NORTH DADE YOUTH & FAMILY COALITION

PROVIDER SURVEY

North Dade Youth & Family Coalition is attempting to analyze the availability of community providers in the 33054, 33055, 33056 and 33169 areas to service youth and families with health, mental health, substance abuse counseling, dropout prevention, literacy, after-school/recreation, GED/tutoring, and parenting/family strengthening programs. The purpose is to prepare to coordinate services for residents and not duplicate services. We need your assistance. Please complete the survey below by including the programs and services your agency provides in the specified catchment area. Thank you for your participation in this important process.

EMAIL TO: **info@ndyfc.org** upon completion.

PROVIDER INFORMATION

Provider Name: _____

Contact Person: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Alternate Phone: _____

Email: _____

Does provider take insurance: ◯Yes ◯No Specify Type: _____ Medicaid? ◯Yes ◯No

TYPE OF PROVIDER

◯ Healthcare ◯ Licensed MH ◯ Mental Health Counseling

◯ Certified MSW ◯ Clinical Social Worker ◯ Substance Abuse Counseling

◯ Directors License Facility(ies) ◯ Literacy ◯ DCF License Facility(ies)

◯ After School/Recreation ◯ Certified Teachers on Staff ◯ GED/Tutoring

◯ Dropout Prevention ◯ Parent/Family Strengthening ◯ Other

◯ Languages Spoken other than English (Specify): _____

WHAT ADDRESS DOES THE PROVIDER PRACTICE

Facility Name: _____ City/Zip Code: _____

Address 1: _____

Facility Name: _____ City/Zip Code: _____

Address 2: _____

Facility Name: _____ City/Zip Code: _____

Address 3: _____

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PROGRAM(S) – PROGRAMS IN THE MIAMI GARDENS/OPA-LOCKA CATCHMENT AREA ONLY

Program Name (1): _____

Description: _____

Address: _____ Zip Code: _____

Closest Middle School: _____ Closest Elementary: _____

Telephone: _____ Fax: _____

Contact Person: _____

Contact Email: _____

Age of participants: ◯0 – 3 yrs. ◯5 – 10 yrs ◯10 – 12 yrs. ◯13 – 15 yrs ◯16 – 18 yrs. ◯Adult ◯65+ yrs

Number of available slots: _____ Transportation available? ◯Yes ◯No

Curriculum: _____ Research-based? ◯Yes ◯No

Program Time/Dates:

◯ Weekdays (Monday – Friday) ◯ Weekends ◯ After School ◯ School breaks/Holidays

Business hours (Specify) _____ ◯Appointment Only

Program Name (1): _____

Description: _____

Address: _____ Zip Code: _____

Closest Middle School: _____ Closest Elementary: _____

Telephone: _____ Fax: _____

Contact Person: _____

Contact Email: _____

Age of participants: ◯0 – 3 yrs. ◯5 – 10 yrs ◯10 – 12 yrs. ◯13 – 15 yrs ◯16 – 18 yrs. ◯Adult ◯65+ yrs

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CLIENT REFERRALS AND CARE COORDINATION PROTOCOLS

REFERRALS

1. The following criteria will be used to make referrals to Partner Agencies:
   a. Documented need
   b. Age and most appropriate location of the client. (i.e., school, home, etc.)
   c. Transportation
   d. When more than one Partner Agency provides the same type of service, in the same service area a system of rotation will be used starting in alphabetical order. (first, second, etc.)
2. Partner agencies must establish one contact person to whom referrals are sent; (b) who is responsible for accepting/rejecting referrals; and who can be reached for communication regarding client services.
3. Referrals are sent to Partner Agencies using established NDYFC Referral Form.
4. Signed Authorization to Release Forms will be sent to Partner Agency along with the Referral Form.
5. All referrals should be copied and retained in client file and a copy placed in the Client Referral Binder.
6. Referrals will be accepted / rejected by Partner Agency/organization within two (2) business days of the referral.
7. Documentation of service determination should be sent to NDYFC electronically within thirty (30) calendar days from referral acceptance.
8. Every thirty (30) days of service or by the 5th of each month, Partner Agencies will provide a monthly report documenting the following:
   a. Documented client goals, if feasible.
   b. Documented milestones reached.
   c. Evidenced-based practice used
   d. Length of time client is expected to remain in service and when services will be complete.
   e. Any barriers to service and/or challenges working with client.

CARE COORDINATION

9. Care coordination services should be conducted at the clients' home or at a place most comfortable and convenient to the client.
10. Each Client should be contacted within 5 business days of referral.
11. Intake should occur within 7 days of contact.
12. Assessment should occur at the time of intake unless not feasible, for which a clear description of why assessment did not occur should be documented in progress notes.
13. The supervisor must sign the Assessment Form within 15 days from the Assessment completion.
14. Referrals should be made timely using Partner Referral Form. The Referral Form should be placed in client file folder with a copy given to Administrative Assistant who will document referral services in database.
15. If care coordinator is unable to contact client after 4 attempts within seven days, a 10-day letter outlining attempts to contact client including programs will be sent.
16. Each attempt to contact client will be recorded within client case file.
17. Monthly file supervision will occur every 30 days.
18. Case note must be documented within 24 hours of visit.
19. Careful client monitoring should occur with face-to-face client visits every week.
20. The Termination Form should include an aftercare plan. The Termination Form should be signed by the client, case manager and the Supervisor must sign the form within 30 days of termination.