



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

**Tampa Housing Authority**

5301 West Cypress St  
Tampa, FL 33607

**November 25, 2025**

**Compliance Monitoring Services Provided by**



## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Tampa Housing Authority for the FY 2025-2026 at its program office located at 5301 West Cypress Avenue, Tampa, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Tampa Housing Authority is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2025 through June 30, 2026.

The compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC, Consultant for Forefront LLC. Agency representatives from Tampa Housing Authority present for the entrance interview were: Natisha Johnson, Program Manager, and Elizabeth Carrasquillo, Treatment Supervisor. The last onsite QI visit was conducted on November 13, 2024.

In general, the Reviewer found that the Tampa Housing Authority is in compliance with specific contract requirements. **Tampa Housing Authority received an overall compliance rating of 58% out of 100% for achieving full compliance with seven out of 12 applicable indicators of the CINS/FINS Monitoring Tool.** 1) There were no recommendations as a result of the monitoring visit. However, there were 5 corrective action items identified as a result of the monitoring visit.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: [keithcarr@forefrontllc.com](mailto:keithcarr@forefrontllc.com)

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

<b>Agency Name: Tampa Housing Authority</b>					<b>Monitor Name: Keith Carr, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 5301 W. Cypress Ave., Tampa, FL 33607</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): November 25, 2025</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"/>	Interview: The program manager report two staff members certified as DJJ QI Peer reviewers: Natisha Johnson and Elizabeth Carrasquillo. Both staff members participated as peer reviewers during FY 2024-2025.	<b>No recommendation of 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"/>	Documentation: The THA provided a list, titled PPS Grant Summary, of multiple contracts for 2025. The list includes: the name of the grant, funding source, contract period, description of funding, and contract amount.	<b>No recommendation of 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"/>	Documentation: The Housing Authority Risk Retention Group provides Commercial General Liability Insurance with a minimum of \$1,00,000 each occurrence, \$1,000,000 personal injury and adv, \$2,000,000 general aggregate, and is effective 10/01/2025-10/01/2026.	<b>No recommendation of 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>		
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>						<p>Workers' Compensation Insurance is provided by Zenith Insurance Company and meets the minimum requirements with a minimum of \$100,000 per accident, \$100,000 per person, and \$500,000 policy aggregate and is effective from 7/01/2025-7/01/2026. The Everest National Insurance Company provides automobile insurance and provides \$1,000,000 in coverage and meets the 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.</p> <p>The FNYFS is listed as a Certificate Holder.</p>	
<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"/>	<p>Interview: The program manager reported the agency had no outstanding corrective action item(s) cited by other funding sources.</p>	<b>N/A - No recommendation of 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>		
<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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: As of the date of the onsite program review, information from the official document request submitted on November 12, 2025 has not been provided.	<b>Corrective Action 1):</b> Provide official agency fiscal policy and procedure manual.
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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: As of the date of the onsite program review, information from the official document request submitted on November 12, 2025 has not been provided.	<b>Corrective Action 2):</b> Provide the official agency general ledger specific to the FNYFS.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Interview: The program manager reported the agency does not utilize a petty cash process associated with the FNYFS contract.	<b>N/A - No recommendation of corrective action.</b>
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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: As of the date of the onsite program review, information from the official document request submitted on November 12, 2025 has not been provided.	<b>Corrective Action 3):</b> Provide evidence that financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt and additional information associated with this request.
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Documentation: The agency does not purchase property over \$1000 with FNYFS funds.	<b>N/A - No recommendation of corrective action.</b>

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	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. <b>PTV/ON SITE</b>							
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"/>	Documentation: As of the date of the onsite program review the program provided documentation of federal tax payments of the 2 <sup>nd</sup> quarter April, May and June and the 3 <sup>rd</sup> quarter July, August, and September	<b>No recommendation of 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: As of the date of the onsite program review, information from the official document request submitted on November 12, 2025 has not been provided.	<b>Corrective Action 4):</b> Provide official agency evidence of Budget to Actual reports that have evidence of being reviewed by management and information associated with this request.
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"/>	Documentation: The annual single audit was conducted by Berman Hopkins CPA & Associates LLP for the year ended March 31, 2024, in a letter dated July 30, 2025. Per the audit report, there were no audit findings that needed to be reported or any questions about costs.	<b>No recommendation of corrective action.</b>

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	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: As of the date of the onsite program review, information from the official document request submitted on November 12, 2025 has not been provided.	<b>Corrective Action 5):</b> Provide evidence of official confidentiality policy and other associated information associated with this request.
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"/>	Interview: The agency reported program manager and treatment supervisor manager have direct care responsibilities and utilize unpaid interns assigned to provide direct care services to clients. Three primary staff members all have evidence of being compensated at the minimum level or above.	<b>No recommendation of corrective action.</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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: As of the date of the onsite program review, information from the official document request submitted on November 12, 2025 has not been provided.  The agency is not required to complete the Universal	<b>No recommendation of 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> I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
<ul style="list-style-type: none"> <li>o Severe weather procedures</li> <li>o Evacuation logistics (shelter only)</li> <li>o Evacuation facility designation (shelter only)</li> <li>o Critical Resource Planning</li> <li>o Florida Network and DJJ notification requirements</li> </ul> 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>						Agreement/Emergency Disaster Shelter document.	

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

**CONCLUSION**

The Compliance Monitoring review consisted of a total of 15 compliance indicators. Three of the indicators were not applicable because: 1) the provider does not have any outstanding corrective actions with external funders; 2) the program does not utilize petty cash; and 3) no new inventory was purchased with Florida Network funds. Tampa Housing Authority will be required to meet the requirements for the FNYFS CINS/FINS contract as a result of full compliance with twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Five of the 12 applicable compliance indicators were not met at the time of the onsite review. Consequently, the overall compliance rate for this contract monitoring visit is 58% out of the 100% requirement.

There are 5 corrective actions that are required to be addressed by the agency as a result of the contract monitoring visit. Currently, your agency has not met the majority of the compliance requirements for fiscal and administrative terms of its contract. In addition, the information necessary was not provided in the notice given on November 12, 2025. Therefore, the majority of indicators could not be reviewed in order to determine if they were carried out as required and minimum compliance performance standards.

**SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS**

**Corrective Action 1): Provide official agency fiscal policy and procedure manual.**

**Corrective Action 2): Provide official agency general ledger specific to the FNYFS.**

**Corrective Action 3): Provide evidence that financial records and reports are current. Include bank statements reconciled within 6 weeks of receipt and additional information associated with this request.**

**Corrective Action 4): Provide official agency evidence of Budget to Actual reports that have evidence of being reviewed by management and information associated with this request.**

**2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
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**Corrective Action 5): Provide evidence of official confidentiality policy and other associated information associated with this request.**

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

Review of Tampa Housing Authority  
CINS/FINS Program

Date: November 25, 2025

Compliance Monitoring Services Provided by



## CINS/FINS Rating Profile

### Domain 1: Background Screening and Compliance

<b>1.0 Background Screening of Employees/Volunteers</b>	<b>Limited</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>Failed</b>
<b>1.5 Data Entry &amp; Collection</b>	<b>Satisfactory</b>
<b>1.6 Analyzing and Reporting</b>	<b>Limited</b>
<b>1.7 Client Transportation</b>	<b>Satisfactory with Exception(s)</b>
<b>1.8 Client Contact</b>	<b>Satisfactory with Exception(s)</b>
<b>1.9 Outreach Services</b>	<b>Satisfactory with Exception(s)</b>

**Percent of indicators rated Satisfactory: 70 %**  
**Percent of indicators rated Limited: 20 %**  
**Percent of indicators rated Failed: 10 %**

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

<b>3.2 Admission Process</b>	<b>Satisfactory with Exception(s)</b>
<b>3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)</b>	<b>Limited</b>
<b>3.4 Case Management, Counseling &amp; Non-Residential Services Policy</b>	<b>Failed</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>Limited</b>
<b>3.8 Youth Records</b>	<b>Satisfactory</b>
<b>3.10 Discharge and Follow Up</b>	<b>Satisfactory with Exception(s)</b>

**Percent of indicators rated Satisfactory: 62.5 %**  
**Percent of indicators rated Limited: 25 %**  
**Percent of indicators rated Failed: 12.5 %**

### 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: 68.42 %**  
**Percent of indicators rated Limited: 21.05 %**  
**Percent of indicators rated Failed: 10.53 %**

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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  
 Crystal Blair Gordon – Regional Monitor, Department of Juvenile Justice  
 Cayla Williams, LMHC - Counseling Service Supervisor, Orange County Youth and Family Services

November 25, 2025

**Methodology**

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

**Persons Interviewed**

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

**Documents Reviewed**

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input checked="" type="checkbox"/> Fire Prevention Plan	<input type="checkbox"/> Youth Handbook
<input type="checkbox"/> CCC Reports	<input type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> # Health Records
<input type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	<input type="checkbox"/> # MH/SA Records
<input checked="" type="checkbox"/> Continuity of Operation Plan	<input type="checkbox"/> Fire Drill Log	<input type="checkbox"/> # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> 7 # Training Records
<input checked="" type="checkbox"/> Contract Scope of Services	<input type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> 5 # Youth Records (Closed)
<input type="checkbox"/> Egress Plans	<input type="checkbox"/> Program Schedules	<input type="checkbox"/> 3 # Youth Records (Open)
<input type="checkbox"/> Fire Inspection Report	<input type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: ___
<input type="checkbox"/> Exposure Control Plan	<input type="checkbox"/> Vehicle Inspection Reports	___

**Observations During Review**

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

**Surveys**

<input type="checkbox"/> # of Youth	<input checked="" type="checkbox"/> 5 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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## 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

### Narrative Summary

Tampa Housing Authority is a non-residential program with administrative offices in Tampa, Florida. The program serves youth six – seventeen years old exhibiting ungovernability, running away, truancy, and other behaviors who primarily reside in the city. The program is located at 5301 West Cypress Street, Tampa, FL 33607. The community counseling program receives referrals from local schools, parents/ family members, other community-based programs, and churches in the Tampa area. The agency reported that it utilized master level interns from local universities to assist in providing services. The agency reported no vacancies or changes in senior leadership positions.

### 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 Limited
- 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 Failed
- Indicator 1.5 Data Entry & Collection was rated Satisfactory
- Indicator 1.6 Risk Management/ Analyzing and Reporting Information was rated Limited
- Indicator 1.7 Client Transportation was rated Satisfactory with Exception(s)
- Indicator 1.8 Client Contact was rated Satisfactory with Exception(s)
- Indicator 1.9 Outreach Services was rated Satisfactory with Exception(s)

**Domain 3:** There are eight indicators for Domain 3.

- Indicator 3.2 Admission Process was rated Satisfactory with Exception(s)
- Indicator 3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment) was rated Limited
- Indicator 3.4 Case Management, Counseling & Non-Residential Services Policy was rated Failed
- 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 Limited
- Indicator 3.8 Youth Records was rated Satisfactory
- Indicator 3.10 Discharge and Follow Up was rated Satisfactory with Exception(s)

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

- Indicator 6.2 Suicide Prevention was rated Satisfactory

November 25, 2025

**Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):****Domain 1:**

- 1.0 - Background Screening: Two out of seven interns hired did not pass the suitability assessment on the initial attempt on 4/27/25 and received a 'low' score. One out of two interns completed the 2nd attempt outside of the 5 day window; however, it was passed with a 'high' score on that 2nd attempt, and it was completed within the 30 days. The 2nd intern passed and completed within the 5 day window. An informal interview with the Program Manager indicated two staff were hired before the background screening was completed, but did not have contact with youth until cleared. An informal interview with the Program Manager indicated that two interns were hired before the background screening was completed, but they did not have contact with the youth until cleared. One five year re-screen has not yet been completed at the time of the review.
- 1.4 - Training Requirements: All staff have Excel-based training logs; however, they do not meet the FN training log requirement to include all required tracking information. Three out of the five have evidence of a training log, but these training logs have limited to no information regarding course completion. The organization of staff training logs is inconsistent in terms of having missing information, such as topics, hours, and dates of completion. Three staff are missing the Agency Policies and Procedures training. Five staff did not have evidence of completing the Building Facility and Layout training. Five staff files had no evidence of completing the File Documentation/Paperwork training. Two staff are not in compliance with completing Confidentiality training requirements. Five staff are missing CCC and Incident Reporting training. One out of five staff lacks evidence of completing the Child Abuse Reporting training. Five staff have no evidence of completing Client Screening and Intake training. Five staff do not have evidence of the Disaster Preparedness training. One staff does not have evidence of completing Universal Precautions training. One staff does not have evidence of completing CPR/First Aid training. One staff does not have evidence of completing CINS/FINS CORE training requirements. One staff does not have evidence of completing FNYFS Suicide Prevention training. One staff does not have evidence of completing Adolescent/Positive Youth Development training. Two staff do not have evidence of completing Cultural Humility/Diversity training. Two staff do not have evidence of Mental Health and Substance Abuse training requirements. Two staff do not have evidence of Child Abuse: Recognition, Reporting, and Prevention training. One staff does not have evidence of Equal Opportunity Employment training. Two staff do not have evidence of Human Trafficking training. One staff does not have evidence of Information Security Awareness training. Two staff do not have evidence of Prison Rape Elimination Part 1 training. Two staff do not have evidence of Prison Rape Elimination Part 2 training. Four staff are not in compliance with completing Sexual Harassment training. One staff does not have evidence of Trauma Response Practices training. Five staff do not have evidence of Naloxone training. A total of two designated staff members received virtual FL Statute 984 CINS Petition Training from a local DJJ attorney on 7/17/2025; however, one staff member did not meet the timeframe requirement. Designated data entry staff do not have evidence of JJIS System Access training. Designated data entry staff do not have up-to-date evidence of JJIS Alerts Part 1 and JJIS Alerts Part 2. One applicable staff did not complete Motivational Interviewing training within the required timeframe. Four staff do not have evidence of NIRVANA Assessment training. The four new staff member files are Bachelor's level non-licensed counseling staff without 2 years of clinical experience assessing youth. There is no documentation in the current training files reviewed that indicates new staff completed the 16-hour plus topic-specific training. Four new staff members had no documentation that Mental health and substance-related disorders, Counseling theory and techniques, Group dynamics and therapy, Treatment and discharge planning training had been completed as required for the applicable files. Per the last revision of the policy from March 2025, the Program Manager is designated as the person responsible for monitoring and managing employee files for compliance through documented routine tracking within the required timeframes for all staff.

- 1.6 - Risk Management/ Analyzing and Reporting Information: Documentation provided by the agency on how the agency reports, analyzes and monitors its internal program and service delivery is limited and vague and lacks detail on issues that require review, intervention, and implementation to correct. The agency reports conducting quarterly case record reviews; however, the review process is limited to a checklist verifying the presence and signatures of required documents. This process does not assess the quality or consistency of service delivery, including documentation of missed or inconsistent counseling sessions. Based on the documentation reviewed, the agency does not have an adequate or comprehensive case record review process to support quarterly reviews in compliance with CINS/FINS requirements. The agency has limited review of its practice. The agency program manager reported that EOM reports are reviewed at monthly meetings. The monthly meetings include limited notes by the program manager of the agency's review of their agency's practice. The agency's approach to correcting performance issues does not detail the identification of the problem, implementation of intervention, review of intervention, and testing of the model for correction. The agency utilizes a sheet with topics for the agency to address. The sheet does not list reviewing the issues, formulating an intervention plan to address the problem, monitoring practice, and whether the solution resolved the issue. E.g. Weekly counseling sessions are inconsistent. Staff members are missing training.

**Domain 3:**

- 3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment): A review of completed NIRVANA assessments entered into NETMIS was not entered within 3 business days of completion for one out of eight client files. Four out of eight client files were missing the supervisor signature for NIRVANA, chrono note, or interview guide in the youth's file within the required time frame. One out of three is missing the Nirvana Post-Assessment.
- 3.4 - Case Management, Counseling & Non-Residential Services Policy: Six out of eight client files reflect not being consistently served once per week. Client one missing evidence of one week of counseling services. Client two missing one week of counseling services. Client three missing two weeks of counseling services and no documentation for missing more than 30 days. Client five missing evidence of two weeks of counseling services. Client six missing evidence of more than three weeks of counseling services. Client seven missing evidence of more than three weeks of counseling services. Six out of eight samples reflect clients not being served weekly, and no reasons for the absence of services explaining missed sessions were documented in the case file or Netmis. One out of eight cases indicate the youth not receiving services more than 30 days and had not been documented as discharged.
- 3.7 - Service Plan: One out of eight cases indicates the service plan was not developed within 1-2 contacts as required. One out of eight cases reviewed did not have a target date listed. Two out of eight cases actual completion dates are not listed. Four out of eight service plans are missing the youth's signature, and no documentation was found explaining the reason for the missing signature. One out of eight service plans is missing the parent's signature, but no explanation is clearly provided for the missing information. Seven out of eight cases do not provide documentation on the reasons explaining absence of the signature. Consultation with parent is verified, but notes do not capture reason for youth absence of signature. Four out of eight cases service plans are missing evidence of the signature of the licensed clinician. One of the eight cases indicated the licensed clinician signed the service plan seven business days outside of the completion. Three out of eight cases indicate the service plan review session was conducted outside of the 30 day time frame. Two out of six applicable cases indicate the service plan review sessions were conducted outside of the 60 day time frame. One out of three applicable cases indicate the service plan review session was conducted outside of the 90 day time frame.

<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>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.0</b>		No
<b>Provider has a implemented policy and procedure that meets the requirement for Indicator 1.0</b>		Yes
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy number is 1.0 and is titled Management Accountability. Policy last reviewed and approved March 2025 by the Program Manager.   Pre-assessment Tool: Berke Assessment Tool by High Match
<b>A total of eight file(s) were reviewed during this evaluation period. Of these, seven new hire file(s) and one 5-year rescreen file(s) were reviewed. The sample included four employee(s) and four 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>Exception</b>	Two out of seven interns hired did not pass the suitability assessment on the initial attempt on 4/27/25 and received a 'low' score.
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>Exception</b>	One out of two interns completed the 2nd attempt outside of the 5 day window; however, it was passed with a 'high' score on that 2nd attempt, and it was completed within the 30 days. The 2nd intern passed and completed within the 5 day window.

<p>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.</p>	<p><b>Not Applicable</b></p>	<p>At the time of this onsite program review. No staff members have a break in service which would require an additional suitability assessment.</p>
<p><b>New Hire</b></p>		
<p>For New Hires-The background screening was completed and applicant determined eligible prior to date of hire.</p>	<p><b>Compliance</b></p>	<p>Background screenings for all new hires were completed, and eligibility was confirmed prior to each hire date.</p>
<p>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.</p>	<p><b>Exception</b></p>	<p>An informal interview with the Program Manager indicated that two interns were hired before the background screening was completed, but they did not have contact with the youth until cleared.</p>
<p>For those with ineligible background screenings, the exemption was obtained prior to working with youth.</p>	<p><b>Not Applicable</b></p>	<p>No eligible background screenings were evident.</p>
<p><b>E-Verify</b></p>		
<p>The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.</p>	<p><b>Compliance</b></p>	<p>All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.</p>
<p><b>5 Year Rescreening</b></p>		
<p>Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.</p>	<p><b>Exception</b></p>	<p>One five year re-screen has not yet been completed at the time of the review.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		

<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>		<b>No</b>
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy number is 1.01 is titled Background Screening. They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.
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.
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>		<b>No</b>
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy number is 1.02 and is titled Incident Abuse Reporting. They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.
Does the program have a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation?	<b>Compliance</b>	The program maintains and enforces a written Code of Conduct that strictly prohibits physical abuse, profanity, threats, or intimidation. All staff demonstrate adherence to these standards.
The program has a process in place for reporting and documenting any child abuse hotline calls?	<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.

Agency is an abuse free environment.	<b>Compliance</b>	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from staff.
<b>Additional Comments:</b> There are no additional comments for this indicator.		
<b>1.3 - Incident Reporting</b>	<b>Satisfactory</b>	
Provider has a written policy and procedure that meets the requirement for Indicator 1.3	<b>No</b>	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy number is 1.03 and is titled Incident Reporting. They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.	
<b>Data sources Reviewed</b>	<b>Dates Reviewed</b>	<b>Logbook Dates for Sample Size:</b>
Reportable incidents documented as reported by the agency.	Incident report logs and DJJ CCC Report 5/24/2025-11/24/2025 included no reportable incidents.	Non-residential programs are not required to maintain a program logbook.
The program notified the Department’s CCC and reportable incidents were consistently reported as required, no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	<b>Not Applicable</b>	DJJ incident report detail and the program's internal incident report log revealed there were no reportable incidents during the review period.
The program completes follow-up communication tasks/special instructions as required by the CCC. (Refer to Policy 1.3 for specifics)	<b>Not Applicable</b>	No eligible incidents reports to review.
Incidents are documented in the program logs and CCC call is documented in the logbooks for Shelter programs (Refer to Policy 5.3)	<b>Not Applicable</b>	No eligible incidents reports to review.
Incidents are documented in the program logs and CCC call is documented in the logbooks for Shelter programs (Refer to Policy 5.3)	<b>Not Applicable</b>	No eligible incidents reports to review.
All incident reports are reviewed and signed by program supervisors/directors.	<b>Not Applicable</b>	No eligible incidents reports to review.
<b>Additional Comments:</b> There are no additional comments for this indicator.		

<b>1.4 - Training Requirements</b>		<b>Failed</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.4</b>	<b>No</b>	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy number is 1.04 and is titled Training. The agency does not have an updated policy for the current FY 2025-2026. The agency's last policy manual was last updated on March 2025.	
<b>A total of 4 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 5 new hire staff and 2 annual staff files were reviewed for compliance with training completed within the required timeframe(s).</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>Exception</b>	All staff have Excel-based training logs; however, they do not meet the FN training log requirement to include all required tracking information. Three out of the five have evidence of a training log, but these training logs have limited to no information regarding course completion. The organization of staff training logs is inconsistent in terms of having missing information, such as topics, hours, and dates of completion. Certificates and training documentation required to verify training are not consistently present across all staff training logs.
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.
<b>Pre-Service Training</b>		
Agency policies and procedures	<b>Exception</b>	Three staff are not in compliance and have no evidence of completing Agency Policies and Procedures training.
Building/Facility layout	<b>Exception</b>	Five staff did not have evidence of completing the Building Facility and Layout training.
File Documentation/Paperwork Requirements	<b>Exception</b>	Five staff files had no evidence of completing File Documentation/Paperwork training requirements.

Confidentiality (FYSB / DCF / Skill Pro)	Exception	Two staff are not in compliance of completing Confidentiality (FSBY/DCF/Skill Pro) training requirements.
CCC & Incident Reporting	Exception	Five staff are not in compliance of completing CCC and Incident Reporting training requirements.
Child Abuse Reporting	Exception	One out of five staff is not in compliance and lacks evidence of completing Child Abuse Reporting training requirement.
Client Intake & Screening	Exception	Five staff have no evidence of completing Client Screening and Intake training requirements.
Disaster Preparedness	Exception	Five staff are not in compliance of completing Disaster Preparedness training requirements.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	Exception	One staff does not have evidence of completing Universal training requirements.
CPR/First Aid (By CPR Certified Instructor)	Exception	One staff does not have evidence of completing CPR/First Aid training requirements.
CINS/FINS Core	Exception	One staff does not have evidence of completing CINS/FINS CORE training requirements.
Florida Network Youth Suicide Prevention	Exception	One staff does not have evidence of completing FNYFS Suicide Prevention training requirements.
Adolescent Development / Positive Youth Development	Exception	One staff does not have evidence of completing Adolescent/Positive Youth Development training requirements.
Cultural Humility/Diversity (Specific training at the agencies discretion. Available sources Bridge / RHYTTAC)	Exception	Two staff not in compliance and do not have evidence of completing Cultural Humility/Diversity training requirements.
Mental Health and Substance Abuse	Exception	Two staff not in compliance and do not have evidence of Mental Health and Substance Abuse training requirements.
<b>Skill Pro Required Trainings:</b>		
Child Abuse: Recognition, Reporting and Prevention	Exception	Two staff do not have evidence of Child Abuse: Recognition, Reporting and Prevention training requirements.
Equal Employment Opportunity	Exception	One staff does not have evidence of Equal Opportunity Employment training requirements.

Human Trafficking Intervention for Direct Care Staff	Exception	Two staff do not have evidence of Human Trafficking training.
Information Security Awareness	Exception	One staff does not have evidence of Information Security Awareness training.
Prison Rape Elimination Act (PREA) - Part 1	Exception	Two staff do not have evidence of Prison Rape Elimination Part 1 training.
Prison Rape Elimination Act (PREA) - Part 2	Exception	Two staff do not have evidence of Prison Rape Elimination Part 2 training.
Sexual Harassment	Exception	Four staff are not in compliance and do not have evidence of Sexual Harassment training.
Trauma Responsive Practices	Exception	One staff is not in and does not have evidence of Trauma Response Practices training.
<b>Additional FL Network Required Trainings:</b>		
Naloxone Training	Exception	Five staff do not have evidence of Naloxone training.
Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	Compliance	Adverse Childhood Experiences training was completed by staff members not participating in NIRVANA training.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only )	Exception	A total of two designated staff members received virtual training from a local DJJ attorney on 7/17/2025. One staff member did not meet the timeframe requirement.
<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)	Exception	Designated data entry staff do not have up to date evidence of JJIS System Access training.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	Exception	Designated data entry staff do not have up to date evidence of JJIS Alerts Part 1.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	Exception	Designated data entry staff do not have up to date evidence of JJIS Alerts Part 2.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	Exception	One applicable staff did not complete Motivational Interviewing training within the required timeframe.

<p>NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA) **Verify Date of Counselor or Case Manager's 1st case assignment with Lead**</p>	<p><b>Exception</b></p>	<p>Four staff do not have evidence of NIRVANA Assessment training.</p>
<p>SNAP Support Overview *This training does not certify staff to facilitate SNAP (Not Required for SNAP Staff but offered for staff in between hire date and completing full SNAP Facilitator training) After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator</p>	<p><b>Not Applicable</b></p>	<p>The program is not contracted to provide SNAP services.</p>
<p>SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups) *If the trained staff has not facilitated groups or participated in fidelity monitoring before the end of one year from the completion of either the SNAP Facilitator Training or Annual SNAP Refresher Training, they will be required to attend SNAP Facilitator Training prior to returning in a facilitation/fidelity monitoring role.</p>	<p><b>Not Applicable</b></p>	<p>The program is not contracted to provide SNAP services.</p>
<p>NetMIS Training (For NetMIS Users prior to accessing NetMIS)</p>	<p><b>Not Applicable</b></p>	<p>The agency Data Manager completes all NetMIS data entry requirements.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY Staff Suicide Assessment Training ** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person's personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)</p>	<p><b>Compliance</b></p>	<p>Non-licensed clinical staff completed the required 20 hours of Suicide Assessment training and five supervised one-to-one assessments under a licensed professional.</p>

<p>NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>The five new staff member files are Bachelor’s level non-licensed counseling staff without 2 years of clinical experience assessing youth. There was no documentation in the training files reviewed that indicated this training was in progress.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY Mental health and substance-related disorders; Counseling theory and techniques; Group dynamics and therapy; Treatment and discharge planning. (Required for Bachelor’s level non-licensed counseling staff without 2 years clinical experience assessing, counseling or treating youth with serious emotional disturbance or substance abuse problems) *To be completed during first year of employment*</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>The five new staff member files are Bachelor’s level non-licensed counseling staff without 2 years of clinical experience assessing youth. There is no documentation in the current training files reviewed that indicates this training is in progress.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>The agency did not have information or documentation of missing trainings or training that was not completed, nor was there any evidence provided to document future training dates.</p>
<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>At the time of the program review, none of the first year staff have training information organized for reviewer to verify completion of all mandatory first year training courses. Direct care staff have several trainings and/or hours of training courses that are still required to be completed.</p>
<p>If there was a break in employment for less than six (6) months, the file contains documentation confirming the supervisor reviewed applicable prior training and verified completion.</p>	<p style="text-align: center;"><b>Not Applicable</b></p>	<p>The program has not rehired any staff during the review period.</p>

<p>If the agency finds that the instructor is not available for the instructor led course within the required timeframe, then document attempts in the staff training file.</p>	<p><b>Not Applicable</b></p>	<p>There were no courses reviewed where the instructor was not available.</p>
<p>The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.</p>	<p><b>Exception</b></p>	<p>Per the last revision of the policy from March 2025, the Program Manager is designated as the person responsible for monitoring and managing employee files for compliance through documented routine tracking within the required timeframes for all staff. However, there is no evidence that there is an internal review by management to track training completed by staff members, and none of the staff team meeting minutes provided for review mentioned training as a topic of discussion or that it is being monitored for compliance regularly.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	<p><b>Exception</b></p>	<p>There was a lack of consistent evidence of completed training file documentation across several staff members provided for the review.</p>
<p><b>Annual Training</b></p>		
<p>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 &amp; 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 )</p>	<p><b>Exception</b></p>	<p>Two staff are not in compliance and do not have evidence of an official training file.</p>
<p>Child Abuse: Recognition, Reporting, and Prevention (Annually)</p>	<p><b>Compliance</b></p>	<p>Child Abuse: Recognition, Reporting, and Prevention training is completed annually and properly documented in staff training records.</p>
<p>Human Trafficking Intervention for Direct-Care Staff (Annually)</p>	<p><b>Exception</b></p>	<p>Two staff do not evidence of the Human Trafficking Intervention training.</p>

Information Security Awareness (Annually)	<b>Exception</b>	Two staff do not have evidence of Information Security Awareness training.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	<b>Exception</b>	None of the two files reviewed contained evidence that PREA 1 training is current. One file showed it was last completed in 2021, prior to the date of hire.
Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)	<b>Exception</b>	None of the two files reviewed contained evidence that PREA 2 training is current. One file showed it was last completed in 2021, prior to the date of hire.
Sexual Harassment (Every 2 Years)	<b>Exception</b>	One staff file does not have evidence of being in compliance with Sexual Harassment training. Documentation indicates this training was last completed in 2021.
Trauma Responsive Practices (Every 2 Years)	<b>Exception</b>	Four staff reviewed do not contain evidence of Trauma Responsive Practice training.
<b>FL Network Annual Required Trainings REQUIRED for Staff Over 1 year</b>		
Florida Network Youth Suicide Prevention (Required Annually)	<b>Exception</b>	Two of the files do not contain evidence of annual FNYFS Suicide Prevention 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>	The program is not contracted to provide SNAP services.

<p>For missed trainings, documentation includes the reason for delay and scheduled completion timeline.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>Written justification for missing training documentation was not provided across both members reviewed. The organization of staff training logs is inconsistent in terms of having missing information, but does not have a place to explain reasons or rationale for missing trainings.</p>
<p>All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training received for the year.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>Two staff member files reviewed did not contain evidence of completing 24 hours of training due to the lack of supporting documentation or evidence provided at the time of the program review.</p>
<p>Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>At the time of the onsite program review, the agency is tracking training based on date of hire. The agency program manager reported that the agency will be transitioning to monitoring training on a calendar year basis in 2026.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>Documentation of trainings completed is not being consistently maintained in the training files. An Excel training log is used to indicate the date training was done; however, there is no supporting evidence to confirm the date of completion.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>1.5 - Data Entry &amp; Collection</b></p>		<p style="text-align: center;"><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.5</b></p>		<p style="background-color: #f4cccc;">No</p> <p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: No specific policy number or title as of this onsite Quality Improvement program review. They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.</p>
<p>The program has a quality improvement process in place to review and improve accuracy of data entry and collection.</p>	<p style="text-align: center;"><b>Compliance</b></p>	<p>The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.</p>

<p>Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement (as reported on most recent End-of-Month ('EOM') report).</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>Monthly review of statewide End-of-Month ('EOM') reports is evidenced. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>		
<p><b>1.6 - Risk Management/ Analyzing and Reporting Information</b></p>	<p><b>Limited</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.6</b></p>	<p>No</p>	
	<p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy number is 1.05 and is titled Incident Reporting. They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.</p>	
<p><b>Data sources Reviewed</b></p>	<p><b>Dates Reviewed</b></p>	
<p>Reviewed agency's most recent list or internal emails associated the agency attempting to review the current data collection and process for follow up with the Data Manager.</p>	<p>Ongoing review of practice for the past 6 months to date of this review.</p>	
<p>The program provides reports of aggregated data and committee/workgroup minutes analyzing information.</p>	<p><b>Exception</b></p>	<p>Documentation provided by the agency on how the agency reports, analyzes and monitors its internal program and service delivery is limited and vague and lacks detail on issues that require review, intervention, and implementation to correct.</p>

<p>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.)</p>	<p><b>Exception</b></p>	<p>The agency reports conducting quarterly case record reviews; however, the review process is limited to a checklist verifying the presence and signatures of required documents. This process does not assess the quality or consistency of service delivery, including documentation of missed or inconsistent counseling sessions.</p> <p>Based on the documentation reviewed, the agency does not have an adequate or comprehensive case record review process to support quarterly reviews in compliance with CINS/FINS requirements.</p>
<p>The program reviews incidents, accidents, and grievances at least quarterly</p>	<p><b>Compliance</b></p>	<p>The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive measures.</p>
<p>The program reviews customer satisfaction data at least annually.</p>	<p><b>Compliance</b></p>	<p>Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.</p>
<p>The program reviews outcome data at least annually.</p>	<p><b>Compliance</b></p>	<p>Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.</p>
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p><b>Exception</b></p>	<p>The agency has limited review of its practice. The agency program manager reported that EOM reports are reviewed at monthly meetings. The monthly meetings include limited notes by the program manager of the agency's review of their agency's practice.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>

<p>Evidence shows strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process</p>	<p><b>Exception</b></p>	<p>The agency's approach to correcting performance issues does not detail the identification of the problem, implementation of intervention, review of intervention, and testing of the model for correction. The agency utilizes a sheet with topics for the agency to address. The sheet does not list reviewing the issues, formulating an intervention plan to address the problem, monitoring practice, and whether the solution resolved the issue. E.g. Weekly counseling sessions are inconsistent. Staff members are missing training.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>		
<p><b>1.7 - Client Transportation</b></p>		<p><b>Satisfactory with Exception(s)</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.7</b></p>		<p>No</p>
		<p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency does have a policy titled Client Transportation. It was last approved in March 2025. The agency reported onsite that they do not provide transportation to youth unless it is an emergency situation and it is preapproved by the program manager.</p>
<p>Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.</p>	<p><b>Not Applicable</b></p>	<p>THA agency did not have a sample eligible for review during the review period. The program reported no transports occurred since the past QI review.</p>
<p>The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.</p>	<p><b>Compliance</b></p>	<p>The agency maintains an established transportation policy and formal approval process that governs all youth transports, ensuring safety and accountability.</p>
<p>All drivers have an approved driver's license.</p>	<p><b>Compliance</b></p>	<p>All approved drivers hold valid driver's licenses verified by the agency prior to transporting youth.</p>
<p>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.</p>	<p><b>Not Applicable</b></p>	<p>A list of approved drivers was not provided, however, the agency reported they only transport if there is an emergency.</p>

The list of approved drivers are covered under the agency's automobile insurance.	<b>Exception</b>	The agency did not provide proof of staff being listed in the automobile insurance 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>	THA agency did not have a sample eligible for review during the review period. The program reported no transports occurred since the past QI review.
Signed parental consent is obtained in advance of any single transport.	<b>Not Applicable</b>	No eligible items for review.
If a single staff is transporting youth in a vehicle, there is evidence that the program supervisor approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.	<b>Not Applicable</b>	No eligible items for review.
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>	No eligible items for review.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.8 - Client Contact Policy</b>	<b>Satisfactory with Exception(s)</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</b>	<b>No</b>	
	The agency follows the guidelines of the Florida Network for this requirement, but did not have an approved updated policy for the current FY 2025-2026 at the time of the program review. The agency has created a new policy to address this requirement. However, the new policy will not be approved and become official until the next Board meeting scheduled in 2026. Additionally, the agency does have extensive personnel policies and includes Client Contact restrictions.	
<b>Additional Comments: There are no additional comments for this indicator.</b>		

1.9 - Community Referrals and Outreach Services		Satisfactory with Exception(s)
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</b></p>	No	<p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.</p>
	<p>Outreach activities include education about services offered and guidance on accessing those services.</p> <p>The following mandatory information of each outreach activity is entered into NETMIS: the title, date, duration (hours), zip code, location, description, estimated number of people reached, modality, target audience and topic. The activities include group presentations/discussions, individual meetings, short-term intervention groups, set up/display and distribution of materials at community events, conducting tours of facilities, and media events or interviews.</p>	<p><b>Compliance</b></p>
<p>The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p><b>Compliance</b></p>	<p>Documentation such as meeting minutes, sign-in sheets, and event summaries confirms active staff participation in all outreach activities.</p>
<p>The program has a lead staff member who conducts outreach, is designated to participate in local DJJ Board and council meetings and leads other outreach activities.</p>	<p><b>Compliance</b></p>	<p>A designated staff member serves as the program’s outreach lead, participates in local DJJ Board and council meetings, and coordinates all outreach efforts on behalf of the program.</p>
<p>This responsibility is specified in their job description.</p>	<p><b>Compliance</b></p>	<p>The outreach lead’s job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities. Documentation such as meeting minutes, sign-in sheets, and event summaries confirms active staff participation in all outreach activities.</p>

<p>Full-Service agencies document meetings with local stakeholders (school districts, judges, and law enforcement) at least two times per year to discuss services available and needed improvements.</p>	<p><b>Not Applicable</b></p>	<p>This is a community counseling program.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.</p>	<p><b>Compliance</b></p>	<p>The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.</p>
<p>Copies of agreements are forwarded to the Florida Network.</p>	<p><b>Exception</b></p>	<p>The agency has agreements that are present, but did not have evidence that they are forwarded to the Florida Network.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>		
<p><b>Domain Three</b></p>		
<p><b>3.2 - Admission Process</b></p>		<p><b>Satisfactory with Exception(s)</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.2</b></p>		<p style="background-color: #f4a460; padding: 2px;">No</p> <p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.</p>
<p><b>A total of eight file(s) were reviewed during this evaluation period. Of these, three were open and five were closed. Among the open file(s), zero residential (RES) and three community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and five community counseling file(s) were reviewed.</b></p>		

<p><u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.</p>	<p><b>Exception</b></p>	<p>Two out of the eight sample client file screenings were completed outside of three business day requirement.</p>
<p><b>Youth and parents/guardians receive the following in writing</b></p>		
<p>Youth and parents/guardians are provided available service options in writing.</p>	<p><b>Exception</b></p>	<p>One out of eight samples were missing the signature of the youth. Parent signature provided. No explanation for the lack of signature provided.</p>
<p>Youth and parents/guardians are provided “Rights and Responsibilities of Youth” in writing.</p>	<p><b>Exception</b></p>	<p>One out of eight samples were missing the signature of the youth. Parent signature provided. No explanation for the lack of signature provided.</p>
<p>Parents/guardians are provided “Rights and Responsibilities of Parents” and/or parent brochure.</p>	<p><b>Exception</b></p>	<p>One out of eight samples were missing the signature of the youth. Parent signature provided. No explanation for the lack of signature provided.</p>
<p><b>The following is also available to the youth and parents/guardians:</b></p>		
<p>Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)?</p>	<p><b>Compliance</b></p>	<p>Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.</p>
<p>Youth and parents/guardians are provided information regarding the programs grievance procedures.</p>	<p><b>Compliance</b></p>	<p>All youth and parents/guardians were informed of the program’s grievance procedures, and documentation confirmed this information was reviewed and acknowledged.</p>
<p>If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.</p>	<p><b>Not Applicable</b></p>	<p>Eight out eight samples were all admitted for services and have evidence of family participation.</p>

The Intake took place in a setting that allows the client to feel safe and heard.	<b>Exception</b>	Six out of eight youth records did not include the location where the intake took place to determine if the client feels safe and heard.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)</b>		<b>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.3</b>	<b>No</b>	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved policy. Policy was last updated on March 2025.	
NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.	<b>Compliance</b>	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.	<b>Compliance</b>	All components of the NIRVANA process initiation, completion, staff qualifications, supervisory review, and NetMIS entry 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). (Review Staff Roster to verify Counseling/Case Management staff degree and completion of MI and NIRVANA training)	<b>Compliance</b>	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.	<b>Exception</b>	A review of completed NIRVANA assessments entered into NETMIS was not entered within 3 business days of completion for one out of eight client files.
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.	<b>Exception</b>	Four out of eight client files were missing the supervisor signature for NIRVANA, chrono note, or interview guide in the youth's file within the required time frame.
A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.	<b>Exception</b>	One out of three is missing the Nirvana Post-Assessment.

A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	<b>Not Applicable</b>	There were no applicable NIRVANA Re-Assessments needed every 90 days.
All files must have the interview guide and/or printed NIRVANA.	<b>Compliance</b>	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>		
<b>3.4 - Case Management, Counseling &amp; Non-Residential Services Policy</b>		<b>Failed</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.4</b>	<b>No</b>	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved policy. Policy was last updated on March 2025.	
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>		
Community Counseling Program: Counseling sessions must be offered at a minimum once a week. (May include Individual, group, and family counseling, Crisis intervention, Parent training, Community-based mental health and substance abuse referrals, Case management, Prevention and diversion services, Skills training, tutorial/remedial services, Vocational, job training, or employment services, and Recreational services)	<b>Exception</b>	Six out of eight client files reflect not being consistently served once per week. Client one missing evidence of one week of counseling services. Client two missing one week of counseling services. Client three missing two weeks of counseling services and no documentation for missing more than 30 days. Client five missing evidence of two weeks of counseling services. Client six missing evidence of more than three weeks of counseling services. Client seven missing evidence of more than three weeks of counseling services.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	<b>Exception</b>	Six out of eight samples reflect clients not being served weekly and no reasons listed for why.
If case management needs extend beyond the counselor's role, a case manager is assigned.	<b>Not Applicable</b>	The agency does not have separate case management staff. All case management services are provided by the same designated counselor.

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 session/s.	<b>Exception</b>	Six out of eight samples reflect clients not being served weekly, and no reasons for the absence of services explaining missed sessions were documented in the case file or Netmis.
If mental health or substance abuse needs, outside of the program's capacity, are identified appropriate referrals are made and documented.	<b>Not Applicable</b>	None of the client files reviewed were identified as needing substance abuse services outside of the agency's offering.
Clients that do not receive services for 30 days or more have their case closed.	<b>Exception</b>	One out of eight cases indicate the youth not receiving services more than 30 days and had not been documented as discharged.
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>		
<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>	<b>No</b>	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.	

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

Substance abuse representative	<b>Not Applicable</b>	There were no applicable case staffings during the period of review.
Law enforcement representative	<b>Not Applicable</b>	There were no applicable case staffings during the period of review.
DCF representative	<b>Not Applicable</b>	There were no applicable case staffings during the period of review.
Others requested by youth/family	<b>Not Applicable</b>	There were no applicable case staffings during the period of review.
The program has an established case staffing committee, and has regular communication with committee members.	<b>Compliance</b>	The program maintains an established case staffing committee with active and consistent communication among all members.
The program has an established case staffing committee, and has regular communication with committee members.	<b>Compliance</b>	Regular collaboration and communication with case staffing committee members are maintained to ensure coordinated planning and support for youth and families.
<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>		<b>No</b>
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved policy. Policy was last updated on March 2025
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>	Sample size did not produce any need for case staffing 8 out of 8 files reviewed.
Case Manager/Counselor completes a review summary prior to the court hearing?	<b>Not Applicable</b>	Sample size did not produce any need for case staffing 8 out of 8 files reviewed.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.7 - Service Plan</b>		<b>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.7</b>		<b>No</b>
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved policy. Policy was last updated on March 2025.

A Case/Service Plan is developed within one contact following the completion of the NIRVANA.	<b>Exception</b>	One out of eight cases indicates the service plan was not developed within 1-2 contacts as required.
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.
<b>Youth and parents/guardians receive the following in writing</b>		
Individualized and prioritized need(s) and goal(s) identified during the assessment process including 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.	<b>Exception</b>	One out of eight cases reviewed did not have a target date listed.
The actual completion date(s) are documented in the service plan.	<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>Exception</b>	Four out of eight service plans are missing the youth's signature, and no documentation was found explaining the reason for the missing signature. Some client cases indicate contacting youth at school.
The signature of the parent/guardian is documented in the service plan.	<b>Exception</b>	Five out of eight cases indicated the service plan was reviewed via phone call. One out of eight service plans is missing the parent's signature, but no explanation is clearly provided for the missing information.

If unavailable, the absence is documented with a reason on the plan.	<b>Exception</b>	Seven out of eight cases do not provide documentation on the reasons explaining absence of the signature. Consultation with parent is verified, but notes do not capture reason for youth absence of signature.
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>Exception</b>	Four out of eight cases service plans are missing evidence of the signature of the licensed clinician. One of the eight cases indicated the licensed clinician signed the service plan seven business days outside of the completion.
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>	Three out of eight cases indicate the service plan review session was conducted outside of the 30 day time frame.
At, 60 Days, following plan initiation:	<b>Exception</b>	Two out of eight cases indicate the service plan review session was conducted outside of the 60 day time frame.
At, 90 Days, following plan initiation:	<b>Exception</b>	Two out of eight cases indicate the service plan review session was conducted outside of the 90 day time frame.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	<b>Not Applicable</b>	None of the eight client files reviewed were court-ordered youth.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

3.8 - Youth Records		Satisfactory
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.8</b></p>		<p>No</p>
		<p>Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved updated policy for this current FY 2025-2026. The agency's last policy manual was last updated on March 2025.</p>
<p>All records are marked "confidential"</p>	<p><b>Compliance</b></p>	<p>All youth records were clearly marked "Confidential," ensuring proper identification and adherence to privacy requirements.</p>
<p>All records are kept in a secure room or locked in a file cabinet that is marked "confidential" and only accessible by staff.</p>	<p><b>Compliance</b></p>	<p>All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.</p>
<p>When in transport, all records are locked in an opaque container marked "confidential".</p>	<p><b>Compliance</b></p>	<p>When transported, all records were placed in locked, opaque containers marked "Confidential," maintaining privacy and data security.</p>
<p>All records are maintained in a neat and orderly manner.</p>	<p><b>Compliance</b></p>	<p>Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.</p>
<p>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</p>	<p><b>Compliance</b></p>	<p>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.</p>

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.
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:</b> Client paper records are scanned into pdf documents and maintained electronically. Each client has an individual electronic folder where all scanned client documents are kept. All scanned records can be made available upon request for audit purposes. The client's PDF file documents are protected and only accessible via the agency's OneDrive.		
<b>3.10 - Discharge and Follow Up</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.10</b>		<b>No</b>
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved policy. Policy was last updated on March 2025.
Provides follow-up after 30 days post discharge?	<b>Exception</b>	Two out of the five closed client cases reviewed were missing documentation of the 30 day follow up.
Provides follow-up after 60 days post discharge?	<b>Compliance</b>	Follow-up contacts were also completed within 60 days post-discharge, ensuring ongoing support and successful transition for youth and families.
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.
Outlines the events of the case, services provided, progress of the youth and family	<b>Compliance</b>	Each discharge summary outlined key case events, services provided, and measurable progress made by the youth and family throughout service delivery.

<p>Describes the living arrangements of 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 appropriate;</p>	<p><b>Exception</b></p>	<p>Two out of the five closed client cases reviewed did not indicate the living arrangement of the youth at discharge. During the interview, the program manager indicated that a new business process and documentation for discharge has been rectified to indicate the living arrangements of youth. The reviewer confirmed observing the new process when reviewing files.</p>
<p>Outlines the aftercare recommendations and the arrangements for case follow-up.</p>	<p><b>Exception</b></p>	<p>Two out of the five closed client cases are missing aftercare arrangements, but did contain documentation of arrangements for case follow-up.</p>
<p>Each file contains a NIRVANA Post Assessment.</p>	<p><b>Exception</b></p>	<p>One out of the five closed cases is missing a required Post Nirvana assessment.</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>Not Applicable</b></p>	<p>There were no cases in this sample that were candidates for truancy and necessary to be referred to truancy court.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		

Domain Six		
6.2 - Suicide Prevention		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 6.2		No
		Indicate policy number, authorized signee, date(s) of last review/revision/approval: They are following the guidelines of Florida Network, but do not have an approved policy. Policy was last updated on March 2025.
Shelter maintains a written suicide prevention & response plan approved by the Florida Network.		N/A
SNAP maintains a written suicide prevention & response plan approved by the Florida Network.		N/A
Community Counseling maintains a written suicide prevention & response plan approved by the Florida Network.		Yes
Core Requirements All Programs: Upon intake, every youth is screened for suicidality using the five Florida Network questions.	Compliance	All youth are consistently screened for suicidality during intake using the five Florida Network questions.
Core Requirements All Programs: Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.	Compliance	Screening results are promptly reviewed, signed by a supervisor, and accurately filed in each youth's case record.
A "yes" to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.	Not Applicable	Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.
Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	Not Applicable	Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.
Core Requirements (All Programs) All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.	Not Applicable	Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.
Core Requirements (All Programs) If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	Not Applicable	Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.

<p>Core Requirements (All Programs) Parents/guardians and the Program Supervisor are notified immediately of any youth determined to be at risk or following a suicide attempt. All notification efforts (in-person, phone, certified mail) are documented in the case file.</p>	<p><b>Not Applicable</b></p>	<p>Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.</p>
<p>Core Requirements (All Programs) If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.</p>	<p><b>Not Applicable</b></p>	<p>Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.</p>
<p><b>Documentation &amp; Family Notification</b></p>		
<p>All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.</p>	<p><b>Not Applicable</b></p>	<p>Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.</p>
<p>If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.</p>	<p><b>Not Applicable</b></p>	<p>Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.</p>
<p>When an immediate assessment is not possible, families receive community resource information.</p>	<p><b>Not Applicable</b></p>	<p>Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.</p>
<p>Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.</p>	<p><b>Not Applicable</b></p>	<p>Sample size did not produce any need for risk assessment 8 out of 8 files reviewed did not require a risk assessment.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		