth’s file.	Not Applicable	None of the records reviewed indicated referral source was truancy court.
Additional Comments: There are no additional comments for this indicator.		
Domain Six		
6.2 - Suicide Prevention		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 6.2		Yes
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a written policy and procedures which meet the requirements and is titled 6.2 Suicide Prevention. The policy was last reviewed and approved by the Chief Executive Officer and the Board of Directors on November 23, 2025.
SNAP maintains a written suicide prevention & response plan approved by the Florida Network.		N/A
Community Counseling maintains a written suicide prevention & response plan approved by the Florida Network.		Yes
Core Requirements All Programs: Upon intake, every youth is screened for suicidality using the five Florida Network questions.	Compliance	All youth are consistently screened for suicidality during intake using the five Florida Network questions.
Core Requirements All Programs: Screening results are reviewed, signed by a supervisor, and filed in the youth’s case record.	Compliance	Screening results are promptly reviewed, signed by a supervisor, and accurately filed in each youth’s case record.
A “yes” to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.	Compliance	Any positive response immediately triggers a full suicide risk assessment by a qualified LMHP or a clinician under direct LMHP supervision.

Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	Compliance	All suicide risk assessments are completed and reviewed by an LMHP within 24 hours of a positive screen.
Core Requirements (All Programs) All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.	Compliance	Assessments are thoroughly documented, capturing all relevant observations, youth statements, risk indicators, and follow-up actions, with proper LMHP signature and date.
Core Requirements (All Programs) If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	Compliance	When assessments are conducted by non-licensed staff, LMHPs consistently co-sign and date the review during their next on-site visit.
Core Requirements (All Programs) Parents/guardians and the Program Supervisor are notified immediately of any youth determined to be at risk or following a suicide attempt. All notification efforts (in-person, phone, certified mail) are documented in the case file.	Compliance	Parents/guardians and program supervisors are notified immediately of any youth at risk, and all contact efforts are well-documented in the case file.
Core Requirements (All Programs) If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	Not Applicable	One applicable record reviewed did not require Baker Act protocols.
Documentation & Family Notification		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	Compliance	All screenings, assessments, and supervision activities—including shift-to-shift handoffs—are clearly recorded in the daily logbook.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	Not Applicable	The guardian was present during the risk assessment and was made aware of the suicide risk screening.
When an immediate assessment is not possible, families receive community resource information.	Not Applicable	An immediate assessment was conducted by the program's licensed mental health professional.
Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.	Not Applicable	The screening was not conducted on school property.
Additional Comments: There are no additional comments for this indicator.		