



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

**Children's Home Society of Florida (Osceola)**

5768 S Semoran Blvd, Orlando, FL 32822

**February 18, 2026**

**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 Children's Home Society of Florida (Osceola) for the FY 2024-2025 at its program office located at 5768 S Semoran Blvd, Orlando, FL 32822. 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. Children's Home Society of Florida (CHS-Osceola) 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, 2025 through June 30, 2024.

The compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from CHS-Osceola present for the entrance interview were: Lauren Fuentes, Vice President of Child and Family Well-Being, Kristi Walsh, Program Manager, Laura Zamjahn (virtually), Senior Director of Out of Home Programs, and Cinthia Muniz, Counselor II. The last onsite QI visit was conducted on February 19, 2025.

In general, the Reviewer found that CHS-Osceola is in compliance with specific contract requirements. **Children's Home Society of Florida (CHS Osceola) 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 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](mailto:keithcarr@forefrontllc.com)

**2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 02-18-2025-2026**

<b>Agency Name: Children's Home Society of Florida (Osceola)</b>					<b>Monitor Name: Keith Carr Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 5768 S Semoran Blvd, Orlando, FL 32822</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): February 18, 2026</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
<b>I. Administrative and Fiscal</b>							
<b>DJJ Quality Improvement Peer Reviewer</b> 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"/>	I: The provider currently has two certified QI Peer Reviewers: Cinthya Muniz (CHS Osceola) and Kristi Walsh (CHS Osceola & CHS Treasure Coast), and both peers are scheduled to participate in at least one onsite program review for FY25-26.	<b>No recommendation or corrective action.</b>
<b>Additional Contracts</b> 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. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I: The agency reported the non-residential program only received funds from the Florida Network.	<b>No recommendation or corrective action.</b>
<b>Limits of Coverage</b> a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency presented a certificate of insurance from Combs Insurance Services, LLC. The certificate showed coverage from 07/01/2025 - 07/01/2026 with Alliance of Nonprofits for Insurance for the following kinds of coverage: Commercial General Liability, Social Service Professional and Improper Sexual Conduct with a limit of \$1,000,000 per occurrence,	<b>No recommendation or corrective action.</b>

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	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
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. <b>PTV</b>					damage to rented premises \$1,000,000, \$5,000 for medical expenses, \$1,000,000 for personal and adv injury, \$3,000,000 for products – comprehensive and OP aggregate, \$300,000 for general policy aggregate and \$1,000,000 for EBLI. Automobile Liability Insurance provides \$1,000,000 for a combined single limit. Directors and Officers liability with a limit of \$1,000,000. Umbrella policy and Excess Liability, with limits of \$2,000,000, per occurrence and aggregate, and \$4,000,000 for excess. The certificate showed coverage from 07/01/2025 - 07/01/2026 with AMTrust Insurance Company for Worker's Compensation and Employer's liability insurance with a minimum of \$1,000,000 per accident, \$1,000,000 per person, and \$1,000,000 policy limit.  The Florida Network is listed as a certificate holder on the certificate of Insurance.		

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<b>External/Outside Contract Compliance</b> a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I: During the entrance meeting, the agency reported there were no corrective action item(s) cited by an external funding source for this program.	<b>This indicator is not applicable.</b>
<b>Fiscal Practice</b> 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. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The Fiscal Policies and Procedures are maintained in the agency's Accounting Policies and Procedures Manual -V3.1 – Finance Department which appears to be consistent with GAAP and provides for limited internal controls. The Accounting Policies and Procedures provided are documented as last revised on December 6, 2019, and in 2024.	<b>No recommendation or corrective action.</b>
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.). <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D/I: The agency provided a general ledger dated from July 2025 – January 2026 that provides the grant activity and tracks fiscal activity with account numbers and separate funds as required.	<b>No recommendation or corrective action.</b>
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"/>	D/I: The agency reported that it utilizes purchasing cards (p-card) in lieu of petty cash for program related	<b>This indicator is not applicable.</b>

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allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – <b>ON SITE</b>						purchases not requiring a check request. Procedures for P-Card purchases and petty cash are contained in the Fiscal Policies and Procedures Manual.	
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). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided the Fifth Third Bank Payables Register and Monthly Account Summary for the following months was provided for review: July 2025 – December 2025. Each reconciliation was signed by two parties: the Accounting Analyst and the Accounting Manager on a monthly basis. If there was a balance due, there was an explanation of the issue currently being researched, which was due to the difference in the timing of the 3rd party payment service as a result of refunds, voids, and reissues of vendor payments.	<b>No recommendation or corrective action.</b>
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. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	D, I - N/A: The program reports that no equipment/inventory has been purchased with DJJ funds.	<b>This indicator is not applicable.</b>

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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. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided a bank statement from the Fifth Third Bank Account Summary for July 2025 - December 2025, CHS Monthly Bank Reconciliation, and the general ledgers showed payments of payroll taxes and applicable deposits.	<b>No recommendation or corrective action.</b>
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Income Statement for the CHS Central Florida CINS/FINS Program is for the current FY 2025-2026. The report reflects the agency's budget and variance. Variances in the budget are monitored on a regular basis by management.	<b>No recommendation or corrective action.</b>
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. <b>Can obtain from FNYFS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided evidence of a single audit titled: The Children's Home Society of Florida and Subsidiaries: Consolidated Financial Report dated June 30, 2025 and 2024 was completed by RSM US LLP on December 2025 and the independent auditor's report stated 'the results of our tests disclosed no findings of noncompliance or other matters that are required official reporting under Government Auditing Standards.'	<b>No recommendation or corrective action.</b>

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	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
						There was no management letter issued for this audit.	
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. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency no changes in this policy and provided the following policies: CHS5004 Equipment and Property Assignment, CHS2001 Records Management Practice, CHS1017 Confidentiality and Access to Client Information and Records – Practice, and CHS1046 Review of Potential HIPAA Confidentiality Violations to address the security and privacy of all employee and client data and how it is discarded, personal information is not easily accessible, and there are security procedures in place to address how equipment is protected and maintained.	<b>No recommendation or corrective action.</b>
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. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided evidence that every direct care staff employee, via CHS Check Report and copies of pay stubs for program staff, that staff are being paid at least \$19.00 per hour.	<b>No recommendation or corrective action.</b>

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<b>Major Programmatic Requirements</b>	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>	<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
<b>Disaster Planning</b> 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 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. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Documentation: The provider maintains an Emergency Disaster Plan that includes a procedural guide in emergency situations. The Disaster Preparedness Plan includes all required elements. The Universal Agreement/Emergency Disaster Shelter document was signed by the agency executive.	<b>No recommendation or corrective action.</b>

**2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
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**CONCLUSION**

CHS Osceola has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the 15 indicators were not applicable because the agency does not use petty cash, made no purchases using DJJ funds, and there were no external corrective action items reported for this review period. Consequently, the overall compliance rate for this contract monitoring visit is 100%. There are no recommendations or corrective actions required as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner that meets the standard described in the report findings.

**SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS**

**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](http://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**

Children's Home Society of Florida (Osceola)  
CINS/FINS Program

Date: February 18, 2026

Compliance Monitoring Services Provided by



February 18, 2026

## CINS/FINS Rating Profile

### Domain 1: Background Screening and Compliance

<b>1.0 Background Screening of Employees/Volunteers</b>	<b>Satisfactory</b>
<b>1.1 Annual Affidavit of Compliance with Good Moral Character Standards</b>	<b>Satisfactory</b>
<b>1.2 Provision of an Abuse Free Environment</b>	<b>Satisfactory</b>
<b>1.3 Incident Reporting</b>	<b>Satisfactory</b>
<b>1.4 Training Requirements</b>	<b>Satisfactory with Exception(s)</b>
<b>1.5 Data Entry &amp; Collection</b>	<b>Satisfactory</b>
<b>1.6 Analyzing and Reporting</b>	<b>Satisfactory</b>
<b>1.7 Client Transportation</b>	<b>Satisfactory</b>
<b>1.8 Client Contact</b>	<b>Satisfactory</b>
<b>1.9 Outreach Services</b>	<b>Satisfactory</b>

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

### Domain 3: Screening, Assessment & Case Management

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

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

### Domain 4: SNAP® Programs

<b>4.0 SNAP® Under 12</b>	<b>Not Applicable</b>
<b>4.1 SNAP® Fidelity Monitoring</b>	<b>Not Applicable</b>
<b>4.2 SNAP® for Youth</b>	<b>Not Applicable</b>
<b>4.3 SNAP® Youth Justice</b>	<b>Not Applicable</b>
<b>4.5 SNAP® for Schools and Communities</b>	<b>Not Applicable</b>

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

### Domain 6: Medication Management

<b>6.2 Suicide Prevention</b>	<b>Satisfactory</b>
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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 %**

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### 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  
 Heather Molinaro - Regional Monitor, Office of Accountability and Program Support Department of Juvenile Justice  
 Anthony Johnson - Counselor, Nehemiah Educational & Economic Development, Inc. (N.E.E.D.)

February 18, 2026

**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**

- Chief Executive Officer
- Chief Financial Officer
- Chief Operating Officer
- Executive Director
- Program Director
- Program Manager
- Program Coordinator
- Clinical Director
- Counselor Licensed

- Case Manager
- Counselor Non-Licensed
- Advocate
- Direct – Care Full time
- Direct – Part time
- Direct – Care On-Call
- Intern
- Volunteer
- Human Resources

- Nurse – Full time
- Nurse – Part time
- 1 # Case Managers
- 1 # Program Supervisors
- # Food Service Personnel
- # Healthcare Staff
- # Maintenance Personnel
- # Other (listed by title): \_\_\_

**Documents Reviewed**

- Accreditation Reports
- Affidavit of Good Moral Character
- CCC Reports
- Logbooks
- Continuity of Operation Plan
- Contract Monitoring Reports
- Contract Scope of Services
- Egress Plans
- Fire Inspection Report
- Exposure Control Plan

- 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

- Visitation Logs
- Youth Handbook
- # Health Records
- 10 # MH/SA Records
- 4 # Personnel /Volunteer Records
- 4 # Training Records
- 5 # Youth Records (Closed)
- 5 # Youth Records (Open)
- # Other: \_\_\_
- \_\_\_

**Observations During Review**

- Intake
- Program Activities
- Recreation
- Searches
- Security Video Tapes
- Social Skill Modeling by Staff
- Medication Administration

- Posting of Abuse Hotline
- Tool Inventory and Storage
- Toxic Item Inventory & Storage
- Discharge
- Treatment Team Meetings
- Youth Movement and Counts
- Staff Interactions with Youth

- Staff Supervision of Youth
- Facility and Grounds
- First Aid Kit(s)
- Group
- Meals
- Signage that all youth welcome
- Census Board

**Surveys**

# of Youth

2 # of Direct Staff

# of Other

February 18, 2026

## 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

Children's Home Society of Osceola County (CHS Osceola) is sub-contracted with the Florida Network of Youth and Family Services (FNYFS) to provide community counseling services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program for Osceola County. CHS Osceola provides services for youth between the ages of ten to seventeen years who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. Children's Home Society is fully accredited by the Council of Accreditation (COA) effective until June 30, 2029. At the time of this onsite program review, there are no vacant staff member positions in the program.

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

**Domain 1:** There are nine 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 Satisfactory

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 with Exception(s)

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

**Domain 6:** There are five indicators for Domain 6.

Indicator 6.2 Suicide Prevention was rated Satisfactory

February 18, 2026

<b>CINS/FINS QUALITY IMPROVEMENT TOOL</b>		
<p><b>Quality Improvement Indicators and Results:</b>                      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><b>Summary/Narrative Findings:</b>                      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>	
<b>Domain One – Background Screening and Compliance</b>		
<b>1.0 - Background Screening</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.0</b>	Yes	
<b>Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0</b>	Yes	
	CHS/7101 Background Screening of Employees/ Volunteers, Annual Affidavit of Compliance with Good Moral Character & Annual Abuse Registry Clearance Laura Zamjahn, Sr. Director of Out of Home Care; 02.03.2026.	
<b>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).</b>		
<b>Suitability Assessment</b>		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	<b>Compliance</b>	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.	<b>Not Applicable</b>	The applicable agency applicant passed the initial suitability assessment on the initial attempt.
Did the applicant pass the suitability assessment?	<b>Compliance</b>	All applicant files confirmed a passing result for the suitability assessment.

February 18, 2026

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.	<b>Not Applicable</b>	The agency did not have any applicable staff members to review this requirement that have been re-employed with the agency with a break in service.
<b>New Hire</b>		
For New Hires-The background screening was completed and the applicant was determined eligible prior to the date of hire.	<b>Compliance</b>	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.	<b>Not Applicable</b>	The agency did not have any contractors, volunteers, or interns applicable to determine eligibility for this indicator.
For those with ineligible background screenings, the exemption was obtained prior to working with youth.	<b>Compliance</b>	All individuals with initially ineligible background screenings obtained required exemptions before working with youth.
<b>E-Verify</b>		
The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	<b>Compliance</b>	All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.
<b>5 Year Rescreening</b>		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	<b>Not Applicable</b>	The agency did not have any staff members, contractors, volunteers, or interns applicable for a five year rescreening.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.1 - Annual Affidavit of Compliance with Good Moral Character Standards</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.1</b>		Yes
		CHS/7101 Background Screening of Employees/ Volunteers, Annual Affidavit of Compliance with Good Moral Character & Annual Abuse Registry Clearance Laura Zamjahn, Sr. Director of Out of Home Care; 02.03.2026.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	<b>Compliance</b>	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.

February 18, 2026

Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	<b>Compliance</b>	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.2 - Provision of an Abuse Free Environment</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.2</b>		Yes
		CHS/7102 Providing an Abuse Free Environment Laura Zamjahn, Sr. Director of Out of Home Care; 02.03.2026.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation and there is evidence that it is provided to staff.	<b>Compliance</b>	The program maintains a formal code of conduct that strictly prohibits physical abuse, profanity, threats, intimidation, and other inappropriate behavior. The code of conduct is provided to all staff, with documented acknowledgment of receipt.
The Child Abuse Hotline number is clearly posted and visible for youth and staff to see.	<b>Compliance</b>	The Child Abuse Hotline number is clearly posted in visible locations accessible to both youth and staff.
The program has a process in place for reporting and documenting any child abuse hotline calls.	<b>Compliance</b>	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.
The agency is an abuse free environment.	<b>Compliance</b>	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from completed surveys.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.3 - Incident Reporting</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.3</b>		Yes
		CHS/7103 Incident Reporting Laura Zamjahn, Sr. Director of Out of Home Care; 02.03.2026.
<b>Data sources Reviewed</b>	<b>Dates Reviewed</b>	<b>Logbook Dates for Sample Size:</b>
CCC reports	02.19.2025- 02.18.2026 NONE	NONE

February 18, 2026

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.	<b>Not Applicable</b>	The program did not have any incidents during the review period which required reporting to the Department's Central Communication Center (CCC). The program has a policy and procedure which ensure all reportable incidents are documented and reported to the Department's CCC within the required timeframe.
The program completes follow-up communication tasks/special instructions as required by the CCC.	<b>Not Applicable</b>	The program did not have any incidents during the review period.
Incidents are documented in the program logs, and the CCC call is documented in the logbook for Shelter programs.	<b>Not Applicable</b>	The program did not have any incidents during the review period.
Agency internal incidents are documented on incident reporting forms or electronically and all CCC reportable incidents were consistently reported to CCC as required.	<b>Not Applicable</b>	The program did not have any incidents during the review period.
All incident reports are reviewed and signed by program supervisors/directors.	<b>Not Applicable</b>	The program did not have any incidents during the review period.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.4 - Training Requirements</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.4</b>	Yes	
	CHS/7104	
	Training Requirements Laura Zamjahn, Sr. Director of Out of Home Care; 02.03.2026	
<b>A total of 0 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 1 new hire staff and 3 annual staff files were reviewed for compliance with training</b>		
<b>Policy &amp; New Hire Training</b>		
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).	<b>Compliance</b>	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.
Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)	<b>Compliance</b>	All staff, including full-time, part-time, and on-call employees, completed Civil Rights & Federal Funds (U.S. Department of Justice) training within 30 days of hire, ensuring compliance with federal requirements.

February 18, 2026

<b>Pre-Service Training</b>		
Agency policies and procedures	<b>Compliance</b>	All new staff completed agency orientation and policy training prior to working independently.
Risk Management	<b>Compliance</b>	Risk Management training was completed prior to independent work with youth.
It's All About Reporting	<b>Compliance</b>	It's All About Reporting training was completed prior to independent work with youth.
Building/Facility layout	<b>Compliance</b>	Staff received orientation to the building and facility layout.
File Documentation/Paperwork Requirements	<b>Compliance</b>	File documentation and paperwork requirement training was completed as required.
Confidentiality (FYSB / DCF / Skill Pro)	<b>Compliance</b>	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	<b>Compliance</b>	Staff completed CCC and Incident Reporting training prior to working independently.
Child Abuse Reporting	<b>Compliance</b>	Child Abuse Reporting training was completed and verified in the staff record.
Client Intake & Screening	<b>Compliance</b>	Client Intake and Screening training was completed prior to independent case assignment.
Disaster Preparedness	<b>Compliance</b>	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	<b>Compliance</b>	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.
CPR/First Aid (By CPR Certified Instructor)	<b>Compliance</b>	CPR/First Aid training was completed by a certified instructor prior to independent duty.
CINS/FINS Core	<b>Compliance</b>	CINS/FINS Core training was completed and verified.
Florida Network Youth Suicide Prevention	<b>Compliance</b>	Florida Network Youth Suicide Prevention training was completed within the required timeframe.
Adolescent Development / Positive Youth Development	<b>Compliance</b>	Adolescent Development and Positive Youth Development training were completed and recorded.
Cultural Humility/Diversity	<b>Compliance</b>	Cultural Humility and Diversity training was completed through an approved provider (Bridge or RHYTTAC).
Mental Health and Substance Abuse	<b>Compliance</b>	Mental Health and Substance Abuse training was completed and documented in the staff record.
<b>Skill Pro Required Trainings:</b>		

February 18, 2026

Child Abuse: Recognition, Reporting and Prevention	<b>Compliance</b>	Staff completed Child Abuse: Recognition, Reporting, and Prevention training within the first 90 days of employment or service.
Equal Employment Opportunity	<b>Compliance</b>	Equal Employment Opportunity training was completed and documented within the first 90 days.
Human Trafficking Intervention for Direct Care Staff	<b>Compliance</b>	Human Trafficking Intervention for Direct Care Staff training was completed as required.
Information Security Awareness	<b>Compliance</b>	Information Security Awareness training was completed within the required timeframe.
Prison Rape Elimination Act (PREA) - Part 1	<b>Compliance</b>	Prison Rape Elimination Act (PREA) – Part 1 training was completed and documented in staff records.
Prison Rape Elimination Act (PREA) - Part 2	<b>Compliance</b>	Prison Rape Elimination Act (PREA) – Part 2 training was completed and verified in the staff file.
Sexual Harassment	<b>Compliance</b>	Sexual Harassment training was completed within the first 90 days of employment or service.
Trauma Responsive Practices	<b>Compliance</b>	Trauma Responsive Practices training was completed and documented as required.
<b>Additional FL Network Required Trainings:</b>		
Naloxone Training	<b>Compliance</b>	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)	<b>Compliance</b>	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 )	<b>Exception</b>	The last Florida Statute 984 CINS Petition training was held just before the community counselor start date (7/19/25). The program will be scheduling this training as soon as possible.
<b>STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles</b>		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	<b>Not Applicable</b>	No direct care staff member is required to complete this course.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	<b>Compliance</b>	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)	<b>Compliance</b>	JJIS Data Entry staff completed JJIS Alerts – Part 2 training before accessing JJIS.

February 18, 2026

Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	<b>Compliance</b>	Staff responsible for administering the NIRVANA® completed Motivational Interviewing (MI) training prior to NIRVANA® instruction.
NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA)	<b>Compliance</b>	Staff assigned to conduct NIRVANA® assessments completed NIRVANA® training prior to administering the assessment, verified with the Lead.
SNAP Support Overview *This training does not certify staff to facilitate SNAP After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator	<b>Not Applicable</b>	This agency does not have a SNAP contract with the FNYFS.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	<b>Not Applicable</b>	This agency does not have a SNAP contract with the FNYFS.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	<b>Compliance</b>	NetMIS users completed NetMIS training prior to being granted system access.
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*	<b>Compliance</b>	Non-licensed clinical staff completed 16 hours of clinical training and 36 hours of topic-specific training prior to working independently with youth.
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*	<b>Compliance</b>	Bachelor's-level non-licensed counseling staff without two years of prior clinical experience completed mental-health and substance-related coursework within the first year of employment.
For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.	<b>Compliance</b>	When trainings were delayed, documentation of the reason and the scheduled completion date was maintained in the staff training file.

**February 18, 2026**

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.	<b>Compliance</b>	Direct-care staff completed all pre-service requirements prior to working independently and achieved at least 80 hours of training within their first year.
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.	<b>Not Applicable</b>	Not applicable to any current staff members.
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.	<b>Not Applicable</b>	Not applicable to any current training courses.
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.	<b>Compliance</b>	The agency has a designated staff member responsible for managing all employee training files and routinely reviews them to ensure compliance.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	<b>Compliance</b>	All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.
<b>Annual Training</b>		
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 )	<b>Compliance</b>	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)	<b>Exception</b>	One of the three reviewed staff training records did not complete the Department's SkillPro Child Abuse training. This staff member is the licensed mental health clinician overseeing the non-licensed staff.
Human Trafficking Intervention for Direct-Care Staff (Annually)	<b>Exception</b>	One of the three reviewed staff training records did not complete the Department's SkillPro Human Trafficking training.

February 18, 2026

Information Security Awareness (Annually)	<b>Exception</b>	One of the three reviewed staff training records did not complete the Department's SkillPro Information Security Awareness training.
It's All About Reporting	<b>Exception</b>	One of the three reviewed staff training records did not complete the " It's All About Reporting" Training.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	<b>Compliance</b>	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)	<b>Compliance</b>	Prison Rape Elimination Act (PREA) Part 2 training is completed every two years and supported by appropriate documentation.
Sexual Harassment (Every 2 Years)	<b>Compliance</b>	Sexual Harassment training is completed every two years and verified in staff files.
Trauma Responsive Practices (Every 2 Years)	<b>Exception</b>	One of the three reviewed staff member training records did not complete the Department's SkillPro Trauma Responsive Practices training.
<b>FL Network Annual Required Trainings REQUIRED for Staff Over 1 year</b>		
Florida Network Youth Suicide Prevention (Required Annually)	<b>Exception</b>	One of the three reviewed staff training records did not complete the FN Youth Suicide Training.
CPR (Every 2 Years - Check for current validity)	<b>Compliance</b>	CPR certification is current and renewed every two years in accordance with Network requirements.
First Aid (Every 2 Years - Check for current validity)	<b>Compliance</b>	First Aid certification is current and renewed every two years, with documentation maintained in the staff file.
SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	<b>Not Applicable</b>	This agency does not have a SNAP contract with the FNYFS.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	<b>Exception</b>	One of the three reviewed staff training records did not have documentation regarding why the annual training was not completed.
All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training hours received for the year.	<b>Compliance</b>	All direct-care Community Counseling staff meet the annual minimum requirement of 24 total training hours.

February 18, 2026

Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	<b>Compliance</b>	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.	<b>Compliance</b>	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.5 - Data Entry &amp; Collection</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.5</b>		Yes
		The agency has a policy titled 7105 Reporting and Analyzing. The policy was effective on 7/1/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
The program has a quality improvement process in place that includes designated staff responsibilities to ensure data accuracy and quality.	<b>Compliance</b>	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.	<b>Compliance</b>	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 (via meeting minutes/agendas). 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.	<b>Compliance</b>	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
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.6 - Risk Management/ Analyzing and Reporting Information</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.6</b>		Yes
		The agency has a policy titled 7108 Risk Management. The policy was effective on 7/1/2010, and approved by Sr. Director of Out of Home Care on 2/3/2026.
<b>Data sources Reviewed</b>		<b>Dates Reviewed</b>
Agency policy Domain 1. Interviewed Program Manager.		Case record reviews were reported in September and December 2025.
The program provides reports of aggregated data and committee/workgroup minutes analyzing information.	<b>Compliance</b>	The program consistently compiles and maintains aggregated data reports and meeting minutes from committees and workgroups, demonstrating active analysis and ongoing program improvement.

February 18, 2026

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.)	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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 that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	<b>Compliance</b>	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.7 - Client Transportation</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.7</b>	Yes	
	The agency has a policy titled 7106 Client Transportation. The policy was effective on 7/1/2025, and approved by Sr. Director of Out of Home Care on 2/12/2026.	
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
All drivers have an approved driver's license.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.

February 18, 2026

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.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
The list of approved drivers are covered under the agency's automobile insurance.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
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.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
Signed parental consent is obtained in advance of any single transport.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
If a single staff is transporting youth in a vehicle, there is evidence that the Program Director approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
If there is no signed parental consent for single staff transport and the transport is necessary and cannot be delayed; in addition to the single staff transportation requirements above, 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.	<b>Not Applicable</b>	This agency does not provide transportation to youth per the agency policy.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.8 - Client Contact Policy</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</b>	Yes	
	The agency has a policy titled 7113 Professional Boundaries. The policy was effective on 7/1/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.	
<b>Additional Comments: There are no additional comments for this indicator.</b>		

February 18, 2026

1.9 - Community Referrals and Outreach Services		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.9		Yes
		The agency has a policy titled 7.01 Outreach and Interagency Agreements. The policy was effective on 7/1/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
Outreach activities include education about services offered and guidance on accessing those services. 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.	Compliance	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.
The program has evidence that provides minutes of the event or other verification of staff participation.	Compliance	Documentation such as meeting minutes, sign-in sheets, and event summaries confirm active staff participation in all outreach activities.
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.	Compliance	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.
This responsibility is specified in their job description.	Compliance	The outreach lead's job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities.
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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

February 18, 2026

<b>Domain Three</b>		
<b>3.2 - Admission Process</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.2</b>		Yes
		The agency has a policy #7201 titled Screening Eligibility for Services and Intake Assessment. The policy was effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
<b>A total of ten file(s) were reviewed during this evaluation period. Of these, four were open and six were closed. Among the open file(s), zero residential (RES) and four</b>		
<b>For Community Counseling Services:</b> 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.	<b>Compliance</b>	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.
<b>Youth and parents/guardians receive the following in writing</b>		
Youth and parents/guardians are provided available service options in writing.	<b>Compliance</b>	Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.
Youth and parents/guardians are provided "Rights and Responsibilities of Youth" in writing.	<b>Compliance</b>	Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.
Parents/guardians are provided "Rights and Responsibilities of Parents" and/or parent brochure.	<b>Compliance</b>	Parents and guardians were provided the "Rights and Responsibilities of Parents" brochure at intake, and signed acknowledgment forms were present in all records.
<b>The following is also available to the youth and parents/guardians:</b>		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	<b>Compliance</b>	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.
Youth and parents/guardians are provided information regarding the programs grievance procedures.	<b>Compliance</b>	All youth and parents/guardians were informed of the program's grievance procedures, and documentation confirmed this information was reviewed and acknowledged.
If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.	<b>Compliance</b>	For any youth or families who declined to participate in services, staff documented the reason on the screening form and accurately logged the case in NETMIS in accordance with policy.
The intake took place in a setting that allows the client to feel safe and heard.	<b>Compliance</b>	Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

February 18, 2026

3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.3		Yes
		The agency has a policy #7202 titled Network Inventory of Risks & Needs Assessment (NIRVANA). The policy was effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.	Compliance	All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.
NIRVANA Assessment is initiated at intake.	Compliance	All components of the NIRVANA process initiation were fully compliant and supported by documentation in each file.
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).	Compliance	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.
All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	Compliance	All completed NIRVANA Assessments were entered into NetMIS within three business days of service commencement, ensuring timely data submission and compliance with reporting standards.
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.	Compliance	Supervisor signatures were documented within seven business days on all completed NIRVANA Assessments, confirming management review and approval.
A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.	Exception	Out of the 10 files reviewed, six were closed, and therefore eligible for review. Of those six files, one file did not meet the requirement because the post-assessment was not completed at discharge as required.
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	Exception	Of the 10 files reviewed, two required reassessment and were eligible for review. Of those two files, one did not meet the timeframe requirement.
All files must have the interview guide and/or printed NIRVANA.	Compliance	Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

February 18, 2026

<b>3.4 - Case Management, Counseling &amp; Non-Residential Services Policy</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.4</b>		Yes
		The agency has a policy # 7203 titled Service/Case Plans and policy # 7207 titled Youth Records & Case Management Services. The policies were effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
Each client is assigned a Counselor.	<b>Compliance</b>	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
<b>The following is also available to the youth and parents/guardians:</b>		
Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or nonlicensed staff working under the direct supervision of a licensed staff.	<b>Compliance</b>	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.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	<b>Compliance</b>	When a required weekly session was not conducted, the reason was clearly documented in both the youth's file and NetMIS, including any barriers to participation.
If case management needs extend beyond the counselor's role, a case manager is assigned.	<b>Compliance</b>	When case management needs exceeded the counselor's role, a dedicated case manager was promptly assigned to ensure comprehensive service coordination.
Case Manager establishes appropriate referrals to services.	<b>Compliance</b>	Case managers established appropriate community referrals and coordinated follow-up services to address the youth's individual needs.
All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed sessions.	<b>Compliance</b>	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.	<b>Compliance</b>	When mental health or substance abuse issues outside program capacity were identified, appropriate referrals were made to external providers and fully documented.
Clients that do not receive services for 30 days or more have their case closed.	<b>Not Applicable</b>	No cases contained evidence of not receiving services for 30 days or more. No cases reviewed in this sample were applicable for this indicator.
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.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

February 18, 2026

<b>3.5 - Adjudication Services: Case Staffing</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.5</b>		Yes
		The agency has a policy #7206 titled Adjudication/CINS Petition Process. The policy was effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
<b>A total of zero file(s) were reviewed during this evaluation period. Of these, zero were open and zero were closed. Among the open file(s), zero residential (RES) and zero community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and zero community counseling file(s) were reviewed.</b>		
A case staffing committee meeting is scheduled when one of the following occur (at minimum): 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	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
Notification to the family is sent no less than 5 working days prior to staffing.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
Notification to the committee is sent no less than 5 working days prior to the staffing date.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
A written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
<b>At a minimum, the case staffing is attended by:</b>		
Local school district representative	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
DJJ rep. or CINS/FINS provider	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
<b>Other members may include:</b>		
State Attorney's Office	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.

February 18, 2026

Mental health representative	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
Substance abuse representative	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
Law enforcement representative	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
DCF representative	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
Others requested by youth/family	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
The program has an established case staffing committee and has regular communication with committee members.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
The program has an established case staffing committee, and has regular communication with committee members.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.6 - Adjudication Services: CINS Petition Process</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.6</b>		Yes
		The agency has a policy #7206 titled Adjudication/CINS Petition Process. The policy was effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
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.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
The Case Manager/Counselor completes a review summary prior to the court hearing for a youth.	<b>Not Applicable</b>	Agency reported no eligible case staffing clients for the program review.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.7 - Service Plan</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.7</b>		Yes
		The agency has a policy # 7203 titled Service/Case Plans and policy # 7207 titled Youth Records & Case Management Services. The policies were effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA in the community counseling program.	<b>Compliance</b>	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.	<b>Compliance</b>	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.

February 18, 2026

<b>Youth and parents/guardians receive the following in writing</b>		
The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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 for each identified goal.	<b>Compliance</b>	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 for each identified goal.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Not Applicable</b>	When applicable, all cases reviewed contained evidence of documentation for all absences of missing information or reasons for missing signatures.
The signature of the counselor is documented in the service plan.	<b>Compliance</b>	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.	<b>Compliance</b>	The plan includes the LMHP's signature within seven days of completion, confirming timely clinical review and oversight.
The date of plan initiation is clearly indicated.	<b>Compliance</b>	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.
<b>The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s):</b>		
At, 30 Days, following plan initiation.	<b>Exception</b>	Out of the 10 files reviewed, three files did not meet the requirement because the reviews were conducted after the 30-day timeframe.
At, 60 Days, following plan initiation.	<b>Exception</b>	Out of the 10 files reviewed eight were eligible for a 60-day review. Three files did not meet the requirement because the reviews were conducted after the 60-day timeframe.

February 18, 2026

At, 90 Days, following plan initiation.	<b>Exception</b>	Out of the 10 files, two files were eligible for a 90-day review. One file met the requirement with a documented review completed within the required timeframe, and one file did not meet the requirement.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	<b>Compliance</b>	For court-ordered youth, the Case/Service Plan is reviewed every six months or more frequently as needed, ensuring alignment with court requirements and ongoing progress toward treatment objectives.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.8 - Youth Records</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.8</b>	Yes	
	The agency has a policy #7207 titled Youth Records & Case Management Services. The policy was effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.	
All records are marked "confidential".	<b>Compliance</b>	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.	<b>Compliance</b>	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".	<b>Compliance</b>	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.	<b>Compliance</b>	Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.
COMMUNITY COUNSELING FILES 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	<b>Compliance</b>	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.	<b>Compliance</b>	Electronic records were securely maintained within password-protected systems with access limited to authorized personnel and were readily available upon request for audit purposes.

February 18, 2026

Records are retained for five years after the termination date of the contract that is funding the youth's service.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.10 - Discharge and Follow Up</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.10</b>		Yes
		The agency has a policy #7311 titled Case Termination/Follow Up. The policy was effective on 07/01/2025, and approved by Sr. Director of Out of Home Care on 2/3/2026.
30 day follow-ups are provided post discharge for all youth served.	<b>Compliance</b>	Follow-up contacts were completed within 30 days post-discharge, with documentation confirming continued client stability and connection to recommended services.
60 day follow-ups are provided post discharge for all youth served.	<b>Compliance</b>	Follow-up contacts were also completed within 60 days post-discharge, ensuring ongoing support and successful transition for youth and families.
Each file contains a discharge summary that describes the reason for termination.	<b>Compliance</b>	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, progress of the youth and family, and recommendations for future treatment or services.	<b>Compliance</b>	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 must contain the reasons for the alternative placement, plans for the child's living arrangement, and interim objectives set that will accomplish an eventual return, if possible and when appropriate.	<b>Compliance</b>	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.

February 18, 2026

<p>Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.</p>	<p><b>Compliance</b></p>	<p>Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.</p>
<p>Each file contains a NIRVANA Post Assessment.</p>	<p><b>Compliance</b></p>	<p>Each file contained a completed NIRVANA Post-Assessment, documenting the youth's progress and outcomes at discharge.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>For cases referred due to truancy, school attendance was verified during the 30- and 60-day follow-ups for youth subject to compulsory education. When verification could not be obtained, all efforts were documented in the youth's file.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>Domain Six</b></p>		
<p><b>6.2 - Suicide Prevention</b></p>		<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 6.2</b></p>		<p>Yes</p>
		<p>The agency has a policy titled 7407 Identification of Suicide Risk in Community Counseling programs. The policy was effective on 7/01/2011 and approved by Sr. Director of Out of Home Care on 2/2/2026.</p>
<p><b>Community Counseling maintains a written suicide prevention &amp; response plan approved by the Florida Network.</b></p>		<p>Yes</p>
<p>Upon intake, every youth is screened for suicidality using the five Florida Network questions.</p>	<p><b>Compliance</b></p>	<p>All youth are consistently screened for suicidality during intake using the five Florida Network questions.</p>

February 18, 2026

Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
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.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
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.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
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.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
<b>Documentation &amp; Family Notification</b>		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
When an immediate assessment is not possible, families receive community resource information.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.	<b>Not Applicable</b>	The agency reported that no clients screened positive on the suicide risk assessment. As a result, no eligible items were available for review for this indicator.
<b>Additional Comments: There are no additional comments for this indicator.</b>		