



The Community Partnership
For The Prevention
of Homelessness

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:

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Summary of Service:

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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	<input type="checkbox"/>	<input type="checkbox"/>	
Agency Organizational Chart	<input type="checkbox"/>	<input type="checkbox"/>	
List of Staff Charged to Contract	<input type="checkbox"/>	<input type="checkbox"/>	
Staff Handbook	<input type="checkbox"/>	<input type="checkbox"/>	
Financial Audit for Previous Fiscal Year	<input type="checkbox"/>	<input type="checkbox"/>	
Forms: Intake and All Assessments	<input type="checkbox"/>	<input type="checkbox"/>	
Program Budget	<input type="checkbox"/>	<input type="checkbox"/>	
Organizational Budget	<input type="checkbox"/>	<input type="checkbox"/>	
Budget Narrative	<input type="checkbox"/>	<input type="checkbox"/>	
Signed Audit Request Form	<input type="checkbox"/>	<input type="checkbox"/>	
Verification of formerly Homeless Board member	<input type="checkbox"/>	<input type="checkbox"/>	
Program Rules	<input type="checkbox"/>	<input type="checkbox"/>	
Scope of Work	<input type="checkbox"/>	<input type="checkbox"/>	
Evidence of Coordination and Collaborative Agreements	<input type="checkbox"/>	<input type="checkbox"/>	

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)	<input type="checkbox"/>	<input type="checkbox"/>	
B. Assertive Engagement (all staff)	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

Do the personnel files contain verification of the following:

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

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

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

<u>Miscellaneous:</u>				
Screens				
Storm Windows				
Porch				
Stairs				
Smoke Alarm				
Fire Extinguisher				
Thermostat				
Other				