First 5 Kings County
Children and Families Commission

Enhancing Programs and Services Toolkit

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Acknowledgements

In September 2006, First 5 Kings County Children and Families Commission funded a capacity building initiative for its Family Resource Center (FRC) grantees. The objective of the capacity building initiative is to:

1) Assess the capacity building needs of service providers identified by First 5 Kings County and create a plan to address those needs, thereby strengthening their performance and accountability, and

2) Develop tools and deliver capacity building services to Family Resource Centers (FRCs) in order to strengthen their programs, practices and sustainability.

The Commission is funding a hands-on approach to working with staff, volunteers, board and/or other persons responsible for achieving results outlined in the individual organizational Capacity Building Plans developed for each FRC. Social Entrepreneurs, Inc. (SEI) is compiling and developing a variety of materials that will be shared with the FRCs through a combination of targeted coaching and technical assistance, including

- Leadership workshops
- Education and training
- Direct technical one on one assistance
- Toolkits, and
- Follow up

First 5 Kings County would like to thank the board, staff and leadership within each of the FRCs for the time, energy and commitment shown to participating in the activities that have led to this point. We recognize that each FRC's primary focus is on delivering needed services and supports to the children and families of Kings County. The time required to conduct the organizational self-assessments, review reports and capacity building plan, and provide feedback and recommendations to the SEI team is time away from serving those families.

We appreciate the commitment shown by the FRCs. The Commission believes that in the long-run, building the capacity of individual FRCs will lead to their increased sustainability; which will ultimately lead to more families and children accessing the critical services and supports provided by the FRCs.

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Introduction and Overview of Enhancing Programs and Services Toolkit

The First 5 Kings County Children and Families Commission established a Capacity Building Initiative for its First 5 funded Family Resource Centers (FRCs). Toolkits are one resource the initiative will use to build capacity. One toolkit for use by the FRCs relates to enhancing programs and services. The components of this module were selected based on the organizational self-assessments completed by the Kings County Family Resource Centers (FRCs) in October 2006 as part of the Capacity Building Project funded through First 5 Kings County. This module is not intended to provide an exhaustive list of resources or instructions related to service enhancement, but rather provide tools and guidance for effectively using the best practice research and tools to apply to daily practice for the enhancement of services. Links to additional resources or websites have been included throughout so that FRC staff and board members can obtain additional information and guidance as needed.

The module explains the principles of family support and key elements of highly effective services. Best practice approaches are presented along with tools and tips on how to integrate them into the daily operations of a Family Resource Center. Included are tools and worksheets to assist FRCs in developing and implementing high quality programs and services. Links are provided to tools in the appendices and to outside resources where additional information can be obtained on topics related to enhancing programs and services.

The Enhancing Programs and Services module is organized into four sections plus appendices:

- Service Approaches
- Using Data to Enhance Services
- Leadership & Staff Development
- The Service Cycle

Each section in this module begins with a brief introduction that explains the topics covered. Development of this toolkit resulted from research on evidence based practices and the tools used in this document have been collected from a variety of programs that possess elements of best practices. All tools and templates referenced in the section will also be provided electronically either as a download from an external website or from a companion compact disk (CD). Files located on a CD will be noted with an icon of a CD.

Whenever a new tool or resource is presented a "key" symbol will indicate the tool. In cases where the tool is not self explanatory a text box is provided with "key" suggestions about who, when and how to use the tool.

As used in this toolkit, the term "family support" is defined by Family Support America, as follows: "Family support involves nurturing and protecting children by nurturing and protecting families who are responsible for those children's care. It also requires strengthening families by strengthening the communities that are made up of those families. Family support provides parents and neighborhoods with the resources and supports they need to succeed at the most important job there is: raising healthy, responsible, productive and joyous children."

MODULE 6 – ENHANCING PROGRAMS & SERVICES

The Enhancing Programs and Services Module is the sixth in a series of toolkits developed as part of the First 5 Kings County Capacity Building Initiative. For information on other toolkits contact First 5 Kings County. This toolkit provides information about how to enhance programs and services operated by family resource centers. The specific topics are in direct response to the capacity building plans developed for each First 5 Kings County FRC in 2006.

Due to the content of this toolkit, it is necessary to provide background information and a framework for each concept along with examples of tools and additional materials.

6.1 – Service Approaches

The First 5 Kings Family Resource Centers (FRC's) indicated in their capacity-building plans that they would like more information on key service approaches to case management, home visiting, the family support framework, serving children with disabilities, and providing family-centered care. This section contains a brief description of each service approach and where applicable the key principles or essential elements of the approach. Related tools or links on each topic are also noted or provided in the appendices. There are essential elements of high quality services common to a variety of disciplines and approaches. Those key attributes are described by Lisbeth B. Schorr in her book, *Common Purpose: Strengthening Families and Neighborhoods to Rebuild America*. A link to additional information on establishing and reaching outcomes for family support programs based on the key attributes can be found at http://www.pathwaystooutcomes.org/index.cfm

The key attributes of Highly Effective Services:

1) They are comprehensive, flexible and responsive.
2) They deal with children in their family and school setting; they deal with families as part of communities; they are deeply rooted in the neighborhood.
3) They have long-term, preventative orientation, a clear mission, and continue to evolve over time.
4) They operate in settings that support high quality standards; skilled, supportive managers hold staff accountable for achieving shared purposes.
5) They operate with enough intensity and perseverance to achieve agreed-upon outcomes.
6) They encourage staff to expand the boundaries of their job descriptions to build strong relationships, based on mutual trust and respect, with the individuals, families and professionals with whom they work.
7) They recognize the limits of what a single program can accomplish, and therefore link up with other efforts to strengthen children and families, build community and expand economic opportunity.

Case Management

Case Management is the mechanism by which FRCs achieve key element #7 "recognize the limits of what a single program can accomplish, and therefore link up with other efforts to strengthen children, families and communities."

Case Management is an approach to service delivery that attempts to ensure that clients with multiple, complex problems receive all the services they need in a timely and appropriate fashion. It is a boundary-spanning approach in that, instead of providing a direct service, it utilizes case mangers who link the client to the maze of direct service providers. Although the emphasis in case management is on linkage, case managers in theory do whatever it takes - whether brokerage, advocacy, or resource development to ensure that all client needs are met; they may even provide a missing service themselves.

Case Management has **four** basic functions: assessment, planning, linking and monitoring.

- Assessment—Case Managers are expected to remain aware of their clients' comprehensive needs as well as their current and potential strengths and weaknesses. They are usually involved in the initial intake and assessment and remain in regular contact with the client. The case manager continues to evaluate and observe the support networks, strengths and needs of the client to determine the appropriate action.

- Planning—Case Managers may be expected to develop an overall case plan for each client. It should include provision for services the client might need day or night. Planning should focus on the progression of services to be provided over time and on the linkages among them and between them and the informal support system. In case management, planning is done early. Case planning is the core activity of case management since a good plan outlines the linkages necessary, the course of action and provides a documented framework that can be updated and reviewed.

- Linking—Case Managers are expected to link clients to the services and entitlements that are available to meet their needs. This includes referring or transferring clients to all required services and informal support networks. It also includes helping clients overcome barriers to utilizing the required services or receiving entitlements. To overcome barriers, case managers sometimes have to function as case advocates for their clients. Case Managers establish and maintain ongoing contact with service providers and referral agencies.

- Monitoring—Case Managers are expected to monitor continuously the services provided to their clients. This requires ongoing contact with clients and service providers to ensure that effective and appropriate services are provided with minimum delay. This contact is often face-to-face which enhances the relationship and improves the quality of feedback. Implicit in monitoring is an evaluation function in which the case manager systematically rates and records progress toward attaining the objectives each component of the service plan is designed to attain. Information gained from monitoring can lead to reassessment and the development of new plans or linkages. (Encyclopedia of Social Work, 18th Edition, 1987)

Home Visiting

Home Visiting is the method FRC's can use to achieve key element #2 "Deal effectively with children in their family and school setting; deal with families as part of communities." Home visitation as a service delivery model has existed for decades, initially serving as a means of providing home health care and public health education. At the core of home visitation is prevention or keeping families safe, healthy, self-sufficient and connected to support resources. This serves not only families directly, but broader communities as well, reducing costs associated with health care, social services, criminal justice, and special education.
(Reference: Galbraith, Laura Proactive Funding Strategies for Home Visitation: A Resource Guide for Counties).

Home visiting programs support positive parent-child relationships, promote optimal child health and development, enhance parental self-sufficiency, and prevent child abuse and neglect. They focus on the importance of children's early years and on the role parents play in child development.

By bringing services to families with young children, rather than expecting them to seek assistance in their communities, home visitors see the environments in which families live, gain a better understanding of families' needs, and tailor services to meet those needs. Home visiting can reduce loneliness and isolation and serve as the first step in linking families to communities. (Excerpted from www.childwelfare.gov)

Key elements of high quality home visiting programs

1. Use research based models-lasting and measurable change has only been documented in models where certain standards and criteria are followed based on a theoretical foundation.
2. Design curriculum for the service population.
3. Increase service integration-secure linkages and the importance of collaboration with a system of services is one of the most conclusive findings from home visitation research and practice.
4. Program flexibility.
5. Strength-based philosophy.
6. Voluntary as opposed to Mandatory.
7. Client openness to services.
8. Recognize barriers to success.
9. Trusting relationship with family.
10. Provide comprehensive services.
11. Follow-up on referrals.
12. Universal assessments.
13. Ensure sufficient time in program, frequency of contact and visit duration.

Reference: Home Visitation Initiative Research by Lodestar for First 5 LA

http://www.childwelfare.gov/supporting/support_services/homevisiting.cfm contains more information on home visiting to support families.

Although home visiting services were not always a formal part of family support efforts, they have become a popular method of delivering preventive and family support services. The increased interest among policymakers in home visiting as a means of reaching children and families early has sparked a number of efforts to measure its effectiveness. The box on the right describes key elements for effective Home Visiting programs based on research.

Appendix A: Home Visiting Models and Curricula contains a comparison of home visiting models and curricula based on elements such as target population, training approach and costs

and supplemental curriculum. The purpose of the document is to provide information on home visiting curricula so that Kings County FRC's will have current information to aid them in possibly selecting a home visiting program in the future.

Including Children with Disabilities and Their Families

Serving children with disabilities is a mandate for First 5 programs and ensures that FRCs meet key element # 1 "to be comprehensive, flexible and responsive." This section describes typical disabilities, the concept of including children with disabilities in your settings (inclusion) and recommended approaches for working with families that have a child with a disability.

Many types of disabilities exist, such as physical, sensory, cognitive, psychiatric, and health-related. Physical disabilities often cause a person to use special equipment like a wheelchair, cane, or prosthetic limb. Persons with physical disabilities may have difficulty with movement or self-care, but are otherwise just like anyone else. Another type of disability that people are familiar with is sensory disabilities. Sensory disabilities affect the senses and include blindness and deafness. Sensory and physical disabilities are usually easy for people to notice, but not all disabilities are visible. An example of an invisible disability is a psychiatric disability. This category includes conditions like bipolar disorder, depression, and many others. Medications and therapies often help persons with psychiatric disabilities to live and function successfully in the community. Cognitive disabilities vary tremendously and can also be difficult to see. Learning disabilities are in this category. A person with a learning disability usually has average to above average intelligence but difficulty learning, remembering and communicating information. Learning disabilities come in many different forms and although they usually affect a person's ability to complete school-related tasks, learning disabilities can also affect school performance. Some people with sicknesses or diseases such as epilepsy, diabetes, and cancer are considered as having a health-related disability. However, not everyone who is sick has a disability. Retrieved from http://das.kucrl.org/iam/studentdis.html on 3-29-07.

A single definition of inclusion within an early education context is yet to be accepted. However for the purpose of this toolkit, we offer a definition that contains several components. First, inclusion is the active participation of young children with disabilities and typically developing children in the same classroom (e.g., in Head Start, public preschool, and private child care programs) and community settings. The term inclusion also means the participation of young children with disabilities in settings outside the school system, such as the community (e.g., shopping for groceries), family events and rituals (e.g., a birthday party with relatives), or church (e.g., Sunday school classes). Last, for purposes of this toolkit the term disabilities refers to delays in development relative to norms of chronological age or culture, formally diagnosed conditions with associated developmental delays (e.g., Down syndrome, autism), and sensory impairments. Retrieved from
http://www.newhorizons.org/spneeds/inclusion/information/schwartz1.htm on 3-29-07

In very young children, disabilities are more difficult to diagnose and therefore careful screenings and assessments are necessary to identify any issues early and refer the child to early intervention services. Services for children birth-to-three are commonly known as early intervention or "Part C" services pertaining to the relevant section of the Individuals with Disabilities Education Act or IDEA. Often a child that receives early intervention services is able to

make developmental progress and no longer requires services once they turn three. If a child does qualify for services for a disability after the age of three, it is commonly known as special education or "Part B" services.

Building successful partnerships for the benefit of young children with disabilities is based on foundations of respect, trust, communication, confidentiality, and willingness on the part of the providers and families to work collaboratively with one another. Below are a few helpful hints from parents about working effectively with them and their child with a disability.

- Focus on the family -- Families of children with disabilities are families first. They are also groups of people who may be faced with a variety of challenges or stresses in caring for their children.
- Positive initial contact -- All parents want their children to be loved and accepted and to "fit in". This is particularly true of parents of children with disabilities. An open, caring and sensitive response to a family's first contact is one of the first steps in building a positive relationship.
- Ongoing communication -- Use a variety of approaches to communication. The need for ongoing communication with parents whose children have disabilities is critical.
- Family Involvement -- Family activity days or special events should be planned with attention to the physical access needs and the interests of families whose children have disabilities. If we embrace the concept of inclusion for children with disabilities, we must also include members of their families at every opportunity.
- Ask for help when you don't know -- Providers must be careful not to extend their skills and roles beyond the boundaries of their knowledge or experience. Being aware of community resources for children with disabilities and asking for help or making a referral is often the best way to help.

Excerpted from Strategies for Good Practice pgs. 96-99 Project EXCEPTIONAL Volume 1 (1996) California Department of Education.

Family-Centered Care: The Key to Partnerships

Family –Centered Care is the approach FRCs can use to achieve element #2 "dealing with children as family members and part of their community."
The goal in creating relationships with families is to build respectful and mutual partnerships. This allows both the parent and the provider to bring together their mutual expertise for the benefit of the child. Family-centered care provides the base upon which partnerships can thrive.

Five characteristics of family-centered programs make them different from other early childhood programs.

In family-centered programs, providers and families:

1. Recognize and respect one another's knowledge and expertise
2. Share information through two-way communication
3. Share power and decision-making

4. Acknowledge and respect diversity
5. Create networks of support

Excerpted from *Parents to Partners: Building a Family-Centered Early Childhood Program* by Janis Keyser (2006).

Family Support Principals

The definition of family support, the principals of family support and the premises are provided as a framework for discussing service delivery and enhancing programs and services. For FRCs, integrating the principles of Family Support into day to day activities is considered best practice. Family Resource Centers are built upon the concept of family support and the related premises and principles. At the core are the development of partnerships between community members and family resource center staff and between the community partners and family resource center staff. This partnership allows the creation of programs and services that meet the unique needs of the community and understands that each child is part of a family and each family is part of the larger community. The goal of family support is to strengthen families by linking them to resources, sharing information, advocating when necessary and ultimately building the capacity of families and community members to help one another and emerge as leaders.

Family Support: What is it? :

- A set of beliefs and an approach to strengthening and empowering families and communities so they can foster the optimal development of children, youth, and adult family members.
- A type of grassroots, community-based program designed to prevent family problems by strengthening parent-child relationships and providing whatever (support) parents need in order to be good nurturers and providers. These programs have been proliferating across the country since the 1970's.
- A shift in human services delivery that encourages public and private agencies to work together and to become more preventive, responsive, flexible, family-focused, strengths-based, and holistic; and thus, more effective.
- A movement for social change that urges all of us - policy makers, program providers, parents, employers - to take responsibility for improving the lives of children and families. The family support movement strives to transform our society into caring communities of citizens so that all children and families get what they need to succeed.

Premises of Family Support are:

- Primary responsibility for the development and well-being of children lies within the family, and all segments of society must support families as they rear their children.
- Assuring the well-being of families is the cornerstone of a healthy society, and requires universal access to support programs and services.
- Children and families exist as part of an ecological system.
- Child-rearing patterns are influenced by parents' understanding of child development and their children's unique characteristics, personal sense of competence, and cultural and community traditions.
- Enabling families to build on their own strengths and capabilities promotes the healthy development of children.

- The developmental process that makes up parenthood and family life creates needs that are unique at each stage in the lifespan.
- Families are empowered when they have access to information and other resources in their communities.

Principles of Family Support:

- Staff and families work together in relationships based on equality and respect.
- Staff enhances families' capacity to support the growth and development of all family members -- adults, youth, and children.
- Families are resources to their own members, to other families, to programs, and to communities.
- Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multi-cultural society.
- Programs are embedded in the communities and contribute to the community-building process.
- Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.
- Practitioners work with families to mobilize formal and informal resources to support family development.
- Programs are flexible and continually responsive to emerging family and community issues.
- Principles of family support are modeled in all program activities, including planning, governance, and administration.

How can you tell if your program implements the principles of family support?

First of all, FRC staff communicate in a way that shows their respect for clients and demonstrates that the family is the expert on their situation not the FRC staff. Communication also includes language about partnering with the clients and working in a collaborative manner to reach the goals identified by the family.

This communication is reinforced by forms, policies and orientation materials that are aligned with the concepts of partnership, individualized services and working toward family identified goals. In addition, the governing bodies or board and managers of the family resource center also talk-the-talk and walk-the-walk by creating opportunities for partnerships and ongoing methods for individualizing services for the unique need of the community. Finally, the family resource center is flexible, responsive and accountable across programs and strives for continuous quality improvement.

6.2 – Using Data to Enhance Services

Using data to enhance services is another way FRCs can achieve key element #5 "they operate with enough intensity and perseverance to achieve agreed-upon outcomes." In Section 1, service approaches and essential elements were presented as a framework for Family Resource Center service delivery. A few key elements were presented that are relevant in Section 2. Primarily, the concepts of assessment, monitoring, being responsive and flexible all are rooted in best practices and are directly tied to the ability of the FRC to use data to enhance services. Program corrections or enhancements can only be made in a meaningful manner if they are tied to high quality data. This can be as simple as using client satisfaction surveys, analyzing the results and then doing more of what people like and doing less or changing what people are not satisfied with. In order to continue to deliver high-quality programs and services it is necessary to collect data through a few key activities. The activities are described below and the related tools can be found in the appendices.

Community Needs Assessments

To provide quality services, there is a need for detailed information about the needs of individuals and the organizations that serve them, as well as the resources that a community has available to solve those needs. Needs can be defined as the gap between what a situation is and what it should be. A need can be felt by an individual, a group, or an entire community. It can be as concrete as the need for food and water or as abstract as community cohesiveness. Examining needs helps us discover what is lacking, and points us in the direction of future improvement.

Resources or assets are those things that can be used to improve the quality of life. They can be anything from people to places to organizations. Everyone is an asset, and everyone has assets that can be used for community building at your FRC.

There are many good reasons to identify needs and resources.

These include:

- Understanding the environment in which you work.
- Knowing how the community feels about an issue and what members think needs to be done about it.
- Making decisions about priorities for program or system improvement. Once you have assessed the community, it is much easier to make improvements that community members will notice and benefit from.

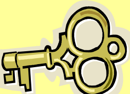
Retreived from Developing a Plan for Identifying Local Needs and Resources at http://eclkc.ohs.acf.hhs.gov on March 17, 2006.

Important things to know about your community:

- *Who is here? (ethnic breakdown of community)*
- *What are they doing here? (jobs available)*
- *Where are they from? (Countries of origin or long-time locals)*
- *When did they arrive to this area? (Migratory pattern)*
- *Why are they here specifically? (Cost of living/Proximity to services/they have always been here)*
- *How do we deal with the population's needs?*

The results of a community needs assessment can provide your FRC with good information about what services are needed; how the residents of your community view present services; what their recommendations are for improvements; and identify what is working well or what new areas need to be addressed. In order to get a comprehensive view of your community, it is important to look at what you have and what you need. With these things in mind, you can have a positive impact on the problem you wish to address. Understanding your community in this manner will also help your FRC clarify where it would like to go and how it will get there.

Retrieved & adapted from the following sources: Guide Cesar E. Chavez Foundation www.cesarchavezfoundation.org on March 17, 2007. Bohse & Associates Inc., .http://www.njslom.org/ConductingCommunityNeedsAssessment.html on March 17, 2007.



Community Needs Assessments

Who? This process should be led by the management team and board of a family resource center. A community needs assessment provides information necessary for the board and managers to plan effectively. Other key stakeholders including community members and parents are important partners in the process but do not have the ultimate responsibility for the data collection.

When? A large scale community assessment should be completed every three to five years with a brief update each year.

How? Review the steps below as well as the website listed for a "How to" in conducting community assessments. Due to financial and staff constraints it may be possible to conduct a community needs assessment in conjunction with other partners.

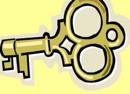
Tip: Every Head Start and Early Head Start must conduct a comprehensive Community Needs Assessment every three years. Other key social service programs are also mandated to conduct community needs assessments. Find out when they complete their surveys to see if you can combine forces, or at a minimum review their findings to determine what is relevant for your FRC. In addition, UCLA completed a Family Needs Assessment Report finalized January 31, 2007 which could be leveraged for each FRC in Kings County. The First 5 Kings County School Readiness application also provides a wealth of data for a community needs assessment.

There are a few basic steps in conducting a community needs assessment:

1. Consider what financial and human resources are available for your assessment and planning effort.
2. Develop and present the purpose of the Community Needs Assessment to your staff and board.
3. Establish a working committee of community members/key stakeholders including parents, service providers, youth, partners to oversee the project. Determine the timeline, confirm the purpose, the approach and how the outcomes will be reported.
4. Determine what types of data to look for/collect and the method of data collection (surveys, focus groups, existing data, etc.).
5. Design a survey instrument.
6. Gather data.
7. Analyze data.
8. Communicate the results of the needs assessment.
9. Develop goals and an action plan based on the results.
10. Document what worked well and how to improve the next community assessment process.

Client Satisfaction

A simple and easy to implement activity that provides feedback to your FRC and allows you to modify programs and services are client satisfaction surveys. When used routinely and consistently, these tools can provide each FRC with ongoing data about how well services are matching the needs of the clients. Appendix B Satisfaction Survey contains a client satisfaction survey customized for First 5 Kings County. The Excel analysis tool is provided on the CD and automatically compiles the scores of the client satisfaction surveys when entered, which provides timely feedback and results.



Client Satisfaction Surveys

Who: FRC staff should introduce the forms to clients in all program service areas.

When: The frequency depends on the service activity but at a minimum ask clients to complete the survey once a quarter, or after each activity.

How: The client satisfaction survey tool has been customized for use at all First 5 Kings County FRC's but can be further customized by clicking into each question and modifying the content. Make sure to change the corresponding question in the Excel analysis sheet as well.

Why: Find out how your clients feel about your services and how you can continue to meet their changing needs.

Monitoring for Continuous Quality Improvement

Ongoing monitoring and self-assessment includes the systematic, comprehensive processes for observing, collecting and analyzing information used to determine a program's effectiveness. Ongoing monitoring and self assessment systems measure progress toward meeting established objectives and achieving program goals. Well designed systems monitor implementation activities on a regular and frequent basis. Such systems annually assess compliance with program requirements and the quality of services provided.

For FRC's this would include establishing a system of data collection, review and analysis of results and the ability to report the results and make modifications. Collecting simple data on a regular basis and then monitoring the data will allow you to provide the best possible services for children and their families. Monitoring can include reviewing at the individual level or the program and service level across an organization. A simple example, is the ability to monitor the completion rate of home visitors by having them track the number of home visits offered and completed on a weekly basis and having them submit key paperwork each week for review and monitoring. A more extensive monitoring tool allows you to review your entire program on a regular basis or at least annually. It is valuable to have staff and board members assist with monitoring so that all levels of the organization are aware of strengths and opportunities for improvement. Appendix C Program Monitoring Self Assessment Tool contains an example of a comprehensive monitoring tool designed for an annual self-assessment review.

Tracking Program Goals and Reporting Results

The ability to implement everything in this section will lead to the ability of your FRC to track program goals and report results. First 5 provides reporting tools and training on how to link your service activities to result areas. First 5 will also provide evaluation assistance in developing evaluation plans, goals, outcomes, indicators and the tools that will be used to measure if the goals are being met. In addition to your First 5 programs you may want to

ensure you are also tracking program goals and reporting results to other funders and potential funders.

In order to report how well your FRC is doing, you must first identify program goals and how each will be met (who will do what, when and for how long). As discussed earlier in this section, goals are best developed after a community assessment has been conducted and analyzed. This provides the board and key decision-makers with information about what programs and services should be offered at the FRC in your community. After goals have been developed, an implementation plan or action plan should be put together to determine how the goals will be accomplished. Additional use of client satisfaction data will enable the key decision-makers of your FRC to design programs and services that further meet the needs expressed by clients. Lastly, it is critical that the FRC operations be monitored to see if services are being delivered in a manner that is consistent with organizational goals, funding goals and personal goals outlined by the families. One framework for building results oriented goals for evaluation and reporting includes the Results Based Accountability Framework which is described below.

Results Based Accountability (RBA) Model

The approach recommended for FRCs is a research-based evaluation framework derived, in part, from the Results-Based Accountability Model developed by the Fiscal Policy Studies Institute. This framework is suggested because it allows for ongoing flexibility and sustainability of evaluation by establishing a model that can be used in future years to determine new accountability measures and evaluate new goals as funding priorities are identified by the Commission.

The RBA framework is very effective in creating meaningful evaluation methods at the program level that connect to the higher-level goals and results defined at the First 5 Commission level. Under this model, evaluation questions are posed in four quadrants that enable assessment of both the processes and activities conducted by a program (*effort*) and the results or outcomes achieved for children, families, communities and/or systems (*effect*) while also concurrently assessing both the level of activity that occurred (*quantity*) and the extent to which activities were performed effectively (*quality*).

Family Resource Center evaluations must:

- Be **credible -** The Commission and community must be confident that the information produced is accurate and relevant; performance measures must be credible representations of the quantity and quality of the services provided.
- Be **fair -** It must create a system that provides fair gauges of agency and program performance and reflects factors and services that can be directly controlled or influenced by the FRC by focusing on bottom-line quality.
- Provide **clear** and easy to understand and use measures. The measures must be tools that help understand performance results and point out where improvements are needed.
- Be **practical** - The way in which data are collected, submitted and analyzed is a major factor in administration and implementation practicality. It makes sense for the evaluation to coordinate and link data collection strategies and instruments.
- Be **adaptable -** When priorities and funded programs changes, data requirements must change as well, and the evaluation needs to keep pace with these changes.
- Be **connected -** Other aspects of organizational planning, budgeting, and management processes need to be connected to and integrated with the evaluation plan, since measures are designed to provide feedback about the effectiveness of agencies and programs.

The approach is summarized in the table below.

	QUANTITY	QUALITY
EFFORT	**Q1** What did we do? How much service did we deliver?	**Q2** How well did we do it? How well did we deliver service?
EFFECT	**Q3** Is anyone better off (#)? How much change for the better did we produce?	**Q4** Is anyone better off (%)? What quality of change for the better did we produce?

In each quadrant the key evaluation questions are answered with program data statements using numeric counts (#), ratios/percentages (%) or scales showing the degree of change:

- What did we do? (e.g. # of clients served, # of activities performed)
- How well did we do it? (e.g. % of timely actions, % complete actions, client staff ratios, unit cost)
- Is anyone better off? (e.g. # and % of clients who show improvements in health, skills/knowledge, behavior or other aspects of well-being)
- How much better off are they? (e.g. degree of change or effect on people served or service delivery systems impacted, such as kindergarten learning assessment scales)

The answers to these questions are the programs' **performance measures.** Currently, most Family Resource Centers' performance measures are considered "quadrant one" measures. While useful in determining volume of service, quadrant one measurements cannot measure the degree of change produced or the quality of service delivered. Once the FRC has completed a community assessment, has identified program goals, has sorted the program goals into result areas defined by First 5 and other funders, then they are able to identify indicators and track progress based on each quadrant of the results based accountability model.

Some examples of quadrant 1-4 performance measure for the result area *Improved Child Development* include:

Quadrant 1: How Much?	Quadrant 2: How Well?	Quadrant 3: Amount of Change	Quadrant 4: Degree of Change
The # of playgroups offered. The # of children and parents that participate in playgroups. The # of children exposed to child development activities that enhance age appropriate child development in key areas.	The level of satisfaction expressed by parents as a result of the playgroup in regard to the type of information and the method of delivery.	# of parents with the demonstrated ability to identify and report on their child's development. # of parents that demonstrate increased interaction with their child that enhances age appropriate child development.	% of parents with the demonstrated ability to identify and report on their child's development. % of parents that demonstrate increased interaction with their child that enhances age appropriate child development.

6.3 – Leadership and Staff Development

Leadership and staff development is a broad topic and it will only be touched on briefly in Section 6.3. Enhancing programs and services through effective leadership is essential for each FRC. The examples set by the board and key decision-makers influence how the staff conduct themselves. The topics of ethics and confidentiality, supervision and community partnerships will be discussed in this section.

Ethics and Confidentiality

The items below form a composite code of ethics for direct service work. The list focuses specifically on relationship issues and will undoubtedly require additions and modifications to fully reflect the disparate fields represented in family support work.

- Staff are accountable at all times for their behavior: They are aware that all actions and behaviors reflect on professional integrity and when inappropriate, can damage their and other professionals' relationship with families.
- Staff must know and take into account the practices of other professional disciplines with whom they work and cooperate with them as fully as possible.
- Staff members should respect families' right to privacy. Once private information is shared, standards of confidentiality apply.
- Staff members should be alert to avoid conflicts of interest that interfere with exercising professional judgment. Staff should inform families in the case of a real or potential conflict of interest, and take appropriate steps to resolve the issues in a manner that puts the families' interests first.
- Staff members may not utilize their relationships with families to further their own personal, religious, political or business interests.
- When a staff member is providing services to two or more people that have a relationship with each other (for example, parents and children, couples, etc), staff should clarify their professional obligations to the various individuals receiving services.
- When a family member's behavior or condition indicates that there is a clear and imminent danger to her/himself or others in the family, staff members must take reasonable action to notify responsible authorities.
- The staff member and the client-family must jointly identify the goals of the service relationship. These plans should be individualized, offer reasonable promise of success, and be consistent with families' needs and abilities. Staff should regularly review the agreed upon goals to ensure their continued viability and appropriateness.
- Staff members should not engage in dual or multiple relationships (professional, social or business) with current or former client-families in which there is a risk of harm to the family. When dual relationships occur, staff are responsible for setting clear and appropriate boundaries.
- Staff who have a working or personal relationship with a family in care must not also serve as the direct service professional for this family, and should refer the family to a colleague.
- Staff members should terminate (or avoid initiating) relationships with families in such case as they are unable to be of professional assistance, when such services are not required, or when they cease to serve the families' needs or interests. Staff members

must suggest appropriate alternatives of referral resources on an as-needed basis in these cases.

Acknowledgement: National Board for Certified Counselors, Inc.'s National Association of Social Workers and the American Counseling Association as seen in a publication by Zero to Three, titled, The Power of Questions: Building Quality Relationships with Families authored by Rebecca Parlakian. ZERO TO THREE is a nonprofit organization dedicated to advancing the healthy development of babies and young children. Their website provides an array of articles for parents and professionals ranging from adoption to social skills. www.zerotothree.org

Two resources are provided in the appendices related to confidentiality. Appendix D First 5 Kings County Consent Form provides the First 5 Consent form to share information and refer a client and Appendix E: Client Confidentiality Policy provides a sample policy for use by FRCs.

Supervision – Reflective / Supportive

Effective and consistent supervision is essential to high quality service delivery. The sometimes intense and overwhelming needs of Family Resource Center clients can impact the ability of staff to do their best on a long-term basis. It is common for people working in the family support field to experience burnout and have "less to give" over time if they do not receive supportive supervision. Staff require nurturing just as the children and families that FRCs serve need support. One method that has been identified as a best practice is "Reflective Supervision." It should be noted that the implementation of reflective supervision takes an administrative commitment of time and funding to make it work. While reflective supervision is a standard best practice that can have a positive impact on programs and services, it may not be a viable option for some FRCs at the current time. A description has been provided below and additional links to resources are provided in the appendices.

Reflective Supervision

The work of Zero to Three over the last quarter-century has found that reflective supervision promotes and supports the development of a relationship-based organization. This approach expands on the idea that supervision is a context for learning and professional development. The three building blocks of reflective supervision—reflection, collaboration, and regularity—are outlined below.

Reflection
Reflection means stepping back from the immediate, intense experience of hands-on work and taking the time to wonder what the experience really means. What does it tell us about the family? About ourselves? Through reflection, we can examine our thoughts and feelings about the experience and identify the interventions that best meet the family's goals for self-sufficiency, growth and development.

Reflection in a supervisory relationship requires a foundation of honesty and trust. The goal is to create an environment in which people do their best thinking—one characterized by safety, calmness and support. Generally, supervisees meet with supervisors on a regular basis, providing material (like notes from visits with families, videos, verbal reports, etc.) that will help stimulate a dialogue about the work. As a team, supervisor and supervisee explore the range of emotions (positive and negative) related to the families and issues the supervisee is managing. As a team, they work to understand and identify appropriate next steps.

Reflective supervision is not therapy. It is focused on experiences, thoughts and feelings directly connected with the work. Reflective supervision is characterized by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee to answer her own questions, and to provide the support and knowledge necessary to guide decision-making. In addition, the supervisor provides an empathetic, nonjudgmental ear to the supervisee. Working through complex emotions in a "safe place" allows the supervisee to manage the stress she experiences on the job. It also allows the staff person to experience the very sort of relationship that she is expected to provide for infants, toddlers and families.

Supervisors can also support staff's professional development by using supervisory meetings as an opportunity to scaffold, or support the acquisition of, new knowledge. One way of doing this is to encourage supervisees to analyze their own work and its implications. Reflection is important because it empowers staff to assess their own performance. Awareness of one's strengths, as well as one's limits and vulnerabilities, allows individuals to make mid-course corrections in work performance that feel natural, unforced, and generated from within.

<u>Collaboration</u>

The concept of collaboration (or teamwork) is often talked about in terms of external collaboration but one principle of collaboration is internal to the FRC as an organization. Collaboration emphasizes sharing the responsibility and control of power in a supervisory relationship. Power in a family support program is derived from many sources, among them position in the organization, ability to lead and inspire, sphere of influence and network of colleagues. But most of all, power is derived from knowledge—about children and families, the field, and oneself in the work. While sharing power is the goal of collaboration, it does not exempt supervisors from setting limits or exercising authority. These responsibilities remain firmly within the supervisor's domain. Collaboration does, however, allow for a dialogue to occur on issues affecting the staff person and the program.

Collaboration allows staff to express interest in taking on new tasks and challenges, as well as to exercise some control over the terms and conditions of their work. It offers supervisors and mentors a chance to learn from, as well as teach, staff. Collaboration also allows supervisors to recognize opportunities to share responsibility and decision-making and, in so doing, cultivate leadership talent from within.

Collaborative supervisory relationships are characterized by a clear understanding of the reciprocal expectations of each partner. This "contract" is jointly developed and agreed upon by the supervisor and supervisee, and will vary in frequency, intensity and focus across the organization. Key issues that should always be addressed, however, include logistical issues, such as when and where supervisory meetings will take place, and what will be discussed.

Finally, true collaboration requires open communication, flowing freely in both directions, and protected from "outsiders." Both partners assume the best about each other. The supervisory relationship is one characterized by a feeling of trust and safety, where difficult issues can be discussed without fear of judgment, disclosure, or ridicule. Open communication implies curiosity and active listening. Either partner can ask "What were you thinking when you did that?" as a means of learning more about the motivations and thoughts of the other.

Regularity
Neither reflection nor collaboration will occur without regularity of interactions. Supervision should take place on a reliable schedule, and sufficient time must be allocated to its practice. This time, while precious and hard to come by, should be protected from cancellation, rescheduling, or procrastination.

That said, everyone working in family support programs knows that there are times when scheduling conflicts or emergencies arise, making it necessary to reschedule supervision meetings. When this happens, set another time to meet as soon as possible. If the need to reschedule arises frequently, it makes sense to consider why this is happening. Is the selected time an inconvenient one? Is the supervisor or the staff member overburdened, or is either having difficulty with time management skills? Is there some tension in the staff/supervisory relationship prompting either party to postpone their meeting?

It takes time to build a trusting relationship, to collaborate, and to share ideas, thoughts, and emotions. Supervisory meetings are an investment in the professional development of staff and in the future of the infant/family program. Staff will take their cues from leaders: do program directors make time for supervision? Do the program's leaders "walk the talk"?

Reference: Parlakian, R. (2001). Look, Listen, and Learn: Reflective supervision and relationship-based work. Washington, D.C: ZERO TO THREE. www.zerotothree.org

Community Partnerships

The importance of partnerships cannot be emphasized enough. The lives and needs of the children and families coming to Family Resource Centers are complex and challenging. The needs cut across service areas and frequently include services for mental health, substance abuse, economic support, housing as well as parenting and child development services. No one agency or set of services is adequate to meet the varied and often intense needs of families. Furthermore, today's community environment dictates that citizens and providers of services develop effective ways to improve the use of limited resources.

Community partnerships help Family Resource Centers and other agencies respond to families by providing: supports, a range of formal and informal services and individualizes responses to meet the needs and strengths of each family. Partnerships result in better outcomes for children and families.

Creating and sustaining community partnerships needs to be a regular part of the practice of an FRC. Community linkages and partnerships develop over several years. Their results and capacity are developmental and grow more sophisticated and stronger with time.

How to manage barriers to collaboration:

- Confront underlying issues, such as a vague vision, low trust, power struggles, and differing work styles;

- Create partner role descriptions and interagency agreements to clarify expectations and responsibilities;
- Re-energize membership by rotating roles or recruiting new partners;
- Stay abreast of significant community developments or trends;
- Evaluate often what is and what is not working; and
- Celebrate!

Community Based Collaboration, Community Wellness Multiplied From the Chandler Center for Community Leadership as seen at http://crs.uvm.edu/nnco/collab/wellness.html on March 12, 2007.

Appendix F Collaboration and Community Partnerships provides information on the key elements of successful collaboration and decision-making. Appendix G: Checklist for Developing an Agreement contains a checklist that helps to build community partnership agreements for more formal and involved partnerships. In addition, Appendix H: Example Memorandum of Understanding contains an example temporary Memorandum of Understandings or (MOU's) also referred to as an Organizational Agreement Summary Form in the First 5 Kings County RFA.

The next section includes the fundamental components of service delivery. A description of the activity from a best practice framework is supplemented with form templates in the appendices.

6.4 -- The Service Cycle

Community Engagement (Outreach & Recruitment)

The goal of outreach in family support services is to reach families who might not otherwise participate in a family support program, obtain their involvement, and foster their participation in the community. The success of outreach efforts depends on the program providers' ability to form community partnerships; target, educate, and engage families who can benefit from their services; and meet the needs and interests of these families in ways which will prove beneficial to them, their children, and the community. Appendix I Community Outreach & Education Plan Template contains a sample community outreach & engagement plan which has been customized for First 5 Kings County FRCs.

Community engagement means:

- Recognizing the barriers that might exist (real or perceived) that might prevent marginalized groups from fully participating in a given activity.
- To empower communities to influence service provision in a meaningful and inclusive manner
- To promote effective channels of dialogue between service providers and service users

Resources:
Child Welfare Information Gateway provides descriptions of key service activities and example forms. http://www.childwelfare.gov/supporting/support_services/outreach.cfm

Center for Healthier Children, Families and Communities, which also provides Technical Assistance to First 5 Agencies provides information on community outreach and engagement. www.healthychild.ucla.edu/First5careadiness/

Useful suggestions from recent research include the following recommendations for community engagement and effective outreach.

- Identify what works and what doesn't
- Make it easy to get the message – how to get their attention
- Go to the target population
- Deliver messages in a format they accept
- Easy-to-read, low literacy, alternative formats
- Select a trusted messenger
- Co-message with accepted and trusted messages
- Creative message delivery

First 5 Kings identifies community outreach as effort made through person to person contacts, public speaking engagements, and use of the media to inform the community about the services and operations of the FRC. Each FRC must conduct community outreach to promote services to their community.

Recruiting Tips

- Define the geographic recruitment or service area
- Develop a recruitment plan consistent with goals (based on community assessment)
- Establish recruitment goals such as outreach to a particular under/unserved population
- Identify specific recruitment strategies that include considerations for linguistic diversity
- Coordinate the FRC's outreach and awareness with other community agencies
- Establish collaborations with organizations that serve the target population
- Distribute flyers, brochures and other program information

Retrieved on March 13, 2007 from
http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20Management/Program%

Selection Criteria (Eligibility)

It is critical to establish selection criteria in order to serve children and families that are eligible for your services. Most eligibility requirements can be taken directly from the guidelines for the funding your FRC receives. For example, First 5 funds are for children 0-5 and their families. Other funding sources may have different eligibility requirements such as members of a certain community, a particular under-served population or a subgroup that may need assistance such as homeless individuals. The target population defined by your funding sources dictate who is eligible and how selection criteria should be established.

The typical steps for developing selection criteria include the following:

1. Develop a formal process for establishing criteria for selecting children and families to be served (Establish a work group to assemble key information and document the discussion and decisions).

2. Review funding requirements (for example for First 5 funds, serve children 0-5 years of age).
3. Review service area requirements (for example for First 5 funds, FRC geographic boundaries have been set).
4. Align the selection criteria with program or community goals (For example, if your organization has a school readiness goal, your selection criteria may give preference to a child who is 4 years old and has not participated in previous early care and education programs).
5. Determine if a waiting list is necessary and if it is use a consistent method of selecting eligible children.
6. Develop specific criteria for maintaining eligibility so that criteria for discharge or termination can be developed and implemented. For example, determine how to transition a child who is four years old out of your program so that the discharge is expected, planned for and handled with sensitivity.
7. Document any problems with your selection process and re-visit the issue with your work group at least annually to ensure you are determining eligibility and selecting families that meet your target group classification and match your organizational goals.

Intake

In the service cycle, the intake process is your opportunity to begin a relationship with the children and families you serve. This may not be the first time you have had contact with the family, but it is the first step in developing a formal relationship and setting expectations with the families. It is also typical to provide the family with an orientation to the program as well as the first opportunity to complete important paperwork.

Common paperwork completed during intake include: consent forms, release of information forms, orientation materials, an intake form, an assessment of family needs, compilation of health information on the child and/or family and the completion of agreements for services also known as contracts. (A mock client record will be provided to First 5 Kings County FRCs in May, 2007).

This is the time when you can first introduce concepts of accountability such as providing updated immunization information on children, the expectations of the program such as attendance at meetings, home visits and playgroups and how to contact the program. Intake is also an opportunity to talk about what needs the family may have and how the FRC can address those needs. Referrals and family plans to do not necessarily need to be initiated at this point, but soon after family screenings have been completed.

Intake is also an opportunity to talk about what your program offers and what is does not offer so you can set realistic expectations and make the necessary referrals for the family early in the relationship. Appendix J First 5 Kings County Demographic Intake Form contains a required form that collects key data elements necessary at intake. Appendix K: Sample Intake Policy is provided as a starting point for developing a individualized intake policy.

Screenings & Assessments

Family-Centered Assessments

Assessment forms the foundation of effective practice with children and families. Family-centered assessment focuses on the whole family, values family participation and experience, and respects the family's culture and ethnicity. Family-centered assessment helps families identify their strengths, needs, and resources and develop a service plan that assists them in achieving and maintaining safety, permanency, and well-being. There are many phases and types of family-centered assessment, including screening and initial assessment, safety and risk assessment, and comprehensive family assessment. Assessment in family support is ongoing. Two assessments that are research-based and commonly used at Family Resource Centers include the Life Skills Progression and the Family Development Matrix. Links to both family assessments are provided below. If your FRC decides to use or currently uses a family assessment tool, make sure it is evidence-based and that staff receive sufficient training on how to implement the tool. If your organization elects not to use a family assessment tool, then make sure your intake forms and family goals plans gather sufficient information on the needs and strengths of the families for goal planning.

Resources:
Family Development Matrix
http://hhspp.csumb.edu/community/matrix/fdmpilotproj.htm

Life Skills Progression Index
http://www.brookespublishing.com/store/books/wollesen-8302/index.htm

Goal Planning

Goal planning also known as service plans, family partnership plans, goal plans, permanency plans, personal responsibility plans, treatment plans and other various names all pertain to a plan of action that is developed in response to screenings and assessments that are conducted with the family. They incorporate the needs as expressed by the family as attainable goals that the FRC and family can accomplish by working together. Goal plans are typically initiated at enrollment or soon after intake and are revisited at least one time a year. If the FRC is using a comprehensive family assessment, the goals are extracted from the top identified needs and written as specific, measurable, attainable, realistic and time-bound goals (SMART). The goal plan also outlines who will do what and when, including making referrals and following up on key activities. Goal plans provide a tool for tracking and documenting progress. Appendix L: Example Goal Plan contains an example of a typical goal plan from a Head Start agency. This is a great example of a simple, family friendly plan document ready for us. In addition a link is provided below to Strategies for a service plan from a Family Resource Center. The goal plan from Strategies incorporates a family intake or assessment with a goal plan and provides an excellent example of a family goal plan.
Resources: Strategies Website
http://www.familyresourcecenters.net/forms/docs/serviceplan.doc
http://www.familyresourcecenters.net/forms/docs/assessmtserviceplan.doc

Linkages or Referrals

Making appropriate and timely referrals and conducting good follow up will enhance service delivery for all FRCs. Simply put, many clients of an FRC are in need of another service which you do not provide. To determine the appropriate referral to make for the client, it is critical that a comprehensive intake and assessment were completed. This allows FRC staff to make a targeted referral based on documentation. First 5 Kings County is emphasizing the FRC's role in providing linkages to clients.

Before you make the referral make sure you know the eligibility requirements of the agency you will refer to and any other specific details that will facilitate the referral. Discuss with the client why you think a referral to this agency will help them reach their goals and determine their openness or motivation to seek services from the agency. Also determine if your FRC has a formal or informal agreement with the referral organization and follow any protocol possibly outlined in memorandum of understanding (MOU) also known as Organizational Agreements I the First 5 Kings County RFA..

When gauging the motivation and comfort level of the client, determine if you need to support them with the referral by making the initial contact, inviting the other organization to a joint meeting with the client, or even making the first contact with the agency in-person with the client. It is helpful for the client to have a copy of the referral form as well as the FRC and the agency you are referring to.

The referral form should contain basic information on the client and their needs and the agency you are referring to and any particular instructions for either party. The referral form or a companion form should also have a section to document what happened and how the client felt about the services. It is essential that FRC staff take the time to follow up with clients to see if they secured services and how they felt about the interaction. This information lets you know a few key things. 1) How well did you do in identifying the client needs and linking them to the appropriate service, 2) What else about the process will help this client and others in the future, 3) Are there any modifications that need to be made on the referral form, with the process, or in the relationship with the other agency? And 4) Did the client achieve the results outlined in their service plan?

Appendix M: First 5 Kings County Referral Form contains the generic referral form for use with First 5 Kings Programs. Appendix N Referral Follow-up Form is a companion follow up form for optional use to gather additional data.

Documentation and Record-keeping

Good recording demonstrates and promotes the quality of services to clients. In records you should identify, describe, and assess the client situation; define the purpose of the services; document service goals, plans, activities, and progress; and evaluate the impact of service.
Recording provides evidence of the quality of thought and action that have gone into the delivery of service. In preparing the record, FRC staff should review the client situation and the service transaction, and as a result of this process, they may gain new insights that permit them to improve ongoing activities with and on behalf of their clients.

Moreover, the record itself enhances service delivery by facilitating case continuity and communication among professionals who are providing services to the client. Records also contribute to practice through their roles in supervision, consultation, peer review, education, research, and administrative decision-making. By keeping accurate, relevant, and timely records, FRC staff do more than just describe, explain and support the services they provide. They also discharge their ethical responsibility to be accountable. Appendix O: First 5 Contact Form has been provided by First 5 for capturing key activities with FRC clients and a mock client record will be available in May, 2007..

Case Coordination/Case Conferencing

Case coordination includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes.

Case Conferencing differs from routine coordination. Case conferencing is a more formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the client and family members/close supports.

Case conferences can be used to identify or clarify issues regarding the client status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans. Case conferences may be face-to-face or by phone/videoconference, held at routine intervals or during significant change. Case conferences are documented in the client's record. A case conference form can help document the participants, topics discussed, and follow up needed as a result of a case conference. When distributed immediately to attendees, the form reminds each participant of the roles and activities they've agreed to perform. Although more difficult to arrange, a face-to-face case conference can clarify issues or resolve conflicts more directly than conferring with parties separately or by phone. Involving clients in face-to-face case conferences with providers encourages participation and recognizes their role in the process. Appendix P Case Conference Form contains and example of a case conferencing form and the link to the reference source is provided below.
Retrieved and adapted from
http://www.health.state.ny.us/diseases/aids/standards/casemanagement/case_coordination_conferencing.htm on March 19, 2007.

Exit (Discharge)

When a client exits from your program it is an opportunity to end the relationship and help them transition to a new service or new phase of their life. Sometimes the need to discharge someone from the program is not related to a transition and is the result of other circumstances.

Typical reasons for exit or discharge from a FRC might include:

Child or family no longer meets the eligibility criteria such as:

- Child ages out of the program
- Family moves out of the service area
- Family does not participate in the program on a regular basis
- Family is doing well and no longer feels they need support
- Child or family needs a higher level of service than the FRC can offer

Whatever the reason for exit or discharge from a program, it is helpful to have a procedure in place to document the closure.

Typical steps for case closure or discharge include the following:

1. Develop a process for exit (checklist)
2. If possible, have the family complete an exit interview
3. Close out any case paperwork or evaluation forms
4. Make any necessary referrals on behalf of the family to link them to new services
5. Follow FRC policies and procedures for closing out files and archiving documents

Appendix Q Case Closure Form provides a template for further customization by First 5 Kings County Family Resource Centers.

Summary

Blending these practices and approaches to implementing the principles of family support and key attributes of highly effective services will ensure successful and sustainable, high quality programs that meet community and children and families' needs for years to come.

Appendices

The following appendices contain worksheets and tools described in the various sections of the toolkit. Electronic copies of the worksheets and tools are also contained on the companion CD.

Appendix A: Home Visiting Models and Curricula

This table provides a structure for reviewing home visiting programs to determine which approach and curricula matches the needs of your community as well as the staff and financial resource requirements of your FRC.

Program	Goals/Purpose	Method & Frequency	Target Population	Home Visitor Exp. & Ed.	Training Requirements	Fees	Supplemental curriculum/info.
Healthy Families America (Prevent Child Abuse America)	National Initiative to help parents of newborns get their children off to a healthy start. The program focuses on promoting healthy families by linking them to health care, parent education and child development services. Program goals include: prevention of negative birth outcomes, increased parenting skills, healthy pregnancy practices and the use of social systems.	*Staff members should have limited caseloads. Home visiting can begin pre-natally or within 90 days of birth. Visits occur one a week for up to one year. Once a family is in the program they can receive services until the child is five years old.	Families identified at-risk with children 0-5 years.	All service providers must have basic training in cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community. Also, they should receive training in family assessments and home visitation.	4 days of initial training with a maximum of 15 participants per trainer. All programs adhere to a series of Critical Elements, which represent the field's most current knowledge about implementing successful home visitation program.	$2,000 per trainer plus travel costs. The trainer provides follow-up telephone consultation and TA. Costs for materials are negotiated as needs of the class are determined.	Not readily apparent *Only those programs that apply for affiliation and promise to adhere to ALL of the critical elements, as determined by a credentialing system may be referred to as a HFA site.
HIPPY (Home Instruction for Parents of Preschool Youngsters Program).	HIPPY is a home-based, family focused program that helps parents provide educational enrichment for their preschool child. Goal: Children enter Kindergarten ready to succeed with parents ready to support them through educational careers. The curriculum is centered on a set of storybooks.	Easy to use Activity Packets, Home Visits, group meetings. Parents receive a progressive series of 60 weekly packets of daily activities. Every other week they attend group meetings with other parents and HIPPY staff.	Focus is on parents and their children 3-5 years old.	Paraprofessionals mostly from the same community. They typically work part-time.	Every program receives training and a monitoring visit from HIPPY Intl. each year.	Requires 9 story books a year=$2,275 65 sets of activity packets a yr.=$3,380 Materials approx. $212 Guides $30 each HV Program participation fee=$1,000 On-site training=$2,000 however costs vary considerably depending on travel. Each program will only be billed actual costs.	Not readily apparent

Program	Goals/Purpose	Method & Frequency	Target Population	Home Visitor Exp. & Ed.	Training Requirements	Fees	Supplemental curriculum/info.
Parents as Teachers (PAT)	The PAT model provides parents (pregnancy through Kindergarten entry) with child development knowledge and parenting support. PAT is a national model but a local program. Family participation is voluntary. Goals: 1. Increase parent knowledge of early childhood development and improve parenting practices. 2. Provide early detection of developmental delays and health issues. 3. Prevent child abuse and neglect. 4. Increase children's school readiness and school success.	Personal Home visits, Group Meetings, Screenings and Resource Network. Home Visits typically occur weekly, bi-weekly or monthly for at least an hour. The focus is on sharing age-appropriate child development information with parents, help them learn to observe their own child, address their parenting concerns, and engage families in activities that provide meaningful parent/child interaction.	A universal access model which recognizes that all families can benefit from support. The program services parents and children from pre-natal through kindergarten entry. Materials are available in English and Spanish and are written at a fifth grade and eighth grade level for parents.	Parent Educators can be paraprofessionals but must attend Born to Learn Training in order to become PAT certified and use the PAT curriculum and materials. Supervisors are encouraged to have a Bachelors Degree.	Must have a trained supervisor (2 days of training). Each parent educator must attend and the complete Born to Learn Institute (5 days) and pass the daily assessments. All programs must submit an approved implementation plan. Annual in-service training required for each parent educator to remain certified and for the program to retain credential.	Cost to attend the Born to Learn Institute run from $475-$725 per participant. A sixth day of TA in six-months is included in the price. A program purchases a set of Born to Learn Curriculum materials (2 modules and 16 segment videos). The curriculum cost $275 and belongs to the program. An administration guide must also be purchased by each program at a cost of $25. A program can attend the prenatal to three training and then follow up with a two-day three to Kindergarten entry training. (Fees may have increased for manuals.)	• Issues in Working with Teen Parents • Supporting Families of Children with Special Needs • Building Relationships within Family Systems • Supporting Care Providers through personal visits • Denver II Training • ASQ & SE Training • Neurotoxins… • Group Facilitation • Parents & Children at Play • Home Visitation Web Based: *Explore the Path to Literacy *Born to Learn-Institute Follow Up (Prenatal to 3 years).
MELD (merged with PAT as of 2005)	MELD merges with PAT, expanding reach and resources for both organizations. (2005)	MELD's initial program incorporated best practice information about adult education, family management and early childhood education.	The program was adapted to reach populations raising children in high-stress conditions, such as adolescent mothers and immigrants/refugees.	See above	See Above	See Above	When MELD joined PAT in 2005, it brought with it a broad inventory of educational and support programs for parents, training for family service providers and publications for parents and those that

Program	Goals/Purpose	Method & Frequency	Target Population	Home Visitor Exp. & Ed.	Training Requirements	Fees	Supplemental curriculum/info.
							work with them.
Center for Development Education and Nutrition (CEDEN) Family Resource Center (FRC)	Provides comprehensive services to promote and strengthen families in need of prenatal, early childhood and parenting education. The agency's programs seek to improve birth outcomes of pregnant adolescents and at-risk women by providing information. The agency also provides services to prevent and reverse developmental delays, increase positive parenting behaviors, reduce injuries and ensure timely immunizations.	CEDEN's home based programs accommodate family needs by working with children at child care centers, relatives' homes, shelters for homeless or battered women, and other community shelters. Frequency of home visits is based on family needs ranging from weekly to monthly.	Primarily low-income families and parents with children birth to five years who have developmental delays or at risk of becoming developmentally delayed.	None listed; however, Home Visitors deliver a series of educational materials including: early childhood stimulation activities, age-appropriate activities, basic health and nutrition care, and home safety and a Pro-Family Curriculum focusing on child development, behavior and skill building.	The CEDEN FRC has a number of home based and center based parenting education program which are available in Spanish and English and reproducible. Materials include: curriculum, manuals, evaluation materials, supportive education materials and training opportunities.	CEDEN provides training to those who purchase curriculum materials. Training is conducted in one day and the cost is $500 for up to 10 people. If conducted outside Austin, TX travel costs are added. Program materials are to be purchased separately from training. Follow up training is available upon request.	Not readily apparent
NICASA Parent Project	The goals of the program are to enrich family relationships and promote healthy environments that build resistance to social and personal dysfunction. Specifically, it focuses on the needed to establish supportive networks among parents; improve parent/child relationships; increase ability to balance work and family life; improve corporate climate for workers; and improve parenting skills in preventing and identifying substance abuse problems in themselves and their children.	Offered typically during lunch time at a worksite.	Parents with children birth to eighteen years old. The NICASA Parent Project includes programs for parents with children of the following ages: birth to three, three to five, five to ten, and eleven to seventeen.	This approach is offered in the parent's work site, rather than the home. The facilitator must have experience in facilitating groups, and an understanding of child development.	Facilitator must be trained by NICASA to implement the program. Training is two days with a maximum of 20 participants. Each facilitator receives a Parent Project Manual which contains lesson plans, handouts, transparencies, and implementation information.	The fees for trainings, manuals and other materials can be discussed with the Parent Project Coordinator. Follow up training or Program Consultation is not required by can be arranged as needed.	This program may work as a possible add on to Home Visiting or the overall concept of the Lassen Family Support Network.

Program	Goals/Purpose	Method & Frequency	Target Population	Home Visitor Exp. & Ed.	Training Requirements	Fees	Supplemental curriculum/info.
Nurturing Parenting Programs	The Philosophy of Nurturing Parenting emphasizes the importance of raising children in a warm, trusting and caring household. It is founded on the belief that children who are cared for develop the capacity to trust, care and respect themselves, other people and living creatures and the environment. The program titled, "Parents and Their Infants, Toddlers and Preschoolers is a 48 session home-based program in which parents learn about recognizing and understanding feelings, infant and child development; brain development; nurturing parenting routines; alternatives to hitting; effective non-violent discipline and ways to build self-esteem and self-confidence in children.	There are group and home based options that vary based on the topic, the age of the child and the service delivery modality. There are 24 session each lasting 2 ½ hours for parents and their children birth-to preschool age and 15 sessions for 2 ½ hours for groups of parents and school – age children. Home-Based parenting sessions last 1 ½ hours and 48 modules exist for parents with birth to preschool age children. **No home based modules exist for children from preschool until the teen years.**	The target population is parents and their children birth to eighteen years old.	Two professionals or paraprofessionals facilitate the parent group; at least two staff (more when necessary) facilitate the children's program. Then the groups join together.	Training is not required, although it is preferred. Program training is designed to meet the needs of those implementing the program. Training formats range from half-day to three-day programs. Workshop costs range between $100-200 hourly rate including prep and travel time. Training rates are negotiable. Travel costs are not included in the hourly rate and are the responsibility of the program being trained.	The Nurturing Program Curriculum costs $35.00 plus $7.00 s/h. Family Activities Manual, $13.00 plus $4.00 s/h. The purchase of companion videos	There are culturally specific programs, school based programs and parenting class programs which include self-instruction, home and group based. This is a good add on to a strong home visiting curriculum.

*Sources: Strengthening Families Website at www.strengthening families.org/html/programs_ , www.nurturingparenting.com The Nurturing Parenting Program/Family Development Resources, Inc. Building School Readiness Through Home Visitation for First 5 Children and Families Commission by Deanna S. Gomby (2003). www.parentsasteachers.org, http://hippy.org, Healthy Families/Prevent Child Abuse America, MELD as seen at www.parentsasteachers.org and Family Home Visiting Program Minnesota Department of Health (MDH) and Department of Human Services (DHS) Home Visiting: Best Practice Resource Guide (December, 2002)

Appendix B: Satisfaction Survey

Date:	Location: __ Armona FRC __Corcoran FRC ___Hanford Elementary FRC ___Hand in Hand FRC __ Kettleman City FRC ___ UCP FRC ___ Lemoore FRC __Other _________________ (Please indicate where)
Name (Optional):	Child's Age: __0-2 __3-5 __5+

Surveys help programs determine if the information that has been shared has been useful and what impact if any, the event has made. The results help programs plan future events or strengthen the way current activities are delivered. Your time completing this survey is appreciated!

Instructions:
Check the appropriate box to indicate your level of agreement with each of the statements below.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not Applicable
1. Contact information (name/phone/address) for this program was easy to find.					
2. Staff were courteous to me when I first contacted them to request services, activities or assistance.					
3. I did not have to wait a long time to obtain services or participate in activities.					
4. Staff explained the activities and/or services I was going to receive and what I should expect.					
5. It was easy to find, travel to, and use the location where the services/activities were provided.					
6. The staff providing the services and/or activities were courteous.					
7. My time was respected during the delivery of services and/or activities.					
8. Staff responded professionally to my questions and concerns.					
9. My overall impression of telephone interactions with staff was very positive.					
10. My overall impression of face-to-face interactions was very positive.					
11. I learned something new as a result of my involvement in the program/activities.					
12. The information provided was useful for me and my child/family.					
13. My child(ren) have benefited from my/their participation in this program.					
14. I received the assistance I was seeking which met my needs.					

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not Applicable
15. I would recommend this program or service to a friend or a family member.					
16. I would rate my overall satisfaction as very good.					

If I were in charge of this program, I would……….

If one more activity or service could be added to this organization, it should be……..

Anything else?

Thank you for your time.

Appendix C: Program Monitoring Self-Assessment Tool

Family Support/Family Resource Center (FS/FRC)
Program Monitoring & Self-Assessment

Agency Name: __________________________ Review Date: _____/_____/_____

Program Name: ___________________________

Review Period: ___/___/___ to ___/___/___ Lead Reviewer: __________________

INSTRUCTIONS:
You will note that space is provided at the end of each category for "Special Information." Please use this space to describe any special circumstances, comments, or to clarify the preceding information. If additional space is needed, please use the back of the form and/or attach any pages of additional information at the end of this form.

PROGRAM DESIGN AND OPERATION:

1. Our Database Entries from the Family Support/Family Resource Center Management System accurately captures program activities and data collected for this review period?

   Yes ____ No ____

2. There is evidence of on-going collaboration with other service delivery systems (i.e., the local Department of Social Services, Early Childhood Program, Maternal Child Health, and other relevant agencies, public and/or private) and consumer families through joint participation in team meetings, on-going interagency collaborative meetings, or close communications?

   Yes ____ No _____

3. Participant family members take an active role in the planning, implementation, and decision making for the family resource center?

   Yes ____ No _____ [If not, is there a plan for how and when this will happen.]

4. We have written referral policies and procedures? We have evidence of such policies & procedures.

   Yes ____ No _____

5. Indicate the average number of participants for the reporting period.
   Average # _____

6. Are the following services routinely provided to families? If no, please explain.

   Family Assessment: Yes ____ No ____ Evidence-Based Tool used:__________________

   Client Advocacy: Yes ____ No ____

   Case Management: Yes ____ No ____

   Referral to Other Services: Yes ____ No ____

7. Are the children and families routinely assessed for and referred to appropriate supportive services?

   Yes ____ No _____

8. How many families/individuals received information and referral for services not provided at your FRC this reporting period?

   Number of Families _______ Number of Individuals _______

9. Are FS/FRC services regularly provided outside of traditional work hours (i.e. after 5:00 pm and on weekends)?

   Yes _____ No ______

10. Does your Advisory board have representatives from community agencies?

    Yes ____ No ____

12. Does your Advisory Board have **consumer/participant family members?**

    Yes _____ No ______ If yes, how many? ______ If no, why not:

13. Does your Advisory Board have representatives from the Faith Community?

    Yes ______ No ______

Special Information on Program Design and Operation.

SUPERVISION AND SUPPORT SERVICES:

1. Does each position at the FRC have an assigned supervisor?

   Yes ____ No_____

2. On average, how often does the director observe and/or participate in FRC activities?

3. On average, how often do supervisors and staff meet to discuss clients and have "supportive supervision" time?

Special Information of Supervision and Support Services:

ADMINISTRATIVE SERVICES:

1. Does the program have written policies concerning qualifications for FRC supervisors and staff?

   Yes ____ No_____

2. Does the program have written job descriptions for all positions, to include volunteers?

   Yes ______ No ______

4. How many FS/FRC employees have provided services or facilitated activities during the review period? _______

5. What is the average tenure (in months) of FRC staff? ________________________

Special Information on Administration Services:

TRAINING SERVICES:

1. Our FRC has a written plan for orientation and training of new workers and for ongoing staff development?
   Yes ______ No ______

2. Services provided in a culturally competent manner in that staff are provided training in cultural competence, or the cultural background of staff reflect the cultural background of families served?
   Yes _______ No _______

3. On average, how many hours of in-service training (formal and informal, ex: workshops, seminars, conferences, etc.) did staff receive this reporting period? ________

4. List in-service training topics.

Special Information on Training Services:

RECORD KEEPING:

1. ALL records are securely stored and kept in an orderly and consistent fashion?

   Yes _____ No _____

2. ALL records are maintained for a minimum period of three years from the ending date of each contract?

   Yes _____ No _____

3. Copies of signed releases, referrals, and other pertinent data are included in each case file?

   Yes _____ No _____

4. Case notes are legible and brief?

   Yes _____ No _____

5. The activity history for participants are recorded prominently in each case file?

   Yes _____ No _____

1. Review of Participant Records, to include:

   a. demographic information for household members
   b. participant activities, comments, suggestions, requests, etc.
   c. releases, if needed
   d. comparison of Database reports with participant record

Conclusions:

a. Describe strengths/weaknesses noted during this monitoring self-assessment activity:

b. Describe areas needing improvement:

c. Describe any issues that result in this program being out of compliance with funders:

d. Describe plans to correct and findings and provide a timeline for corrections.

Retrieved from and adapted on March 18, 2007
http://www.dhhs.state.nc.us/dss/Monitoring/docs/2006_2007_monitoring/Section%20VI%20FSCW-03%20FSFRC.doc

Appendix D: First 5 Kings County Consent Form

CONSENT FOR RELEASE OF INFORMATION
& AUTHORIZATION TO REFER
TO COMMUNITY RESOURCES

Program: ____

In order to provide better services to you and your family, this program would like your permission to connect you with other community resources that may be available to you. By signing this consent form, you will allow us to provide you with the best possible service.

Please check the community partners that you agree to have your information shared with:

□ WIC	□ UCP	□ YMCA
□ Head Start	□ Kings County Office of Education	□ Kings Co Health Dept
□ KCAO: ________________	□ Hospital: ____________________	□ Kings Co Human Service
□ Proteus	□ Health Clinic____________________	□ Kings Co Probation
□ School: ________________	□ Kings View Counseling	□ Central CA Legal Service
□ Fire Department: __________	□ Healthy Families	□ Other: ___________
□ Law Enforcement: _________	□ Private Physician: ____________	□ Other: ___________
□ FRC: ___________________	□ Healthy Start: _______________	□ Other: ___________
□ Central Valley Regional Center	□ Dental Provider: ______________	□ Other: ___________

You will know in advance when we are making a referral on your behalf. Our program will only voluntarily release your name(s), phone number, address, and family needs/family plan to the community partners named above. Medical information, financial information, and social history are only released to providers who are directly linked to those services. To protect your confidentiality, your information will not be shared with non-essential persons and will be stored in a secure area.

**Neither this program, or the above-named community partners will ever share your personal information with anyone else unless they/we believe you are a danger to yourself or to others, or in the event that child abuse is suspected.*

RELEASE OF INFORMATION TO PROGRAM FUNDER

This program received funding from First 5 Kings County. All programs receiving First 5 funding are required to participate in an evaluation. The purpose of the evaluation is to make sure that all children and families receive the best possible services. UCLA is the First 5 Kings local evaluator. UCLA collects local program data for First 5 Kings evaluation. UCLA also cooperates with the First 5 California evaluation team in the sharing of local data for statewide evaluation. Confidential information, however, is not shared with the state evaluation team.

During the process of evaluation, you may be contacted to provide feedback on the services you have received. In addition, members of the UCLA evaluation team and/or First 5 Kings staff will access and review database records that may include specific information about you and your family and the services you are receiving. All information specific to your family will be kept private. No personal information will be released that could identify you or your family in any way.

We appreciate your willingness to participate in the evaluation. You may change your mind at any time about participating by completing a request to deny release of information form. If you have any questions about the evaluation, you may contact the Executive Director of First 5 Kings County at 224 W. Lacey Blvd., Hanford, CA 93230, (559) 585-0814.

□ I agree to participate in the local evaluation of First 5 Kings County
□ I agree to participate in the First 5 State Evaluation

I agree with the terms above and acknowledge that I have been given a copy of the consent form. This authorization is effective immediately upon the required signature(s) below and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires 5 years from the date if the signature.

Signature of Adult Participant | Signature of Additional Adult Participant

______________________ ________ | ______________________ ________
Name (Print) Date | Name (Print) Date

This Consent also covers:

______________________ | ______________________
Child #1 | Child #2

______________________ | ______________________
Child #3 | Child #4

______________________ | ______________________
I certify that I am the legal guardian of the above named children. **Relationship to child:** □ Mother □ Father □ Caregiver

______________________ | ______________________ ________
Legal Guardian Signature | Name (Print) Date

Appendix E: Client Confidentiality Policy

Family Resource Center
Policy and Procedure
Client Confidentiality

Policy

To protect the legal rights of the client from invasion of privacy as a result of indiscriminate and unauthorized access to and disclosure of confidential information, communications between clients and staff and all information recorded in the client record or other forms are confidential and shall be safeguarded to protect the legal and civil rights of the client.

Procedure

All employees shall sign an Oath of Confidentiality form agreeing not to divulge any information or records concerning any client without proper authorization in accordance with the California Welfare and Institution Code, Section 5328 et.seq.

Confidentiality of client information shall be included in the orientation of all new employees.

Employees shall be informed that the unauthorized release of confidential information is subject to a civil action under the Welfare and Institution Code, Section 5330 and may result in the termination of their employment.

The Oath of Confidentiality form shall be maintained in the employees personnel file.

Staff will inform clients of limits of confidentiality, and all clients will sign confidentiality statement.

Approved: ____

Executive Director/Date Board Chair/Date

Updated: ____

Executive Director/Date Board Chair/Date

Appendix F: Collaboration and Community Partnerships

The following table is presented as a tool for staff and community partners as a reference document to underscore the levels of collaboration, types of decision-making structure and key process attributes. This allows board, staff and community members to gauge progress and understand the typical and expected phases of collaboration. It is a long yet worthwhile process.

Community Collaboration and Decision-Making			
Levels	**Purpose**	**Structure**	**Process**
Networking	• Dialogue and common understanding • Clearinghouse for information • Create base of support	• Non-hierarchical • Loose/flexible links • Roles loosely defined • Communication is primary link among members	• Low key leadership • Minimal decision making • Little conflict • Informal communication
Cooperation or Alliance	• Match needs and provide coordination • Limit duplication of services • Ensure tasks are done	• Central body of people as communication hub • Semi-formal links • Roles somewhat defined • Links are advisory • Little or no new financial resources	• Facilitative leaders • Complex decision making • Some conflict • Formal communication within the central group
Coordination or Partnership	• Share resources to address common issues • Merge resource base to create something new	• Central body of people consists of decision makers • Roles defined • Links formalized • Group leverages/raises money	• Autonomous leadership but focus is on issue • Group decision making in central and subgroups • Communication is frequent and clear
Coalition	• Share ideas and be willing to pull resources from existing systems • Develop commitment for a minimum of three years	• All members involved in decision making • Roles and time defined • Links formal with written agreement • Group develops new resources and joint budget	• Shared leadership • Decision making formal with all members • Communication is common and prioritized
Collaboration	• Accomplish shared vision and impact benchmarks • Build interdependent system to address issues and opportunities	• Consensus used in shared decision making • Roles, time and evaluation formalized • Links are formal and written in work assignments • Resources and joint budgets are developed	• Leadership high, trust level high, productivity high • Ideas and decisions equally shared • Highly developed communication systems

Appendix G: Checklist for Developing an Agreement

A Checklist for Developing a Partnership Agreement/Contract

Early education and family support partners can use this checklist to assist them in developing a comprehensive agreement that clearly addresses each partner's roles and responsibilities and many of the elements needed for the partnership to run smoothly. While agreements can and should be reviewed and revised over time, a strong agreement forged early in the partnership lays the foundation for a strong and sustainable collaboration.

A partnership agreement between providers contains critical information and clarifying details. Agreements include some standard legal sections, but the language used often sets the tone for a "partnership spirit." On the following pages, a list of specifics that partners might include in a written agreement are provided, although not every item need be addressed. Agreements vary, reflecting the uniqueness of the partnership. Providers can use this document as they develop or review their partnership agreements.

The checklist consists of the following five sections:
I. General Information
II. Partnership Services
III. Fiscal/ Resources
IV. Systems
- A. Planning and Decision-Making
- B. Communications
- C. Oversight
- D. Recordkeeping and Documentation
- V. General Administrative Elements

A Checklist for Developing a Partnership Agreement/ Contract

	I. General Information *(often introductory)*	Not Yet Addressed	Under Discussion	Finalized	Action Steps
☐	General statement of the agreement's purpose				
☐	Partners' affiliation and legal status				
☐	Contractual period				

❑	Contract amendments, renewal, and termination procedures				
❑	Role of each partner's decision-making bodies in the contractual development and approval process				
❑	Compliance with local, state, and federal regulations and policies				
❑	Conflict of interest statements and prohibited activities				
❑	Signatures of key parties and date of signing (usually at the end of the document)				
II. Partnership Services		Not Yet Addressed	Under Discussion	Finalized	Action Steps
❑	Number of children served: hours, days, weeks of operation Number of programs, clients served: hours, days, weeks of operation				
❑	Location of services				
❑	Each partner's role in service delivery: child education, child/family health, mental health, disabilities, nutrition, family services/parent involvement, home visits/conferences, meetings, recordkeeping, transportation, supervision, oversight				
❑	Staff assigned to support the partnership; which entity/partner employs and supervises which staff				
❑	Responsibilities of each partner’s staff				
❑	Staff schedules				
❑	Supervision procedures				
❑	Staff qualification requirements				
❑	Professional development responsibilities (in-service, training, college courses)				

❑	Staff selection procedures				
❑	Annual performance appraisal procedures				
❑	Provisions for substitutes				
III. Fiscal/Resources		Not Yet Addressed	Under Discussion	Finalized	Action Steps
❑	Funding and resource commitment of each partner				
❑	Funding/resources accessed and by which partner				
❑	Payment per child or client /per year by partners and payment procedures				
❑	Contingencies (enrollment, etc.) required by partner for payment				
❑	Funds targeted and/or designated for specific improvements (renovations, salary enhancements, quality issues)				
❑	Designated responsibilities for: facilities/space, maintenance, repairs, food service, and supplies and equipment (who will retain ownership of equipment when/if the agreement ends)				
❑	Non-federal share/in-kind services				
❑	Provisions for collection and non-payment of parent fees				
❑	Provisions for the loss of child care subsidies and parent fees				
IV. Systems		Not Yet Addressed	Under Discussion	Finalized	Action Steps
A. Planning and Decision-Making					
❑	Role of each entity's decision-making bodies in planning and decision making				

❑	Advisory Board representation and elections				
❑	Community assessment process				
❑	Collaborative, inclusive strategies involving partners' staffs and parents and the community				
❑	Items needing prior approval (items a partner reserves the right to approve)				
B. Communications					
❑	Type, frequency of meetings; meeting participants				
❑	Type and frequency of reports				
❑	Information exchange (training calendars, personnel policies, position openings, etc.)				
❑	Work with other agencies and responsibility of each partner				
❑	Use of technology, i.e., shared databases for tracking, e-mail communication, etc.				
❑	Protocols for information sharing				
❑	Parent communications				
❑	Dispute resolution procedures				
C. Oversight					
❑	Notification procedures/follow-up on local, state, and federal monitoring/assessment				
❑	Ongoing observation of partnership operations, review of records, written feedback, follow-up				
❑	Annual program self assessments and other reviews				
❑	Improvement initiatives (partners' obligations to each other when the				

	partnership is not progressing as envisioned)				
D. Recordkeeping and Documentation					
☐	Recruitment, enrollment applications, and intake				
☐	Parent permission procedures				
☐	Child screening, assessment, outcomes				
☐	Curriculum planning and individualized child plans				
☐	Parent contacts, home visits, parent-teacher conferences				
☐	Disabilities, medical, dental services				
☐	Storage of records and access				
☐	Parent partnership plans				
☐	Procedures for recording/tracking of services and follow-up				
☐	Transfer of information, confidentiality				
V. General Administrative Elements		Not Yet Addressed	Under Discussion	Finalized	Action Steps
☐	Designated contact person for each organization involved				
☐	Travel policies				
☐	Liability/insurance				
☐	Use of partners' names (how partners will publicize the services sponsored by the partnership)				

Adapted and Retrieved from: www.nccic.org on March 20, 2007. The document is for informational purposes only. No official endorsement of any practice, publication, program, or individual by the U.S. Department of Health and Human Services, the Administration for Children and Families, the Child Care Bureau, or the National Child Care Information Center is intended or is to be inferred. For additional information on this or related topics, please contact the National Child Care Information Center at (800) 616-2242 or info@nccic.org.

Appendix H: Example Memorandum of Understanding

Family Resource Center

**Temporary Interagency
Memorandum of Understanding**

This agreement serves as a temporary MOU between (Insert your name) Family Resource Center and ____.

(Insert your name) Family Resource Center (FRC) is a non-profit agency providing comprehensive family support services to the communities of (INSERT YOUR SERVICE AREA) in Kings County, California. The **(Insert your name)** FRC Collaborative is unified by a set of principles based on prevention, family centered services, and the enhancement of strengths and assets.

The **(Insert your name) (Insert your name)**FRC acts as the hub of activity for families and community residents. It exists for the dual purpose of improving the lives of individuals and families as well as changing the community in which they live and the systems that serve them.

COMMITMENTS:

The **(Insert your name)**FRC shall provide:

- Appropriate work and meeting space.
- Access to necessary office equipment and operational support, i.e., telephones, fax machine, photocopy machine, Internet.
- Leadership for collaborative planning, including coordination and facilitation of activities and meetings.
- A referral process to enhance clients' ability to access services.
- The promotion of programs and services to community residents.
- Cross-training activities for collaborative partners.

The participating agency will:

- Attend and be an active participant in regular meetings of the FRC Collaborative.
- Collaborate with the **(Insert your name)**FRC and other partners to provide awareness of the Center and its services.
- Support consensus building and conflict resolution among all collaborative partners.
- Participate in cross-training activities for collaborative partners.
- Explore the ability to expand services offered through collaboration.
- Participate in community-based strategic planning sessions.
- Support guiding principles/mission of the **(Insert your name)**FRC.
- Cooperate with and participate in data collection activities required by funding sources.
- Comply with all State and Federal laws pertaining to issues of confidentiality and mandated reporting.

TERMS OF AGREEMENT:

This agreement shall commence ____________________________ and remain in full force and effect while the formal MOU is being created and adopted by the **(Insert your name)**FRC Advisory Board. Upon its adoption, each agency will be asked to sign the Council-approved MOU, which will then supercede this document.

The terms of this agreement can be renegotiated:

- By either party's initiation.
- By both parties calling a meeting to redefine.
- After 30 days' notice.

SIGNATURES:
These responsibilities are agreed to by the following authorized signature.

Name (Print) __________________________ Title: ___________________

Signature _____________________________ Date ___________________

Name (Print) __________________________ Title ___________________

Signature _____________________________ Date ___________________

Name (Print) __________________________ Title ___________________

Signature _____________________________ Date __________________

Appendix I: Community Outreach & Education Plan Template

Partial Example Plan Only
FIRST 5 Kings Family Resource Center
Proposed Community Outreach and Education Communication Plan
2007-2008

Objectives:

1. Reach families with news and information on programs and services.
2. Inform all audiences on the importance and value of early child development.
3. Ensure residents of Kings County are aware of the value of First 5 Kings County Programs.
4. Facilitate public and private partnerships, inclusive of partnerships with community hospitals and other health educators, for education on health and developmental issues.

1. Strategy: **A multi-media campaign focused on early learning and available services funded by First 5 Kings County for children ages 0-5 and their families**.

Objectives Addressed: 1, 2, 3, 4

Desired Outcome: Community members will understand the importance of the first five years and First 5 Kings County's role in providing services to children ages 0-5 and their families.

Print Media

Activities	Frequency	Start Date
Develop and distribute press releases	A minimum of one time per month	Ongoing
Research and utilize opportunities to print display ads in community publications (Insert Kings County Publications here)	Four times per year	Ongoing
Purchase and manage distribution of promotional items	Ongoing	Ongoing
Display ads in English and Spanish newspapers	Four times per year	July 2007
Complete Report to the Community through FY 2006-07	Once in November 2007	August 2007
Submit prewritten articles to English and Spanish newspapers focused on early learning and connecting families to available services	One time per quarter	September 2007
Include inserts in ECE Stipend mailings	At start of program	September 07

Local Cable Access/Community College Cable Stations

Activities	Frequency	Start Date
Air PSAs/commercials	A minimum of two stations, per PSA policy	January 2008
Utilize existing show formats (interviews, talk shows, etc.)	As available	February 2008

Radio

Activities	Frequency	Start Date
Utilize existing show formats (interviews, talk shows, etc.)	As available	September 2007

2. Strategy: **Community based outreach focused on early learning and available services funded by First 5 Kings County for children ages 0-5 and their families.**

Objectives Addressed: 1, 2, 3, 4
Desired Outcome: Parent/care providers of children ages 0-5 will know how to access services funded by First 5 Kings County.

Presentations

Activities	Frequency	Start Dates
Presentations to community groups (service clubs, partners, clubs, etc.) utilizing DVD & other created media	A minimum of one per quarter	August 2007
Develop a Speaker's Bureau, including presentation and training, to make regular presentations on a variety of topics including access to funded services	A minimum of one per quarter	August 2007
Participation at Community Events	Two times a year	Ongoing
Sponsor Community Events	Ongoing	Ongoing

Appendix J: First 5 Kings County Demographic Intake Form

PARTICIPANT DEMOGRAPHIC / INTAKE FORM

Welcome! To better serve you, we request that you complete this form. Our funding sources require this demographic information. All identifying information will be kept confidential. Your cooperation in completing all of the items is appreciated. Please **PRINT**.

Head of Household (HOH) Name: ____________________________ (Last, First, M.I) **Relationship to child:** ☐ Mother ☐ Father ☐ Caregiver

Address: ____________________________ (Street (include apartment #), City, State, Zip Code)

Home Phone: ______________ **Work Phone :** ______________ **Cell Phone:** ______________

Email: ______________ **Emergency Contact**: ______________ **Phone**: ______________

DATE OF BIRTH	ETHNICITY: (Check one)	GENDER: (Check one)	PRIMARY LANGUAGE: (Check One)	DISABILITY (Check One)	DISABILITY (Check All That Apply)	MEDICAL COVERAGE (Check One)
/ /	☐ Asian: ________	☐ Female	☐ English	☐ Yes	☐ Mental	☐ None
	☐ African American	☐ Male	☐ Spanish	☐ No	☐ Physical	☐ Medi-Cal
	☐ Hispanic: ________	☐ Other	☐ Asian: ________		☐ Emotional	☐ Medicare
	☐ White/Non-Hispanic		☐ Tagalog		☐ Behavioral	☐ Healthy Families
	☐ Native American		☐ ASL		☐ Speech	☐ Private
	☐ Pacific Islander		☐ Portuguese		☐ Hearing	☐ Unknown
	☐ Multi-Ethnic: ________		☐ Other: ________		☐ Sight	
	☐ Other: ________				☐ Dev Delay	
					☐ Other	

ADDITIONAL PARTICIPANTS (Children/Spouse/Partner/Parent/Caregiver/Sibling)

#___ Name: ____________________________ **Lives with HOH**: ☐ **Yes** ☐ **No**

DATE OF BIRTH	ETHNICITY: (Check one)	GENDER: Check one)	PRIMARY LANGUAGE: (Check One)	DISABILITY (Check One)	DISABILITY (Check All That Apply)	MEDICAL COVERAGE (Check One)
/ /	☐ Asian: ________	☐ Female	☐ English	☐ Yes	☐ Mental	☐ None
	☐ African American	☐ Male	☐ Spanish	☐ No	☐ Physical	☐ Medi-Cal
	☐ Hispanic: ________	☐ Other	☐ Asian: ________		☐ Emotional	☐ Medicare
	☐ White/Non-Hispanic		☐ Tagalog		☐ Behavioral	☐ Healthy Families
	☐ Native American		☐ ASL		☐ Speech	☐ Private
	☐ Pacific Islander		☐ Portuguese		☐ Hearing	☐ Unknown
	☐ Multi-Ethnic: ________		☐ Other: ________		☐ Sight	
	☐ Other: ________				☐ Dev Delay	
					☐ Other	

Relationship to HOH: ☐ Child ☐ Foster Child ☐ Partner/Spouse ☐ Parent ☐ Foster Parent ☐ Sibling ☐ Grandparent ☐ Other: ________

#___ Name: ____ **Lives with HOH**: ☐ **Yes** ☐ **No**

DATE OF BIRTH	ETHNICITY: (Check one)	GENDER: (Check one)	PRIMARY LANGUAGE: (Check One)	DISABILITY (Check One)	DISABILITY (Check All That Apply)	MEDICAL COVERAGE (Check One)
/ /	☐ Asian: __________	☐ Female	☐ English	☐ Yes	☐ Mental	☐ None
	☐ African American	☐ Male	☐ Spanish	☐ No	☐ Physical	☐ Medi-Cal
	☐ Hispanic: __________	☐ Other	☐ Asian: __________		☐ Emotional	☐ Medicare
	☐ White/Non-Hispanic		☐ Tagalog		☐ Behavioral	☐ Healthy Families
	☐ Native American		☐ ASL		☐ Speech	☐ Private
	☐ Pacific Islander		☐ Portuguese		☐ Hearing	☐ Unknown
	☐ Multi-Ethnic: __________		☐ Other: __________		☐ Sight	
	☐ Other: __________				☐ Dev Delay	
					☐ Other	

Relationship to HOH: ☐ Child ☐ Foster Child ☐ Partner/Spouse ☐ Parent ☐ Foster Parent ☐ Sibling ☐ Grandparent ☐ Other: ___________

#___ Name: ____ **Lives with HOH**: ☐ **Yes** ☐ **No**

DATE OF BIRTH	ETHNICITY: (Check one)	GENDER: (Check one)	PRIMARY LANGUAGE: (Check One)	DISABILITY (Check One)	DISABILITY (Check All That Apply)	MEDICAL COVERAGE (Check One)
/ /	☐ Asian: __________	☐ Female	☐ English	☐ Yes	☐ Mental	☐ None
	☐ African American	☐ Male	☐ Spanish	☐ No	☐ Physical	☐ Medi-Cal
	☐ Hispanic: __________	☐ Other	☐ Asian: __________		☐ Emotional	☐ Medicare
	☐ White/Non-Hispanic		☐ Tagalog		☐ Behavioral	☐ Healthy Families
	☐ Native American		☐ ASL		☐ Speech	☐ Private
	☐ Pacific Islander		☐ Portuguese		☐ Hearing	☐ Unknown
	☐ Multi-Ethnic: __________		☐ Other: __________		☐ Sight	
	☐ Other: __________				☐ Dev Delay	
					☐ Other	

Relationship to HOH: ☐ Child ☐ Foster Child ☐ Partner/Spouse ☐ Parent ☐ Foster Parent ☐ Sibling ☐ Grandparent ☐ Other: ___________

PLEASE CHECK ALL AREAS YOUR FAMILY MAY NEED ASSISTANCE WITH (Check all that apply)

☐	Preparing your kids for Kindergarten	☐	Health Insurance	☐	Food	☐	GED
☐	Preschool Assistance	☐	Getting Medical Care	☐	Clothing	☐	ESL Classes
☐	Prenatal & Birth Care Education	☐	Getting Dental Care	☐	Transportation	☐	Employment Assistance
☐	Screening for Developmental Delays	☐	Getting Mental Health Care	☐	Housing Assistance	☐	Immigration/Citizenship
☐	Car Seat Distribution	☐	Getting Vision Services	☐	Domestic Violence Services	☐	Tax Preparation
☐	Disciplining Your Child	☐	Well Baby Check-up	☐	Legal Assistance	☐	Substance Abuse
☐	Childcare	☐	Immunization/shots	☐	Money Management (Budgeting)	☐	Utility Assistance
☐	Parenting Assistance	☐	Physical Fitness	☐	Translation Assistance	☐	Application Assistance
☐	Managing your Child's Behavior	☐	Nutrition Education	☐	Adult Literacy	☐	Other (specify):

WHO REFERRED YOU TO SERVICES: (Check one)

☐	School	☐	Medical Provider	☐	Law Enforcement	☐	Self-Referral
☐	Social Service Provider	☐	Mental Health Provider	☐	Friend	☐	Other:

FOR OFFICE USE ONLY **PROGRAM NAME:** ______________________________ **Date:** ____/____/____
STAFF NAME: __________________________ **INTAKE SITE:** ☐ FRC ☐ SR Site ☐ Home ☐ Other (Specify): _______________
STAFF RECOMMENDATION: ☐ **Referral to Case Management** ☐ **Further Assessment Needed** ☐ **One-time Service** ☐ **Enroll into Program**

Appendix K: Sample Intake Policy

Family Resource Center
Policy and Procedure
Intake Policy

Policy
To ensure children and families that qualify for First 5 services are enrolled in the appropriate programs. To ensure when the status of a family changes and they are no longer eligible for First 5 services and that they be removed from First 5 files, data collection and reporting systems.

Procedure

All potential clients will provide verification of the age of their child and their current address to ensure compliance with First 5 standards related to serving children 0-5 years living in the FRC service area.

Once eligibility is determined and documentation has been obtained, FRC staff will provide an orientation to the program including the expectation of notifying the FRC when the family moves, a child ages out, or some other reason they would no longer be eligible.

FRC staff will routinely ask for the child's birth date and family address during the service cycle. For example, when developing a referral or a goal plan, be sure to verify eligibility requirements.

FRC staff will flag the child & family file once eligibility is not longer maintained and make the necessary changes in the First 5 documentation.

FRC staff will conduct a client closure process and document the activities.

Approved: ____
Executive Director/Date Board Chair/Date

Updated: ____
Executive Director/Date Board Chair/Date

Appendix L: Example Goal Plan

Family Partnership Goal Plan

General information

Our program places an emphasis on developing partnership with families. In order to help us develop the best partnership possible, there is some general information we would like to ask you about.

Family Name: ______________________ Family Resource Center: ______________________

Child's Name: ______________________ Date: ______________________
(month) (day) (year)

Family Advocate: ______________________

Tell me about the members of your family and those who live with you:

NAME	RELATIONSHIP	BIRTHDATE

What are some of the most important things we need to remember about you and your family as we work together?

____

____

Circle one

Are both parents involved in your child's life? Yes No

Is there a non-custodial parent? Yes No

Is there a court order/legal document in place? Yes No

Would you give us permission to contact this parent? **Yes** **No**

Signature: (Approval to contact non-custodial parent) ____

Are you currently involved with another agency or program in which you have developed a goal or plan?
Yes **No**

If yes, with what agency:____________________________ **Contact Person:** _____________________

May we contact this agency for goal/plan information? **Yes** **No**

Signature: (Approval to contact other agency/agencies for goal planning) __________________________

Our program offers parent meetings, trainings, community involvement, and opportunities for parents to get together. If you choose to participate, when would be the most convenient time for you to attend such activities?

☐ mornings ☐ evenings ☐ afternoons ☐ weekends ☐ various times

Check topics that would interest you:

- ❑ Family Health
- ❑ Child Development "How Your Child Grows"
- ❑ Child Safety at Home and in the Community
- ❑ Healthy Eating for Children
- ❑ Family & Community Partnerships…Being involved in Your Community
- ❑ Positive Parenting…Communication, Relationship Building, Behavior Management
- ❑ Other

Our program conducts home visits several times throughout the year. When is the best time for us to make such visits with you?
Day of the Week: Time:

Family Partnership Plan
Family Goal Statement

(THIS FORM MUST BE COMPLETED WITHIN 90 CALENDAR DAYS OF ENROLLMENT)

FAMILY NAME: ______________________CHILD'S NAME: ___________________________________

FAMILY ADVOCATE: _________________LOCATION: ___________DATE:_____________________

A goal is a step or a necessary part to enhance current strengths. It should be specific, realistic, measurable and you should be able to know when you have completed it. In order to make it specific, we might say: "I will spend 30 minutes a day playing with my child". We ask all of our families to develop a goal that they can achieve by the end of the year.

FAMILY GOAL:
Example: We would like our child to be enrolled in preschool by August, 2007.

____

____

STEPS TO ASSIST IN REACHING GOAL:

1.Example: Determine if family qualifies for First 5 services, Head Start,State Preschool or child care subsidies for private preschool.

2. Once eligibility is determined for an appropriate preschool, gather necessary documentation (immunizations, proof of income, birth certificate, etc.)

3. Complete paperwork for preschool (If assistance is needed, FRC staff will help to complete).

4. Submit paperwork for preschool and ask what the child will need to bring to school (lunch, backpack, change of clothes, etc.)

5. Visit preschool and prepare for transition issues.

RESOURCES NEEDED TO MEET GOAL:

____

____

THIS GOAL CAN BE MET BY: ____________________________
(Month) (Year)

PARENT/GUARDIAN SIGNATURE: ____

When family goal is met, a new goal should be developed on a new Family Goal Statement form.

****

GOAL WORK FOLLOW-UP

MID-YEAR FOLLOW-UP DATE:	MID-YEAR ACHIEVEMENT SCORE	END OF YEAR FOLLOW-UP DATE	END OF YEAR ACHIEVEMENT SCORE
______, ______, ______ (month) (day) (year)	1 2 3 4	______, ______, ______ (month) (day) (year)	1 2 3 4

SCORING:
1. GOAL ACHIEVED
2. GOAL PARTIALLY (1/2) ACHIEVED
3. MINIMAL PROGRESS
4. NO PROGRESS

Appendix M: First 5 Kings County Referral Form

REFERRAL FORM

Date: ______________________________

Referral to (Agency Name): ____

Contact Name: ____

Address: ____

City/State/Zip: _____________________________ Phone: ______________________

INTRODUCTION OF PARTICIPANT SEEKING SERVICES

Participant Name: ____

Address: ____

City/State/Zip: ______________________________ Phone: ____________________

Assistance Needed: ____

____

____

____

Referred By: ____

Program Affiliation: ____

Phone: ____

I, ____, hereby authorize the release of any information between the above described “referral to” agency and the “referred by” agency for the purpose of my continuing care and case management.

This authorization is effective immediately upon the required signature(s) below and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires 5 years from the date of the signature.

I realize this is an authorization for consent. The required signature(s) below must be made voluntarily and knowingly before any records can be released. I understand I may refuse to sign. In this event, records cannot and will not be released. I further the referral agency from any liability arising from the release of information to the person(s) designated above.

____ ____________________

Signature of Client Date

____ ____________________

Signature of Witness Date

White – Client File **Yellow** – Data Entry **Pink** – Referral Agency **Gold** – Client

Appendix N: Referral Follow-up Form

*Name of Family Resource Center:*______________________*Phone:*__________*Fax:*________

Referred by: Date:

Referral Source | Agency

______INSERT NAME is currently in____INSERT PROGRAM_______________program.

Referral to:

Address:

Phone #: Fax #: Contact Person:

Family Information

Family Name: Adult's Relationship to Child(ren):

Address: Age/# of children: 0-2 ☐ 3-5 ☐ 6-12 ☐ 12+☐

Phone #:

Medi-Cal: ☐Yes ☐No Healthy Families: ☐Yes ☐No Private Insurance : ☐Yes ☐No

Area of concern / need: ☐ Basic Needs ☐Health ☐ Oral Health ☐ Mental Health

☐ Child care/ education ☐ Parent ed. or employment ☐ Transportation Describe:

☐ Special Instructions, i.e., directions, worksheets, contact times, etc.

Plan of Action

Service Provided by Referral: ☐ Not Accepted (please attach documentation) ☐Accepted (complete next section)

☐ Appt. Sched. ☐Appt. Kept

Date:

Recommended Follow-up: (attach additional documentation) ☐ Initiate External Referral To:

☐ No action needed ☐ One Visit ☐ Ongoing Visits: Frequency:

Follow-up

FOR FRC, or First 5 USE ONLY: Follow-up Date:

Family Feedback

Family's Assessment of Service Received: Date:

Parent Signature : ________________________________ Date : _________________

Staff Signature : _________________________________ Date : _________________

Instructions:

Referral Source:

- Indicate by filling in the section which program is making the referral

Who Referred Who:

- Referred by: Write your name in this space provided.
- Date: Indicate the date of the referral.
- In the space provided, write in the name of the family member you are referring.
- Indicate the program associated with the person you are referring (FRC, First 5 K-Camp, Oral Health). If the family is on the wait list or has applied then the program would be waitlist.

Agency:

- Initiate referral to: Write the name of the program or agency in this space provided.
- Address: Write the name of the program or agency address in this space provided.
- Phone #, Fax # and Contact Person: In the space provided type or write in the respective information.

Family Information:

- Family Name: In the space provided indicate the family name(s) by writing it in. Adult's Relationship to Child: In the space provided type or write in the relationship of the adult receiving the referral to any child in the program or awaiting services, i.e., mother, uncle, father, grandparent, guardian, etc.
- Age and number of children. Please indicate the number of children by each age range in the family.
- Family's Address & Phone: In the space provided type or write in the correct address and phone number of the person being referred. (This is important for the program or agency that is receiving the referral for follow-up.)
- Medi-Cal, Healthy Families or private insurance: Check the box for Yes or No. If you don't know or it is pending, indicate that.
- Area of Concern/Need: Check which box the referral matches: Basic Needs includes: Food, Clothing, Housing, Utilities, WIC, TANF, Food Stamps, HUD etc. Health includes: PHN, Medical coverage, Doctor visits, prescriptions, immunizations etc. Oral Health includes any dental assessments, consultations and treatments. Mental Health includes any assessment, consultation and services relating to social emotional health. Child Care includes any referral for child care, education and/or Head Start for children. Parent education/employment includes and work, training or education referral for an adult. Transportation includes anything related to obtaining a driver's license, insurance, a vehicle and/or other form of transportation. In the space provided next to the boxes, describe the reason for the referral. For example: √ ☐ Health Well baby check up and immunizations
- Check the box if there are additional instructions attached to the referral.

Plan of Action:

- Service Provided by Referral: Type or write in the type of service provided, i.e., Screening, Assessment, Consultation, Physical, Evaluation, Office Visit, Food, Clothing, Education, Income Assistance, Counseling, Housing, etc.
- Check the appropriate boxes for the appropriate responses. For Timelines indicate the approximate completion dates.

Follow-up:

- Indicate the date of the follow-up and the specific action taken. Follow-up on all referrals within two weeks of initiation with person you made the referral for and possibly the agency you referred to. You may need to date and re-date this section until the referral loop has been completed.

Family Feedback:

- Include the families' assessment of the services they received as a result of the referral if any, or why they did not follow-up.

Parent and Staff Signatures:

- Have the parent/caregiver sign the referral whenever possible. Staff signature will be required prior to making the referral.

Appendix O: First 5 Kings County Contact Form

Service Date: ____/____/____ Begin Time: _____________ am / pm End Time: ________________ am / pm

Participant Name: _______________________________________ ☐ Head of Household ☐ Additional

Participant Name: _______________________________________ ☐ Head of Household ☐ Additional

Please list Head of Household Participant Name below, if service being recorded is for an additional participant.

Head of Household Name: ____

SERVICE TYPE: PLEASE CHECK ALL THAT APPLY

	Child Development Services		**Health Related Services**		**Family Support Services**
	Developmental Screenings/Assessment		Healthcare Enrollment		Food
	Developmental Services		Immunization		Clothing
	Recreational/physical activity		Health Education		Transportation
	Family Literacy Activity		Health Screening		Housing Assistance
	Kindergarten Preparedness Activity		Mobile Health Services		Employment Assistance
	Childcare Services		Medical Care Access Assistance		Immigration/Citizenship
	Child Development Activity		Mental Health Access Assistance		Tax Preparation
	Childcare Resource & Referral		Vision Care Access Assistance		Money Management Assistance
	Child Development Education		Dental Care Access Assistance		GED Classes
			Immunization		ESL Classes
			Car Seat Distribution		Adult Literacy Services
	Parenting Services		Nutrition Education		Legal Assistance
	Parenting - Individual		**Other Services (specify)**		Domestic Violence Education
	Parenting - Group				Child Abuse Prevention Education
	Parent Support Group				Family Support Group
	Pre-natal & Birth Care Education				Family Recreation Activity
	Special Needs Awareness/Education				New Parent Kit Distribution
					Computer Literacy
					Non-Therapeutic Listening/Support

CASE MANAGEMENT: PLEASE CHECK ALL THAT APPLY (ONLY USE IF FAMILY IS RECIEVEING CASE MANAGEMENT SERVICES – CHECK ONLY IF SERVICE IS INCLUDED IN FAMILY PLAN)

	Initial Enrollment		Regular Services		Regular Services
	Needs Assessment (Family)		Home Visit		Money Management
	Needs Assessment (Child 0-3)		Parenting Lesson - Individual		Home Maintenance
	Needs Assessment (Child 4-5)		Parenting Lesson - Group		Childcare – In home
	Needs Assessment (Child 6-18)		Kindergarten Preparedness Activity		Childcare Enrollment
	Needs Assessment (Adult>18)		Child Literacy Activity		Welfare Benefits sign-up
			Family Literacy Activity		WIC Sign-up
	Action Plan/Family Plan		Education Assistance - Child		Medi-Cal Sign-up
			Education Assistance - Adult		Healthy Families Sign-up
	General Service Info		Section 8 sign-up		Immunization Assistance
			Homelessness Assistance		Child Enrichment Activity
	Case Management Review		Nutrition Assistance		Job Assistance
			Parent/Child Interaction Activity		Housing Assistance
	Interim-Assessment		Parent/Child Interaction Observation		Other (Specify):

CLIENT REFERRED TO: (Check all that apply) ATTACH REFERRAL FORM SPECIFYING NEED

	UCP		Health Department		Law Enforcement
	School		Medical Provider		Probation
	Pre-school		Dental Provider		Kings Community Action Organization
	Childcare Provider		Vision Provider		Parent & Me
	Kings County Human Services		Employment Development Department		Mental Health Services
	Housing Authority		Central CA Legal Services		Family Resource Center

PROGRAM IDENTIFICATION: (Check appropriate program)

	Family Resource Center		School Readiness Program		UCP
	Special Projects Initiative		Other (Please Specify):		

SERVICE SITE: (Check one only)

	FRC		School Readiness		Home		Parent & Me		Other:

SERVICE MODALITY: (Check one only)

	In-person Consultation (Scheduled)		Home Visit		Mobile Service (specify):
	In-person Consultation (Walk-in)		Support Group		Off-site Service (specify):
	Phone Consultation		Class/Workshop		Other (specify):

SERVICE PROVIDER: (Check one only)

	Program Staff		Partner Agency (specify):
	Program Volunteer		Mobile Unit Service Provider (specify):

NOTES: ____

PROGRAM NAME: ____________________ **STAFF NAME:** ____________________

Appendix P: Case Conference Form

First 5 Kings County Family Resource Center
Case Conference Form

Client Name ________________________________Staff Person:_____________

Date of Case Conference:____________________

Participants (Name/Position)	Agency/Phone	Face-to-Face or by Phone

Client Present? Yes or No

Is there a signed release for all agencies present? Yes or No

Purpose of case conference (State the facts of the case, include strengths as well as needs).

Example: Support mom in her role as a mother, employee and recovering substance abuser. Secure housing and child care and possibly mental health support. Cross-agency collaboration is necessary to fully support the family and help them succeed.

Overall assessments of client's status and current needs. Include progress in goal plan areas:

Example: Mom has a voluntary plan with Child Protective Services and is trying to provide for her three children ages 1-4 years. She works at a fast food restaurant but currently makes too much to qualify for child care subsidies and is on the waiting list for Head Start. She is also in recovery from substance abuse and has received an eviction notice from her landlord. Family is currently in crisis and needs immediate support and action. Mom has secured a job, did apply for child care subsidies and Head Start. Mom also attends Narcotics Anonymous meetings when possible. Another strength is her willingness to work with CPS on a voluntary basis and ask for assistance.

Plan/actions to be taken, by whom and timeframes:

Agency/Individual:	Agrees to:	Due date:

Staff person Signature:__________________________ Date:____________________
Supervisor Signature:____________________________ Date:____________________

Appendix Q: Case Closure Form

First 5 Kings County Family Resource Center
Case Closure Form

Name of Client:_____________________ ID #:_____________________
Case Opening Date:_________________ Case Closing Date:__________

Summarize services rendered to the client/family and reasons why case is being closed. Comment on the progress made toward goals in the goal plan. Where necessary, include provisions for continued services, listing agencies and contact persons.

Reasons for Closure:
☐ Child Aged Out ☐ Family Moved out of service area ☐ Family no longer requests services
☐ Family requires more intensive services
☐ Family is not participating in the program according to agency guidelines.
Other:
____
____
____

Services Provided and Progress Toward Goals:
____
____
____
____

If applicable, is client aware of case closure? ____ Yes ____No

If yes, how was the client notified?
____

Did you complete any final evaluation forms, referral forms and exit interview? ___ Yes ___ No

Document transfer, discharge, or follow up plans:
____
____
____
____
____

Staff Signature:__________________________Date:______________________________________
Supervisor Signature:_____________________Date:______________________________________