



The Community Partnership
For The Prevention
of Homelessness

THE COMMUNITY PARTNERSHIP FOR THE PREVENTION OF HOMELESSNESS

TCP PROGRAM SITE VISIT REPORT (Scattered Site Programs)

Provider Name:

Contract Number:

Contract Period:

Program Name (s):

Program Type:

Capacity:

Target Population:

Maximum Length of Stay:

Contact Person (s)/Title:

Address:

Phone:

Email Address:

Date/Time of Visit:

TCP Staff Conducting Visit:

Visited Site Staff Present:

I. Purpose of visit:

Routine Site Visit

Unusual Incident Report

Client Complaint

Failure to Report Required Information

Failure to Comply with Corrective Action Plan

Other: _____

II. Summary of Visit

III. Master Contract Deliverables

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

	Yes	No	Notes
Agency Organization Chart	<input type="checkbox"/>	<input type="checkbox"/>	
Employee Handbook/Policy Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Organizational Budget	<input type="checkbox"/>	<input type="checkbox"/>	
Property Agreements	<input type="checkbox"/>	<input type="checkbox"/>	
Insurance Certificate	<input type="checkbox"/>	<input type="checkbox"/>	
Signed Certification of Fiscal Controls	<input type="checkbox"/>	<input type="checkbox"/>	
Drug-Free Work Place Policy	<input type="checkbox"/>	<input type="checkbox"/>	
Verification of Formerly Homeless Board Advisory Group Member	<input type="checkbox"/>	<input type="checkbox"/>	
Board of Director President and Executive Director signature Verification Sheet	<input type="checkbox"/>	<input type="checkbox"/>	
Signed Audit Request Form (297 form)	<input type="checkbox"/>	<input type="checkbox"/>	
Completed Previous Fiscal Year Audit	<input type="checkbox"/>	<input type="checkbox"/>	
Blank	<input type="checkbox"/>	<input type="checkbox"/>	

Assessment/Screening Forms			
First Source Agreement	<input type="checkbox"/>	<input type="checkbox"/>	
Certificate of Good Standing	<input type="checkbox"/>	<input type="checkbox"/>	
Business License	<input type="checkbox"/>	<input type="checkbox"/>	
Certificate of Occupancy	<input type="checkbox"/>	<input type="checkbox"/>	
Emergency Preparedness Plan	<input type="checkbox"/>	<input type="checkbox"/>	
ACH Enrollment-Change Form	<input type="checkbox"/>	<input type="checkbox"/>	

IV. Tier One Deliverables

Did the provider supply the listed tier one contract deliverables at the time of review?

	Yes	No	Notes
Signed Contract	<input type="checkbox"/>	<input type="checkbox"/>	
Initial Budget	<input type="checkbox"/>	<input type="checkbox"/>	
Budget Narrative	<input type="checkbox"/>	<input type="checkbox"/>	
Staffing List	<input type="checkbox"/>	<input type="checkbox"/>	
Payroll Calendar/Schedule	<input type="checkbox"/>	<input type="checkbox"/>	
Program Rules	<input type="checkbox"/>	<input type="checkbox"/>	
Scope of Work	<input type="checkbox"/>	<input type="checkbox"/>	
Program Job Descriptions	<input type="checkbox"/>	<input type="checkbox"/>	
Personnel Protected Information Certification	<input type="checkbox"/>	<input type="checkbox"/>	
Staffing List of Safety Sensitive Positions	<input type="checkbox"/>	<input type="checkbox"/>	
Evidence of Coordination Agreements	<input type="checkbox"/>	<input type="checkbox"/>	
Program Staff Information Form	<input type="checkbox"/>	<input type="checkbox"/>	
Confidential File Management Procedures	<input type="checkbox"/>	<input type="checkbox"/>	

V. Staff Requirements and Personnel Files

Frontline Staff Training (excluding maintenance staff):

Staff Name	Title	Number of Trainings Completed	Notes

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. Completed Reference Checks	<input type="checkbox"/>	<input type="checkbox"/>	
E. MPD Background Check	<input type="checkbox"/>	<input type="checkbox"/>	
F. FBI Background Check	<input type="checkbox"/>	<input type="checkbox"/>	
G. Current TB Screenings	<input type="checkbox"/>	<input type="checkbox"/>	
H. Current toxicology screenings	<input type="checkbox"/>	<input type="checkbox"/>	
I. Performance evaluations within the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	

VI. Staff Interview

Summarize the staff interview (s) below.

VII. Home Visits

How often are home visits completed?

Are HPAR surveys kept in client files?

Yes No

Indicate evidence that the provider conducts home visits for all clients and the frequency in which they are

conducted below. Please provide dates of the last 3 home visits conducted for clients' files reviewed.

Does the provider have the "Interpreter Services Available", Desktop Displays posted and visible in intake and/or communal areas?

Yes No

Please explain observations below:

VIII. Client Files

Does each client on the roster have a case file?

Yes No

Client ID:	Yes	No	N/A	Notes
A. Does the client have an emergency contact listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. Are there a set of signed program rules in the client file?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C. Does the provider maintain a record of all transactions of the client escrow savings plan within the client file?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D. Does the files of the client contain the most recent VI-SPAT or TAY VI-SPDAT completed for the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

E. Is there a signed confirmation of receipt for the Reasonable Accommodations brochure in the file of each client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
F. Does the client file contain evidence provider participate in the Coordinated Assessment and Housing Placement System?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
G. Does the client's file contain HPAR surveys?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
H. Does the client's file contain updated HMIS case notes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Client ID:	Yes	No	N/A	Notes
A. Does the client have an emergency contact listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. Are there a set of signed program rules in the client file?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C. Does the provider maintain a record of all transactions of the client escrow savings plan within the client file?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

D. Does the files of the client contain the most recent VI-SPAT or TAY VI-SPDAT completed for the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E. Is there a signed confirmation of receipt for the Reasonable Accommodations brochure in the file of each client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
F. Does the client file contain evidence provider participate in the Coordinated Assessment and Housing Placement System?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
G. Does the client's file contain HPAR surveys?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
H. Does the client's file contain updated HMIS case notes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

IX. Service delivery and Case Management

Does the provider offer support 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

Does the provider maintain documentation of delivery of on-site services (sign in/out sheets to on-site programs, case files etc.)?

Yes No

Does the provider maintain files in a double locked setting?

Yes No

Does the provider give the client a means to provide feedback about the program and other services?

Yes No

Indicate how the provider extends the opportunity to give feedback on programs and services. Provide the date of last Client Satisfaction Survey.

X. HMIS

Does the provider maintain client information in HMIS?

Yes No

Are all clients on the program’s roster in HMIS?

Yes No

Does the provider have 90% data completion in HMIS?

Yes No

Please complete the following information for the clients reviewed as documented in HMIS:

Client ID	Goals			Action Steps		Case Notes				
	# of Active Goals	Dates of Active Goals	If Temp/TH, Income & Perm. Housing Goals			Action Steps Present	Dates of Last Action Steps	Case Notes Present	Dates of most recent Case Notes	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Client ID	Goals			Action Steps		Case Notes				
	# of Active Goals	Dates of Active Goals	If Temp/TH, Income & Perm. Housing Goals			Action Steps Present	Dates of Last Action Steps	Case Notes Present	Dates of most recent Case Notes	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Client ID	Goals			Action Steps		Case Notes				
	# of Active Goals	Dates of Active Goals	If Temp/TH, Income & Perm. Housing Goals			Action Steps Present	Dates of Last Action Steps	Case Notes Present	Dates of most recent Case Notes	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

XI. Escrow Savings

Does the DHS Approved Program Rules state that the collection of escrow is allowed?

Yes No

Does the provider collect escrow savings for program participants?

Yes No

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.

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

Yes No

Is there a reconciliation process?

Yes No

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

XII. Client Interviews

Was the provider provided with the contact information for TCP STAFF in effort to provide to clients to conduct client interviews via phone?

Yes No

Please identify the timeframe in which time was allotted for clients to contact TCP staff to conduct client interviews via phone.

Were client interviews successful?

Yes No

If so, summarize the client interview (s) below

XIII. Findings of Visit

XIV. Corrective Action Plan Needed

Description of Deficiency	Reference	Date Due

Report Completed By: _____

Signature: _____ **Date:** _____

Report Reviewed By: _____

Signature: _____ **Date:** _____

Client Interview

Name of Client (optional): _____

Date of Interview: _____

1. Do you know how to request a reasonable accommodation?

2. Do you know how to file a complaint??

3. What is the name of your case manager?

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

5. Are there services that you need that are not provided?

6. What are the things that you like about the program?

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

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

Staff Interview

Name of Staff Member (optional): _____

Date of Interview: _____

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

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

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

4.
 - a. Please describe your reasonable accommodations policy?

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

5. How does the program receive clients?

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

7. How would you assist a non-English speaking client?

8. Please provide a brief statement about your understanding of the Youth Bullying Prevention Act of 2012.

Facility and Unit Inspection Form

Program Name:

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				

