THE COMMUNITY PARTNERSHIP FOR THE PREVENTION OF HOMELESSNESS

TCP PROGRAM SITE VISIT REPORT

Contractor Name:

Contract Period:

Program Name (s):

Program Type:

Capacity:

Target Population:

Maximum Length of Stay:

Contact Person (s)/Title:

Address:

Phone:

Fax:

Email Address:

Date/Time of Visit:

TCP Staff Conducting Visit:

Visited Site Staff Present:

Purpose of visit:

Summary of Service:

Contract Deliverables and General Administrative

I. Did the provider supply the listed contract deliverables at the time of review?

	Yes	No	Notes
Required Permits for Operation: 501(c)3 Letter, BBL, Certificate of Occupancy, Insurance Certificates	☐	☐	
Agency Organizational Chart	☐	☐	
List of Staff Charged to Contract	☐	☐	
Staff Handbook	☐	☐	
Financial Audit for Previous Fiscal Year	☐	☐	
Forms: Intake and All Assessments	☐	☐	
Program Budget	☐	☐	
Organizational Budget	☐	☐	
Budget Narrative	☐	☐	
Signed Audit Request Form	☐	☐	
Verification of formerly Homeless Board member	☐	☐	
Program Rules	☐	☐	
Scope of Work	☐	☐	
Evidence of Coordination and Collaborative Agreements	☐	☐	

II. Staff Requirements and Personnel Files

Is the front line staff (excluding maintenance staff) trained on the following:

	Yes	No	Notes
A. ADA and Reasonable Accommodations (all staff)	☐	☐	
B. Assertive Engagement (all staff)	☐	☐	

C. Boundaries and Confidentiality (all staff)	☐	☐	
D. Conflict Resolution (all staff)	☐	☐	
E. Crisis Intervention (all staff)	☐	☐	
F. Customer Service and Language Access (all staff)	☐	☐	
G. Emergency Preparedness (all staff)	☐	☐	
H. Financial Literacy (Case Managers, Program Managers Housing Specialist)	☐	☐	
I. Financial Management & Contract/Grant Administration (Program Managers/Directors, Finance Officers and Executive Leadership)	☐	☐	
J. HIPPA (all staff excluding executive leadership)	☐	☐	
K. Homeless Services Reform Act of 2005 Regulation Overview (all staff)	☐	☐	
L. Housing Based Case Management (Program Managers, Case Managers and Housing Specialists)	☐	☐	
M. Housing First (Program Directors, Case Managers, Housing Specialist)	☐	☐	
N. Housing Quality Standards (Facilities Personnel and Directors, Program Managers, Operations Directors)	☐	☐	
O. LGBT Cultural Competency and Sensitivity Training (All Staff)	☐	☐	
P. Motivational Interviewing (Case Managers and Program Managers)	☐	☐	

Q. Non-coercive approaches to case management (Program Managers, Case Managers, Resident Monitors and Front line staff)	☐	☐	
R. Nonviolent Crisis Intervention (All Staff)	☐	☐	
S. SOAR (Case Managers, Program Managers, Housing Specialist	☐	☐	
T. Stages of Change (All Staff)	☐	☐	
U. Suicide Risk Assessment and Prevention (All Staff)	☐	☐	
V. Trauma Informed Care (All Staff)	☐	☐	
W. Understanding Special Needs (All Staff)	☐	☐	
X. Unusual/Critical Incident Reporting (All Staff)	☐	☐	

Do the personnel files contain verification of the following:

	Yes	No	Notes
A. Application or Resume	☐	☐	
B. Orientation Verification	☐	☐	
C. Description of Duties Signed at Hire and Annually	☐	☐	
D. Reference Checks	☐	☐	
E. Background Checks	☐	☐	
F. Current TB and Health Screenings	☐	☐	
G. Drug and Alcohol screenings	☐	☐	
H. Performance evaluations within the last 12 months	☐	☐	
I. When performance improvement is necessary	☐	☐	

III. Staff Interview

Summarize the staff interview (s) below.

IV. Home Visits and Facility Requirements

Does the provider conduct monthly home visits (scattered site programs such as permanent supportive housing and rapid rehousing programs)? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider conducts monthly home visits below.

Does the provider complete housing assessment forms? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider completes housing assessment forms with the date of last submission to TCP.

Does the provider have a fire drill log book?

☐ Yes ☐ No ☐ N/A

If no or not applicable, please provide notes below.

Does the provider conduct fire drills every thirty (30) day? ☐ Yes ☐ No ☐ N/A

If no or not applicable, please provide notes below.

Does the provider have properly functioning fire extinguishers?

☐ Yes ☐ No ☐ N/A

Indicate where the extinguishers are located and when they were last serviced below.

Did the provider conduct an annual fire inspection?

☐ Yes ☐ No ☐ N/A

Indicate verification of fire inspection below.

Does the provider have emergency evacuation routes posted and visible?

☐ Yes ☐ No ☐ N/A

Indicate where the plans are posted in the building below.

Has the provider submitted emergency planning and preparedness documentation?

☐ Yes ☐ No ☐ N/A

Does the provider have an exit sign at all exits?

☐ Yes ☐ No ☐ N/A

If yes, do electrical exit signs have working light bulbs?

☐ Yes ☐ No ☐ N/A

Does the provider have maintenance service records?

☐ Yes ☐ No ☐ N/A

If yes, please indicate last date of service or attempted service for unit or building below.

Does the provider have pest control records?

☐ Yes ☐ No ☐ N/A

If yes, indicate last date of service for unit/building below.

Does the provider conduct unit inspections of all client units? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider conducts unit inspections of all client units and the frequency in which they are conducted below.

Were resident unit inspections completed at the time of visit?

☐ Yes ☐ No ☐ N/A

If yes, please refer to attached unit inspection form for finding of unit inspections.

Does the provider have the, "Interpreter Services Available," Desktop Displays posted and visible in intake and/or communal areas? ☐ Yes ☐ No ☐ N/A

V. Reasonable Accommodations and Accessibility

Is the site in which services are rendered handicapped assessable? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider is handicapped assessable.

Is there a signed confirmation of receipt for the Reasonable Accommodations brochure in the file of each client? ☐ Yes ☐ No ☐ N/A

Indicate evidence that verifies the provider has provided a copy of the brochure to the client.

Is the provider compliant with TCP's Policy on Serving Transgender and Gender Nonconforming Clients?

☐ Yes ☐ No ☐ N/A

If yes, please provide evidence verifying that the provider is compliant with TCP's Policy on Serving Transgender and Gender Nonconforming Clients below.

VI. Coordinated Entry

Does the provider participate in the Coordinated Assessment and Housing Placement System?

☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider participates in the Coordinated Assessment and Housing Placement System.

Does the files of the client contain the most recent VI-SPAT or TAY VI-SPDAT completed for the client? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider has the most recent VI-SPDAT or TAY VI-SPDAT on file for the clients in their program.

VII. Service delivery and Case Management

Does each client on the roster have a case file? ☐ Yes ☐ No ☐ N/A

Does each client on the roster have an emergency contact? ☐ Yes ☐ No ☐ N/A

Does the provider on-site resource services. Services include but are not limited to case management, job referrals, housing placements, benefit assistance, and referrals to health and mental health services? ☐ Yes ☐ No ☐ N/A

Indicate evidence that shows on-site services are being rendered below.

Does the provider develop individual service plans? ☐ Yes ☐ No ☐ N/A

Indicate evidence that verifies the provider has completed individual service plans below.

Does the provider maintain documentation of delivery of on-site services (sign in/out sheets to on-site programs, case files etc.)? ☐ Yes ☐ No ☐ N/A

Indicate evidence that shows delivery of on-site services below.

Does the provider maintain documentation of referrals to health, mental health services and other support services? ☐ Yes ☐ No ☐ N/A

Indicate evidence that details the maintenance of documentation of referrals below.

Does the provider maintain files in a double locked setting?

☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider maintains files in double locked setting below.

Does the provider give the client a means to provide feedback about the program and other services? ☐ Yes ☐ No ☐ N/A

Indicate how the provider extends the opportunity to give feedback on programs and services. Also indicate how the feedback is used.

VIII. HMIS

Does the provider maintain client information in HMIS? ☐ Yes ☐ No ☐ N/A

Does the provider have records of clients in HMIS? ☐ Yes ☐ No ☐ N/A

Are all clients on program roster in the HMIS? ☐ Yes ☐ No ☐ N/A

Do all clients (heads of household for all family programs have goals documented in the case plan in HMIS? ☐ Yes ☐ No ☐ N/A

- Is there a goal about income? ☐ Yes ☐ No ☐ N/A
- Is there a goal of moving to permanent housing (TH and Shelter Providers only)? ☐ Yes ☐ No ☐ N/A
- Do all clients have at least one action step? ☐ Yes ☐ No ☐ N/A

Does each goal have case notes? ☐ Yes ☐ No ☐ N/A

Is there at least one note per goal per month? ☐ Yes ☐ No ☐ N/A

Does the provider have 90% data completion in HMIS? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider is maintaining client information in HMIS below.

IX. Escrow Savings

Does the DHS Approved Program Rules state that the collection of escrow is allowed? ☐ Yes ☐ No ☐ N/A

Does the provider collect escrow savings for program participants? ☐ Yes ☐ No ☐ N/A

If yes, describe where the client funds are stored, the process for clients access funds deposited, and who is responsible for overseeing the account below.

Does the provider collect escrow savings for program participants? ☐ Yes ☐ No ☐ N/A

Has the provider given a copy of the guidelines complete with client signature of the escrow savings plan?

☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider has provided proper notice of the guidelines of the escrow savings plan.

Does the provider maintain a record of all transactions of the client escrow savings plan within the client file? ☐ Yes ☐ No ☐ N/A

Indicate evidence that the provider maintains a record of all escrow savings plan transactions for the client within the file.

Is there a reconciliation process? ☐ Yes ☐ No ☐ N/A

If so, indicate ow often reconciliation takes place and the staff person responsible for conducting reconciliation below.

X. Client Interviews

Summarize the client interview (s) below.

XI. Summary of Visit

XII. Findings of Visit/Corrective Action Plan

Appendix A

Client Interview

Name of Client (optional):_____

Date of Interview:_____

1. **How long have you been a participant in the program?**

2. **At entry, were you give a copy of the program rules?**

3. **At entry, was the reasonable accommodation procedures explained to you?**

4. **At entry, were the complaint and grievance policies explained to you?**

5. **Do you meet with case management? If so how often?**

6. **What is the name of your case manager?**

7. **Do you feel that you are getting the services that you need?**

8. **What are the things that you like about the program?**

9. **What are the things that you do not like about the program?**

10. **Are there any other comments that you would like to make about the program?**

Appendix B

Staff Interview

Name of Staff Member (optional):_____

Date of Interview:_____

1. **How long have you been an employee with the agency?**

2. **At hire, were you given and employee handbook?**

3. **At hire, did you complete a drug screening?**

4. **Have you attended trainings for The Community Partnership and Department of Human Services within the last year?**

5. **Are you aware of the policy on serving transgender and gender nonconforming clients? If so, Please describe the policy.**

6. **How does your organization make accommodations for clients of this population? How are the items listed below handled?**

    a. **Access to sex-segregated facilities and programs**

b. **Access to family facilities and programs**

c. **Access to bathrooms**

d. **Accommodations for safety and/or privacy**

e. **Use of preferred names and gendered-pronouns**

f. **Homeless Management Information System (HMIS) data collection and intake form**

7. **Please describe your reasonable accommodations policy?**

8. **Please explain how you would handle a reasonable accommodation that you may not be able to grant.**

9. **Who are the staff persons responsible for attending the CAHP Meetings held monthly?**

10. **Please provide a brief statement about your understanding of the Language Access Act 2004.**

11. **Please define the acronyms LEP and NEP.**

12. **Please explain your agencies policies/procedures on serving non-English speaking clients.**

Facility and Unit Inspection Form

Program Name:_____ Unit Number:

Program Type:_____ Inspection Date:

Code:
A = Acceptable
M = Maintenance Needed R = Requires immediate attention

Room/Area	Comment	A	M	R
Property/grounds:				
Grass				
Trash Receptacles				
Walk ways				
Entry				
Sign In/Check In Location				
Laundry				
File storage area				
Staff offices				
Communal areas				
ROOM	**COM**	**A**	**M**	**R**
Kitchen: Ceiling				
Doors				
Walls				
Floors				
Window				
Stove				
Refrigerator				
Sink				
Electrical Fixtures				
Cabinets				
Bathroom: Doors				
Walls				
Ceiling				
Floor				
Toilet				

Basin				
Mirrors				
Towel Bars				
Fans				
Tub/Shower				
GFI Fixtures				
Window				
Living Room: Doors				
Walls				
Ceiling				
Floor				
Electrical Fixtures				
Window				
Other				
Room #1: Doors				
Walls				
Ceiling				
Floor				
Electrical Fixtures				
Closets				
Window				
Other				
Room #2:				
Doors				
Walls				
Ceiling				
Floor				
Electrical Fixtures				
Closets				
Window				
Other				
Room #3: Doors				
Walls				
Ceiling				
Floor				
Electrical Fixtures				
Closets				
Window				
Other				
Room #4: Doors				
Walls				
Ceiling				
Floor				
Electrical Fixtures				
Closets				
Window				
Other				

Miscellaneous: Screens				
Storm Windows				
Porch				
Stairs				
Smoke Alarm				
Fire Extinguisher				
Thermostat				
Other				